Nurses' Experiences of Caring for Patients and Families During the COVID-19 Pandemic: Communication Challenges

Study findings demonstrate nurses' ability to adapt and suggest ways for improvement.

Nearly two years in, the global COVID-19 pandemic continues to evolve, with profound implications for health care delivery. Caused by a novel virus known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), COVID-19 can present as mild to severe illness in people of all ages.[1] As of November 2021, the number of confirmed cases worldwide stood at nearly 250 million, with more than 5 million people dead.[2] To mitigate the disease's rapid spread and meet the public's rising health care needs, health care systems have had to shift the way care is delivered. Mitigation strategies include the practices of social distancing and social isolation. (The terms are sometimes used interchangeably, but there are differences.)

Social distancing (also called physical distancing), which involves keeping at least six feet of space between individuals,[3] is a crucial tool in containing the spread of COVID-19 in both community and health care settings.[3-5] It may also involve precluding close contact with others by staying at home and avoiding crowded places or social gatherings.[3] *Social isolation* involves having minimal social contact, often to the point of absence of social relationships.[6, 7] Amid concerns about the spread of COVID-19, the Centers for Disease Control and Prevention set forth stringent guidelines for health care facilities to restrict patient visitation, causing hospitalized patients to be separated from their families and friends.[8] But limitations to or lack of social interactions with other people has been shown to adversely affect mental health and threaten overall well-being.[7, 9, 10] Feeling socially isolated can also aggravate preexisting health issues and undermine cognitive and immune system function,[7, 10] thereby compromising a patient's ability to heal. The protective influence of relationships between and among nurses, patients, and patients' loved ones has undoubtedly diminished as a result of these mitigation strategies.

Moreover, the pandemic has created communication challenges for nurses and other health care workers, patients, and families, not only because of the need to practice social distancing and isolation, but also because of the expanded use of personal protective equipment (PPE) and virtual means of communication. As frontline workers, nurses have been markedly affected as they strive to foster and sustain strong nurse–patient relationships.

Study purpose. The aim of this study was to gain an understanding of the perceptions and experiences of nurses caring for patients and families while facing the aforementioned communication challenges during the COVID-19 pandemic.

METHODS

Study design. This study used a qualitative descriptive design. Watson's theory of human car-

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ABSTRACT

Objective: The purpose of this study was to gain a better understanding of the perceptions and experiences of nurses caring for patients and families under the COVID-19 pandemic's socially restrictive practices and policies.

Background: The COVID-19 global pandemic has affected the delivery of health care to patients and their families, with many aspects altered because of the need for social distancing, social isolation, and visitation restriction policies. These policies have created communication challenges for interdisciplinary health care teams, patients, and families. As frontline caregivers, nurses have felt strongly the impact of these challenges.

Methods: A qualitative descriptive study was conducted among 17 RNs who were caring for patients during the COVID-19 pandemic and were recruited via social media posts on Facebook, Twitter, and LinkedIn. Watson's theory of human caring served as the conceptual framework for the study.

Results: Several themes emerged regarding nurses' experiences of communication with patients and families. These include communication challenges and barriers, prioritization, integration of group communication, nurse self-reflection, and acceptance of gratitude.

Conclusions: The study findings underscore the importance of nurses' communication with patients and families under the pandemic's restricted conditions. They demonstrate the value of nurses' ability to innovate in fostering all parties' participation in the plan of care, and highlight the comfort nurses provide to patients who are isolated from loved ones. Strategies that fostered communication were identified, as were areas for further research.

Keywords: communication, COVID-19, nurses, pandemic, social distancing, social isolation, visitation policy

ing served as the conceptual framework.[11,12] In this model, all components of caring are considered vital elements of nursing practice. Caring occurs when one person connects with another by giving them authentic attention and conveying concern for their inner life.

Sample. Following approval from Villanova University's institutional review board, the research team placed recruitment posts through their personal accounts on Facebook, Twitter, and LinkedIn social media platforms, briefly describing the study and inviting prospective participants. The posts contained a link to an online survey and consent to participate and were posted three times on each platform. The posts could also be shared by site readers, which allowed snowball sampling to identify additional potential participants. Both recruitment and data collection occurred between June 24 and July 17, 2020, during the COVID-19 pandemic.

Inclusion criteria were being an RN, being English speaking, and practicing during the COVID-19 pandemic by providing patient care, regardless of whether their patients tested positive or negative for COVID-19.

Tools. The survey tool was developed by the research team. It collected demographic data, including gender, age, race and ethnicity, practice location, primary practice site, highest level of education, employment status, shift worked, years practicing as a nurse, and average number of patients cared for per shift. Participants responded via Qualtrics, an online platform. Consent was obtained first, on a separate screen, before the site proceeded to the survey questions.

The interviews used qualitative descriptive inquiry to identify the experiences of RNs who cared for patients and families under the pandemic's restricted visitation policies. The interview guide was also developed by the research team. One of us (LCC) is an expert in the field of qualitative nursing research and guided final approval of the interview guide.

Data collection. Informed consent was obtained from all participants, and participation in the study was voluntary. Semi-structured interviews were conducted by two of us (CAP, MAM) via Zoom, a virtual communications platform. Interviews lasted between 20 and 60 minutes and were held in real time. An interview guide was used for each session (see *Interview Guide*). Each interview was recorded using external digital audio recorders and then transcribed by a professional transcription service. The researchers reviewed the transcripts and compared them to the digital recordings to ensure accuracy. Participants were also emailed a summary of identified themes and asked whether the results captured the content of their interviews.

Interview Guide

1. Please share with me your experiences of caring for patients during this time of maintaining social distance.
2. Please share with me your experiences of caring for the families of your patients during this time of maintaining social distance.
3. Please share with me your experiences of caring for patients diagnosed with COVID-19 during this time of maintaining social distance.
4. Please share with me your experiences of caring for the families of your patients diagnosed with COVID-19 during this time of maintaining social distance.
5. What are your experiences interacting with patients' families after visitation policies were restricted?
   Sub-questions:
   a. How did the restricted visitation policies change the way you deliver nursing care to patients?
   b. How did the restricted visitation policies change the way you communicate with patients?
   c. How did the restricted visitation policies change the way you communicate with families?
   d. How did the restricted visitation policies change the way hospitalized patients and families communicate with each other?
   e. How did the restricted visitation policies change the way hospitalized patients and families communicate with the health care team?
6. What means did you use at your place of employment that were helpful for communicating with patients and families?
7. What means did you use at your place of employment that were helpful for communicating with families?
8. What barriers did you encounter when communicating with patients?
9. What barriers did you encounter when communicating with families?
10. Please briefly describe the population for which you are currently providing care.
11. Please describe any recommendations you have for facilitating communication with your patients' families.
12. Based on the population which you just described, what communication methods and strategies have you used when providing care to them?
13. Please describe any recommendations you have for facilitating patient communication during the delivery of nursing care.
14. What feedback from families or other people influenced the way you communicated during this time of social distancing and visitation restrictions?
15. Is there anything else that you would like to share with me?

Data analysis was done using thematic analysis, as described by Braun and Clarke.[13] This is a six-phase process "for identifying, analysing, and reporting patterns (themes) within data" that organizes and describes a data set in rich detail.[13] In our study, the questions in the interview guide served to aid in organizing the data and creating codes. Each of us reviewed the interview transcripts independently and coded the data. The team then met to discuss the codes and identify themes. Similar themes were then grouped together and discussed further until a consensus was reached.

RESULTS

Sample. Thirty-three potential participants responded to the recruitment posts and were then contacted by the research team for the purpose of scheduling a virtual interview. Sixteen potential participants either didn't respond or stated that they were no longer available or were no longer interested in participating, leaving a final sample size of 17. Data saturation (the point at which no additional or new data emerges) was reached after 10 interviews. All 17 participants were interviewed in order to allow for richer saturation and to increase our confidence in the findings.

Of the 17 nurses interviewed, 16 were female and one was male. All identified as White, and the median age was 41.5 years. Employment status of full- and part-time nurses was nearly equal. The participants represented a variety of practice sites including adult and pediatric ICUs, EDs, and medical–surgical units—as it happened, all hospital settings, although this was not an inclusion criterion. All participants were located in the United States, with 15 in the Northeast and two in the West. See Table 1 for detailed demographics.

Thematic analysis. Five themes emerged, including communication challenges and barriers, prioritization, integration of group communication, nurse self-reflection, and acceptance of gratitude.

Communication challenges and barriers. This theme was prominent throughout the participants' responses to the majority of interview questions. Participants spoke of the challenges they faced when their patients were unable to have supportive friends and family at the bedside. In general, as one participant stated, nurses made

> a proactive effort to reach out . . . and help [the family] understand that their loved one is getting good care and we're trying as much as we can to keep their spirits up.

Many participants described how they began to adapt and discover ways to connect patients with loved ones. Mobile devices such as smartphones and tablets were used throughout the course of shifts. At first, many nurses used their own personal devices to facilitate contact; over time, their input influenced their employers to provide staff with facility-issued devices. The nursing staff soon realized that teaching patients and families how to use these devices had become part of patient care. Nurses uncovered various technological challenges, particularly that of facilitating access to and participation for all parties on the same virtual meeting call. For example, as one participant said, "We have to initiate the Zoom [call] because the other person doesn't have the recording capabilities if they are not the host." Family members often asked that a Zoom call be left open for long periods, just hoping they could be with their loved one. Such situations often posed a dilemma for nurses, who were trying to coordinate and provide care to multiple patients while also meeting the psychosocial needs of patients and family members.

Participants were very aware of the need for family members to check on their loved ones and monitor what was happening, albeit from a distance. As one said, "They just wanted to see into the room and check on them all the time." Another said,

> There is a lot of time spent on the phone giving patient updates to family, family asking questions, obviously having a hard time understanding what's actually going on with their loved one.

The variation in access to smartphones and tablets was also acknowledged: "Not everybody is privy to a smartphone and texting." Older patients frequently needed a nurse or nursing assistant to help them connect with a friend or family member using unfamiliar technology. A participant commented, "Technology worked well and so that was good for the younger population, but [for] the older population not so much."

Table 1. Participant Characteristics (N = 17)

Characteristic	Value
Median age, years	41.5
Gender	
Female	16
Male	1
Race	
White	17
Ethnicity	
Not Hispanic or Latino	17
Primary practice site	
Critical care	6
Maternity/neonatal	1
Telemetry	3
Emergency	2
Pediatrics	2
Medical–surgical	1
Case management	1
Wound and ostomy	1
Highest level of education	
Associate degree	1
BSN	13
MSN	3
Employment status	
Part time	7
Full time	10
Years practicing as a nurse (median)	15.41
State of practice	
California	1
Colorado	1
Connecticut	1
Delaware	1
District of Columbia	1
New York	3
Pennsylvania	9

Some barriers to communication were physical in nature. One of the most frequently identified was PPE. Participants reported that the masks muffled their voices and altered acoustics; one commented on "the loss of touch" as a barrier to communication. If a patient or family member had compromised hearing, PPE added to the difficulty. As one participant said,

> For anybody that was hard of hearing . . . it's hard for them to hear you to begin with. You often feel like you're yelling at these patients.

Participants observed that patients with hearing loss struggled to take in and comprehend information spoken by the nurse, which made it harder for them

to participate in their care. In some cases, the nurses had difficulty hearing patients who couldn't verbalize their needs clearly because of severe pain, confusion, sedation, cognitive impairment, or other serious injury.

Environmental barriers to communication were also noted. One participant said, "We couldn't visually see [our patients] on some units because . . . [there] was a wooden door that was closed." Others described the impact of reconfiguring or repurposing units for designated COVID-19 patients. A participant described how the facility had moved patients with COVID-19 to units with glass walls so that staff could have "quick eyes" on them. While the nurses were glad to have the view into patients' rooms, some expressed guilt about spending more time looking in rather than being physically present at the bedside. Such barriers made it harder for nurses to communicate closely with patients, as well as with family members and other health care providers.

Some barriers were not so much physical as situational. A particular barrier that participants noted involved interacting through a patient's designated contact person. Often a multitude of family members would call seeking information and updates about a patient's condition, and exceptions to going through that contact person were made. This was done primarily in response to specific patient requests. For example, a patient might have named a daughter as the contact person, but at some point might ask the nurse to "tell my son what is going on." Exceptions weren't always possible. One participant reflected,

> We've had people call where it's like, the son calls but they're not listed as a contact, and we [have to] say, 'We can't really tell you anything. You have to call your sister or . . .'

Language and cultural barriers were also identified. Communication was more difficult with patients who spoke either little or no English. Translator services were used in such cases as needed. One participant described caring for a patient and family that traditionally did not use any technologies or mobile devices; but when the patient was hospitalized during the pandemic, they all had to begin using a phone to communicate.

Prioritization. This theme reflects participants' felt need to prioritize devoting time and other resources to patient communication. The nurses recognized the importance of human contact for their patients, who were being deprived of unrestricted talk, touch, and the presence of families and friends. Some participants expressed guilt for not spending more time at the bedsides of patients with COVID-19. They talked about the need to constantly assess patients' needs and desires and quickly identify which were paramount. One nurse described the inner conflict:

> We have iPads that we can FaceTime family members with, but that's really difficult. . . . I feel like I have to let people talk to their families, but I also am sacrificing time doing other parts of my job in order to sit there.

As hospitals shifted toward social isolation and restricted visitation policies, the nurses in our study adapted how they communicated.

The topic of death was common throughout the interviews. Many nurses expressed great concern about end-of-life care for their dying patients, often commenting on the role of technology. One participant described time spent "updating families when their family member was very close to death. . . . One patient passed away while we were on FaceTime." Another participant said,

> All the families I interacted with on the FaceTime calls were . . . grateful to be there at a time of imminent death. They were so grateful that I don't even know how to describe it. I think FaceTime is just huge because it helps you [the family member] feel like you're there.

And another participant reported,

> We had one family with about 20 people around the country, and they were beyond grateful they could be on the same call from different areas in the country and see [the patient] . . . and he died 30 minutes later.

Some participants, in caring for patients who were dying but didn't have COVID-19, reported prioritizing having a nursing aide sit with the patient to help them use a tablet or smartphone to connect with their families.

Integration of group communication. This theme concerns the need for nurses to bring people together to interact and exchange information. Facility isolation and restricted visitation policies separated patients from their families, causing increased anxiety and fear. Nurses worked to bring them together using virtual means of connection; in many cases nurses also worked to integrate family members into health care rounds. It was common for the study participants to speak of the value of having designated times for communication, an initiative that was largely driven by the nursing staff. In general, the nurses accepted responsibility for initiating communication between patients and their family members; patients and health care providers; and family members and health care providers.

Group communication was frequently noted when a patient was near the end of life. One participant described how "one patient passed away while we were on FaceTime, actually, saying the rosary." Participants spoke of how technology helped them to bring patients and families together virtually at such crucial times. The health care teams frequently discussed the elements of effective communication with families. One participant reported, "The teams always talked after rounds, and they say 'Who is going to call the family?'" Another said, "It was definitely in everyone's mind to call them and inform them, more than I ever noticed before." This team communication helped keep families updated:

> Family members could call us, at any time, but they didn't do that a lot. I feel like they didn't call a lot, maybe because the team was talking to them more.

Nurse self-reflection. This theme emerged as many participants spoke of using self-reflection to determine what actions they could take to ease the hospital experience for patients and families. They expressed concern about the barriers interfering with essential nurse–patient communication; during the pandemic it became harder not only to keep hospitalized patients and their families updated, but also to provide education about postdischarge care and services. A participant noted, "It's more of an effort, more [need] for being vigilant and understanding, and you just had to do it." Another said, "I had to be very clear and very specific in my communication, also very open."

Participants also spoke of the inner strife they felt when people came to the hospital to see a patient and asked them to make an exception to the visitation restrictions. In such instances, the nurse tried to balance the need to maintain pandemic policies with the need for human compassion. Several participants reflected on this. For example, one stated, "I think [the interaction] was a more meaningful experience because we could really empathize with them not being able to be with their family members"; another stated, "I had to be more empathetic and flexible."

Participants understood the severe effects of social isolation.

Acceptance of gratitude. This last theme stems from the participants' experience of the appreciation expressed by patients and family members. Often, this served to increase their motivation to meet their patients' needs and the families' concerns. As one participant stated, "Their appreciation and gratitude encouraged me to continue." Such expressions also helped the nurses to recognize how important the emotional comfort they provided was, especially given the pandemic's social restrictions and isolation. Moreover, participants reported that family members' acknowledgement of and gratitude for the care being provided indicated to the nurses that they were indeed doing everything they could for patients.

DISCUSSION

In the interviews, it was clear that participants understood the severe effects of social isolation, not only on patients and families, but also on the delivery of health care. Good communication among all parties is vital to ensuring positive patient outcomes. Yet during this pandemic, social isolation and restricted visitation policies have led to markedly fewer in-person opportunities for such communication. Despite the challenges, the reported actions taken by participants to adapt and sustain means of communication and connection reflected their caring.

Our findings indicate that the need for nurses to incorporate technology into health care delivery is paramount. Writing before the pandemic, Sitzman and Watson emphasized the use of text, audio, and video technologies to facilitate interac-

tions in a digital world.[11] In our study, participants used devices such as smartphones and tablets and streaming platforms such as Zoom and FaceTime to do so to an unprecedented extent. Using technology to facilitate communication in itself wasn't new; it's been used by nurses to communicate with patients with speech impairments,[14] as well as with chronically ill homebound patients[15] and their family caregivers.[16] But the pandemic has required further adaptations. For example, study participants made use of their personal devices (as well as those provided by the health care system) to facilitate communication. Over time, participants also expanded such use to make it part of everyday nursing care, thus helping patients to maintain connection with their support systems and nurses to deliver caring as well as care to both patients and families. In a study conducted during the pandemic by Ong and colleagues, the researchers concluded, "The technology enabled us to provide more humane care."[17] Montauk and Kuhl have advocated that communication-related technology "be incorporated as early into care as possible" to help ease families' suffering at being separated from an ill loved one.[18]

Several participants mentioned the element of time. The use of technology often meant that, besides providing patients with the physical care they required, the nurse was now often the sole facilitator of communication. Moreover, participants reported having to teach patients and families how to use available devices and platforms, and some nurses had to learn more themselves. All of this took time. A better understanding of the education and support a bedside nurse needs in order to use technology efficiently and effectively is important and should be built into future standards of care. After the pandemic, the use of communication-related technologies will most likely expand further. Ong and colleagues have called for such postpandemic use to facilitate care coordination, telehealth consults, and patient education, as well as to provide comfort and even entertainment to hospitalized patients.[17]

Several participants reported on the challenges of communicating through PPE. As others have noted, wearing full PPE can "significantly reduce the clarity of verbal communication . . . [and] it may be more difficult than usual to read nonverbal cues."[19] This has never been more apparent than during the current pandemic. Health care professionals in several countries have reported significant difficulties in hearing, seeing, and communicating while in PPE.[20,21] This can lead to altered situational awareness and the potential for inappropriate care and negative patient outcomes.[21] For example, delays caused by altered communication and decreased situational awareness could lead to worse outcomes for patients needing urgent care. More training in effective communication while wearing PPE is essential.

The nurses in our study cultivated emotional sensitivity, not only to patients and families, but also to themselves.

Moreover, the separation of patients and families may have long-term ramifications. Montauk and Kuhl have described the trauma experienced during the current pandemic by families who weren't permitted to be present with loved ones admitted to ICUs.[18] For family members physically separated from a loved one during critical events such as birth and death, it can be harder to understand and accept what happens, leading to a lack of closure.[18] Participants in our study recognized this and strove to connect patients and families using virtual means. Montauk and Kuhl also cautioned that it may be too overwhelming for some people to witness what a critically ill loved one is experiencing. They recommended that family members be assessed for potential trauma and posttraumatic stress disorder. In our study, several participants described including family members in virtual end-of-life communications; but none reported addressing the potential for a family member to become overwhelmed or further traumatized.

The timing of interactions between health care providers and patients and their families was frequently discussed by participants. They described using technology to incorporate families into patient care. This included highly emotional situations, such as end-of-life, and those when families "needed to see" the care being pro-

vided to their loved one. Several nurses expressed how much they liked having a scheduled time for communicating with a patient's family and a nurse or nursing aide whose role was to facilitate this communication. Participants felt this gave them more time to be fully present at the bedside with the patient.

Limiting patient visitation was problematic and especially distressing for nurses. One participant stated that their facility primarily served a lower income population, with many single parents taking care of multiple children. Because of visitation restrictions, there were times when only one adult, but no siblings, would be allowed to visit a sick child. This often meant that the child had no visitors because the parent couldn't leave the other siblings alone at home; and if the parent did visit, the nurse felt troubled about how childcare was being provided for the siblings. At the same time, as Valley and colleagues have noted, underserved communities may have less access to technology, and restricted visitation policies may worsen preexisting health care disparities.[22] Valley and colleagues advocate consideration of the ways "restricted visitation and changes to communication practices might unintentionally foster poor health outcomes, inequity, and animosity toward health care."[22]

Despite communication challenges and restricted visitation policies, study participants recognized patients and families' needs for connection and quickly adapted to using other means to make this happen. That said, a few participants voiced a sense of relief or ease at not having family members physically present at the bedside. These nurses spoke of how this gave them more time to focus on the patient without distraction. It was interesting to learn that some nurses preferred not having families at the bedside, as this was not found in the literature.

While all areas of health care have been affected by altered visitation policies, critical care units caring for large numbers of COVID-19 patients are among the most strongly impacted. Bowman and colleagues have reported that, as a result of knowledge gaps and resource uncertainties, frontline clinicians "experience distress during patient and family conversations."[23] In a related letter to the editor of *Intensive and Critical Care Nursing*, Negro and colleagues acknowledge the challenges of using virtual means to connect ICU patients with family members.[24] They provide a checklist for use with video calls that incorporates many of the elements our study participants described. These include assessing family members' readiness to connect, designating a time for connecting, and using a team approach that includes the patient. Negro and colleagues also suggest some additional steps, including determining whether children will be on the call, asking the patient whether they want to connect, assessing the call's impact on participants, and assessing the patient for potential fatigue or distress during the call.[24]

Participants clearly understood the heightened need for self-reflection and compassion as part of care delivery.

One participant described fear and its impact on nurses personally, as well as its consequences for nursing practice. Indeed, as the current pandemic has spread, so has fear—fear for oneself and one's families, friends, and coworkers; and in communities and health care settings.[25] The nurses in our study cultivated emotional sensitivity, not only to patients and families, but also to themselves. A further step might be to allocate time during huddles or shift changes to check on nurses' emotional status and promote supportive resources that might be available for them.

As Jennings and Yeager have noted, in contrast to past outbreaks of serious diseases like Ebola, COVID-19 has spread across much larger populations and has been far less contained.[25] As we went to press, the virus continues to spread, and it seems likely that health care professionals and systems will be dealing with its impact for years to come. The results of this study underscore the importance of meeting the communication needs of patients, families, and health care professionals, even as social isolation and visitation policies fluctuate in response to local conditions.

Limitations. Although we attempted to recruit a nationally representative sample by using social media platforms, there were undoubtedly practicing nurses who weren't using social media during the recruitment period. Moreover, the study occurred

during the first months of the pandemic, and many nurses may have simply been too overwhelmed to respond. Another limitation is the homogeneity of the gender and racial and ethnic characteristics of the sample. All of the participants identified as White and non-Hispanic; and all but one were female. Future research should revise recruitment strategies to include more demographically diverse populations.

CONCLUSIONS

The study findings captured the communication experiences of nurses working during the global COVID-19 pandemic. As hospitals shifted toward social isolation and restricted visitation policies, the nurses in our study adapted how they communicated with patients, families, and other providers. Many participants reported initially using their personal mobile devices, and described how facilities quickly began to provide and support additional technological equipment. The findings demonstrated the importance of delegating a member of the health care team to facilitate communication with families. Participants also clearly understood the heightened need for self-reflection and compassion as part of care delivery, particularly under necessarily restrictive policies that kept families from being at a loved one's bedside.

More research is needed to identify which communication strategies are most effective under pandemic conditions, and what nurses and other providers will need to implement them. Specific areas for study include further examination of the use of virtual patient–family visits, the provision of adequate logistical and technical support, the mitigation of physical barriers (such as PPE) to communication, and the impact of adding staff such that nurses have time to provide meaningful updates for patients and families. ▼

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