



Family Integrated Care for COVID-19 – Frequently Asked Questions

Q1 What is FICare and why is it so important right now?

FICare is a model of delivering care in neonatal units which empowers parents to be primary caregivers, working as equal partners with staff in the care of their baby. This partnership includes involvement in decision making for their baby as well as active participation in many care tasks (e.g. mouth care, nappy changes, warming milk, testing gastric pH, holding syringes, giving oral medications and supporting babies during procedures with comfort containment). FICare is recognised to improve outcomes for babies and parents, including increased breast feeding and earlier discharge home.

The current COVID-19 crisis is placing our health service under unique pressure and the benefits of shared working with parents who receive appropriate training and support is valuable for both families and staff. However, we do need to be mindful of the additional pressures on parents in the context of the current pandemic; including increased anxiety, limited access to their baby and potentially less opportunity for training from a reduced workforce.

Q2 How should we manage parental access during this time?

Mandated changes to all hospital visiting in the context of COVID-19 have impacted on parental access, however it's important to remember that parents are not visitors but key partners in their baby's care. We recommend risk assessing the situation and trying to negotiate a policy where at least one parent can be present for as long as possible within current constraints (meaning both parents can have access but taking turns). Compassionate exceptions to reduced parental access should be facilitated, for example during end of life care.

Parents should receive clear instructions from the unit on to how to practice hand hygiene and how to follow Public Health guidance. Siblings and other children should not visit, except in exceptional circumstances, as they carry a risk of transmitting the virus even if well. Available family rooms should be prioritised daily for parents in greatest need. Parents may also need support with travelling to the unit, but family members helping with transportation should not visit the unit.

Q3 How can we minimise the impact of enforced family separation?

The impact of limited parental access and government directives to stay at home will add to the stress of a neonatal stay. This should be acknowledged by staff and novel ways to support families developed. The use of secure video messaging services (e.g. vCreate) will be essential for parents, extended family and friends to continue to engage in their baby's progress. With careful data protection advice (no patient identifiable data, no other babies/staff in view etc) parents can use video calls such as FaceTime and WhatsApp. Other local digital communications should be utilised to support excluded family and friends e.g. non-visiting parent recording a story to be played to the baby.

Parents who are following advice to isolate due to suspected or confirmed COVID-19 should not access the unit. The psychological impact of this separation from their baby should not be underestimated and supportive resources that parents can access from home should be sign posted.



Q4. How can we support family wellbeing at a time of heightened anxiety and uncertainty?

Acknowledgment of heightened levels of stress during this time with the offer of psychological and faith-based services, may provide a valuable outlet for parents. More than ever it will be vital for parents to express their fears and desires to care for their baby, so offering additional communication tools may be of benefit here; e.g. use of a cot side white board, communication cards and proactive questions may facilitate discussion. Where parents express concerns about health care professionals touching their baby increasing the risk of COVID-19 infection, provide reassurance and support parents to take over as much of their baby's care as possible using the FiCare teaching resources on your unit.

Q5. How can we best disseminate information in a timely and effective way?

Information and advice around best practice is evolving rapidly and it can be challenging to ensure that staff and parents are up to date. Avoiding the additional stress of inaccurate or inconsistent information for parents should be a priority. Social media has a valuable role to play sign posting staff and parents to up to date announcements online; examples include the Websites of professional bodies such BAPM, RCOG, RCPCH, local WhatsApp groups, local Hospital Intranet. However, it's important to remember that not everyone has social media, and this often includes the more vulnerable groups e.g. those where language is a barrier. In this situation staff may need to proactively contact families and/or consider the use of available translation services.

Q6. How can FIC help us prepare for staff shortages?

Neonatal units will face staff shortages during the COVID-19 pandemic. Potentially there may be shifts when recommended staff to patient ratios are not achievable. FiCare enables parents to perform many of their baby's care tasks potentially sharing the workload with the staff. Parents should be appropriately trained and supported to perform these tasks and their competency evidenced via a learning journal or booklet, which allows the bedside nurses to assess daily where parents are in their journey, and what tasks/skills they can perform.

However given the speed of change precipitated by the COVID-19 crisis, the pressures on staffing and limitations imposed on parental access perhaps the most important things we can do is use the FiCare model to facilitate earlier, supported discharge, acknowledging that community services are also under severe pressure. Some novel approaches are being taken such as establishing emergency network regional community teams.