Evaluation of the Family Liaison Officer role during the COVID-19 pandemic

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ABSTRACT

Communication within healthcare settings is often a subject of contention for patients' families at the best of times; however, contention was greatly magnified in the United Kingdom by restrictions on hospital visitations during the early stage of the COVID-19 pandemic. To support communication between families and patients, a central London hospital introduced the role of the family liaison officer (FLO). This study was designed to evaluate the rapid implementation of the FLO and to explore potential for it to become a standard role. Semi-structured interviews were conducted with five FLOs and seven colleagues who had worked alongside them between April and June, 2020. Two versions of the role emerged based on FLOs' previous background: clinical (primarily nurses) and pastoral (primarily play specialists). The FLO became a key role during the pandemic in facilitating communication between patients, clinical teams, and families. Challenges associated with the role reflect the speed in which it was implemented. It was evident to those in the role, and clinicians who the role was supporting, that it had potential to help improve hospital communication and the work of healthcare staff beyond the pandemic.

Introduction

COVID-19 was declared a global pandemic in March 2020 by the World Health Organization.[1] In preparation for the first expected peak of the pandemic, the National Health Service (NHS) in the United Kingdom mobilized emergency protocols to engage the surge in admissions. This resulted in many staff being redeployed to combat the developing pandemic and restrictions being placed on movement throughout hospitals. Among these restrictions was a strict limitation for visiting patients admitted to hospital wards. This limitation was put in place to reduce the spread of the virus to both healthcare workers (HCWs), inpatients, and the general public and to protect the available stock of personal protective equipment (PPE) and COVID-19 diagnostic tests.[2] Pragmatic decisions were needed to ensure policies of social distancing and control of the virus. Because transmission of COVID-19 can tran-

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Key words: COVID-19; patient; family; communication; support; improvement.

Acknowledgements: We would like to thank our staff who took the time to participate in the study.

Contributions: All authors were involved in developing the protocol. LH and LA co-ordinated the running of the study. LH was responsible for data acquisition. LH and RMT contributed to the analysis and drafted the manuscript. All authors critically revised and approved the final manuscript.

Funding: No funding was given for this evaluation. The hospital supported LH to conduct the study. RMT is funded through UCLH Charity and is a National Institute for Health Research (NIHR) Senior Nurse Research Leader. The views expressed in this article are those of the author and not necessarily those of UCLH Charity, NIHR, or the Department of Health and Social Care.

Conflict of interest: The authors declare no conflict of interest.

Availability of data and materials: All data generated or analyzed during this study are included in this published article.

Ethics approval and consent to participate: This project was assessed as being service evaluation according to the toolkit published by the English Health Research Authority (HRA). As such, no formal research ethics approval was required.

Informed consent: Written informed consent was obtained from a legally authorized representative(s) for anonymized patient information to be published in this article.

Preprint: An earlier version of this paper was made available as preprint before peer review as: Hughes L, Anderton L, Taylor RM. Evaluation of the Family Liaison Officer (FLO) role during the COVID-19 Pandemic. medRxiv 2021.05.18.21256801; doi: https://doi.org/10.1101/2021.05.18.21256801

Conference presentation: This study was presented at the Royal College of Nursing (RCN) International Nursing Research Conference 2021 on 9th September 2021 [virtual conference]

Received for publication: 16 November 2021.
Revision received: 13 May 2022.
Accepted for publication: 18 May 2022.

Qualitative Research in Medicine & Healthcare 2022; 6:10287
doi:10.4081/qrmh.2022.10287

spire among asymptomatic patients, screening tools to moderate visitation often added to already stressful circumstances. While it was recognised that limiting visitors would add to anxiety already felt among patients and their families during this period, the global risk framework ultimately accepted the inherent uncontrollability of the situation as taking precedence.[2-4]

Despite the pragmatism of visitation policies, restricting support from family or caregivers has serious implications—not just for the emotional and mental wellbeing of patients, but also their physical health.[5] The incorporation of family members into a patient's care has always been a complex issue in healthcare, as it requires a balance between the family's need for information and access to their loved ones, on one hand, and medical teams' often time-sensitive management of respective cases, on the other.[6] Indeed, family members often play key roles in supporting patients in areas where healthcare staff are less available, such as at mealtimes or during times of anxiety and distress.[7,8]

In particular, communication between the healthcare team and their patients' families is a significant factor influencing patient experience and one which is frequently a source of contention and complaint.[9] Families frequently enter a space of liminality and powerlessness when a loved one is admitted to hospital and can feel further marginalized by the communicative approaches (or lack thereof) taken by healthcare staff.[10,11] However, in recent years, a shift has been made towards both patient- and family-centred care, focusing on communication and collaboration between patients, families, and the multidisciplinary team (MDT).[12] Emphasis is placed on the family as a crucial component for developing short-term and long-term care plans, with an emphasis on clear communication.[5]

Adding further complexity to the difficult balance, COVID-19 has deeply impacted communication between healthcare workers (HWCs) and patients' families. In the early stages of the pandemic, with so much uncertainty abounding, hospital communication necessarily became focused primarily on the physical needs of patients, leaving families without knowledge of their loved ones' emotional wellbeing in a time of great distress.[13] Due to the overwhelming nature of the first wave of the pandemic, family-centred care was not seen by some critics as a priority, despite it being an essential cornerstone of healthcare.[13] At the same time, research (e.g., Rose et al.) demonstrated that making a conscious effort to maintain communication with families during the pandemic was a necessary, protective factor for both patient and staff wellbeing.[14] In particular, it was found that having tailored support for families from a designated staff member was of enormous benefit.[15]

An example of such tailored support is the family liaison officer (FLO)—a role traditionally seen in police departments and school systems. The aim of the FLO is to improve and mediate communication for service users and their families, building a bridge between families and professionals to create more fulfilling relationships.[16] An adaption of this role was introduced at a central London hospital in the early stages of the first wave of the pandemic in March, 2020 to facilitate family and patient communication while restrictions were in place. It was created by the patient experience team within the hospital who sought to counterbalance the impact of visitor restrictions for inpatient care during a time of heightened stress.

FLOs were assigned to in-patient wards caring for patients presenting with acute COVID-19 infections to help maintain contact between patients and their families, while also supporting families with updates in a variety of forms. The aim of this study was to evaluate this new FLO role in light of emerging studies suggesting potential for a role like the FLO to become embedded in standard practice outside of pandemic protocols;[13-15] therefore, we asked the following questions: How well was the FLO role functioning? Should the FLO role be incorporated into the workforce on a routine basis, and if so, how? Because the FLO was a new role established rapidly during the early months of the pandemic, it was important to understand what worked well, what did not work well, and how the role was experienced by individuals performing it and those who worked with them.

Materials and Methods

Participants

Our initial goal was to recruit all nine staff members who had been redeployed to the FLO role during first wave of the pandemic, along with a convenience sample of 10 HCWs who had worked with them in the clinical area. One member of the research team emailed the FLOs and the HCWs who had worked with the FLOs to invite them to take part in the study. Of the original nine FLOs, five agreed to participate; three were nurses, and two were play specialist/youth workers. Seven HCW colleagues agreed to take part: two medical consultants, three ward sisters, and a two-person, volunteer service/patient experience team. The age range for the FLOs who were interviewed was 20 to 40 years, while the age range for their colleagues was 30 to 45 years. The FLOs had mixed levels of experience working in healthcare, with some as little as a one year and others with over five years of experience in a healthcare setting. Their colleagues tended to have over five years of experience working in the field. All of the FLOs who were interviewed were female as were the majority of staff ultimately redeployed to this role who were not interviewed. Among the colleagues we spoke to, one of the consultants was male while the other was female, the ward sisters were all female, and the volunteer team members were also both female.

The Health Research Authority (HRA) has the Re-

search Ethics Service as one of its core functions, and it determined the project was exempt from the need to obtain approval from an NHS Research Ethics Committee.[17] Approval for the evaluation was nevertheless given by the hospital's Research Governance Manager. The purpose of the evaluation was explained to the participants through a video call, and then they were given the opportunity to ask questions. If they agreed to continue, they were asked to give a recorded consent. All participants were able to stop the interview at any time and were assured of anonymity and confidentiality.

Data collection

Semi-structured interviews were conducted through online video software. To avoid bias, data were collected by an evaluation team consisting of redeployed researchers from the cancer clinical trials department. The interview guide was developed by the evaluation team through open discussion with the patient experience team who managed the FLO role during its inception and deployment. Interviews were conducted by a member of the evaluation team with experience of qualitative interviews with HCWs and a background in mental health to ensure that participant wellbeing was a priority during the interview. Consent for the interviews to be recorded, for the use of quotations, and the use of an artificial intelligence (AI) transcription service (otter.ai) were all provided at the beginning of the interview. Interviews were between 40 and 60 minutes. Both FLO interviews and their colleagues' interviews encompassed seven key topics: the day-to-day running of the role, positive elements of the role, negative elements of the role, effects on wellbeing, efficacy of technology, the relevance and future of the role, and general reflections on the role.

Data analysis

Completed transcripts were anonymised by removing any identifiable information such as names, job titles, and ward locations. Data were analysed using framework analysis developed by the National Centre for Social Research (NatCen) as a method for facilitating analysis by multiple researchers and to ensure rigour throughout the analytical process.[18]

The five-stage process began with familiarisation wherein the lead researcher gained a thorough knowledge of the contents of the transcripts by repeatedly reading the transcripts and listening to the recordings. The second and third stages consisted of identifying a thematic framework and indexing, i.e., deductively specifying codes and applying the codes to the transcripts. The initial framework was developed from the interview schedule to provide the main themes, followed by examination of the transcripts line-by-line so that all relevant sub-themes were identified and tagged. Other sub-themes emerged from subsequent transcripts so that the framework evolved until there were no new emerging themes or sub-themes. In the fourth analytic stage, we developed a grid chart for each main theme, entering key words, phrases, and/or quotes that related to the sub-themes along with respective reference line numbers from the transcripts. In the final stage, we mapped the range and nature of the experience, looking for associations and explanations (i.e., concordance and divergence in experience based on data recorded on the grid).

FLO and colleague interviews were analysed separately using the same framework, and their perspectives were synthesised at the point of interpretation. This enabled divergences in their perspectives to emerge. The framework was created by two researchers, with one performing the analysis of the matrix which was independently reviewed by a third for consistency.

We established methodological rigour in our analysis by using a semi-structured guide for the interviews and by empowering participants to expand on their responses according to their personal experiences (applying Beck's concept of "credibility").[19] To ensure fittingness of the findings, the secondary analysis included a purposive sample of FLOs and colleagues who delivered the service or worked alongside them. To ensure the auditability of the findings, framework analysis was used, which enabled multiple researchers to review the coding to check for accuracy of the interpretation.

Results

Three key themes emerged from the interviews of both the FLOs and their colleagues: *the role*, *the impact*, and *the future*.

The role

The *role* theme had five subthemes: *role interpretation, professional background, personal skills, role boundaries*, and *preparation*.

Role interpretation

Two distinct perceptions of the FLO emerged through the interview process, hinging on how the individual interpreted the role of the FLO and usually based on the respective FLO's previous professional background. For the purpose of identification, we will refer to these groups as the "clinical FLO" and the "pastoral FLO." Clinical FLOs were redeployed from healthcare roles (i.e., clinical nurse specialists and research nurses) and put emphasis on liaising with patients' families, providing medical updates, and acting as a conduit between the medical team and the family unit. Clinical FLOs tended to be based on the higher needs wards such as the High Dependency or Intensive Care step down units. These FLOs took a medical team approach to the role, attending ward rounds and liaising with the ward team. They helped to support patients communicating with their families, be it helping set up video/tele-

phone calls or through more interactive support based on patients' needs. As one clinical FLO described her role:

> I'm going on the ward round with them, knowing exactly what was going on with the patient and then sort of dividing up the work for who needs to be contacted by a doctor and who could be contacted by the family liaison officer. Whereas I know some of the other FLOs did it differently on different wards.

Of the five FLO participants in this study, three were clinical FLOs.

Clinical FLOs helped with supplying provisions and comforts to patients—e.g., specific food items—though some did report that they were unsure if this was a part of their role. The clinical FLO role, in general, was performed differently on each ward, so there was a degree of variance in their approaches; some clinical FLOs were more involved in the medical updating of families and dealing with the communication for end of life (EOL) patients or discharge, with others being more focused on patient support.

Clinical FLOs and their colleagues noted that having the time to talk through detailed patient care plans in more accessible ways led to patients feeling more involved and aware of their own treatment. It was felt that this level of detail and time spent with patients was not easily afforded to ward teams in normal practice, as a FLO colleague explained:

> I think if that role had been given to […] a lower banded role that had less nursing or medical knowledge […] I'm not sure it would have been as effective. I think the fact that it was a senior nurse that knew what she was talking about […] had that kind of background knowledge.

In contrast, the two pastoral FLOs among the participants came from a non-clinical background (play specialism and youth work) and tended to focus more on holistic and pastoral patient care (e.g., decorating a patient's room). They tended to liaise with families, but did not provide medical updates—not feeling confident or best placed to do so. However, they did provide daily social updates in terms of patients' wellbeing and comfort and updated families on how they were spending their time. The pastoral FLOs put emphasis on keeping patients engaged, comfortable, and stimulated during their admission. These FLOs spoke mostly of spending time with patients by the bedside to help mitigate loneliness and boredom and providing elements of pastoral care, for example:

> We would […] do newspaper round, then we'd do a little tea round and […] see who wanted to speak to their families […] sitting with them, helping them if they needed help eating their lunch, because a lot of them did need help with that. And then in the afternoon, we tried […] to do at least one, like, focused activity a day. So whether that was […] bingo […] a ward quiz […] painting […] making stuff for their grandkids […] we tried to sort of do one activity a day, so they had something to focus on in the afternoon.

In some ways it appeared that the clinical FLO may have been more focused on the families and communication element of the role, while the pastoral FLOs were more concerned with the patient's experience. This may have been influenced by their previous roles. Regardless of background, all of the FLOs played key roles in building relationships with patients and families—roles that were viewed as crucial and useful by the ward staff. Likewise, FLOs of either background took on important roles in supporting communication with families—including EOL patients—and advocating for the needs of their patients. The colleagues of the FLOs all found the role very useful and complementary to their ward teams. In particular, colleagues of clinical FLOs found that having a consistent touch point for family communication was time efficient for both the families and the ward team alike, for example:

> It was very good for time efficiency […] to actually spend time phoning each family member […] was really quite time consuming, big time efficiency saver for us as doctors. So on a practical level that was really important for us.

Another FLO colleague concurred:

> Having that insight from the FLOs was really valuable. They would pick up on all sorts of things that, you know, we just wouldn't either get from the patients because they don't feel it's relevant to tell the medical team about a certain kind of social situation or something […][W]e found out a lot more about their home situations.

Similarly, having a member of staff with insight into patients' individual home lives was useful for care planning and discharge; this advantage was reported by colleagues of the pastoral FLOs as well. Although FLOs did not handle medical updates, their colleagues found social updates for families very helpful in easing anxieties and that engagement of patients throughout the day had a positive effect on patient morale and, subsequently, on the morale of the ward staff.

Professional background

Backgrounds of clinical FLOs were viewed as essential for understanding patient care, helping patients understand their own treatment plans, and being able to give

meaningful updates to families. Clinical FLOs felt not having this background would make the role difficult. FLOs who were originally senior nurses felt that even nurses who did not have as much medical experience were likely to struggle. In particular, it seemed having a background in the ward speciality was key; a FLO placed in a surgical ward with a surgical background, for example, felt it would be difficult to work there without insight into the minutia of the ward's functions. As one clinical FLO explained, "I felt like if I hadn't had those experiences, it would have been very difficult to explain to patients what was happening." Another clinical FLO agreed:

> A FLO who did not have any medical background […] expressed it was difficult for her [pastoral FLO] to get into the medical side of things, so she didn't have that understanding. So she was asking us, you know, so what does that mean [...] She was […] struggling a little bit.

This difference reflected the clinical FLOs' interpretation of the role being based on providing medical updates to families, in contrast to the Pastoral FLOs who approached the role from a different perspective. Further evidence of this interpretation could be seen in one clinical FLO's experience when their ward reverted from a COVID-19 ward to its original medical department, which she had little experience with. Without much knowledge in this area, the FLO struggled with how to support families—a contrast to the pastoral FLOs who focused solely on more personal, day-to-day updates.

It was also noted by the clinical FLOs that having some level of seniority within the hospital was useful. Key professional skills that clinical FLOs felt were useful included risk assessment and accountability and awareness of how to communicate appropriately with families, e.g., knowledge about how to communicate concerns of patients and families within the correct channels: "It was quite difficult to have the conversations because I didn't really know what the tests were, things I hadn't heard of before," as one clinical FLO put it. Another explained:

> From my experience, and I think as a nurse, you know, everything you do, you're accountable for. You would risk assess it. If someone asked for something and you think "Oh, actually, this wouldn't be right to do this to this patient." […] [Y]ou'd have to know how to escalate them properly. I suppose as a nurse, you know all of these things.

On the other hand, pastoral FLOs did not feel confident about giving medical updates to families. Instead, these FLOs brought their skills of engaging patients to the role, providing holistic and pastoral care, helping with meals, sitting with patients to give them company and emotional support, and trying to keep patients engaged by having daily activities to prevent boredom and loneliness. These FLOs seemed best-placed for care of the elderly as opposed to be being placed on the more intense medical wards such as the High Dependency Unit or surgical wards. Their background in play and youth engagement, for example, was shown to have a high level of transferability to working with patients experiencing dementia or delirium.

Colleagues of clinical FLOs agreed that a medical background was an essential element of the role and that a level of seniority within the hospital was desirable. It was noted that similar roles had been unsuccessfully attempted before using less qualified and less experienced staff. Most agreed that while a nursing background was not always necessary, having some clinical knowledge would be important if the role was to be implemented as standard. This was felt to be a critical skill enabling the FLO to understand patients' circumstances and health status, to give meaningful updates to families, to help patients better understand their treatment plans, and to have an awareness of what level of detail was appropriate to communicate to the family.

On the other hand, colleagues also valued expertise brought to the role by pastoral FLOs. For example, some colleagues said that it was important for FLOs to have some experience with emotional support. Colleagues of pastoral FLOs also felt that the role highlighted a missing element of geriatric care; specifically, they did not feel that giving medical updates to families was as essential as providing social updates for this client base who tend to be in hospital more long-term, with less immediate risks.

Personal skills

Important personal skills for a FLO were unanimously agreed upon by clinical FLOs, pastoral FLOs, and their colleagues. It was agreed that being a good communicator was essential, particularly knowing when to speak and when to listen. Being a caring, compassionate, empathetic, flexible, and a dynamic person were also attributes that were noted to be important. As one colleague put it, the role needed: "Innate kindness, some patience […] understanding and kind of just being empathetic." Another colleague spoke about skills required in tense situations: "Good negotiating skills, because we do get relatives who are very angry about not being allowed in to visit. And we have had situations particularly out of hours, where it's been really uncomfortable."

Similarly, some FLOs (both clinical and pastoral) as well as their colleagues, noted that having skills in conflict resolution and de-escalation were very important, as they were often dealing with very distressed family members, particularly regarding adherence to visitor policies. Resilience was also noted as a key skill, given the emotional nature of working with critically ill patients who were frequently distressed, isolated, and anxious.

Role boundaries

FLOs appeared to struggle initially with their role, as there were no clear boundaries, duties, or line management for them on the wards. Many felt they had been given little preparation before being thrust into the role. A clinical FLO noted that "There wasn't a lot of organization; it was just sort of […] thrown into it to see what we could do," and another said:

> They don't know actually what your role is. They think you're looking after the patients. So instead of the nurses looking after the patient and us being present, we had to explain that over and over. I felt like every time I had to explain what my role was, what I was doing here.

Many of the wards were made of teams comprised of newly deployed staff who were unfamiliar with their coworkers or the clinical setting, and with no induction, introduction, or clarity of responsibilities, FLOs found it difficult to establish themselves. Some noted that other staff would frequently ask them to carry out tasks that were not outside their professional remit, but were outside the parameters of the FLO role (e.g., those with nursing backgrounds being asked to check control drugs).

Setting professional boundaries seemed to be an individual task—meaning that some FLOs carried out some activities that others did not—which could potentially have resulted in inconsistent care. Many described feeling distant from the rest of the ward team and not knowing where exactly they fit. The lack of a clear line of duty for the role also meant that some FLOs were unsure if their duty of care was primarily with the families or with the patients; although they all eventually began to focus on both the patients *and* their families, this expectation was unclear in the initial stages of their deployment.

This ambiguity could be stressful for the FLOs in a time that was already generally difficult for many staff "[e]specially at the beginning to see how each other were doing it because none of us really knew what we were doing. And there was no job, no real job plan," as one clinical FLO explained. Some FLOs mentioned conflict with management who they felt were taking a hard line on visitation policies, recounting how they advocated for their patients. A clear benefit for these FLOs was meeting with other FLOs to discuss their roles, allowing them to develop their skills and methods as a group.

FLO colleagues noted boundaries were not always clear for them either. In particular, they did not know to what extent a FLO should be expected to communicate medical information to families, such as breaking bad news. The majority of ward-based colleagues felt this was something that was the responsibility of the doctors. Overall, most medical staff believed that the more serious medical updates should come from the medical team and not the FLO, but that a certain level of routine medical updates on patients' status was much appreciated by families and could be effectively provided by the FLO. One colleague described the ambiguity inherent in the, as yet, unclear communication protocol: "It is good for efficiency for the doctors, but at the same time, I'm not sure it can completely replace the primary medical team communicating with the family, especially around the more difficult and complex decisions."

Ethical boundaries for communication were also discussed by both FLOs and their colleagues. For example, there were no guidelines on how to react in some situations regarding privacy for EOL patients who were communicating with family members online who, in turn, were bringing other family members to join the call without the patients' consent. Likewise, clarity was needed on what the safeguarding for both staff and patients would be in scenarios where families wanted to speak with a patient, but the patient did not want to speak with the family. To protect the rights of all parties involved, some guidelines on this would need to be introduced.

Preparation

No training or preparation was provided prior to being redeployed into the FLO role. Some of the FLOs felt that there would have been no time, while others wished they could have been prepared more. Two of the three clinical FLOs felt that in the future non-clinical staff could be given enough training to help them understand the basic clinical knowledge to provide similar support; however all three agreed they would not be able to be trained to the degree of knowledge clinical staff would have. In general, FLOs felt very unprepared for their redeployment and were given little to no time to prepare for the role before it began, as a clinical FLO explained:

> It was very chaotic at the start, so it was very quick to happen. So it was sort of […] I got a phone call, I think on the, it was like Monday or Tuesday, and then the role started two days later. So it was very quick.

Overall, redeployment was a stressful and chaotic time for everyone.

FLOs struggled with not having a timeframe to know how long they would be redeployed for, and when the role ended, there was no clear transition back into their previous roles which was equally difficult. A clinical FLO, for example, said:

> I think the uncertainty of being redeployed like that, that was a really strange feeling and not knowing when I'd go back to my other job and how long redeployment would last so it's quite, there was quite a lot of feelings.

For their part, ward colleagues agreed that they had little preparation to receive the FLOs on the ward without a spe-

cific brief or formal induction of the role. This caused some initial confusion, and it was felt that more structure for the role was needed for them to know how best to lean upon the FLOs and utilize them to their capacity. For example, one colleague noted that they were unsure how much they needed to communicate with the FLO throughout the day, and this caused some miscommunication of tasks. While all the interviewed colleagues felt the role had been a success, they also agreed that for the sake of both the ward team and the FLOs, a formal induction to the role would be necessary next time. As one colleague put it:

> When they arrived on the ward, we couldn't really tell them exactly what we wanted because we weren't sure ourselves. But they managed to work out and do some trial and error and work out the best way to do things.

The impact

The theme of impact had two subthemes: *staff wellbeing* and *patient and family experiences*.

Staff wellbeing

The onset of COVID-19 was a stressful time for everyone: a wave of adrenaline proceeded widespread emotional exhaustion. FLOs struggled with the liminal space of their redeployment and not having any clear plan about when they would return to their old roles. Some FLOs felt isolated and would have preferred more clinical supervision. The work with COVID-19 patients was described as being particularly draining as the unknown nature of the virus and the critical level of sickness that affected some patients meant that many patients experienced a turbulent medical journey. The nature of the FLO role meant that staff became quite close to patients and their families so that they inevitably were taken along patients' journeys as well. FLOs from both clinical and non-clinical backgrounds were no strangers to complex medical journeys or EOL patients; however, the mercurial nature of COVID-19 saw patients vacillating between extremes of health, which had a notable impact on the staff, as a clinical FLO reported:

> When they were discharged, I felt really emotional, which I was quite confused about how that felt. I thought I should feel really happy. But I think it was just, you know, you've seen people really sick, and then they bounce back, and you do have that really close contact with the family. So you feel for them, you feel empathy.

Elements of burnout were noted among interviews with FLOs, particularly with regard to patients and families experiencing extremes of undulating health during their admission. Some FLOs found support more useful in their own teams, while others did not feel comfortable in group psychology sessions with their team or attending sessions from home due to their family being present. Clinical FLOs often found support among other FLOs. Pastoral FLOs, on the other hand, were largely contained within their own team, which had pre-existing support sessions, and they frequently engaged in these on the ward.

Fears over transmitting the virus to family members were also a cause for concern. Some FLOs noted that during the initial stages of the pandemic when it was "all hands-on deck," there was no room for seeking psychological support, but when numbers of patients reduced considerably, staff felt stranded in an uncertain space waiting to be deployed back to their original roles. This was the time when they experienced more complicated emotions, as described by a clinical FLO:

> The thing that caused me the most stress was not knowing how long I'd be redeployed for […] and like knowing at any stage, because I remember being really anxious before I was redeployed, and then I was for about two weeks I felt OK […] Then I thought, oh, gosh, this is gonna happen again, because I need to get back to my old job […] That's more about redeployment than the FLO role to be honest.

FLOs' colleagues also agreed that the pandemic had been an arduous and exhausting period and that FLOs had the added emotional burden of dealing with distressed family members. They also felt most support had been internal within their teams. Some colleagues felt that the role of the FLO took on some of the extra burden of emotionally supporting patients, which facilitated time for the ward team to be more engaged in time-sensitive care. Other colleagues maintained that even with the presence of the FLO, it was inevitable that they, too, would take on the emotional burdens of patients.

Patient and family experiences

All FLOs discussed supporting their patients in a variety of ways. As discussed, the clinical FLOs tended to focus first on the medical communication aspect for families and then on patient support, while the pastoral FLOs focused primarily on direct patient support (i.e., sitting and speaking with patients, providing them with entertainment) and providing day to day updates to family on their wellbeing. All the FLOs noted the number of fatalities were difficult for them to deal with, as they were more emotionally involved with their patients in this role.

Family visitation was a particularly troubling issue for FLOs and patients alike. While visitors were not allowed in the hospital, changes were made to the rules for patients who were receiving EOL care. This was something some of the FLOs were instrumental in advocating, as they were acutely aware of patients' and families' enhanced psychological and emotional needs at the time. Speaking of the

pastoral FLOs, a colleague working in elderly medicine noted:

> I suppose it was applying what they normally do in paediatrics to geriatric care for the purposes really, and keeping people cognitively stimulated. Patients were happier, and staff were happier as a result.

All FLOs noted the difference even small comforts could bring to patients' experience of hospital care and felt that the role generated many experiences of meaningful work. FLOs' colleagues found this facet of the role invaluable for patient-centric care, and having a role specifically mandated for giving patients the time and care that the ward staff simply did not have time for was seen as hugely beneficial for patients, families, and staff. Furthermore, colleagues reported that FLOs built up good rapport with patients and that they were an essential point of insight into patient's individual circumstances, nuances, and needs, for example:

> Dealing with difficult […] distressed patients dealing with distressed relatives, and you know, some relatives' expectations are one call a day, one call a week. Some relatives […] we have them queuing outside the hospital waiting […] Their level of anxiety was, you know, off the scale.

In terms of family support, FLOs perceived that the onset of COVID-19 was an extremely distressing time for families of patients due to both the risk of death from the virus and strict rules about visitation. FLOs felt that anxiety was particularly high if they were not stationed on the ward over the weekends, causing families to wait for extended periods without substantial updates.

FLOs were instrumental in helping families communicate with patients throughout this period, particularly so for EOL patients. FLOs reflected that staff often promised to return to speak to them, but often became busy. As a result, the patient and family were left with unresolved anxiety and stress. FLOs were important for bridging this gap in care. The role gave families structure for when and how they would be contacted and a person they could contact when needed, as a FLO's colleague reported:

> The biggest frustration of relatives certainly at the moment is the nurses change each day, because they're all doing shifts, so they don't get to speak to the same nurse twice. And the nurse in-charge phone, which is currently their only contact with the ward, is used as kind of as a clinical liaison phone, so has multiple people trying to get through at all times, and relatives can't get through. Whereas there was a dedicated phone that the FLOs had. The relatives knew […] they would get to speak to someone who knew their patient.

Families differed in how much contact and updates they wanted, and FLOs were able to identify and cater to these needs. In particular, pastoral FLOs provided social updates to families that were also useful for easing anxieties, helping families to see patients were comfortable and even in some cases, enjoying their experiences on the ward.

The future

All of the staff redeployed to the FLO role felt it was an important role and should be continued where possible. Consistency of care was identified as a clear benefit by having the same staff based on the same ward to help build rapport and trust with patients, family, and clinical staff. Many experienced deeply meaningful moments in their role, including making significant connections with families and patients. For example, a pastoral FLO described the powerful experience of working with an elderly patient who thrived in the care of the paediatric team:

> [T]hey had a patient that they said was palliative […] they took him off end of life […] once we started spending time with him daily, like we'd spent a good couple of hours, keeping him busy, like doing his hair in the morning, like getting him back into a routine. He left the ward six weeks after […][H]e said that they should rename the ward a holiday camp […][H]e thought it was really great.

Similarly, FLO colleagues felt the role was valuable, agreeing that having a consistent member of staff was useful for families to contact and build a relationship, especially among the most at-risk populations. As one colleague put it, "If you've got a patient population that's very vulnerable and very complex, and fairly elderly […] those kind of wards is where they'll be very valuable." Typical routines of ward staff within a hospital can conflict with interests of families, such as repeatedly changing the roster of nurses, which can be frustrating for families. Again, consistency is crucial. Indeed, when FLOs returned to their original roles, ward staff struggled to keep up with the demand of the communication needs of families. As one colleague said, "We're finding increasingly that the communication with families is really difficult at the moment when visiting isn't back up [permitted]. I think actually the role itself was so good."

Clinical staff who work primarily in adult medicine were particularly impressed with the system of care provided in paediatrics and how this could be transferrable to other areas of the hospital—particularly elderly care, given the depth of research about how keeping patients stimulated via music or art or other activities can be beneficial. One colleague, for instance, praised FLOs by saying, "I feel like it was like revolutionary geriatric care."

All FLOs agreed that the role had a definite place in

the future of hospital care, but it needed proper formalisation and induction for the ward staff and consultants. Training was recommended for FLOs without a clinical background to support them in engaging with low tier clinical updates. Alternatively, the role could be separated into different roles: one that focused on medical updates and another that could focus on patient support.

Discussion

Interviews with FLOs and their colleagues indicated that the role of the FLO was valued by healthcare professionals working in frontline COVID-19 areas where there were restrictions to visitors. Early in the COVID-19 pandemic, healthcare teams were unable to provide the level of communication required by affected families, so the FLO role was implemented to ensure channels of communication were in place to prevent family distress and dissatisfaction. The new role was also to support clinical staff in reducing the moral distress of delivering patient care when direct links to families was necessarily limited.

The role was implemented rapidly, with no policy in place so that nurses and youth worker/play specialists who acted as FLOs were initially unclear of their role; similarly, healthcare teams were unsure of what the FLOs' responsibilities were. However, over time, as FLOs became embedded within the team, the benefit for acting as a conduit for information between the healthcare team and the family, on one hand, and a link between patient and family, on the other, became evident. An unexpected finding was the added benefits that those without a medical background brought to the role, providing stimulation to patients who would have otherwise been left to provide their own divertissement.

It is particularly worth noting that FLOs relied heavily on each other as a support network to manage the uncertainty of their new role. This reflects aspects of Brasher's Uncertainty Management Theory,[20] in which individuals develop strategies for emotional responses to ambivalent situations. This is a positive sign, as staff members were able to come together for social support in the face of difficult and trying circumstances, mostly of their own accord. A less positive outcome was that both clinical FLOs and pastoral FLOs were not integrated well by their management; moving forward, it would be necessary to make sure all staff working as FLOs are connected to the whole team in order to avoid FLOs feeling isolated or marginalized. This would have diminished responsibility of the FLOs developing and establishing the role themselves while simultaneously performing it and dealing with the difficulties inherent to redeployment.

Besides becoming smoothly assimilated into the healthcare team, FLOs should be prepared to deal with extreme stress associated with the role. Folkman and Greer's framework for coping with illness[21] provides useful suggestions for maintaining psychological wellbeing in roles such as the FLO, especially during healthcare crises. This framework posits that feelings of distress and upset are common human experiences in the face of adversity, and rather than seek to remove them, it allows the individual to accept that these emotions are not signs of weakness. The framework focuses on maintenance of positive attitudes towards difficult tasks and finding a sense of purpose. We can see this reflected already in how FLOs approached their work—work that was emotionally distressing, but ultimately meaningful and rewarding—thus functioning as a protective and motivating factor. This form of resilience could be further developed in formal FLO training.

Overall, the FLO role was shown to be valuable during the early stage of the COVID-19 pandemic. Much evidence has shown that effective communication is an essential element of family-centred care and that families' involvement in care is essential for ensuring care meets patients' needs.[13] This was recognised as a challenge during the pandemic as most healthcare organisations or government policies required visitation reduction or suspension.[22-25]

Limitations

The current study has a number of limitations. First, we were only able to engage five of the nine members of staff who had been in the FLO role in a single setting. The four FLOs who were not represented may have not agreed to participate because they had a different perspective of the role that they were not willing to share, so we could potentially have a biased view of the role. Similarly, we were only able to interview seven colleagues who worked alongside the FLOs, so there could be other viewpoints not captured in these data.

Second, this evaluation focused on the FLOs who were based on wards impacted by COVID-19, not in the critical care or emergency departments. These other departments had their own internal systems akin to the FLO, and they conducted their own evaluation specific to their own services. A comparison between these services and the FLOs found in this evaluation and in other settings would therefore be of interest for future work.

Finally, the benefit to patients and families is from the professional perspective, which does not necessarily reflect the experiences of patients or families. In order to fully understand the value of the FLO role, exploration from the perspective of patients and families is therefore something recommended for future research.

Despite these limitations, this evaluation illustrates significant benefits in providing a dedicated role to maintain and improve communication between healthcare teams and families during a healthcare crisis. While this is a single centre evaluation, other organisations may recognise similar experiences and so will be able to apply knowledge gained to their practices if they see the day-to-day value in the role.

Conclusions

The FLO role was introduced into clinical practice out of necessity. Results of this study strongly suggest that the role should be a staple of pandemic protocols. Furthermore, there is compelling evidence for the FLO to be a standard role within the NHS and not just during an emergency. Similar studies have found similar outcomes, particularly in reference to having fixed staff members to carry out the FLO role.[14-16] Similar studies also endorse the use of more widespread communication training for HCWs, as previous findings have shown that many nurses find it more difficult to integrate psychosocial care into their interactions with patients and often default to communication styles which are more centred on physical health rather than a more holistic perspective of patient wellbeing. This is an area HCW often feel more prepared, knowledgeable, and comfortable speaking about.[26] This was replicated to some degree by the experiences of the clinical FLOs compared to the pastoral FLOs in terms of how they both interpreted and approached the role. This research shows that there is potential for both roles to inform one another moving forward.

Epilogue

This report was written based on the early development of the FLO role at the beginning of the COVID-19 pandemic in March 2020. The role of the FLO has evolved throughout the pandemic in relation to the data provided in this initial report and the changing needs of services. In its initial inception, the FLO role was carried out by redeployed staff; this is no longer the case. With redeployed staff recalled to their original positions, the role was taken on by volunteers.

In line with our evaluation, the role was revised to make sure that all new FLOs had clear responsibilities, an induction to ward teams, competent and frequent training sessions, and a clear emphasis on a network of peer support between the volunteers and their central coordinators. The FLO was again requested by many of the wards who had a FLO assigned to them in the early stages of the pandemic, including elderly care and higher dependency units. The role of the FLO has become a hybrid of the clinical and pastoral FLO roles described in this evaluation, with an emphasis on maintaining family contact during inpatient care and with most inpatient wards covered for a seven-day period.

However, as the FLOs are now primarily volunteers with no background in clinical or medical care, they are no longer able to provide the medical updates to families that the clinical FLOs were able to provide, nor are they able to take the time to discuss patient care pathways in much detail. Equally, the role is a considerable time commitment for volunteers, and given its sensitive nature, recruitment to the role has had to be quite selective. As time has progressed, rules around visitation have also changed in reaction to COVID-19, and FLOs are now required to take on administrative tasks that were not initially a part of their role.

There are some preliminary conclusions we can make from this trajectory. It is clear that the role is desired by the ward teams. Many of the factors that made the role difficult and uncertain have been addressed, and it is also clear that the FLO is recognized as a member of the wider multidisciplinary team. However, continuing the role as a purely voluntary position is likely to lead to its underutilization. The ability of the clinical FLO to provide medical updates and to spend time explaining patient care pathways was a vital element of its success in its first incarnation. The structure and network of the FLO has been established, but considering the patterns noted in this study, for the role to have longevity, it would merit consideration as a full-time occupation, rather than depending on volunteer altruism.

There is evidence that the FLO is desirable in healthcare[13-15] and adapting this role outside of the pandemic could be a critical step toward improving communication with patients and families, increasing the opportunity for them to be involved in decisions about their care moving forward. It should no longer be a question of whether the FLO role is useful, but rather how we can ensure the FLO role *remains* useful.

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