

LASTING LEGACY IN INTENSIVE CARE MEDICINE



Visitation policies in the ICU and the importance of family presence at the bedside

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The relationship between hospitals and family/caregivers has evolved significantly over the past 200 years. Nineteenth century hospitals adopted a practical dynamic and tolerated visitors, since they often assisted with feeding and general patient care [1]. In the late nineteenth century, hospitals transitioned to a more rigid organizational structure [1], which included strictly prescribed visiting hours in adult and pediatric hospitals. This was in response to medical and nursing staff concerns that visitors may disrupt daily routines, introduce alcohol/tobacco or other prohibited items, and promote transmission of infection. Intensive care units (ICUs) initially embraced this tradition of strict visitation with similar concerns that family/caregivers may disrupt the provision of care, promote undue physiologic stress for the patient and result in exhaustion for the family [2]. These practices were informed by opinion and historic policies rather than evidence.

The cultural shift to patient- and family-centered care has fostered a research agenda that evaluates the benefits of family presence in the ICU. Family/caregivers are defined as those individuals who are essential to the care of the patient and are not merely “social visitors”. The term restricted visitation refers to limitations on timing, duration, or number of visitors. Flexible visitation observes some restrictions but can be altered according to the needs, choices and specific circumstances of patient and hospital. Open visitation generally describes visiting of any duration allowed at any time. Flexible ICU

visitation hours decrease anxiety, increase satisfaction and improve well-being for patients [3]. The attenuation of symptoms of delirium associated with the presence of family at the bedside has been reported in observational studies [4] but not replicated in a randomized controlled trial [5]. Empowering families and engaging them in the care of their family member allows for improved communication and enhanced relationships with the medical team. Flexible visitation decreases anxiety and depressive symptoms in family/caregivers [5] and, although it may be associated with increased psychological distress for ICU nurses [6], has been overall perceived to be beneficial by the healthcare team [6, 7]. Considering this evidence, ICUs worldwide gradually changed their visitation policy allowing for an increase in family presence over the past two decades.

Perhaps the greatest evidence for the benefit of open visitation policies arose from the restriction of visitors at the onset of the coronavirus disease 2019 (COVID-19) pandemic. Given the uncertainty of transmission risk of COVID-19 among visitors, patients and health care workers, most international health care systems introduced some form of restriction on visitation. The well-being of the individual patient was balanced against the societal responsibility to prevent further transmission of SARS-CoV-2. In addition, the limited availability of personal protective equipment (PPE) at the beginning of the pandemic further justified a restriction in the number of visitors to hospitals. Guided by the ethical principle of maximizing net benefit and minimizing harm [8], visitation was restricted to limit further preventable spread of COVID-19.

As the pandemic evolved, medical information accrued rapidly, vaccines became available, and community prevalence of COVID-19 decreased. Evidence emerged showing that visiting family members/caregivers did not pose a high risk for further transmission of COVID-19 [9].

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Most hospitals did not distinguish between essential caregivers and general visitors and failed to acknowledge the important emotional impact and advocacy role essential caregivers have for patients and the paucity of evidence to support true harm related to visitation.

Restrictions on visitation impacted the health and well-being of patients admitted with COVID and non-COVID related diagnoses, as well as the wellbeing of their families and the overall provision of care over a wide range of healthcare facilities [10]. Early data support an impact of restrictions in visitation on mental health outcomes, quality of life, well-being, and coping—for patients, their families and members of the healthcare team [11]. Isolation from family has particularly injurious consequences on palliative and end-of-life care. Nuanced, complex goals of care conversations are challenging when essential caregivers cannot be present at the bedside. Not being able to say good-bye has been described by families as “stolen moments” [12] and may contribute to complicated grief in family members.

Despite this evidence, many hospitals remained very cautious and delayed in re-integrating family/caregivers in the delivery of care by de-adopting restrictive visitation policies [13]. There is no scenario for which the current literature supports a complete restriction on visitation [14]. Upholding the focus on patient and family centered care should be foundational for any framework guiding changes in visitation policies. Existing limitations in visitation hours should be reviewed and carefully deliberated among all stakeholders: policy makers, hospital administration, patients and community representatives. A process should be implemented to draw a clear distinction between family/caregivers and social visitors. The reasoning for any restrictions in visitation hours should be communicated in a transparent and public form. Restrictions should be proportional, time limited and subject to frequent responsive adjustment. A clearly delineated appeal process should be communicated to the public. An exemplary framework incorporating these considerations has been established by the Canadian Foundation for Healthcare Improvement and includes: ensuring a foundation of patient- and family-partnered care; revisiting policies on family presence in collaboration with patient, family and caregiver partners; distinguishing between essential family caregivers and visitors; consideration of those who face specific risks in the absence of family presence and ongoing comprehensive, balanced risk assessment; establishment of a rapid appeal process and a commitment to increase the evidence regarding effects of family presence in the ICU [15].

The COVID-19 pandemic highlighted the unintentional consequences that restriction in visitation may have for the psychological health and well-being of

patients, families, and health care workers. Restriction on visitation needs to be proportional and policies require real-time and responsive adjustment according to public health needs balanced against harm imposed on patients and families. Adhering to a framework based on the fundamental tenant of patient- and family centered care, which allows for patient and family insight to be incorporated in the decision-making process, can be a step to inform future decisions around visitation policies.

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