CHEST

Family Presence for Critically Ill Patients During a Pandemic

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Family engagement is a key component of high-quality critical care, with known benefits for patients, care teams, and family members themselves. The COVID-19 pandemic led to rapid enactment of prohibitions or restrictions on visitation that now persist, particularly for patients with COVID-19. Reevaluation of these policies in response to advances in knowledge and resources since the early pandemic is critical because COVID-19 will continue to be a public health threat for months to years, and future pandemics are likely. This article reviews rationales and evidence for restricting or permitting family members' physical presence and provides broad guidance for health care systems to develop and implement policies that maximize benefit and minimize risk of family visitation during COVID-19 and future similar public health crises.

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Critical illness has lasting effects on patients and their families long after the illness episode.[1-3] Family members of critically ill patients themselves frequently experience symptoms of depression and traumatic stress.[1] Family-centered care improves quality of critical care and the experience for patients and families.[2,4] Over the past two decades, ICUs have made significant progress toward family-centered care, including building the evidence base and implementing effective approaches.[2] Central to this progress has been the designing of structures in which family members are an integrated part of the critical care team rather than visitors; such designs include open visitation, inclusion in interdisciplinary team rounds, participation in direct caregiving, frequent communication, shared decision-making, and opportunities to be present during resuscitative efforts.[2] In-person family presence is a key facilitator of these family-centered care practices.

However, the emergence of the COVID-19 pandemic in 2020 resulted in deimplementation of family-centered care because of prohibitions or restrictions on the presence of patient family members.[4-7] Avoiding gathering and maintaining social distancing have been central strategies in reducing the transmission of SARS-CoV-2, the virus causing COVID-19. The application of these principles in hospitals led to restrictions on the presence of family members.[8,9] Although such restrictions were

ABBREVIATIONS: PPE = personal protective equipment

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reasonable in the early periods of limited scientific knowledge about viral transmission, supply shortages, and rapid efforts to restructure hospitals to expand capacity,[10] reevaluation of these policies is now critical given our increased information and resources.[11-13] ICU visitation restrictions such as those enacted because of COVID-19 lead to incomplete grief (eg, inability to fully experience the grieving process)[11,14-18]; emotional distress experienced by patients, families, and physicians[11,14-23]; barriers to high-quality communication and decision-making[11,14-22,24]; perpetuation of existing inequities[11,20]; and poor clinical outcomes.[11,14,17-20,24-26] Given the serious and long-lasting harm these restrictions cause for patients, family members, staff, and communities, we believe broadly prohibiting visitation of family members of patients with critical illness, including those with COVID-19, is no longer justified.

Although improved COVID vaccine availability and decreased COVID-related hospital strain have led hospitals to relax some restrictive visitation policies, prohibitions and restrictions on family visits to patients with and without COVID-19 persist.[27,28] Because COVID-19 will continue to be a public health threat for months to years and similar future pandemics are likely,[29] hospitals urgently need to develop visitation policies that maximize family-centered care while mitigating the risks of in-person family presence to patients, family members, and hospital staff. This article provides broad guidance for hospitals to develop and implement policies that maximize benefit and minimize risk of family visitation during COVID-19 and future similar public health crises.

Common Rationales for Limiting Family Presence

During the pandemic, hospitals broadly prohibited visitation because of concerns that family members of admitted patients may transmit virus through person-to-person contact within the hospital.[4,30,31] Persistence of visitation restrictions for patients with COVID-19 reflects the desire to protect family members from contracting and transmitting COVID-19 after exposure to the infected patient.[32] However, there is no existing evidence that family members of admitted patients are a significant contributor to nosocomial respiratory viral spread, or that prohibiting visitation to patients with COVID-19 protects against viral transmission to patients, staff, or visitors.[33,34] Existing Centers for Disease Control and Prevention guidelines detail infection control processes that effectively prevent viral transmission in health care settings, particularly the proper use of personal protective equipment (PPE).[32] The increased availability of effective COVID vaccines, including for health care workers and individuals at high personal risk of severe COVID-19, have further reduced the direct risks to staff and patients.[35] Providing family members with the opportunity to discuss and judge the benefits and potential harms of visitation, using these risk reduction methods (eg, PPE use, prior vaccination, and distancing when out of the patient's room), promotes their individual autonomy.[34] Protecting families' and patients' self-determination by allowing them to decide whether in-person presence is preferred, based on their personal risk of severe COVID-19 and individual values, may mitigate against the loss of control they commonly experience during an ICU stay.[36] Health care systems and physicians may view family presence as a potential threat to resources, specifically PPE and hospital staff time. Initially, the decision to prohibit family presence reflected the primacy of dedicating space, equipment, and personnel resources to provide life-saving care to the surge of patients with COVID-19.[10,30] However, advancement in our knowledge and stabilization of resources since those early months have led to an enhanced understanding of the anticipated effect of family visitation on health care system resources.

PPE was in short supply early in the pandemic, and health care systems experienced challenges in acquiring and maintaining sufficient PPE to protect health care workers.[37,38] PPE is now more readily available and proven effective in reducing viral transmission.[32] Health care systems should incorporate the PPE needs of family members into supply chain calculations without concern for compromising the availability of adequate PPE for health care workers.

Hospital staff are a valuable health care resource, particularly during the COVID-19 crisis. Implementing processes to allow families to safely visit patients with COVID-19 will likely require additional effort by health-care personnel, specific to the need of individual sites. The additional needs might include dedicated personnel for screening and logging family members entering the hospital and assisting them with safely donning and doffing PPE. During times of extreme resource strain when no dedicated personnel are available, bedside physicians can facilitate PPE use to family members, although this should be a short-term solution if possible.

Overall, the benefits of permissive family visitation are expected to more than offset the additional personnel effort required to facilitate safe visitation.[13] Physicians are now more comfortable in caring for patients with COVID-19, and the need to simplify bedside workflow to enable adaptation to a dramatically altered environment is no longer pressing. In the typical ICU environment, there is no evidence that family presence contributes to strain.[39,40]

Benefits of Unrestricted Family Presence During COVID-19

First, the physical presence of family members enhances integration of family members into the ICU workflow. Communication strategies, such as videoconferencing processes and routinized outreach to families, have partially filled gaps left by visitation prohibitions.[4,19,22] Yet, these strategies also create demands on health care workers to facilitate patient-family connections, explain technological tools, and establish longitudinal relationships with distant family members.[41] Family-centered care guidelines support family presence during ICU rounds, and the vast majority of families prefer to be present.[2,42] In observational work, family presence was associated with higher satisfaction with care, collaboration with the medical team, shared decision-making, and facilitated information gathering for family members, with minimal additional rounding time.[43,44] COVID-era visitation restrictions lengthened ICU stays and delayed decisions to limit treatments before death.[24] Therefore, supporting family presence for patients with COVID-19 is expected to improve the efficiency and quality of relationship-building between families and the medical team and preserve ICUs and their staff as critical resources.

Second, family presence may reduce delirium, which is common among patients with COVID-19.[25,26,45,46] Delirium is associated with longer ICU and hospital lengths of stay, reintubations, ICU readmissions, and higher workloads for nursing staff.[46,47] An observational study of more than 4,500 critically ill patients with COVID-19 from 69 ICUs revealed that family visitation was associated with a lower risk of delirium among critically ill patients with COVID-19, one of only two modifiable risk factors the study identified.[26] Therefore, supporting the presence of family members will lead to multiple improvements in patient- and ICU-level outcomes related to reduction in delirium.

Finally, family presence is critical to optimizing end-of-life and grief experiences for patients, families, and physicians. For families, deaths in the ICU are associated with complicated grief, posttraumatic stress disorder, and prolonged grief.[17] This is undoubtedly exacerbated in the setting of family separation around the time of death, due to incomplete grief resulting from health care system limits on the opportunities of families to carry out mourning rituals, or doing so in an abbreviated or delayed manner.[4,15,17] Prohibiting family presence is likely to further strain the ICU workforce in the short and long term.[27] Physicians may experience secondary trauma and moral injury due to participating in separation of families during critical illness and death, which has been widespread during the COVID-19 pandemic.[5,27,48-51] Added to the already high baseline levels of distress among critical care physicians, this may contribute to long-term attrition of the ICU workforce due to burnout, depression, anxiety, and posttraumatic distress.[52,53] Supporting family cohesion during critical illness may, in turn, protect ICU physicians from psychological distress associated with their role in the care of patients with COVID-19.

Policy Recommendations

To guide health care systems in creating safe, equitable, and family-centered visitation policies, we provide a blueprint for supporting family presence for patients with COVID-19 in adult ICUs that can be adapted to the individual health care system's culture and structure (Table 1). Although these recommendations are directly relevant to pediatric and non-ICU settings as well, there may be additional considerations and logistics relevant for families of hospitalized children to respond to the children's developmental needs.

Development of equitable and acceptable visitation policies requires a diverse, interdisciplinary approach inclusive of key stakeholders,[54,55] such as patient and family advocates or representatives, community members, physicians from representative service lines, ethics staff, safety and quality experts, infection control experts, and security staff. Health care systems should leverage existing or novel community partnerships and patient advisory committees to participate in policy creation. After drafting and implementing an initial proposal, revisiting the procedures and policies can mitigate concerns through ongoing evolution and adaptation to meet or balance the needs of all stakeholders.

TABLE 1] Recommendations for Visitation Policy Design and Implementation

Development of policy
Convene key stakeholders to draft policy
Avoid policies that are highly dependent on levels of community viral transmission
Coordinate approach across units, hospitals, and health care systems
Establish and communicate plans to rapidly reassess and adapt policy
General visitation rules
Permit at least two family members per patient, including those with COVID-19
Avoid exceptions based on clinical condition or prognostication (eg, end-of-life periods)
Avoid establishing visiting hours but, if enacted, maximize hours to allow for overlap with rounds and access to family members with caregiving or work responsibilities
Entry and screening procedures
Encourage family members to make individualized decisions to visit based on personal risk of severe COVID-19, vaccination status, and values
Do not restrict visitors on the basis of relationship to the patient to promote opportunities for low-risk family members to visit rather than individuals at higher personal risk of COVID-19
Identify and mark entrances for visitors to undergo standardized screening for COVID-19
Establish a centralized visitor logging and pass process coordinated with the bedside teams
Educate visitors on safety protocols, such as universal masking and distancing, and use the built environment to encourage adherence
Personal protective equipment (PPE) use
Establish rapid N95 fit assessment protocols for visitors with local infection control
Mandate that visitors adhere to federal and local guidance for PPE use
Identify and train staff to observe visitors doffing and donning PPE
Nonphysical family presence
Support robust alternatives to in-person visitation, such as routinized communication standards and videoconferencing
Provide technology support to patients and families, particularly when restricting visitation
Communication of the policy to patients, families, and staff
Provide a clear rationale for the established policies, including the decision-making process leading to the policy
Written communication should be at a fifth to eighth grade reading level to promote public understanding
Provide information in Spanish, as well as other locally prevalent non-English languages
Navigating exceptions
Centralize visitation adjudication when possible to preserve the role of the clinical team and promote consistency and equity
Use a standardized approach to evaluate and grant exceptions that promote family-centered care and reduce moral distress while avoiding bias and harm associated with viral transmission
Other policy considerations
Visitors should not eat in the rooms of patients with COVID-19, due to inability to maintain PPE; other accommodations should be arranged
Health care systems choosing to restrict visitation to patients with COVID-19 should establish clear procedures for removing patients from isolation once no longer infectious
Clergy and spiritual leaders should not be considered visitors; visitation policies do not apply to these individuals
Hospitalized patients with disabilities may require reasonable accommodations and protections, including the presence of a caregiver. Caregivers of such patients should not be considered visitors; visitation polices do not apply to these individuals

Policies that are stable over time are likely to cause less confusion and eliminate additional strain on staff members who must learn and implement visitation procedures. Models for stable policies include those that do not need to be altered during viral surges in the community (ie, that permit visitation throughout periods of strain and to patients with and without COVID-19) or those that include planned adaptations to changes in viral spread or health care system strain (ie, with clearly communicated thresholds for procedural changes).

Policies affecting family members of admitted patients should promote a standardized experience throughout the hospitalization, including transitions between ICUs and ward locations. When possible, this should include all health care systems in a referral area, similar to processes proposed for regional allocation of scarce resources.[56] Regional coordination and collaboration across health care systems, or across entities within a single system, can improve continuity for patients and family members.

General Visitation Rules

A standard policy that permits at least two visitors for each patient with COVID-19 allows family members to provide mutual support and reduces the demands on a single individual. Flexibility and clearly delineated common exceptions should be included in the visitation policy to promote the respect and well-being of patients, family members, and staff. Adhering too strictly or too loosely to the standard policy is likely to result in distress among these groups given the complexity of family relationships and situations.

ICUs have been challenged by what has become a common exception allowing for more permissive visitation for patients at the end of life.[57] Although this is intended to promote family cohesion and grief during the dying process, the "end-of-life period" for a critically ill patient is difficult to define.[58] Indeed, family members of critically ill patients with COVID-19 experience preloss grief.[59] Because ICUs serve patients with life-threatening conditions requiring advanced monitoring and life support, rapid clinical decline is common. Even among ICU physicians, there is little agreement on when a patient is "acutely dying."[58] Eliminating the end-of-life exception protects ICU staff from the stress of prognostication errors or disagreements. Promoting family presence throughout the critical illness also prevents unintended coercion leading patients or families to choose treatment limitations for the primary purpose of reuniting and avoids missed opportunities for meaningful final connections between patients and family members that are important for the grieving process.[17,18] Further, linking policy exceptions to discretionary judgments such as prognostication may predispose to inequitable application due to implicit or explicit biases.[60] We recommend making the standard policy for family visitation, particularly in the ICU, as permissible as is feasible rather than relying on exceptions based on patient clinical conditions.

There is no reason to limit family presence on the basis of time of day in most circumstances. Providing flexible or "open" visitation reduces distress experienced by family members.[39] However, if drafting a policy with visiting hours, feedback from those affected is critical. Consider overlapping with common ICU rounding times to facilitate family member presence on rounds, which can improve the efficiency of communication and integration of the family member into the critical care team.[42] Provide family-centered times that avoid unnecessary gaps during the day and that can accommodate visits by family members traveling from long distances and those with variable work schedules or other caregiving responsibilities to avoid inequity in access.

Entry and Screening Procedures

Establish and communicate a clear structure for visitors to obtain entry. For families of patients with COVID-19, discussion with the family members of their personal risks and benefits of visitation should ideally occur before their arrival at the hospital and be based on their own health conditions, vaccination status, and values. Site-specific legal consultation can inform whether obtaining a liability release and waiver is appropriate. Visitation policies should not restrict on the basis of relationship to patient (eg, immediate family members only), to allow families and patients to identify the most appropriate individual to provide in-person support based on many factors, including personal risk related to COVID-19.

Entry procedures may include a dedicated entrance for visitors, a visitor logging process coordinated with the bedside teams, and standard screening procedures to identify visitor COVID-19 symptoms or high-risk exposures. Provide basic PPE education as they enter, using signs and other environmental cues throughout the hospital to reinforce the need for universal masking, hand washing/sanitizing, and distancing.[61] Dedicating staff to manage visitation logs, visitor screening and approvals, and enforcement of policies using deescalation techniques when necessary will reduce the potential for perceived visitation-related strain on ICU physicians.

PPE Use by Visitors

All family members present in rooms with patients must adhere to recommended PPE guidelines.[32] For patients with COVID-19, this includes N95 masking, eye

protection, and gowning and gloving. Identifying ICU staff to teach and supervise donning and doffing by family members of patients with COVID-19 is essential. Discussions with the health care system's local infection control experts should establish strategies to rapidly assess the fit of N95 models available to visitors. Visitors who are unable or unwilling to maintain PPE in place should be offered alternatives to physical presence, such as videoconferencing.

Nonphysical Family Presence

Providing robust alternatives to in-person family presence is important to ensure high-quality decision-making about the benefits and harms of in-person presence by family members and patients. ICUs should deliver family-centered care regardless of the personal situations and decisions of family members.[4] This is particularly relevant for critically ill patients with COVID-19 because family members may also have COVID-19, be under quarantine, or be at high personal risk of developing severe COVID-19 if exposed to their ill family member. ICUs should capitalize on gains made in the advancement of technological communication strategies during COVID-19 and aim to optimize family engagement through digital platforms, routinized family-physician communication, and extended bereavement support.[4,62] For example, prior work primarily in neonatal ICUs demonstrates that continuous bedside videoconferencing may improve the experiences and outcomes of family members and has no negative effects on physicians.[62-65] Further implementation of such innovative approaches to support the nonphysical presence of family members is relevant during and after visitation restrictions to expand access to family members who feel it is too high risk or who have been exposed to SARS-CoV-2. Because many families of critically ill patients may experience barriers to in-person presence because of work or caregiving responsibilities, geographic distance from the hospital, and transportation or health limitations, maintaining these infrastructures and processes of care will have lasting positive impacts even when the burden of COVID-19 subsides.

Communication of the Policy

The visitation policy itself should make the health care system decision-making process transparent (eg, who was involved in policy decisions), include a clear rationale for the policy, and express concern for the maintenance of family-centered care. These elements are important for staff as well as families and patients.

Written communication of the policy should be publicly available, including to all patients, and target a fifth to eighth grade reading level.[66,67] On the basis of the individual health care system's patient population, non-English language versions of the policy should be readily accessible. We recommend that all health care systems provide Spanish language materials because of the disproportionate effects of COVID-19 on individuals identifying as Latinx or Hispanic.[68,69]

On admission, a designated staff member or physician should explain the visitation policy to patients and family members, as applicable. Staff should recommend that family members evaluate their personal potential for harm and benefit from visiting a patient with COVID-19, as well as their willingness to take the necessary steps to mitigate risks. Alternatives to in-person visitation should be clearly explained and supported, including establishing plans for routine family-physician communication and family-patient engagement.[41] If visitation prohibitions are in place, the health care system should provide families and patients with technological resources and support to overcome any barriers to such routinized communication.[41,70]

Navigating Exceptions

Although we encourage health care systems to establish permissive visitation policies, it is still necessary to avoid gatherings of people while community transmission rates of SARS-CoV-2 are high. Therefore, visitation policies are likely to have some restrictions in place, such as the number of visitors at a time or throughout the hospitalization. Navigating individual exceptions to the policies established by the health care system requires particular attention to reduce inequity, prevent moral distress among physicians, and protect relationships. Clear processes for adjudicating and granting exceptions will help avoid conflict within clinical teams or across units.

We recommend that health care systems separate clinical teams from visitation adjudication when possible, akin to proposed allocation of scare resource plans.[56] Such centralized decision-making can preserve the clinical relationship, avoid exacerbating moral distress experienced by physicians, and promote equity.[56] However, input from clinical leaders and bedside physicians, patient advocates, and ethicists is

important to maintain acceptable and appropriate procedures. When considering a case-by-case exception to a standard policy, attention should be given to (1) what specific situational attributes make the exception necessary; (2) the potential impact on other patients, visitors, and staff; (3) whether the exception could be reasonably applied to all patients in similar situations; and (4) how individual biases influence the desire to grant an exception (A. Narva, JD, MSN, email communication, March 2021). Because biases may lead directly to perpetuating or reinforcing health inequities for disenfranchised or frequently underresourced groups, decision makers should carefully interrogate this before granting (or not granting) exceptions.

For example, consider a patient with two adult children and a spouse who requests an exception to a policy that only two family members may visit during the hospitalization. Similarly, consider an 11-year-old child who asks to visit a critically ill parent, yet a policy does not permit children under 12 years of age to visit. In both cases, the health care system could reasonably support all patients and family members being granted exceptions under such circumstances, and these exceptions would respect relationships, promote patient and family well-being, and cause little additional threat to infection control.

Other Policy Considerations

Family members of patients with COVID-19 should not eat in the patient room, as this requires removal of PPE. Consider discussions with food services and facilities staff to facilitate options for family members, such as outdoor or designated seating areas and grab-and-go or delivered meal options to avoid cafeteria exposures or congregation.

Patient- and family-centered ICU care includes meeting the spiritual needs of patients.[2] In the United States, clergy should not be considered visitors under federal civil rights protections.[71] Their access to the patient should not be restricted and they should not count toward any visitor limits placed by the health care system.

Patients with disabilities may require accommodations during hospitalization to ensure they receive a high quality of care. In countries such as the United States and the United Kingdom, hospitals are legally obligated to provide such accommodations.[72,73] This includes access to essential supporters or communicators when necessary to provide care during a hospitalization.[73] Health care systems should not consider these supportive, caregiving individuals as visitors.

Health care systems that choose to restrict visitation to patients with COVID-19 should develop clear policies and procedures for removing such patients from isolation.[74] Family members may then visit under the health care system's standard policies once the patients are deemed noninfectious.

Given existing variability in local public health regulations, health care systems may choose to consult with legal counsel to ensure compliance. However, the existing evidence and the family-centered care approach frames family members as essential to the clinical care of critically ill patients. As such, similar to health care workers, they may be exempt from some regulations limiting "congregating" to facilitate caregiving.

Conclusion

The prolonged COVID-19 pandemic has the potential to set family-centered critical care back decades through ongoing visitation restrictions, with a particularly devastating impact on patients with COVID-19 and their families. Health care systems can now leverage knowledge and evidence gained over the first year of the pandemic to promote the safe return of families to the bedside, which will promote the well-being of patients, families, and physicians.

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