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The Importance of Family Presence at the Bedside of Critically Ill Patients

A Paper Submitted in Partial Fulfillment of the Requirements

For NURS 5382: Capstone

In the School of Nursing

The University of Texas at Tyler

by

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August 13, 2023

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Executive Summary

In January 2020, our country was thrown into a global pandemic. With its rapid spread, our leaders had to act fast and make policies regarding healthcare. Not having the knowledge, we needed to stop the spread or to treat the virus, that became known as COVID-19, our nation just stopped. Groceries, gas, and other needed essentials were scarce. The only people who were allowed to continue to work were what the government called “essential workers”. Healthcare workers were scared to catch this horrible illness or bring it home to their families. With this fear came a strict visitation policy to hospitals, nursing homes, and hospices. The nursing staff was overworked and worried. The patients were critically ill and missing their families. The families were overwhelmed with grief. The restrictions lead to post-traumatic stress disorder and complicated grief (Chen et al, 2021).

The Importance of Family Presence at the Bedside of Critically Ill Patients

The COVID-19 pandemic didn't just have overwhelming cases of death, but it also changed the way healthcare was seen and implemented. Were the visitor restrictions harmful to critically ill patients? Was it ethical? These are just a few of the questions that arose from this pandemic. Hospitals and other healthcare facilities tried to accommodate communication with families the best they could, but it just wasn't enough, and it was more work for the nurse and took the nurse away from patient care to answer the family's questions on the phone. The pandemic was a trying time for everyone but if you lost someone to the virus or complications from it or just someone who was critically ill with another disease, you can understand that in the next pandemic, we need to do better. “.... cutting in and out of the room for 15 minutes through glass screens on camera watching from afar isn't the same as touching.....” (Dugdale, 2023).

Rationale for the Project

The rationale for my project started out as a personal one. After researching, I discovered that many others felt the same as my family and I did about the visitor restrictions. Yes, we are a world of technology, and we can face time, skype, and Zoom chat; but it is not the same as holding a hand, stroking hair, or just being present. Technology was better than nothing during this time; but what when technology failed? Patients' phones get lost, the patient is unable to communicate, and needs the nurse to be in the room to operate the device. These patients are critically ill, and a nurse is usually assigned to more than one. This form of communication was taking the nurse away from direct patient care; furthermore, so were the visitor restrictions. When the nurse must answer the phone many times during her shift that is time taken away from patient care. It's hard to be an advocate for your family members when you cannot have good communication with the healthcare team taking care of them.

1.1 Project Goals

The goal of this Benchmark Study is to make the stakeholders and policymakers aware of the importance of family presence at the bedside. The Benchmark Study was done instead of an implementation project due to the development of the COVID-19 vaccine. Since the vaccine, the strict visitation rules have been lifted. The hopeful goal of this study is to help prepare healthcare facilities for any future pandemics.

Literature Synthesis.

Twelve articles were synthesized for this project. The information obtained regards visitation policies of different facilities during the COVID-19 pandemic around the world. While most of the articles discussed the importance of family presence at the bedside, there were some that discussed the ethics that may have been breached by these restrictions. Most of these articles

were tied to the COVID virus but others focused on the critically ill patient and how they were affected by the restrictions. The research showed different ways that were introduced to keep communication between family, patient, and physician. These techniques ranged from electronic communication, ICU diaries, phone calls, and of course the fifteen-minute visits behind glass. The articles were written from various viewpoints, the physicians', the nurses', the patients', and the patients' families. There is not a lot of research that is from the patient's point of view because there were few who survived during this time.

Project Stakeholders

The stakeholders that need to be reached for this project are the physicians, nurses, family members, patients, volunteers, healthcare workers from other disciplines, and the facility's board. This proposed implementation would affect anyone who encounters a critically ill patient. It is important to have the stakeholders present when presenting a proposed change in policy because they are not always the ones in the specific units that are affected by visitor restrictions or the grieving families.

Implementation Plan

Every project needs a strong implementation plan. The implementation plan for this Benchmark Study is done using the ADKAR model for change. 1. Awareness-Have a meeting with the stakeholders to explain the change that would be implemented. 2. Desire-This step helps to see the stakeholders' reactions to the proposed change and to address any concerns they may have. 3. Knowledge-Show how the employee or volunteer would be trained to make the implementation a success. 4. Ability-This step would be used to have practice runs before the change was fully implemented and to monitor the process and get constructive feedback. This is also the step where reasonable goals will start, and adjustments will be made if necessary. 5.

Reinforcement-This step is to monitor the change to ensure it is working as planned. The use of positive feedback and recognition to the employee or volunteer who will be implementing the change.

Timetable/Flowchart

Awareness	Desire	Knowledge
<ul style="list-style-type: none"> • Visitor arrives at the ICU for visiting hours • CNA or Volunteer will document the patient's vital signs before going to get the family member • CNA or Volunteer watches the family member wash their hands 	<ul style="list-style-type: none"> • The volunteer gives the visitor the proper PPE to put on • The visitor puts the PPE on in the proper order as directed by the volunteer 	<ul style="list-style-type: none"> • Visitor is now escorted by the CNA or volunteer to visit their family member • CNA or volunteer documents the patient's vital signs as soon as the family is at the bedside

Ability	Reinforcement
<ul style="list-style-type: none"> • Visitor activates the call light and CNA or volunteer goes to the patient's room and assists the visitor in taking off PPE in the correct order • Visitor washes hands in the hallway and exits the ICU • CNA or Volunteer once again documents the patient's vital signs and any concerns the patient had with the visit • CNA or Volunteer gives the family member a questionnaire to fill out and return on the next visit 	<ul style="list-style-type: none"> • Monitor the vital signs for the length of the patients' hospital stay • Give positive feedback and recognition to the CNA/Volunteer • Collect the questionnaires and analyze.

Data Collection Methods

The data collection method for this Benchmark Study will be discussed in the rest of this paragraph. 1. Hire the certified nursing assistant (CNA) or Volunteer that you are going to use for the change process, (they are key to the project coming out positively). 2. Determine which patients are going to be selected for the study and which of their family members. 3. Teach the CNA or Volunteer how to obtain the patient's vital signs. 4. Show the CNA or Volunteer the questionnaire so they are familiar with it in case the family members have any questions. 5. The CNA or volunteer will document the patient's vital signs and mood before the family member is allowed in to visit. 6. CNA or volunteer will escort the family to the patient's room once all proper PPE has been donned. 7. The CNA or volunteer will document the patient's vital signs and mood upon the arrival of the family member to their bedside. 8. Family will visit until the allowed time is up. 9. CNA or volunteer will come and assist the family member in removing their PPE; observe them wash or sanitize their hands and then hand them the questionnaire. (The questionnaire may be filled out while at the hospital or at home and returned on the next visit.) 9. CNA or volunteer documents the patient's vital signs and mood after the family member has left. 10. The vital sign/mood documentation and the questionnaires are collected and analyzed to determine if the implementation was successful or not. The results should be that the patient's vital signs and overall mood improved while the family was present at the bedside. The questionnaire analyzes the family members' overall satisfaction.

Cost/Benefit Discussion

The cost will vary depending on if the person who is helping to implement the study is a certified nursing assistant or a volunteer. The CNA's pay for a daily twelve-hour shift would approximately be \$187.44, based on the average of the pay scales for area hospitals. The needed

personal protective equipment (PPE) for each visitor would approximately be \$2.51. If the patient has a family member visit at all three visitation times, then it would be a daily total of \$7.53 plus the salary of the CNA or the total if there is a volunteer.

Discussion of Results

Because this is a Benchmark Study, the results are unavailable. The outcomes that this implementation of change would bring are improved patient outcomes, uncomplicated grief for the family members, and closure in the event of the death of the patient. The patient and family would also feel that even though the patient expired, they had a good death. The research showed that one of the most common complaints from family members of patients who passed away was that they died alone.

Conclusions/Recommendations

Recommendations for the future Covid 19 Visitation Policy include the elimination of the restriction on visitors to ICU-housed COVID-19 patients under aerosol-generating treatments or procedures with guidelines for donning of proper PPE and infection control protocols. It is recommended for all stakeholders related to this policy approve and update the existing policy to reflect these changes.

This policy brief recommends changes be made to the facilities' Covid 19 Visitation Policy. Even during a national pandemic, ALL patients deserve to have in-person visitations where they can see and be touched by their loved ones. All families deserve to know that their loved ones were not alone in their fight especially if they are in their final hours together. Sometimes what is best for patients and family members is hard for staff but that doesn't mean it shouldn't be done (Rodriguez, et al., 2016).

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Appendix A

Synthesis Table

Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
Author, Year, Title	Theoretical basis for study Qualitative Tradition		Number, Character istics, Attrition rate & why?	Independent variables (e.g., IV1 = IV2 =) Dependent variables (e.g., DV =) Do not need to put IV & DV in Legend	What scales were used to measure the outcome variables (e.g., name of scale, author, reliability info [e.g., Cronbach alphas])	What stats were used to answer the clinical question (i.e., all stats do not need to be put into the table)	Statistical findings or qualitative findings (i.e., for every statistical test you have in the data analysis column, you should have a finding)	<ul style="list-style-type: none"> Strengths and limitations of the study Risk or harm if study intervention or findings implemented Feasibility of use in your practice Remember: level of evidence (See PICOT handout) + quality of evidence = strength of evidence & confidence to act Use the USPSTF grading schema http://www.ahrq.gov/clinic/3rduspstf/ratings.htm
#1 Nguyen (2021) Impact of asynchronou s electronic communicati on-based visits on clinical outcomes and health care delivery: Systematic review	None	SR 3 databas es Searche d: Medline , Embase, and	N=19 Studies Sample sizes ranged from 36- 2531	IV=e-visits DV1=Access DV2=Utiliza tion DV3=Costs	PRISMA guidelines		DV1=no difference DV2=no difference DV3=reduced for some conditions	Evidence Level I Strengths: EV may be comparable to IPV and reduce cost in certain conditions Weakness: Not all conditions can benefit from EV

		Web of Science						Recommendations: Further studies need to be performed to see if EVs are accessible to everyone because there wasn't enough evidence found.
#2 Sayde (2020) Implementing an intensive care (ICU) diary at a large academic medical center: Results from a randomized	None	RCT	60 pts enrolled and randomized, 35 pts completed PDFU, N=18 in the DIG and n=17 in the PEOG	IV1=DWPE IV2=PEO DV=PICA	Blank journals, Psychoeducation	IES-R, PHQ-8, HADS, GAD-7	DV was reduced in those who had DWPE more than those with PEO	Evidence Level II Strengths: diaries were available for families and clinicians Weakness: too many withdrawals from the program due to complications Recommendation: Future studies need to be conducted to see if better data can be provided through a follow-through program

control trial evaluating psychological morbidity associated with critical illness			Control groups					
#3 Hugelius, K. (2021) Consequences of visiting restrictions during the COVID-19 pandemic: A		SIR	DBS	DV1=HC for pt DV2= HC for FM DV3=C for the relations within the family	17 Scientific papers covering IC, PC, GMC, HC, PaIC, and NHC were reviewed by two authors	Thematic and subthematic analysis	HC for increase in body pain HC for FM=crated worries, anxiety sadness, need for more information C for the relations within the family: TC	Level of Evidence III Strengths: Brought awareness to the need for family visitations Weaknesses: Level of evidence regarding the effect of VR is low; only 2 of the 17 articles were from actual CS

integrative review				DV4=C for the provision of care			Didn't compare to SI via face-to-face or OV C for the provisions of care, increase need for HCW to provide information	Recommendation: Further studies are strongly needed.
#4 Jones-Bonfigliolo (2021) A practical approach to hospital visitation during a pandemic: Responding with	MD MI MH	Stepwise Approach	Literature search of the following databases: MedLine, PubMed, Embase,	UP=variations in the prevalence T=rapid test, verbal screening DPP=Children spared at the beginning of the outbreak SR=resources unavailable	For each of the variables, a stepwise approach to decision-making for HV was divided up into tiers	Analyzed by consensus among authors to cover MD, MI, and MH	UP=variations were noted throughout the country T=scarcity to get lacked s/s; not getting results in a timely manner DPP=only 1%-5% of the total children population tested positive SR=shortage of tests, PPE,	Level of Evidence: Level III Strengths: helped to open the eyes of the decision-maker to see the importance of family Limitations: had to be able to test out theories on more than one facility Recommendations: to allow this method into hospitals nationwide

compassion to unjustified reactions			Web of Science	IIC=communication has been confusing and information sometimes is misleading			sedatives, and ventilators IIC=conflicting reports had people scared and anxious	and adapt it to work for all patients.
#5 Fong (2020) Child and family outcomes following a pandemic: A systemic review & recommendations on COVID-	None	SR DB researched: PsycInfo, PubMed, Scopus, Web of Science, Google Scholar	DBS N=17 studies Sample size ranged 17-2,729	CO= child outcomes from the study PFO=Parent and family outcomes from the study	PRISMA protocol	Thematic Analysis	Themes: NEI CD Fear Changes in parental and professional roles Living with uncertainty, heightened vigilance, FB, and isolation	Level of Evidence: Level I Strengths: Making more people aware of the need to have good communication regarding the pandemic and how having family bedside helps alleviate some of the mentioned themes. Weakness: limited amount of time information regarding the impact of the COVID-19 pandemic; but adequate findings regarding previous pandemics.

19 policies								Recommendations: Make better use of technology for communication purposes. Emphasis on family-centered care.
#6 Inness (2022) The effect of hospital visitor policies on patients, their visitors, and health care providers during the COVID-19 pandemic: A	None	SR DB research WHOGL CDD	N=26 Sample size range 26-1214 Adult ICU, delivery, PP, NN, SX	CIP, clinicians, FSP, Communication and mental health	PROSPERO protocol SRS, Rayyan	Reviewed by 3 authors NS performed including SD, PP, HVPC, and PO	GP-neonatal, pediatric, adult CS-ICU, GFU, EOL, GCVP	Level of Evidence: Level I Strengths-systemic investigation of the available literature of HPT during the COVID-19 pandemic. Limitations: inability to assess the impact of VP on COVID-19 policies. Lack of reporting status. Recommendation: To have stakeholders take a closer look at their policies and individualize them instead of using a blanket policy.

systematic review								
#7 Dugdale (2023) Ethical guidance on family caregiving, support, and visitation in hospitals and residential care facilities, including during public health emergencies: an American College of	Justification and harms imposed by visitor restrictions	Physician Position Paper		D=CV ID=VR, F, P, HCW	A case review study done by several P who reviewed visitor policies along with ethical policies	4 positions were reviewed	1-ethical principles 2-VP 3-public health emergencies and VP 4-P advocate for patients and FM	Level of Evidence- Level IV The paper did not show any weaknesses or strengths It did show the ethical connection of strict visitor restrictions and the unintended harms that go with them

Physicians position paper								
#8 Hardin (2011) Critical-care visitation The patients' perspective	The Synergy Model for Patient Care of the American Association of Critical Care Nurses	Correlation design	n=122 men n=69 women n=54	IV=visitations Time, frequency,	11-item questionnaire	SAS Fr, %, means, medians CS CA	OV, FC, PC	Level of Evidence: Level III Strengths: by allowing the patients to have more control over visiting hours; they felt it was more beneficial to them Limitations: small sample size, only 1 hospital sampled, limited to English-speaking patients only. LOS was not considered
#9 Greenburg (2021)		QSD	n=62 UAMC	IV=participants DV=HP, M, Procudeure, Analysis	Surrogates of adult patients who were expected to require MV	Thematic content analysis	Telephone interviews Discovered four types 1- Communication	Level of Evidence- Level II The strengths and weaknesses of this study were very vague. It was unclear if more could or should have been done to support the families and patients.

							<p>with the medical team</p> <p>2-communication among FM</p> <p>3-Understanding and tracking MI.</p> <p>4-Distress related to VR</p>	
<p>#10</p> <p>O'Brien (2022)</p> <p>"We were treading water."</p> <p>Experiences of healthcare providers in Canadian ICUs during COVID-19 visitor</p>	Thematic framework	QDS	n=10 (HCP)	DV=participants IV=telephone & email	Telephone interviews and emailed questionnaires	SSI OEROQ	<p>5 themes</p> <p>14 subthemes were found</p>	<p>Level of Evidence-Level II</p> <p>strengths: having patient and FM participate in the research.</p> <p>Limitations: making sure that the patient and family voices are represented in the future.</p>

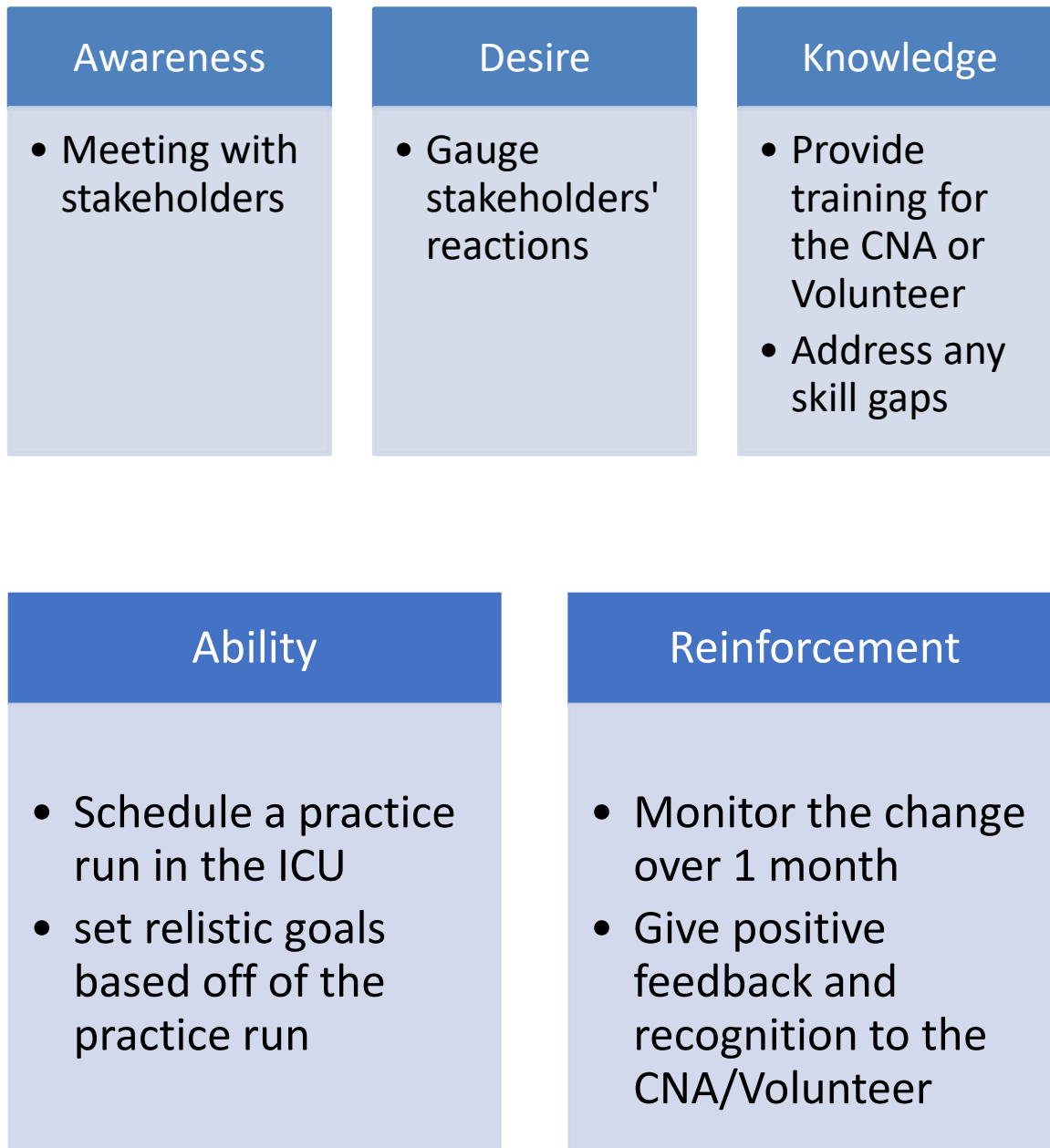
restrictions: A qualitative descriptive study								
#11 Hart (2021) Family presence for critically ill patients during a pandemic		RCA cohort study	Because this was a review made by two physicians, there was no sample size or characteristics.	IV=FP DV=Pt., FM, HCW	Two MDs did a cohort study with reviews of several medical facilities		FB for future VR in a pandemic	Level of Evidence-Level II Strengths: shows a way to enable a safe VP during the next pandemic
#12 Marmo (2023) From open to closed; covid-19	ECMMD	Qualitative evidence	n=99	IV=MPEH DV=NL	Reviewed hospital website and spoke with NL	Latent pattern content analysis	VNW, DH, EDSL VWL, CCCNW	Level of Evidence-Level II Strengths: showed focus on the nurse's perspective and encouraged that they are utilized in VP making

restrictions on previously unrestricted visitation policies in adult intensive care units						Thematic analysis		Limitations: only being able to access the public VP found on the websites
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Legend: SR: systematic review; IV: independent variable; DV: dependent variable; EV: electronic visits; IPV: in-person visits; PDFU: post-discharge follow-up; DIG: diary intervention group; PEOG: psychoeducation only group; DMorWPE: diary with psychoeducation; PEO: psychoeducation only; PICS: post-intensive care syndrome; SIR: systematic integrated review; DBS: database research; HC: health consequence; pt: patient; FM: family member; IC: intensive care; PC: pediatric care; GMC: general medical care; HC: hospital care; PalC: palliative care; NHC: nursing home care; C: consequence; HCW: healthcare workers; VR: visitor restrictions; MD: Moral Distress; MI: moral injury; MH: moral hazard; UP: understanding prevalence; T: testing; DPP: different patient populations; SR: Scarce resources; ICC: importance of information and communication; HV: hospital visit; s/s: sensitivity/specificity; PPE: personal protective equipment; NEI: negate emotional impact; CD: communication difficulties; FB: financial burden; WHOGLCDD: World Health Organization COVID-19 Global Literature on Coronavirus Disease Database; ICU: intensive care unit; PP: post partum; NN: neonatal; SX: surgery; SRS: systemic review software; NS: narrative synthesis; SD: study design; PP: patient population; HVPC: hospital visitor policy changes; PO: primary outcomes; GP: grouped populations; CS: clinical setting; HPT: high policy turnover; VP: visitor policy; CV: coronavirus; P=physicians; HCW: health care workers; F: family; SAS: Statistical Analysis Software; Fr: frequency; %: percentages; CA: correlation statistics; OV: open visitation; PC=patient choice; FC= family choice; QSD: qualitative search design; UAMC: urban academic medical center; HP: hospital policy; M=measures (individual interview guide); MV: Mechanical Ventilation; MI: medical information; QDS: qualitative descriptive study; HCP: health care professionals; SSI: semi-structured interviews; OEROQ=open-ended responses from online questionnaire; Pt: patient; MD: medical doctors; FB: feedback; ECMMD: exploratory concurrent mixed-methods design; MPEH: Magnet and Pathway to Excellence hospitals; NL: nurse leaders; VNW: visitors not welcome; DH: doing harm; EDSL: external decisions at system level; VWL: visiting within limits; CCCNW: changes in critical care nursing work;

Appendix B

Flowchart



Appendix C

Instrument

Family Visitation Questionnaire (Hardin et al, 2011) was modified to question family members and not patients.

Age: Age of Patient:	Marital Status: M D W S	Gender: Male Female
The following is the current policy for Critical Care unit visitation to patients: <ul style="list-style-type: none"> • Visitation hours are scheduled by the patient's point of contact person. • Only 1 visitor in a 24-hour period • Visitors must stay outside of the room and visit the patient through a glass door or via an electronic device. • No children are allowed under the age of 12 		
Did your family follow these guidelines? Yes No		
How satisfied are you with the visiting policy?		
Very Dissatisfied Moderately Dissatisfied Somewhat Satisfied Moderately Satisfied Very Satisfied		
Do you like this method of visiting with your loved one? Yes No		
After visiting hours are over, did you experience mental anguish?		
Not at all Somewhat Moderately Very Extremely		
While your loved one was hospitalized and in critical care, how often would you like to visit?		
Every hour Every 2 hours Every 4 hours Every 6 hours Every 8 hours Other:		
What hours of the day would you prefer to visit?		
Does not matter 8a-12p 12p-4p 4p-8p 8p-12a 12a-4a 4a-8a		
How long would you like them to visit at one time?		
10 minutes 20 minutes 30 minutes 60 minutes 2 hours No limit Other:		
How many times during the day would you like to see your loved one?		
Once/day Twice/day Three/day Four/day All day Other		
When should visiting hours end for the day (PM hours)?		
8:30 pm 9 pm 9:30 pm 10 pm 10:30 pm 11 pm 11:30 pm 12:00 am 12:30 am None		
How many visitors would you have liked to have had with you?		
One Two Three Other _____ None		
How can we make our visiting guidelines better for you?		

