The enablers and barriers to children visiting their ill parent/carer in intensive care units: A scoping review

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Abstract

Objectives: To identify the enablers and/or barriers to children visiting their ill parent/carer in intensive care units.


Data Sources: An extensive literature search of CINAHL+, MEDLINE PsychINFO, PubMed and Proquest Dissertations and Thesis Global databases, using key terms was conducted between May 2019 to July 2020; studies published between 1990 -2020 were considered for inclusion. Double screening, extraction and coding of the data using thematic analysis and frequency counts were used.

Results: Fifteen barriers, 19 facilitators, five situationally contingent, and six personal judgement considerations were identified that influenced children visiting their ill parent/carer in intensive care units. Most barriers (n = 10) were related to organisational factors including restrictive policies, nurses’ level of education, age, working hours, nurses’ attitudes and lack of required skills to promote emotional resilience and/or to communicate with children. Family perception factors relating to parents’ perceptions, attitudes and concerns of staff/parents, and anticipated behaviours of children were also identified.

Conclusions: There is a lack of consistency in the application of policies and procedures to facilitate children visiting their loved ones in an intensive care unit. Without key involvement from the nurses and health care team, there may have been opportunities lost to optimise Family Centred Care practices in critical care settings.

Key Words: Nurses’ attitudes; intensive care units, child visitors, family centred care, policy

Children visiting, child visitation, intensive care unit, visiting policies
1. Introduction

Family life is an integral component of peoples' lives and sustaining links with families when individuals are hospitalised in any context is an essential component of holistic care. (1) (Marco) The admission of a loved one to an intensive care unit (ICU) is traumatic and stress provoking for any adult. (2, 3) (Imanpor, Rojas) It can be argued however, that adult family members by way of their emotional maturity have some insight into the processes that prompted the admission, the intended plan of care and potential outcome. This may not be the case for children or young people dealing with their parent or carer admitted to ICU as they may lack the emotional maturity and resilience to make sense of the experience(4) and require specific care and support to navigate this. An unexpected and enforced separation from their parent/carer can have significant consequences for children, provoke stress reactions resulting in potential deleterious and lasting psychological consequences for them. (4, 5) (Borjas, Johnstone) Seminal work (6) (Bowlby) identified that separating an infant from a parent created a “grief like” response resulting in rejection and denial of the parent on their return.(7) This phenomenon is now referred to as Separation Anxiety Disorder (SAD), characterised by significant distress and long-term behavioural problems. Separation Anxiety Disorder is generally referred to in early infancy, but it can be identified across all ages with an impact upon the adolescent (formal operational stage) age group. In the adolescent age group persistent and extreme worry results in serious loss of self-esteem, phobias and a transition of mental health issues into adulthood.(8) (Fergé et al., 2018)

The evidence suggests that attempts to protect a child by not enabling them to visit their ill parent/carer in ICU, should they wish to do so, can have detrimental effects, potentiating feelings of sorrow and loss for children.(9) (Knutsson & Bergbom, 2016) In this context, it is important that ICU health carers are cognisant that children and young people are not “mini adults” and as such, their emotional and psychological needs are very different, which should be reflected in ICU practice and policies. Despite the general liberalisation of ICU visiting practices in recent years,
(10)(Anzoletti et al., 2008) there remains an incongruent approach to the facilitation of children visiting their loved ones, a process in which nurses play a significant role. (11) (S. Kean, 2010)

Not all children and young people may wish to visit their critically ill parent in ICU, but it is vital to support those who wish to do so. (9) (Knutsson & Bergbom, 2016) Facilitation of visits does not always occur however, as evidence suggests a disparity in practice for children and young people visiting their parents/carer in ICUs across the world (4, 10, 12)(Anzoletti et al., 2008a; Borges et al., 2010; Spreen & Schuurmans, 2011) The views of the ill parent about their children visiting cannot be overlooked and there has been recognition that increased length of visits for children would be preferred by patients (13) (Hardin et al., 2011) and are beneficial to the well-being of the children and young people. (9) (Knutsson & Bergbom, 2016)

**Background/ justification for review**

The length and type of access by family members to ICU patients has long been debated within the ICU community and a disparity in visiting practices in general still pervades in ICUs across the world, (14)(Cappellini et al., 2014) are frequently restrictive (15)(Garrouste-Orgeas et al., 2016) and there has been a call for liberalisation of visiting practices. (16) (Giannini et al., 2014) There has been wide exploration of open visitation and the benefits of family visiting in ICU, but there has been limited exploration of children and young people’s visitation, or how to facilitate a positive experience for them when they do visit. (17)(Rainer, 2012) Open access visiting practices in ICUs vary and range from 1% of ICUs in Italy, to the highest rate of 70% of Swedish ICUs. (14) (Cappellini et al., 2014) The prevalence of open visiting in the United States of America (USA) in one study (n=536) (18) (Milner et al., 2020) has been identified in over half of the units (51%) but restrictions were imposed in other ways including age of visitors, usually children less than 14 years, as well as the number and hours visitors could attend. In a survey of United Kingdom (UK) ICUs (n=206) only 41 (20%) reported unrestricted visiting but despite this, 192 (93%) of units restricted visiting to two people at a time. (19)(Hunter et al., 2010) The definition of open/flexible visiting differs across countries and units themselves, and further exploration has been called for to standardise these
definitions and explore the challenges of this approach. (20) (Ning & Cope, 2020) This disparity prevails in spite of unequivocal evidence that confirms that families prefer flexible visitation to their loved ones in ICU and that this helps to retain a family bond and sense of connection to them. (21-23) (Fumis et al., 2015; Jacob et al., 2017; McKiernan & McCarthy, 2010) Current practice is also incongruent with the recommendations of many critical care professional bodies across the world. (23-25) (American Association of Critical Care Nurses, 2012; Gibson et al., 2012; Mitchell & Aitken, 2017) There have been many calls for the liberalisation of strict visiting policies as a component of a family centred approach. This has been recognised to be beneficial to families’ emotional health and overall satisfaction, (21, 22, 26) (Chapman et al., 2016; Fumis et al., 2015; Jacob et al., 2017) and promotion of well-being and healing processes for patients. (13, 22) (Hardin et al., 2011; Jacob et al., 2017)

**Aims and objectives of review/research questions**

Aim: The aim of this review was to identify and synthesise the available evidence that reports on the barriers and enablers to children visiting their ill parent/carer in an ICU setting by examining the visiting policies as practiced or perceived by nurses and experienced or perceived by parents and caregivers.

4. **Design and methods:**

The review adhered to the Joanna Briggs Institute (27) (Munn et al., 2014) reporting guidelines for conducting scoping reviews and considered primary research studies published in English comprising qualitative, quantitative and mixed methods approaches.

**Research Question**

What are the enablers and/or barriers to children visiting their critically ill parent/carer in the light of ICU policies, nurse perception and practices, and parents/caregiver perceptions?

4.1 **Search strategy**

A logic grid was constructed to guide the search strategy aligned with the mnemonic PCC (population – ICU staff, well parents, carers; concept – children visiting an ill parent/carer in an ICU;
context – Adult ICU), (Supplementary material A). From this grid, key words were identified. The initial search strategy was:

(Adult Intensive care unit OR Adult Critical care unit OR Adult Cardiac critical care unit OR Adult Cardiac intensive care unit OR Adult Neurological critical care unit OR Adult Trauma intensive care unit OR Adult Surgical intensive care unit OR Adult High dependency care unit OR Adult critical care unit OR Adult Cardiac icu OR Adult Neuro* icu OR Adult Trauma* icu OR Adult Surg* icu) AND (Child* visit* Or ICU visitation Or Family centred care Or Family visitation Or Visitor to patients OR Child friendly OR Child friendly practices OR Child friendly policies OR Visiting policies OR Visiting guidelines OR Barriers) AND (Nurses’ experience or perspective or view or attitude OR parent attitude OR parent beliefs OR parent perceptions OR caregiver attitude)

The search strategy aimed to find studies in Cumulative Index of Nursing and Allied Health Literature (CINAHL+), Medical Literature Analysis and Retrieval System Online (MEDLINE), PsychINFO (distributed by American Psychological Association), PubMed (United States National Library of Medicine) and Embase.

A three-step strategy was applied in this review. An initial limited search of CINAHL+ was undertaken using identified key words, followed by an analysis of text words contained in the title, abstract, and index terms of identified articles. A second search using all identified key words was undertaken across the included databases. Third, the reference lists of all identified articles were searched for additional studies. The search was conducted between May to July 2019, and studies published between 1990 -2020 were considered for inclusion (Supplementary Material A for initial CINAHL strategy).
4.2 Inclusion criteria: Studies of any methodology were included if they reported on nurses’, physicians or parents/caregivers’ attitudes, perceptions or beliefs about children and young people visiting their sick parent in any adult intensive or critical care unit.

4.3 Exclusion criteria: Primary studies were excluded if they did not discuss the issue of child visitation in the results section of the article, or that considered the child’s point of view. All systematic reviews, literature reviews, opinion texts were excluded because they were not primary studies, however, the reference lists of these articles were screened for possible articles to include.

4.4 Screening and Critical appraisal

The review process of eligible studies consisted of two screening steps. First, one author screened articles at title and abstract level (Munn et al., 2014) Study quality was assessed and scored independently by two of the reviewers, using standardised critical appraisal instruments from the Joanna Briggs Institute (Munn Z et al., 2019). Any disagreements were resolved though discussion with a third author. Analytical cross-sectional studies required eight questions to be completed, while qualitative research studies required 10 questions to be completed. Each question could be answered with one of four answers (yes, no, unclear, not applicable). All studies, regardless of the results of their methodological quality, underwent data extraction and content analysis (where possible). Any discrepancy in quality assessment between reviewers was resolved through discussion (Table 1).

4.5 Data analysis

A descriptive/narrative analysis was performed by one of the authors, aiming to index and summarise the included studies using a specially developed tool in Microsoft Excel (2016) spreadsheet (See Supplementary Material C Data analysis). Information related to author, year,
country, purpose, methods, study population, results and limitations are presented in a review matrix (see Table 1). Second, a thematic analysis (Thomas & Harden, 2008) was conducted involving all authors in the discussion of the categories. Study results with focus on parents, carers, or health care providers’ perceptions and attitudes with respect to child visitation to the ICU formed the basis of the descriptive categories. Responses received from the research team confirmed the importance of identifying factors facilitating or hindering children’s visitation to the ICU, and this helped with our analysis.

Data were obtained by following the steps in the inductive thematic analysis described by Thomas and Harden (2008). The analysis focused on coding which factors enabled and/or hindered children visiting their ill parent/carer in ICU, and how the challenges experienced with relation to children’s visitations to the ICU could be managed. The analysis was constructed as follows: (1) Line-by-line codes and related categories were extracted based on the studies’ findings with relation to the overall research aim and question. (2) Codes and related categories were then freely lined and organised and then presented into broader descriptive categories, within and across our main findings. Findings were initially coded into two broader categories (barriers and facilitators), then, articles with both categories incorporated were coded and added to the two broader categories. (3) The descriptive categories formed the basis for the next level of analysis where a synthesis was made across the studies’ findings, leading to a third category (contingent factors). The analysis was frequently discussed and revised by the authors and a conclusion was drawn up based on the thematic analysis, showing how some factors were related to organisational or individual/family perception factors.

5. Results

5.1 Search results and screening

The search of records and identification of potential records was conducted by one author between May 2019 - July 2020 (Figure 1 Prisma Flow diagram) (Moher et al., 2009).
5.2 Assessment of methodological quality

It was found that two of the seven cross sectional studies were of high quality; (31, 32) (Flick, 2014; Simon et al., 1997) it was unclear if strategies to deal with confounding factors were implemented in two studies, (10, 33) (Anzoletti et al., 2008a; S. Knutsson & I. Bergbom, 2007a) and in one study it was unclear whether the exposure was measured in a reliable and valid way, if objective standard criteria were used to measure outcomes, nor was it clear if the outcomes were measured in a valid and reliable way. (33) (S. Knutsson & I. Bergbom, 2007a) Both the analytical research articles were of a high quality, except it was unclear if the influence of the researcher on the research was addressed in one study (34) (Knutsson et al., 2017) (Table 1).

5.3 Study characteristics, settings and population

Seven studies were cross sectional descriptive studies, and two were qualitative exploratory studies (Table 2). Three studies were conducted in Sweden, four in the USA, and one each in Italy and the United Kingdom. Five studies focused on nurses’ attitudes and perceptions, the remaining three studies focused on both nurses and physicians, nurses, physicians and family members, and finally, parents/custodians respectively.

All studies examined attitudes towards ICU visiting policies involving families, and children. Although not specifically child-focused, three studies did report on attitudes towards children and young people visiting critically ill relatives (10, 32, 35) (Anzoletti et al., 2008a; M. A. Halm & M. G. Titler, 1990; Simon et al., 1997). The other six studies considered child visiting as the focus of their studies. All the studies were conducted in countries of high human development index as per the United Nations Development Report (36) (United Nations Development Programme, 2019) with participants ranging from 12 - 544 per study.

5.3 Main findings
The findings from this review have identified the many barriers and enablers that exist for children’s visitation to ICU with two major categories and two sub-categories identified. The first category was organisational factors with two subcategories of policies and staff perceptions, and the second category of family perceptions. These categories and sub-categories were either facilitators, barriers, situationally contingent or based on professional/personal judgement and were common across all studies.

Insert Table 3 here

Organisational factors: Established policies

Seven out of eight studies reported that official ICU visiting policies were restrictive i.e. visiting restrictions were in place in relation to children under 12 years,(10) promote patients’ rest (32) or time of visitation (37) and so were barriers to child visitation, as were policies that were detailed and specified the number of visitors allowed at any one time or the length of visiting time, even though these were less common. (10)(Anzoletti et al., 2008a) Only two studies reported restrictions to visiting for events such as medical rounds.(35)(M. A. Halm & M. G. Titler, 1990) Four studies reported that although there were restrictive policies in place, nurses/physicians either routinely made exceptions or made exceptions in special circumstances to facilitate child visitation, to meet either the patient’s or family’s needs, rather than the specific needs of the child. (35)(M. A. Halm & M. G. Titler, 1990) These exceptions to policy also correlated with longer visiting times than four hours and if there were more than one person visiting at a time.

Four studies identified ICUs that had open visiting policies, making these in practice, facilitators. In one of those, participants described the policy as open but several participants were unaware of the visiting policy and perceived them based on their individual judgement. (38)(Clare M. Clarke, 2000) Anzoletti et al (10)(Anzoletti et al., 2008a) found that less restrictive policies in terms of length of visits, number of visitors and willingness to make policy exceptions, generally meant that children were more likely to be permitted to visit. Where exceptions to policy were identified in this
review, these were generally nurse-led, and were often dependent on the experience, educational level and age of the nurses, which has the potential to lead to inconsistencies in practice within individual units.

Organisational factors: Perceptions of ICU staff

The two most reported reasons for disallowing children and young people visiting were cited as patient care needs in six studies, and nurses prioritising their work needs, i.e. perceiving that children visiting would detract nurses from providing care to their patient in five of the studies (9, 10, 32, 35, 38) (Simon et al., 1997). (Anzoletti et al., 2008b; C. M. Clarke, 2000; M. Halm, A. & M. Titler, G., 1990; Knutsson et al., 2016) Other barriers identified were that nurses perceived that they lacked additional support to adequately care for visitors who were children or young people, (32, 38) (C. M. Clarke, 2000; Simon et al., 1997) and gave a lower priority to the needs of children than to adult family members. (35) (M. A. Halm & M. G. Titler, 1990) Deterring child visitation by suggesting infection risk was an issue to protect their own emotional needs and maintain resilience was noted in two studies (34, 38) (C. M. Clarke, 2000; Knutsson et al., 2017) and where participants considered that in some instances it was emotionally demanding and distressing for them. An emergent category was that nurses are not prepared for children to visit their parent and need additional support. (31, 34) (Flick, 2014; Knutsson et al., 2017) are not equipped to deal with the emotional impact this visit could have on the child, the parent or themselves and therefore chose not to allow visits regardless of policies in place. (10, 31, 32, 35) They acknowledged that they did not seek out support though, including from children’s specialists: “I think there is a lot more we could do to find out what support is out there” (38) (C. M. Clarke, 2000, p336) instead “we talk...and help each other”. (34) (Knutsson et al., 2017, p12) Nurses perceived that there were benefits to them and the patients by restricted visiting including reductions to their workload, (10) (Anzoletti et al., 2008a) increased patients’ rest time and decreased environmental noise. (32) (Simon et al., 1997) In one study nurses who were able to conduct psychosocial assessments of the children’s preferred coping styles, were more open to children 0-5 visiting. (37) (Desai et al., 2020) However, restrictions on
visiting were also likely to increase patient anxiety and family dissatisfaction. (32) (Simon et al., 1997)

Factors that facilitated nurses/physicians to permit child visiting were the patient’s/family’s wishes, (31-33, 35, 37, 38) (C. M. Clarke, 2000; Desai et al., 2020; Flick, 2014; M. A. Halm & M. G. Titler, 1990; S. E. Knutsson & I. L. Bergbom, 2007; Simon et al., 1997) that the child was prepared for the visit, (31, 33, 34, 37-39) C. M. Clarke, 2000; Desai et al., 2020; Flick, 2014; M. A. Halm & M. G. Titler, 1990; S. Knutsson & I. Bergbom, 2007; Knutsson et al., 2017; S. E. Knutsson & I. L. Bergbom, 2007) and the child’s need to visit. (7, 38) (C. M. Clarke, 2000) Six studies reported that child visitation should be at the discretion of nurses or physicians, so discretion could be either a barrier or a facilitator in this case. (31-35, 37, 38) (C. M. Clarke, 2000; Desai et al., 2020; Flick, 2014; M. A. Halm & M. G. Titler, 1990; Knutsson et al., 2017; S. E. Knutsson & I. L. Bergbom, 2007; Simon et al., 1997) Less common contingent factors were the type of critical care unit, (32, 35) (M. A. Halm & M. G. Titler, 1990; Simon et al., 1997) and the staff’s working hours within them, (32, 35) (M. A. Halm & M. G. Titler, 1990; Simon et al., 1997) For example, cardiovascular and combined ICUs were more restrictive to children visiting than medical or coronary care units, and weekend and part-time staff were less restrictive than day or full-time staff. (32) (Simon et al., 1997) Flick (31) (Flick, 2014) and Desai et al (37) (Desai et al., 2020) also found that nurses with higher qualifications were less restrictive to children visiting than those with lower qualifications and more receptive to younger children aged 0-5 years visiting. Other facilitators were staff rapport with the family, (31, 38) (C. M. Clarke, 2000; Flick, 2014) the child’s awareness of the patient’s condition, (31, 34) (Flick, 2014; Knutsson et al., 2017) the child’s parent was the patient, (31, 34, 37, 39) (Desai et al., 2020; Flick, 2014; Knutsson et al., 2017; S. E. Knutsson & I. L. Bergbom, 2007) and the family’s wishes. (31, 32, 34, 35, 37-39) (C. M. Clarke, 2000; Desai et al., 2020; Flick, 2014; M. A. Halm & M. G. Titler, 1990; Knutsson et al., 2017; S. E. Knutsson & I. L. Bergbom, 2007; Simon et al., 1997) If nurses were able to provide informational and emotional support to the child, in the context of less restrictive visiting policies, this was also considered a facilitator. (31, 34, 38) (Clarke & Harrison, 2001; Flick, 2014;
Knutsson et al., 2017) category (Anzoletti et al., 2008a; Desai et al., 2020; Flick, 2014; S. E. Knutsson & I. L. Bergbom, 2007) It was apparent in six of the studies in that nurses feared that children would be unsupervised/disruptive when visiting or would be traumatised by the visit. (10, 31-33, 35, 37, 39) (Anzoletti et al., 2008a; Desai et al., 2020; Flick, 2014; M. A. Halm & M. G. Titler, 1990; S. Knutsson & I. Bergbom, 2007; S. E. Knutsson & I. L. Bergbom, 2007; Simon et al., 1997)

Family factors: Patient/Family members’ perceptions about child visitation

Only two of the nine included studies considered the perceptions of patients and their families for child visitation. (33, 35) (M. A. Halm & M. G. Titler, 1990; S. E. Knutsson & I. L. Bergbom, 2007) Barriers to children visiting included protecting the child from potential trauma, the patient’s condition, the age of the child or the staff being unable to communicate with the child. (33, 35) (M. A. Halm & M. G. Titler, 1990; S. E. Knutsson & I. L. Bergbom, 2007) Halm and Titler (35) (M. A. Halm & M. G. Titler, 1990) noted that patients and families expressed concern about the child misbehaving as a barrier to visiting and sometimes considered the child’s needs as a low priority. Facilitators to child visitation included the patient, well parent or child requesting the visit, the child understanding the gravity of the situation, the risk to the child’s welfare by not visiting, the child was given the choice to visit and staff working in partnership with the well parent or being able to provide the child with information. (33, 35) (M. A. Halm & M. G. Titler, 1990; S. E. Knutsson & I. L. Bergbom, 2007) One study confirmed that well parents considered child visitation as “a natural part of life”. (35, 39) (S. E. Knutsson & I. L. Bergbom, 2007, p367) The attitude of the staff and parent as well as the age of the child could be either a barrier of a facilitator to child visitation.

6. Discussion

The consequences of not being able to visit their ill parent in ICU, potentially for some for the last time, can be life changing for children and young people and despite the evidence which supports visits for children who wish to, inconsistencies in practice prevail. This lack of consistency is within policy and practice, and their application, (14, 31) (Cappellini et al., 2014; Flick, 2014) which may if standardised, enable children to visit and maintain the relationship with their ill parent/carer
whilst in ICU. Flexible visiting policies are the first step in promoting child visitation to adult ICUs, (40, 41)(Hanley & Piazza, 2012; Netzer & Iwashyna, 2017) and has been shown to be well received by families of the critically ill .(42)(Mitchell & Aitken, 2017) Flexible visiting hours have not only shown to increase family satisfaction(42) (Mitchell & Aitken, 2017) and reduce anxiety(21) (Fumis et al., 2015), but also have the potential to reduce delirium and anxiety in patients,(43) (Nassar Junior et al., 2018) although this requires further exploration.(44) (Rosa et al., 2019) Nurses have been shown to prioritise adult family members for visitation above the child which does not respect the rights of families to be together at such a difficult time (7, 35)(Clarke & Harrison, 2001; M. A. Halm & M. G. Titler, 1990) and does not value the importance and rights of the child within the family unit. It is apparent that families wish to be at the bedside of their loved one whilst they are in ICU and family dissatisfaction with limited visitation has been identified.(45) (Khaleghparast et al., 2017). The notion of family centred care in ICU has been explored in the literature but it is not apparent if this approach serves to increase child visitation to ICU or not,(46) (Ciufo et al., 2011) but it has improved nurses’ interactions with children of patients in other settings(34) (Knutsson et al., 2017) and should be explored further in the ICU setting.

In this review we found that nurses remain the key gatekeeper for child visitation and there are many dependent factors which inform their decision-making process. Nurses have reported that they feel unprepared to care for children who may experience distress when visiting ICU. As a consequence nurses provide reasons why children should not visit which may not be evidence based, in essence to protect themselves from exposure to difficult situations.(7, 34) (C. M. Clarke, 2000; Knutsson et al., 2017) It can be postulated that this is because of a lack of knowledge of the processes and fear of harm coming to the child as a result of the visit, although many nurses agree that a child is at greater risk if they do not visit their ill parent/carer in ICU. (33)(S. E. Knutsson & I. L. Bergbom, 2007) This indicates a lack of preparedness and education in the needs of a child whilst visiting ICU, particularly in relation to the child’s developmental stage(31). This is an area of unmet need for the development of ICU nurses who should be educated in the benefits of child visitation,
the processes that should be undertaken to facilitate a child visitation and how to maintain their own well-being through potentially difficult events. (31) (Flick, 2014)

The establishment of a clear and transparent approach to child visitation as a fundamental component of ICU culture is recommended. This approach would also enable new staff to be orientated to the child visitation processes, the underpinning philosophy and actively supported during visitation by colleagues who are confident with and committed to supporting visitation by children where required. Standardisation of practices builds confidence and enhances a culture of best practice. Inclusion of education about child visitation within postgraduate ICU education programs is also an opportunity to provide evidence-based and developmentally appropriate education for ICU nurses, as more educated nurses i.e. at postgraduate level, tended to adopt more liberal visiting practices than less educated nurses. (31)

On the ground support is also required for ICU nurses during child visitation processes, not only in terms of written resources but also human resources from colleagues who specialise in the care of children (34). Myths surround child visitation in ICU and will continue to propagate to those less experienced staff unless sound education is implemented in practice. The development of standardised and evidence-based resources to enable ICU nurses to prepare the well parent and child throughout the stages of the visitation process could allay some of that anxiety that nurses may experience in relation to child visitation.

Barriers to child visitation were similar for both nurses and families, indicating that education needs are similar, strengthening the need for resources for well parents to prepare them to make an informed decision in collaboration with the child where age and developmentally appropriate. The development of a standardised, national set of resources would be of significant benefit for parents, children and ICU staff. Instances of units developing resources that provide evidence-based information for the well parent, the child and nursing staff have been implemented and have improved the preparedness of the child, well parent and staff throughout the entire visitation process. (47, 48) (Johnson, 1994; Pierce, 1998) The provision of emotional
support prior to, during and following the visit has also been shown to reduce negative behavioural and emotional responses in the child. (Nicholson et al., 1993) A facilitated, supportive and developmentally appropriate evidence-based approach to child visitation has been recommended (Susanne Kean, 2010; Rushforth, 2007) and should be considered.

There is a paucity of literature that has detailed the experiences of the child during visitation, although there is evidence that suggests that visiting their ill parent brings about feelings of involvement with them as well as feelings of calm and relief. (Knutsson & Bergbom, 2016) Exploring and sharing children’s experiences of visiting are recommended to inform evidence-based education for nurses and well parents. This would enable an understanding of the experience of the child through their lens, and the impact of a visit in addition to dispelling the myths which pervade around this topic, enabling an informed decision-making process to enable child visitation.

A family centred approach to the care of ICU patients and their families has been a focus for some time. (Wong et al., 2018) However, this has not translated to the care of the children in the family as decision makers and reduces their value as its members. Some nurses did not interact with the child and ignored them during the visits, which could indicate a lack of support for the concept of children visiting ICU but also a strategy to protect themselves from the perceived emotional trauma of the visit. The notion that the older the child, the more able they are to cope with visiting their ill parent was a perception of the nurses and has been refuted within the literature. (Flick, 2014; Knutsson et al., 2017) This also strengthens the call for evidence based guidelines to be developed to facilitate child visitation in ICUs. (Susanne Kean, 2010) Nurses did not appear to value the child in the hierarchy of ICU visitors, and lacked insight into the effect that parental hospitalisation has on a child, and are uncertain of how to cope with questions and emotions of a child and therefore discourage their visits. (Titler et al., 1991) The notion of nurses
not acknowledging the importance of children visiting and prioritising their work tasks over family visitation, has been reported elsewhere including within palliative care.(54) (Karidar et al., 2016)

The concept of certified child health specialists and children’s nurses supporting children through crisis situations including having an ill parent in ICU, has been implemented in some states in the USA and is increasing in prevalence.(55) (Crider & Pate, 2011) This role has been viewed as a valuable resource in this context,(40)(Hanley & Piazza, 2012) but this approach has not been widely adopted elsewhere. This model could meet the needs of ICU nurses who have indicated that they require education and support and the provision of those nurses who are practicing as children’s nurses to offer this education and support is also a potential area of exploration.

Both nurses and caregivers gave children’ needs less consideration when making decisions than other factors about visitation practices compared to nurses, or adult relatives. Undoubtedly children experience suffering when their loved one is critically ill, and visiting them does appear to alleviate that and it is recommended that children be involved in their relative’s care to alleviate that suffering.(9) (Knutsson & Bergbom, 2016) There is a paucity of literature which explores the experience of children able to visit ICU and those who do not and the potential impact that this has on them in the short, medium and long term (50)(Susanne Kean, 2010) This is an area of future research that could significantly inform current practice in this area.

Interventions that educate ICU staff on the value of family centred care and child visitation are also warranted. Future research should review global approaches to visiting practices, as well as resources utilised to facilitate visits by preparing the child, well parent and ICU staff pre, during and post visits.

A further area of exploration would be to develop an understanding of the predisposing factors which influence the well parent who does not allow their child to visit and why this is so.

A review of resources available to support child visitation in ICU, and an evaluation of the impact of such guidelines on those involved at all stages of the visitation process, is also an area of future exploration.
7. Limitations

The limitation of this review included that the literature was limited to peer reviewed literature that which was published in English and as such relevant literature in other languages or in the grey literature may have been overlooked. Two of the four authors appraised the studies and extracted the data which is also a limitation of this review.

9. Conclusion

A lack of a consistent approach and application of policies and procedures to guide child visitation practices in ICUs is apparent. The decision-making processes to enable child visitation are not always based on best evidence or policies, leading to inconsistencies of practice even within individual units. A lack of recognition of the effects of child visitation in ICU and the long-term effects of being able to visit their ill parent or prevented from doing so, is yet to be explored and could provide valuable evidence in this area. The development and application of policies and practices that are flexible but based on best evidence would reduce the risk of inconsistent application of practices that is currently occurring. The development of flexible, unambiguous, and evidenced based, policies which promote standardised practice and a culture of trust and negotiation with families in relation to their care involvement is recommended. Standardised evidence-based guidelines addressing all aspects of child visitation in ICU to support children, well parents and staff through all aspects of a child visitation should be developed. There is an urgent need for education of staff and family members to enable informed decision-making processes to promote the best interests of the child, and their parent in ICU. Family centred care is an emergent practice within ICUs, and further exploration of the impact this approach may have on child visitation practices is yet to be explored.

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