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WHAT'S NEW IN INTENSIVE CARE

Ten recommendations for child-friendly visiting policies in critical care

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For many years, there has been a debate about whether children and adolescents are allowed to visit their sick parents, grandparents, siblings, and others in the intensive care unit (ICU) [1–3]. Whereas worldwide visiting regulations in paediatric ICUs are mostly open for children's visits, very heterogeneous policies exist in ICUs for adult patients [4, 5]. Children, defined as infants, toddlers, school-age children, and adolescents from 0 to 17 years [5], are part of the whole family and when it comes to family-centred care, the question arises: do we let them in [6]?

In most cases, children's visits have more beneficial than harmful effects [7]. Children want to be informed and in touch with their sick loved ones, but when they are not allowed to visit, they often feel excluded or scared [8]. Most children can handle visits just fine if they are given age-appropriate information and support [9]. Visits can be a valuable corrective experience for a child's fantasies [10], since visiting children are better able to understand reality and preserve their relationships and attachment bonds with family members [11]. Children also do not pose an increased risk of infection if hygiene requirements are met [12]. In rare cases, visits may increase the risk of harmful effects, e.g., by observing disturbing bodily or behavioural appearance of patients. The decision, if children are let in or not, is complex and sometimes leads to an ethical dilemma [13]. Nurses and physicians especially are encouraged to reflect on their own practice as gatekeepers for visitors [7].

In Autumn 2022, the German Interdisciplinary Association of Critical Care and Emergency Medicine proposed a White Paper regarding children as visitors in adult and paediatric ICUs and Emergency Departments [14]. The recommendations are based on comprehensive literature research and have been developed in a consensus process with experienced specialists such as physicians, nurses, psychologists, microbiologists, lawyers, and others from paediatric, developmental, child-protection, and adult specialities. The aim of this work is to provide assistance for clinicians in critical care to develop, adapt, and implement a substantial culture of humanised, family-centred care including child-friendly visiting policies [3, 15]. We have developed ten recommendations for children visiting the ICU. Prerequisites, decision, preparation, visit, and follow-up including tasks for staff, parents, and children are summarised in Fig. 1.

Recommendation 1: Plan the visit of children in the interprofessional team

First, patients (if conscious), parents, children, and clinicians agree to the visit (see Fig. 1). Parents/caregivers play a central role in the whole process. Involved clinicians plan the visit step-by-step, document it as a daily goal, and communicate it to the team, patient, and family. Any necessary support from psychosocial professionals is requested in advance.

Recommendation 2: Strengthen parental competencies

The decision to let children visit a critically ill patient depends on the will of the parents/caregivers. They are involved in the children's visit and the ones who ask their child if they want to visit the ICU. Parents/caregivers are strengthened in their parental

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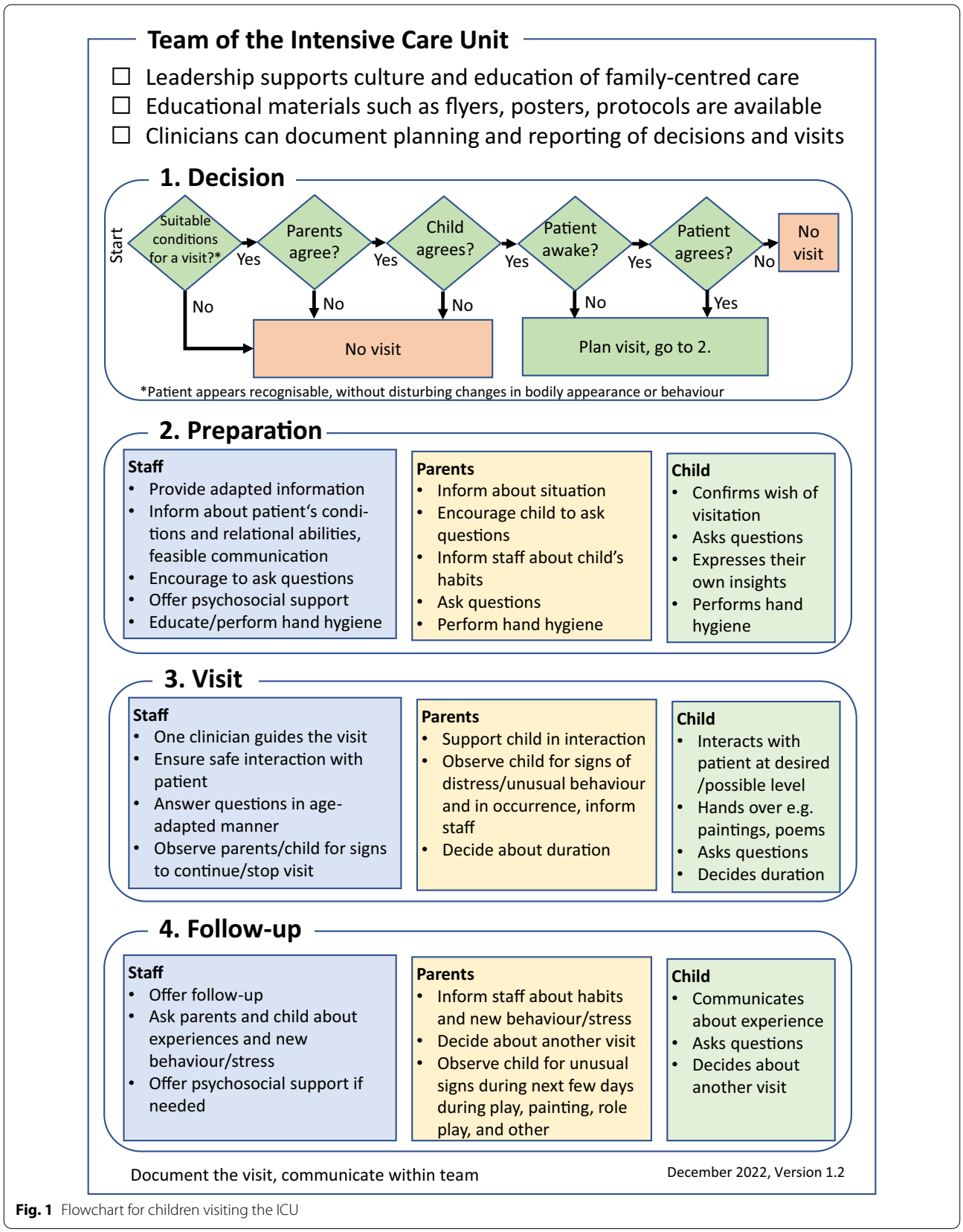

Fig. 1 Flowchart for children visiting the ICU

competencies for perceiving and reacting to children's needs by guidance, information, and conversations.

Recommendation 3: Ensure child-friendly information

Parents and clinicians prepare and accompany the children. The information provided is tailored to the children's cognitive and emotional developmental age and supported by booklets, videos, or brochures. Especially in very young children, the parents/caregivers communicate the information on the developmental level of the children. The children are encouraged to express their understanding of the situation. Communication is always characterised by honesty, transparency, and appreciation of the children's contributions.

Recommendation 4: Prepare, accompany, and follow-up the visit of children

The date for the visit is known to everyone involved; the patient and the room are prepared. A designated person in the medical/care team supervises the entire visit. During the visit, children are respected and supported to do what they are confident in, e.g. touching the loved one, ask questions, chat, or terminate the visit. After each visit, a short separate debriefing with the children and the team is recommended.

Recommendation 5: Offer psychosocial support

Psychosocial support around the visit of children is ensured, depending on local availability, e.g., through psychologists, spiritual counsellors, or crisis intervention teams. It is helpful to make the contact details of these institutions available to staff, relatives, and parents/caregivers.

Recommendation 6: Offer special support in palliative situations

In palliative situations and when patients have already died, clinicians seek an open conversation with children about the topics of dying, death, and mourning. It is helpful to have an open exchange at eye level, in which children can contribute their own ideas and fantasies. If available, palliative care competencies of clinicians are integrated.

Recommendation 7: Provide child-friendly support in emergency departments

Since important preparation time is usually lacking in emergency departments, a member of the team and/or a psychosocial professional facilitate a safe visit of the children, prepare and accompany them, and arrange a follow-up appointment with the family.

Recommendation 8: Creating the culture and addressing barriers for children's visits

The visit of children in an ICU is also a management task. Leadership sensitises staff to the importance of the issue and motivates them to develop effective strategies. Continuous training of the team and opportunities for critical reflection of previous habits play an important role. The interprofessional leadership considers and discusses possible insecurities and stress within the team.

Recommendation 9: Integrate quality and risk management

Proactive quality and risk management and structured quality control are required for the successful implementation of children's visits to the ICU. Potential contraindications are discussed and considered. Children's visits can be defined as part of a protocol to determine the desired quality of the visit and the process.

Recommendation 10: Documentation of children's visits and family rounds

Clinicians document children's visits including decisions, planning, and involvement of children and parents as well as an evaluation in patients' charts. All staff members have access to this information.

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Declarations

Conflict of interest
All other authors report no conflicts related to this work.

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