Critical Commentary: The psychological burden of restricted parental visiting in paediatric intensive care.

Nursing in Critical Care

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A recently published study in this journal found that more flexible visiting arrangements reduced the heart rate and blood pressure of adult intensive care patients, in addition to improving patient satisfaction (Akbari et al 2020). Although this article does not discuss visiting arrangements in relation to the Coronavirus (COVID-19) pandemic, it does acknowledge the positive effects that visiting has on physiological parameters. There have been some recent publications observing the collateral damage this pandemic has caused in children's education, social care, and health services (Feltman et al. 2020; Crawley et al. 2020). This commentary refers to collateral damage in terms of visiting restrictions on children in Paediatric Intensive Care Units (PICU). A pertinent consideration is the psychological burden of separation on children, young people, and their families during this time.

Separation of a child and their parents has previously been reported to cause significant stress (Lisanti et al. 2017). In the UK, parental visitation is usually not restricted on PICUs and parents can visit their child any time of the day or night. Open parental visiting is a key aspect of family centred care and something valued by children and families (Foster et al. 2018). Siblings, extended family members, and friends may also be allowed to visit during the day. In most UK PICUs, to ensure a safe environment, the number of visitors by the child's bed is often restricted to two, except in specific circumstances such as end of life care. Despite this, people close to the child are encouraged to be present, as this socialisation is valued as important for the child and the family. In paediatrics, we take pride in our ability to work closely with families to provide individualised and child focused care, even on the PICU (Latour and Coombs 2019). As children's nurses, we recognise children within the context of their family and provide support for families whilst providing medical and nursing care for their children. We empower parents to take an active role in the child's personal care and provide psychological support for the families to reduce their stress; this constitutes a family centred care approach (Coats et al. 2018). There is evidence that reducing parental stress can reduce the adverse psychological effects on both children and their parents (Yagiela et al. 2019). Spending time with their family enables a child or young person to feel reassured, safe, and orientated (Coyne 2015). To have an advocate present who understands their cultural and spiritual needs whilst providing emotional support is an essential part of their care. This is vital when the PICU environment is foreign and frightening, and the care, albeit essential, is often invasive, intrusive, and disruptive.

During the COVID-19 pandemic in the UK, the Department of Health introduced new guidance on restrictions for visiting patients in hospital as a matter of public health and safety (Public Health England 2020). During the early stages of this pandemic it became clear that this was an ever-evolving situation with constant change and flexibility required in all areas of planning service delivery. An issue that has become apparent was that children who are positive for COVID-19 do not have the same healthcare trajectory as their adult counterparts (Dong et al. 2020). They were also less likely to be symptomatic and require hospitalisation, even considering our developing understanding of paediatric inflammatory multisystem syndrome temporally associated with COVID-19 (PIMS-TS) (Kache et al. 2020, Viner and Whittaker 2020).

Despite NHS England guidance stating that visiting should be restricted with exceptions such as the parents of paediatric patients (Public Health England 2020), most PICUs in the UK have restricted visiting to one parent only. Some units enforced this by only allowing one consistent parent through

the entire hospitalisation, while others have allowed a second parent to take over after a set period. Some UK PICUs had the capacity to swab parents for COVID-19 and if they were negative, a parent could stay at the child's bedside to sleep, eat and use ensuite toilet and washing facilities; others who were positive had to return home for 7 days or until they had a negative COVID-19 swab. Those families who had other children suffered even more difficulties, especially around childcare as extended family or friends were often reluctant to help. For single parent families, this was also a problem, as they could not have an appointed a friend or relative for support, and therefore experienced their child's PICU stay alone.

Existing economic hardships were heightened as some parents were unsure of job security. Others were furloughed, and some had to rely on universal credit (social security payments), and this added to their stress and anxiety on the PICU. The one 'designated visiting parent' had to process their child's prognosis and treatment, make life changing decisions, and then relay this information back to other family members, on top of their other concerns. In some PICUs, before the pandemic, a designated family liaison team would be available to support the family through these difficulties; however, these nurses were often redeployed into the bedside nursing workforce. Religious services and clinical psychology services were also either not available or reduced to video calls.

A recent Paediatric Intensive Care Audit Network (PICANet) report identified only 71 children that were admitted to PICU who were COVID-19 positive between 15 March and 13 June 2020 (PICANet, 2020). This highlights the stark difference between paediatric and adult COVID-19 positive patients requiring intensive care. Data from the UK (PICANet 2020), China (Dong 2020) and the USA (Bialek et al 2020) confirm that the incidence of COVID-19 as a cause of PICU admission is much lower than that in adults. However, even though the physical impact of COVID-19 on children was minimal compared to that of adults, the collateral damage caused by separation and severely restricted visitation of children on PICUs needs urgent consideration. This is increasingly crucial, as we approach the winter season where paediatric respiratory illnesses cause high admissions on top of a potential second wave of COVID-19 in the UK.

The absence of relatives in adult intensive care has been discussed in the literature in relation to COVID-19 (Hart et al. 2020, Montauk and Kuhl 2020), but the impact of the partial absence of close family members/parents in PICU has not yet been investigated in primary research. Longitudinal studies are required to observe the longer-term effects of this separation on both children and their families. Psychological support for children, young people and their parents has not yet been operationalised as these support services were overwhelmed during the pandemic (Crawley et al. 2020). In addition, long-term support plans for families need to be developed by PICU family liaison teams and psychologists to try to ameliorate the impact of this experience.

Moving forward into the winter months and with a second wave of COVID-19 threatening, we call on those involved in decision making to consider the detrimental impact of restricted visiting on children and their families. In the absence of any research into the effects of parental separation during the pandemic, we need to heed previous research focusing on the detriment caused by parent separation. We need to utilise our own experiences and judgement, to support the family through their PICU journey. This includes efforts to minimise the long-term psychological damage to the child and their parents or siblings. Given the contrasting paediatric data regarding mortality from COVID-19 we need to question whether the strict parent-visitation restrictions are still needed in PICU. Can we allow family members to support each other by allowing more contact with their sick child whilst still reducing the risk of COVID-19? Furthermore, without research into the impact these restrictions have had, it is difficult to know how to plan for a potential second wave or how to

provide long term support for these families. Therefore, until this evidence is available, it is imperative to start these conversations within our own institutions now.

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