

APPENDIX: Impact of Hospital Visitor Restrictions during the COVID-19 Pandemic

APPENDIX A: Public Health Rationale Behind Strict Visiting Policies

The adoption of visitor restrictions is not unique to SARS-CoV-2 and has occurred during past pandemics. The rationale for strict visitor policies include: (1) protect against the transmission of SARS-CoV-2 from the community to health care workers and patients, (2) minimize transmission from patients to visitors, and (3) preserve personal protective equipment (PPE) when concerns existed surrounding supply.

Distinguishing General Visitors from Family/Essential Caregivers

Hospital visitors may range from individuals who are visiting for social reasons to family members or essential caregivers. Essential caregivers encompass family/essential caregivers who are active and essential in the ongoing care of a patient admitted to hospital. They are active not only in the care of patients but can also provide a lens into diagnosis, management, and future care planning. The term “visitor” in this brief excludes social visits and refers specifically to family/essential caregivers. In this Science Brief we evaluate the rationale for visitor restrictions during a pandemic, the impact that strict visitor policies have on patients, families and health care workers, ways to safely bring visitors to the bedside and mechanisms to mitigate risk of visitor absence.

Historical Perspective

Outside of pandemics, restrictive visiting policies across hospitals were built on historical roots extending from the 1800s. There existed a belief in medicine that a liberal approach to visiting would be associated with increased physiologic stress, and physical and emotional “exhaustion” for patients and impair provision of care by health care workers. However contemporary data from the inpatient and critical care settings has demonstrated that these concerns are not grounded in evidence. Emerging evidence over the past two decades has shown the clear benefit of family/essential caregivers presence across certain patient populations.¹⁻⁵ In response to this, a gradual relaxation of visitor restrictions has been seen over the decades. By early 2020, just prior to the COVID-19 pandemic, a review of hospitals by the Canadian Foundation for Healthcare Improvement found that 73% of hospitals had adopted accommodating visitor policies (increased from 32% in 2015).⁶

Visitor Restrictions at the Beginning of Canada’s First Wave of COVID-19

An almost complete restriction of visitors occurred across all hospitals surveyed in a 35-hospital pan-Canadian study at the onset of the COVID-19 pandemic.⁶ This action was an application of the ‘precautionary principle’, a core recommendation in the 2007 SARS Commission report: “the precautionary principle, which states that action to reduce risk need not await scientific certainty, be expressly adopted as a guiding principle”.⁷ The potential of a hospital visitor related COVID-19 outbreak was therefore considered of sufficient risk that decisions were made to restrict visitors despite a lack of scientific evidence linking visitors to SARS-CoV-2 transmission. Indeed,

lessons learned from seasonal influenza suggest preventing outbreaks of respiratory viruses in the acute hospital sector is vital to ensure that hospitals can provide needed care for all.² In early 2020, data supporting the benefit of strict visiting policies during pandemics was largely extrapolated from studies surrounding mechanisms of transmission or prior outbreaks. An analysis of hospital-based outbreaks in Taiwan and Toronto during the 2003 SARS pandemic found that between 28-38% of those infected were visitors to hospitals.⁸

Evidence from the COVID-19 Pandemic

Only a limited number of studies to date have evaluated the role of family/essential caregivers in hospital-related SARS-CoV-2 transmission – most of which were conducted prior to the emergence of the variants of concern (VOCs).⁹ The prevalence of SARS-CoV-2 infection among family/essential caregivers who screened negative for symptoms ranged from 4% to 10%^{10,11} according to 2 studies. In a study from Brazil, 150 asymptomatic family/essential caregivers were tested for SARS-CoV-2 in a single day, using quick RNA viral kits. Six family/essential caregivers (4%) were positive for SARS-CoV-2 (one family/essential caregivers had COVID-19 infection 20 days prior, one family/essential caregivers became symptomatic the subsequent day, and four remained asymptomatic). Two subsequent patients, who had repetitive contact with the family/essential caregivers, developed symptoms.¹⁰ In a study from New York, pregnant patients and their support persons were tested for COVID-19 one day prior to planned delivery if they screened negative for symptoms of COVID-19.¹¹ The prevalence of asymptomatic COVID-19 was 15.5% (9.8-21.2%) across 155 patients and 9.6% (4.8-14.4%) across 146 support persons. However, these data were obtained at a time when there was a very high community incidence of SARS-CoV-2 and prior to public masking in New York. Ontario long-term care data suggests consistently low rates of positive results (< 0.7%) in routine asymptomatic screen testing of long-term care staff even during times of high community incidence of SARS-CoV-2.¹²

Even in the face of high community incidence of SARS-CoV-2, there is limited evidence that family/essential caregivers are a major source of transmission, especially with appropriate infection and prevention control measures (IPAC). Early in the pandemic, and prior to the widespread implementation of public health and IPAC measures, a systematic review of nosocomial acquisition of COVID-19 from case series in Wuhan demonstrated that only 2% of nosocomial cases were from individuals other than medical staff (e.g. family/essential caregivers).¹³ Another study of 9,149 US-hospitalized patients from March 7 to May 30, 2020 in Boston found low rates of hospital-acquired COVID-19.¹⁴ Across 697 patients with COVID-19, 1.7% (12/697) were defined as testing positive 3-days after admission or within 14-days of discharge. The majority (10/12) were likely late identification of community-acquired cases (delayed due to absence of symptoms or initial negative test). Only one of these cases was deemed to be acquired from a pre-symptomatic visitor before restrictions were implemented. The low rates cannot be attributable solely to visitor restrictions as restriction policies were implemented at the midpoint of this study time-period (April 3, 2020). In a study from a tertiary care hospital in Singapore, nosocomial-associated respiratory viral infections were tracked as they transitioned from no visitor to one visitor and two with IPAC measures in place over June-August 2020.¹⁵ There was no statistically significant difference in nosocomial associated respiratory viral infections when they relaxed their policy to one family/essential caregivers per

day compared to no family/essential caregivers (June to July 2020 – one family/essential caregivers vs. May to June 2020 – no family/essential caregivers; incidence rate ratio (IRR) 0.36, 95% confidence interval(CI) 0.03-2.24, p=0.21). When further relaxed to two family/essential caregivers, nosocomial associated respiratory viral infection rates remained stable (August to September 2020 – two family/essential caregivers, vs. May to June – no family/essential caregivers; IRR 0.57, 95% CI 0.01-9.76, p =0.573). Outside of a pandemic, a systematic review evaluating liberal versus restrictive visiting policies in a critical care setting found no increase in acquired infections or septic complications among patients with the liberal visiting policies.¹⁶

Risks to the family/essential caregivers are minimized with the use of universal masking, hand hygiene, and hospital specific IPAC measures. A study from Atlanta evaluated whether heightened risks exist for family/essential caregivers across COVID-19 units where aerosol-generating procedures may occur.¹⁷ Lane and colleagues evaluated bioaerosol samples for COVID-19 from corridors and nursing stations of intensive care units (ICUs) and general medical units caring for patients with COVID-19. Five-hundred and twenty-eight samples were collected over six hours for three days across six different units. No samples were positive for COVID-19.

How the risk profile of visiting policies changes as the incidence of SARS-CoV-2 increases or decreases in the community remains unknown. Importantly, factors that may increase risk of family/essential caregivers include the presence of the new VOCs given their greater risk of transmission and low incidence of vaccination against SARS-CoV-2.^{9,18} Community case numbers, asymptomatic carriers and unrecognized or unknown exposures by family/essential caregivers may increase the risks. However, factors that may reduce risk include vaccination (with ongoing IPAC measures), rigorous infection control measures such as masks, handwashing, screening upon arrival to hospital, education for essential caregivers around PPE use, and COVID-19 vaccination. Still, we need contemporary data to better determine the balance between these competing factors.

APPENDIX B: Potential Harms of Visitor Restrictions for Patients, Families, Caregivers, and Health Care Providers

Supporters of the precautionary principle may argue that short-term visitor restrictions are ethically sound in the setting of a pandemic given that the benefits for public health protection may override individual freedom. However, when temporary restrictions need to be implemented, fair operationalization is necessary to ensure that the individuals being impacted are not disproportionately harmed.¹⁹ While there exists a theoretical benefit of strict visitor policies to mitigate transmission of the SARS-CoV-2, this must be balanced against the toll of widespread and sometimes indiscriminate visitor restriction policies. Family/essential caregivers are recognized as being key to the delivery of patient-centred care (e.g., assisting with feeding, mobility, hygiene, orientation, emotional support) (Table 2). Previous literature has demonstrated that their presence is associated with benefits to patient care including improved safety, enhanced communication, and better clinical outcomes.

Communication	Accommodating visiting policies are associated with improved communication, greater trust in the health care system, optimal communication in patients' language of choice, more timely goals of care discussions, improved transitions of care, and better understanding of discharge instructions.
Racial Disparities and Socio-Cultural Barriers	Patient advocates are needed to support patient populations who might historically be subject to structural racism or cannot advocate for their individual needs.
Cognitive Impairment and Enhanced Care Needs	Across patients with cognitive impairment or enhanced care needs (e.g., feeding, mobility, behavioural), visitor restrictions may put them at increased risk of harm (e.g., aspiration or falls) and increase the workload for the hospital health care staff. These risks could be more effectively address by essential caregivers/families.
Delirium	Family presence has been shown to lower the risk of delirium, decrease ICU length of stay, improve ICU costs, patient experiences and family mental health outcomes.
Surgery and Procedures	Visitor restrictions were associated with delays in receiving medications, social isolation, difficulty with mobilization, increased anxiety associated with procedures and discharge preferences not adequately considered.
End-of-Life Care	Inability to spend time with family at the end of life is associated with complicated grief on the part of the family, confusion, or fear on the part of the patient, and symptoms of anxiety or depression on the part of health care workers.
Labour and Delivery	The continued presence of designated support persons is associated with more favourable delivery outcomes.

Table 2. Settings Across Which Accommodating Visiting Policies are Beneficial to Patient Care

The term visitor needs to distinguish between “social visitors” and “essential caregivers”. Family and essential caregivers are active and essential in the ongoing care of a patient admitted to hospital.

Communication, Decision Making, and Advocacy

Accommodating visiting policies have been shown to improve communication and build trust between families and care providers. It further improves the accuracy and quality of information surrounding the diagnosis, transitions of care and discharge instructions. Language barriers are common in Canada and lead to poorer quality healthcare. Furthermore, language barriers can lead to the misdiagnosis of delirium, leading to unnecessary use of psychotropic medications or physical restraints for hyperactive delirium.²⁰

In the pediatric literature, family presence has been found to improve hospital safety through increased surveillance and detection of potential medical errors.²¹ When patients experience a change in their clinical status or clinical conditions that prevent them from articulating their preferences, family members and substitute decision makers become essential in

communication surrounding escalation of care particularly in the setting of incapacity.¹ Visitor restrictions have disrupted the routine structure and processes of family communication and in-person meetings.² In a study by Piscitello and colleagues that evaluated content of family meetings during the COVID-19 pandemic using electronic communication for critically ill patients who lacked decision making capacity, goals of care re-evaluations and modifications were less likely to occur over video communication compared to in-person meetings (11% vs. 35%, $p=0.0006$).²² Challenges in the exchange of information and timely involvement in decision-making has been further compounded by unprecedented increases in clinical demands in the general internal medicine and ICU settings. All of these factors limit timely and effective communication with families.

Racial disparities and structural racism have been documented across the provision of health care in North America. The COVID-19 pandemic amplified underlying and pre-existing health disparities, with racialized communities being disproportionately affected.²³ Patient advocacy has been one mechanism to mitigate the potential for structural racism in health care. Visitor restrictions limit the presence of patient advocates for more vulnerable or marginalized patients who have been historically subject to structural racism. These restrictions could pose a disproportionate risk to this population. More data is needed to evaluate the impact of visitor restrictions in this population.^{3,4}

Delirium

Delirium and associated short- and long-term psychologic disturbances have been well documented in the acute and critical care setting.^{24,25} Patients with COVID-19 critical illness experience a high incidence of acute brain dysfunction (>80% coma, >50% delirium).²⁶⁻²⁸ In general, patients with delirium have longer hospital stays, are at higher risk of subsequently being diagnosed with dementia, and are at increased risk of ICU mortality. Prior to the pandemic, nurse-facilitated family participation reduced ICU delirium experienced by patients and led to improved psychologic recovery at 4, 8 and 12 weeks after ICU discharge.²⁹ In a systematic review and meta-analysis by Nassar and colleagues, flexible visiting policies in the ICU setting led to a reduced frequency of delirium (odds ratio (OR) 0.39, 95% CI 0.22-0.69).¹⁶ Furthermore, family centered care interventions have demonstrated a decreased ICU length of stay, improve ICU costs, patient experience and patient/family mental health with family engagement.⁵ In study from Japan, Kandori and colleagues retrospectively evaluated adult emergency room admissions from January 2019 to June 2020. Across 5,254 patients (median age 74 (interquartile range (IQR) 56-83), a higher incidence of delirium was found after the implementation of visitor restrictions in March 2020. (6.2% vs. 1.8%).³⁰ A study published by Pun and colleagues evaluated the incidence and risk factors for delirium across 2,088 critically ill patients (69 participating ICUs) with COVID-19.²⁸ Eighty-seven percent of patients were mechanically ventilated, 55% (1,147 patients) were delirious for a median of 3 days (IQR 2-6).²⁷ Family visiting (in person or virtual) was associated with a lower risk of delirium (~ 30% lower risk of delirium, $p<0.0001$).²⁷

Surgery

A recent observational study evaluated the effect of visitor restrictions on post-operative experiences of patients undergoing surgery during the COVID-19 pandemic.³¹ Zeh and colleagues

evaluated 117 non-COVID-19 positive patients who underwent surgery from February to April, 2020 (48% oncologic surgery, 32% transplantation). Those exposed to visitor restrictions had delays in receiving medications, greater social isolation, difficulty in getting out of bed and were more likely to have discharge preferences not adequately considered. Family/essential caregivers have also been shown to be vital in decreasing anxiety during procedures, improving compliance with transition of care and discharge instructions, and in enhancing safety/falls prevention.^{32–39}

End-of-Life Care

Human connection, compassion and honoring one's life and legacy has been found to be a meaningful component of end-of-life care for families and health care providers.^{40,41} Modification of end-of-life practices has been one of the most psychologically distressing consequences of strict visiting policies.⁴² As a consequence of this, during the pandemic patients were dying alone across institutions where exceptions were not accommodated. Cook and colleagues conducted a mixed methods study to understand perspectives on adaptations to end of life care for seriously ill hospitalized patients from March 2020 to July 2020. Only 44% of patients had a family member physically present in their room at the end of life (which different than 87% of patient pre-pandemic times).⁴³ One of the greatest sources of moral distress experienced by the health care team had been about connections with family members. Dying alone can lead to substantial emotional distress to not only the patient but also family and health care providers. Otani and colleagues found that a dying patient's inability to say goodbye to family was significantly associated with complicated grief on the part of the family.⁴⁴ In a study of 1,058 health care providers across 21 ICUs in France between April and May 2020, deep regret about the COVID-19 visiting restrictions was expressed leading to symptoms of anxiety or depression.⁴⁵ Many health care providers currently feel significant distress associated with being a "placeholder" for families at the end of life. Following the 2003 SARS pandemic, significant anxiety, depression and stress was present across health care workers months to years after following the pandemic.⁴⁶

Labour and Delivery

Prior data has demonstrated that the continual presence of family or a designated support person during labour is associated with more favourable delivery outcomes (more likely to have spontaneous vaginal delivery and avoid interventions).⁴⁷ Their absence is a risk factor for birth trauma and post-partum post-traumatic stress disorder.⁴⁸ This data has led to the liberalization of traditional visitor restrictions for labour and delivery. To better understand the psychological experiences of labour and delivery expectant mothers during the COVID-19 pandemic, Mayopoulos and colleagues conducted a study of 136 women in labour (68 with suspected or confirmed COVID-19).⁴⁹ They hypothesized that the absence of family or a designated support person due to COVID-19 would be a unique stressor and potentially impact outcomes. Acute stress response to labour was evaluated using the Peritraumatic Distress Inventory – a self-reported tool. COVID-19 patients were matched on demographic and clinical characteristics. Women with COVID-19 who were not permitted family or designated support person had a 6-fold higher odds of acute stress symptoms during childbirth compared with women with COVID-19 women who were permitted visitors (OR 5.70, 95% CI 1.39 to 42.44). Likewise, women with COVID-19 without a support person had higher odds of experiencing greater pain during delivery, of delivering newborns with lower birthweight, and of having increased NICU admission rates

compared to women with COVID-19 with a support person. In contrast, Greene and colleagues evaluated IPAC measures including visitor restrictions on maternal and newborn length of stay. The institutional restrictions were implemented in March 2020 and participants were divided into a pre-implementation (January to February 2020) and post-implementation group (March to April 2020).⁵⁰ As part of the visitor restrictions, one support person was permitted during delivery but not post-partum until April 2020, at which time a single post-partum visitor was permitted. Across 1016 deliveries pre-implementation (January to February 2020) compared to 920 deliveries post-implementation (March to April 2020), hospital length of stay was significantly shorter in the post-implementation period after delivery without increases in rates of adverse maternal or neonatal outcomes up to 28 days.

Appendix C: Mechanisms to Mitigate Harms to Patients and Families Associated With Visitor Absence and Strict Visiting Policies

Occasionally, more stringent visiting policies may need to be adopted (e.g., hospital COVID-19 outbreaks) in order to protect in-patients and healthcare workers. After evaluating and making exceptions for patients at high risk of essential caregiver absence, we evaluated the literature for methods to enhance communication in the absence of in-person visitors.

Mitigating the Harms of Family and Essential Caregivers Absence

In a qualitative study evaluating family perspective pre-and post- visiting restrictions for patients admitted to an ICU, 4 themes emerged surrounding the importance of family presence: (1) coping with the illness by being present, (2) advocacy and support for the patient, (3) building trust with the health care team, and (4) emotional support from the health care team.¹ These patient/family centered themes could be addressed with effective communication focused on (1) connecting with the health care team and (2) connecting patients to families.

Connecting with the Health Care Team

Close communication between families of acutely and critically ill patients has been shown to improve psychologic outcomes and lead to higher quality surrogate decision making.^{41,42} When family must be kept away, electronic communication through phone calls or video conferencing was widely adopted by health care systems around the world.⁵¹ In a study by Valley and colleagues, 82% of surveyed hospitals in Michigan reported changes to how clinicians were routinely communicating with families.⁵² A study that evaluated the feasibility and acceptability of e-communication for palliative care family meetings during the pandemic found that video conferencing was successfully scheduled across 97% of cases, and 80% of family members felt comfortable articulating questions and expressing thoughts throughout the meeting.⁵³ Following the meeting they expressed trust in the clinical team. A series of other studies reported that electronic communication was inferior to in-person communication but felt to be somewhat effective.^{43,54} Telephone communication was useful for sharing brief updates but not ideal for more complex discussions surrounding goals of care – video conferencing (if in person meetings were not feasible) were preferable methods of communicating to ensure family and clinician perspectives were aligned.⁵⁴ Nardo and colleagues report on their success with the implementation of routine brief updates via WhatsAppTM video calls to communicate with

families of surgical patients.³ Daily, brief video calls via WhatsApp™ led to a high percent of satisfaction by patients and their families and a reduction in emotional stress.

Effective, frequent, timely, and uninterrupted communication with each family may not always be feasible by acute care and critical care providers during the height of a pandemic. Family medical communication teams (FMCT) are a unique approach to facilitating communication when health care providers may be overstretched with minimal time for meaningful and frequent updates.^{55,56} Wendel and colleagues report on the effectiveness of their FMCT model during the first wave of the pandemic at their institution in New York city.⁵⁵ The FMCT includes expertise across various subspecialties (e.g., anaesthesiology, palliative care, spiritual care, social work, service excellence member) whose goal was to provide a 24-hour a day/7 days a week liaison service to support families of patients admitted to the ICU.

A “service excellence” department existed prior to the pandemic and functioned as a communication coordinator between families and the medical/surgical services. A FMCT professional was assigned to each patient’s family at the time of ICU admission with the goal of developing and maintaining a relationship with the patient’s family for the duration of the ICU stay. Following an update from the medical team, the FMCT would update the family at a consistent time each day. Feedback from 20 families transferred to the ICU and enrolled in this program early during the pandemic felt there was (1) an improved transfer of information, (2) a better understanding of care provided, and (3) reduced fear that their loved one was alone. It also provided FMCT members a sense of renewed purpose during the pandemic.

However, this format of communication may not be culturally appropriate for all populations which warrants further evaluation. More data is needed to better quantify the effectiveness of these formats of communication across all care settings.

Connecting Patients to Families

Telephone and, in particular, video-communication has been an effective way to connect patients to families.^{28,43,52,54} In the study by Pun and colleagues that demonstrated a lower incidence of delirium across COVID-19 patients admitted to ICUs who experienced family visits, with approximately half of these visits occurring virtually.²⁸ Video conferencing can reduce risks associated with the feeling of patient isolation. Where a patient cannot communicate, the visualization of the patient has been associated with a heightened sense of awareness on the part of the family of the clinical and/or critical state their family member is in.

Outside of clinical updates, facilitating video or telephone calls between families may lead to increased workload for nursing staff who may need to be present to facilitate communication between patients and families. Often times, nurses and bedside clinicians have limited time to set up and stay for a facilitated communication session between families and the patient. Given this, certain centers adopted unique strategies through the utilization of designated volunteers whose primary focus was to arrange and facilitate family communication. Moolla and colleagues describe their experience with establishing a video call visit system in their hospital in South Africa.⁵⁷ A designated video call champion was established on each ward. Their role included ensuring patients know about devices allocated to wards to facilitate video calls and taking primary responsibility for making the calls. Staff underwent training in privacy, device utilization

and device decontamination between patients. If using the ward device, families could book calls by calling the nursing station or messaging the video call visit device. Disposable plastic sleeves to cover the device was used to minimize fomite transmission followed by decontamination with alcohol-based solutions between patients. To enhance privacy, if the designated ward-device was used, any video call history or media would be deleted by the designated video call champion following the session. For families without access to devices, the hospital provided devices to be used at a safe and distanced location on the hospital premises. Similar successful programs have been implemented in other jurisdictions using medical student volunteers.⁵⁸ One such program also included medical students training families on methods of using video calls if they were unfamiliar, booking dates/times with the bedside nurse and family, and generating a list of multilingual students available to emergently assist in the setting of language barriers.

Given that video conferencing requires access to devices, it may not always be feasible if families do not have one or multiple electronic devices. Even if the device is provided to patients by the institution, without the family member having a device capable of video conferencing, this mode of communication would not be possible. Access tends to follow socioeconomic lines with related equity considerations. In the study by Piscitello and colleagues, there were more documented telephone/electronic communication meetings for White or African American patients compared to Hispanic or Latino.²² Darrat and colleagues characterized socio-economic disparities in the use of (outpatient) telehealth during the first wave of COVID-19 in the State of Michigan.⁵⁹ From March to May 2020, across 1,162 patient for the Department of Otolaryngology,⁵⁹ 990 visits occurred (virtual, telephone, in person) of which 44% were virtual. Increasing age and lowest median household income quartile were associated with a lower odds of completing a virtual visit overall. This study highlights the importance of identifying vulnerable populations who may not engage in telehealth and addressing barriers to ongoing health care engagement. Furthermore, electronic communication does not allow for impromptu conversations, often is challenging when discussing escalation of care or end of life care and may be associated with the sentiment of loss of privacy. A study by Cattelan and colleagues explored the psychologic impact of being the designated family member receiving e-communication for patients in the ICU with visitor restrictions. Despite 99% reporting that they felt their loved one was safe, they were confident in the care team and valued the information provided, 83% experience anxiety and 73% depression.² Widespread formal training in e-communication techniques (“web-side manner”) is currently not provided. This medium can be particularly challenging for difficult conversations, breaking bad news or facilitating terminal goodbyes.^{60,61} A video good-bye tool that provides a structured approach to virtual end-of-life conversations and a framework on how to facilitate the “good bye” process between families and their loved ones have been proposed by Frydman and colleagues.⁶¹ Techniques described to enhance the effectiveness of e-communication while maintaining privacy are outlined in Figure 2. Where feasible, some centres have used outdoor spaces to facilitate visits between patients and families.

Mediums of Communication and Communication Teams	General Communication Considerations and Preparation	Health Care Team and Family Communication Considerations	Patient and Family Communication Considerations
<ul style="list-style-type: none"> ▪ Electronic communication (e.g., telephone, teleconference, video-Call (Facetime, WhatsApp, Skype, Zoom etc.) ▪ Distant in-person communication (e.g., outside visits, window visits) ▪ Family medical communication teams ▪ E-communication teams 	<ul style="list-style-type: none"> ▪ Provide electronic devices to wards/family members to facilitate equitable access ▪ IPAC involvement to guide disinfectant approach ▪ Platform chosen should align with hospital privacy policies ▪ Identify a single point person amongst family for whom communications will be arranged ▪ Consider E-communication teams to arrange, prepare for meetings ▪ Test electronic devices in advance 	<ul style="list-style-type: none"> ▪ Significant updates (deterioration or end-of-life) ideally arranged in-person ▪ If not feasible, video conference is preferable to telephone ▪ Consider Family Medical Communication teams if work load does not allow for frequent family updates ▪ Video conferencing may facilitate presence of translator if needed ▪ Arrange for communication to be in a quiet location with minimal interruptions. 	<ul style="list-style-type: none"> ▪ Arrange communication outside of the health care team update with family ▪ Nursing staff may not be able to facilitate, consider e-communication teams (e.g., other health care professionals arrange/education/facilitate communication session) ▪ Table stands for devices ▪ Delete any history if communal device ▪ Offer to provide visual of the room

Figure 2. Communication Considerations in the Setting of Visitor Restrictions

Culturally appropriate forms of communication need to be further evaluated and developed through engagement with different cultural leaders. The effectiveness of mediums of communication should be re-evaluated through feedback from patients, families, and caregivers.

When Visiting or Connecting With Families is Not Feasible

Occasionally families or designated care givers are not available or are simultaneously hospitalized. In the setting of visitor absence, facilitating care, particularly in the setting of delirium or cognitive impairment may be challenging. Ensuring a culturally congruent approach to care where possible should be pursued (i.e., in the setting of language barriers, trying to match health care staff that may speak the language with the patient could minimize fear, delirium or feelings of social isolation).²⁰ End-of-life companion or “No-one-dies-alone” programs are some examples of pre-existing or new programs established during the pandemic that allows health professional volunteers (allied health, medical students) to provide the gift of presence to terminally ill patients who might have otherwise died a lonely death. Across different programs, volunteers provide a wide variety of support including psychologic, spiritual, or social.^{62,63}

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