


Commentary

SHEA Pediatric Leadership Council commentary: Inpatient visitor considerations for pediatric patients during the coronavirus disease 2019 (COVID-19) pandemic

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Visitor restriction during the respiratory viral season is a common practice among children's hospitals. Specific visitor limitations vary by institution but often include a reduction in the total number of adult visitors a patient may have, restriction of visitation by children younger than a particular age, and restriction of all visitors with respiratory symptoms.¹ In a study prior to the coronavirus disease 2019 (COVID-19) pandemic, a policy of visitor restriction was associated with a >50% decreased risk of hospital-acquired respiratory viral infections.²

In the era of COVID-19, the critical importance of social distancing to decrease transmission has required a reduction in the numbers of people present in hospitals and clinics. As a result of physical distancing, the common spaces of hospitals (eg, cafeterias, waiting rooms, and elevators) cannot support pre-COVID-19 volumes, so many members of the healthcare team and support staff have transitioned to remote work arrangements. Many adult hospitals have banned all visitation and have increased the capability for videoconferencing and telephone contact among patients, families, and the healthcare team.³

Parents and guardians are not merely 'visitors' of pediatric patients. They are essential members of the care teams for pediatric patients, providing comfort, reassurance, and support, to their children in addition to assisting with feeding, bathing, toileting, and diaper changes.⁴ They are also involved in the clinical decision-making process with the primary team. Therefore, restriction of parental visitation could negatively affect the child's care and well-being; such restrictions have also been shown to

increase stress levels for the parents.⁵ For children with complex healthcare needs, parent or guardian involvement is crucial to ensuring a safe hospitalization and discharge for the child. Infection prevention and control programs are responsible for the safety of patients, visitors, and healthcare workers, and decisions around visitation must consider all these groups.^{6,7} Recommendations for mitigating COVID-19 transmission risk will continue to evolve as prevalence fluctuates in communities, as variants emerge, and as vaccination becomes widely available, including for children.

Parents and guardians most often share the same household as the hospitalized child and therefore have similar COVID-19 exposure risk.⁸ Parents and guardians of children hospitalized with COVID-19 have already been exposed (or potentially have already been infected), and the incremental increased risk of SARS-CoV-2 transmission with their continued presence with the patient is unknown, but it is likely to be low in most circumstances.⁹ It is useful to consider the patient and parent or guardian as a 'family unit' of exposure to the healthcare system and to plan risk mitigation strategies accordingly (Table 1).

Limiting exposure of the 'family unit' to other patients and visitors in the hospital or clinic can be accomplished (1) by requiring parents or guardians to remain in the patient's room; closing or limiting access to common areas (eg, family kitchens, lounges, and child life spaces); (2) by having a program for symptom screening; and (3) by enforcing masking and social distancing when interacting with the healthcare team and when entering and exiting the facility. If age- and developmentally appropriate, pediatric patients should wear masks if they need to leave their rooms for a medical procedure and at discharge. Appropriate use of personal protective equipment (PPE) by healthcare workers can prevent transmission of COVID-19, and PPE can be tailored to the risk of COVID-19 of the 'family unit.' For example, if the parent of a patient has been exposed to COVID-19 and is under quarantine,

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Table 1. COVID-19 Risk Mitigation Strategies For Visitors of Hospitalized Pediatric Patients

Scenario	Mitigation
Too many individuals in a clinical area make physical distancing more difficult	Based on current state of community transmission, limit visitation to a single or limited number of adult caregiver(s) that remain(s) in a private patient room if available at all times. Provide meals for visitor(s). Leverage technology to supplement communication (see family-centered rounds below).
Family-centered rounds	Videoconferencing platforms to allow additional family members and healthcare team members to participate in conversations.
Need for caregiver to leave the hospital	Allow adult parents or guardians in the same family unit to switch places with one other designated parent or guardian minimizing time spent in public spaces of hospital. Parents should undergo symptom screening each time they re-enter the hospital.
End of life	Exceptions to allow sibling visitation may be appropriate. Siblings should be screened for COVID-19 symptoms before entry, should wear masks, and should perform hand hygiene. Exceptions for additional adults (eg, grandparents) may also be appropriate, but the risk of severe complications with COVID-19 in visiting adult(s) should be taken into consideration.
COVID-19–positive patient, COVID-19–unknown parent or guardian who may be at risk of developing infection	Members of a family unit have likely already had significant COVID-19 exposure. Risk of additional exposure to a contagious child is generally outweighed by the benefit of parental presence. Parents should be informed of risk of infection and counselled to wear PPE and to maintain physical distance. The healthcare team will be using appropriate PPE for the COVID-19–positive patient (and parent). Parents and guardians who develop symptoms concerning for COVID-19 should seek an alternate asymptomatic adult caretaker and should seek COVID-19 testing.
COVID-19–positive patient, COVID-19–positive parent or guardian	If the parent or guardian is well enough to stay at the bedside and contribute to the child’s care, and no alternative caregiver is available, allow the parent to isolate in the patient’s room, encourage masking when an HCW is in the room.
COVID-19–negative patient, parent or guardian with symptoms concerning for COVID-19	If available, asymptomatic adult caregiver preferred. Parents and guardians with symptoms concerning for COVID-19 should seek COVID-19 test. If symptomatic, the parent or guardian needs to stay in the room, and they should wear a mask and maintain physical distancing as much as possible while awaiting test result.
COVID-19–negative patient, parent or guardian positive for COVID-19	If no alternative adult caregiver, consider shared decision-making with family and healthcare team on a case-by-case basis. If benefit of parental presence is believed to outweigh risk, allow parent to isolate in patient’s room (eg, place patient on COVID-19 isolation). Encourage masking and physical distancing by parent.

the ‘family unit’ should be placed on appropriate COVID-19 isolation and workflows while in the hospital or clinic.

Many of these mitigation recommendations presume private patient rooms. The risk–benefit ratio of parent or guardian visitation changes when other patients and families are at risk of exposure. The Centers for Disease Control and Prevention (CDC) recommends at least 1 m between patient beds,¹⁰ so social distancing may not be feasible in all shared rooms. Hand hygiene, mask use by parents or guardians, and physical barriers (eg, curtains) should be emphasized. Perinatal transmission of SARS-CoV-2 infection is very infrequent¹¹; thus, there is little concern about patient-to-patient transmission in the neonatal intensive care unit, even if there is an open pod with multiple patients. Parents and guardians and healthcare workers are the primary risk factor for acquisition of COVID-19 infection for these vulnerable patients; therefore, basic prevention measures focusing on parents or guardians and healthcare workers are most important.

The presence of parents or guardians at the bedside facilitates delivery of family-centered care.¹² Multiple mitigation strategies have been applied to maintain family communication remotely, although this can be logistically complicated for both care teams and families.³ Clear communication regarding visitor restrictions and expectations is critical and should ideally be communicated to families prior to planned visits and hospitalizations, and as early as possible within an unplanned or emergent visit. Policing and enforcing policies can be an additional stressor on our already overextended clinical workforce. There will always be need for

situation-based exemptions, and teams can work with their local infection prevention and control teams to minimize risk to patients, families, and the healthcare team. Possible scenarios include end-of-life care, developmental-delay or complex-care planning, and education at discharge (Table 1). A formal escalation process for visitor policy exceptions to ensure standardization and equity should also be considered.

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References

1. Pong AL, Beekmann SE, Faltamo MM, Polgreen PM, Shane AL. Visitor restriction policies and practices in children’s hospitals in North America: results of an Emerging Infections Network survey. *Infect Control Hosp Epidemiol* 2018;39:968–971.
2. Forkpa H, Rupp AH, Shulman ST, *et al*. Association between children’s hospital visitor restrictions and healthcare-associated viral respiratory infections: a quasi-experimental study. *J Pediatric Infect Dis Soc* 2020;9: 240–243.
3. Hart JL, Turnbull AE, Oppenheim IM, Courtright KR. Family-centered care during the COVID-19 era. *J Pain Symptom Manage* 2020;60:e93–e97.
4. Lulgiuraj D, Maneval RE. Unaccompanied hospitalized children: an integrative review. *J Pediatr Nurs* 2021;56:38–46.

5. Kirschbaum MS. Needs of parents of critically ill children. *Dimens Crit Care Nurs* 1990;9:344–352.
6. Virani AK, Puls HT, Mitsos R, Longstaff H, Goldman RD, Lantos JD. Benefits and risks of visitor restrictions for hospitalized children during the COVID pandemic. *Pediatrics* 2020;146:e20200000786.
7. Antommaria AHM, Monhollen L, Schaffzin JK. An ethical analysis of hospital visitor restrictions and masking requirements during the COVID-19 pandemic. *J Clin Ethics* 2020;32:35–44.
8. Laws RL, Chancey RJ, Rabold EM, *et al.* Symptoms and transmission of SARS-CoV-2 among children—Utah and Wisconsin, March–May 2020. *Pediatrics* 2021;147:e2020027268.
9. Lee E, Kim D, Chang S, *et al.* Absence of SARS-CoV-2 transmission from children in isolation to guardians, South Korea. *Emerg Infect Dis* 2021; 27:308–310.
10. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Centers for Disease Control and Prevention website. <https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>. Accessed May 21, 2021.
11. Shalish W, Lakshminrusimha S, Manzoni P, Keszler M, Sant’Anna GM. COVID-19 and neonatal respiratory care: current evidence and practical approach. *Am J Perinatol* 2020;37:780–791.
12. Family presence policies for pediatric inpatient settings during the COVID-19 pandemic. American Academy of Pediatrics website. <https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/family-presence-policies-for-pediatric-inpatient-settings-during-the-covid-19-pandemic/>. Updated January 25, 2021. Accessed February 12, 2021.