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Appendix 1. Methods of the modified Delphi process.

Round 1

We e-mailed each participant the electronic link to the Round 1 survey on February 2, 2021, followed by periodic reminder emails. The Round 1 survey included 154 items. Items were categorized into 12 themes (Figure 1), that were divided into two domains: (1)experiences related to restricted visitation during the COVID-19 pandemic (n=50 items) and (2)strategies to mitigate the impact of restricted visitation during the COVID-19 pandemic (n=104 items) (Appendix 1). Participants rated each item using a 9-point Likert scale (1=not significant/not essential, 9=significant/essential). Each theme included a qualitative, open text field for participants to provide comments or suggestions for new items that were important but not currently included. We determined consensus for any statement a-priori as a median score of 1-3 (not significant/not essential) or 7-9 (significant/essential). We excluded items with median score of 1-3 (not significant/not essential) from Round 2. We thematically analyzed new items suggested in the open text field (in duplicate by KM/KK/NJ/LH) and grouped them by previously determined themes, which grouped related experiences and strategies. These items were rated during Round 2.

Round 2

We sent each participant the electronic link to the Round 2 survey on March 9, 2021, followed by periodic reminder emails. During Round 2, participants used the same 9-point Likert scale to rate items that did not meet consensus during Round 1 and new items suggested in Round 1. Participants ranked importance of consensus items from Round 1 (median=7-9;n=82) using a weighted ranking system. We asked participants to assign a weighted rank to items on a scale of 0-100, based on the perceived importance of that statement, relative to the other statements within the same theme.

Round 3

Items that did not reach consensus in Round 2 were rated on the first day of a Zoom-based virtual National Stakeholder Meeting (Round 3) using the same 9-point Likert scale. All items that reached consensus (median=7-9;n=82) were re-ranked during the second day of the National Stakeholder Meeting to determine priority.

Appendix 2. Delphi Survey from Round 1 Sample Set

INSTRUCTIONS

The goal of this work is to generate national evidence-informed consensus statements on restricted visitation policies that are informed by patients, families, healthcare professionals, and decision makers' experiences. We used data from our research program to assemble a list of experiences and recommendations. The research included: 1) An environmental scan of Canadian hospital restricted visitation policies throughout the first wave of the COVID-19 pandemic; 2) Semi-structured interviews to understand the personal impact of restricted visitation policies on ICU patients, families, critical care clinicians, and decision makers; and 3) A scoping review to synthesize the existing literature on impact of restricted visitations.

This survey is Round 1 of a multi-part consensus process. It contains the initial list of experiences and recommendations. We clustered similar experiences and recommendations into themes to facilitate the review process.

In this first round of review, we ask that you:

1. **Review**

Please review each experience or recommendation. Tentative definitions have been provided to clarify themes.

2. **Rate**

Rate each experience and recommendation based on its importance in future restricted visitation policies from "not essential" to "essential". Please use the full range of the 9-point scale.

3. **Advise**

Please provide any other experiences or recommendations that you think are missing from each theme.

There are a total of 15 experiences and recommendations to review. Experiences and recommendations that do not achieve consensus in Round 1 will be re-rated in Round 2 of the consensus process. Panelist-suggested experiences and recommendations will also be included for rating in Round 2. Results will be used to inform a virtual National Stakeholder Meeting on April 7th and 8th, 2021. This event will create evidence-informed consensus statements with input from patients, family members, critical care clinicians, healthcare administrators, and ministers of health.

We expect Round 1 to take approximately 30 to 45 minutes to complete. You can save your responses and return to the survey at any time before February 15th, 2021.

Please email us directly if you have any questions.

Thank you for your participation

TABLE OF CONTENTS

The following is a list of headings that encompasses the overarching themes of the experiences and recommendations to be reviewed. We present them in a Table of Contents to give you a **high-level** overview.

1) DEMOGRAPHICS
2) KEY EXPERIENCES
    1. Impact on patients and their families during restricted visitation
    2. Impact of restricted visitation on patient and family-centered care (PFCC)
    3. Impact of restricted visitation on healthcare professionals
    4. Experiences with alternatives to in-person visitation (e.g. virtual visits, phone visits)
3) RECOMMENDATIONS
    5. Communication of policy and policy changes
    6. Strategies for policy implementation and consistency
    7. Facilitation of in-hospital visitation for family or visitors
    8. End-of-life policy
    9. Criteria for visitation exceptions if no visitation allowed
    10. Facilitation of out of hospital communication with family or visitors
    11. Technological supports to facilitate communication
    12. Organizational supports

Sample Set: Domain 1 (Experiences)

This section will ask you to reflect on the COVID-19 pandemic and implementation of restricted visitation policies within the context of critically ill patient admissions and care. Rate each element as to how accurately it reflects the key experiences of the restricted visitation policies during the COVID-19 pandemic using the scale provided. Please use the full range of the 9-point scale to rate items from "not significant" to "significant."

1. Impact on patients and their families during restricted visitation
    1.1. Patient isolation, loneliness and/or sense of hopelessness
    1.2. Less connection between patient and healthcare
    1.3. Visitor and family risk exposure
    1.4. Family members experience anxiety of COVID-19 exposure; family refused to come visit even if it was allowed
    1.5. Family was absent at end-of-life
    1.6. Healthcare workers were concerned regarding the psychosocial impact on patients and their families
    1.7. Patients experienced lack of spiritual care
    1.8. Families experienced decreased sleep
    1.9. Families were in denial or did not understand the how sick the patient was (E.g., severity of critical illness)
    1.10. Families felt like they were an inconvenience to the bedside nurse when phoning for an update on the patient
    1.11. Families were turned away from entering the hospital (E.g., felt like they are already in crisis, lack of compassion from security, etc.)
    1.12. Geographic distance from hospital limited families access to the patient during periods of rapid decline (E.g., end-of-life)
    1.13. Families needed reassurance that their loved one was not abandoned
    1.14. Families needed to be listened to or emotionally supported

    Are there any other impacts on patients and families that are missing and should be included? (free text)

Sample Set: Domain 2 (Recommendations)

Reflect on the COVID-19 pandemic and the implementation of restricted visitation policies within the context of critically ill patient admissions and care. Rate each recommendation based on its importance and benefit for inclusion as recommendations in the development of restricted visitation policies during an infectious disease outbreak using the scale provided. Please use the full range of the 9-point scale to rank items from "not-essential" to "essential."

5. Ways to improve communication of policy and policy changes

5.1. Provide a pamphlet that includes information on reasons for restricted visitation; concise single page
5.2. Website with brief communication of policy or clear location for policy changes (E.g., pop-up messaging)
5.3. Send electronic messages to staff and patient's families with periodic reminder of current policies (E.g., email, text message, page)
5.4. Include policy changes in chief medical officer of health announcements
5.5. Use news segments to provide updates on restricted visitation policies to the public
5.6. Use social media as a resource for regional, up-to-date restricted visitation policies
5.7. Implement hard copies of up-to-date restricted visitation policies at the hospital (E.g., posters and signage within the hospital, at entrances, and throughout the units)
5.8. Incorporate in-person communication by management and leadership to healthcare team regarding policy changes (E.g., team huddles, at shift transitions, at handover)
5.9. Create a shared online portal with up-to-date policy information (E.g., SharePoint, Google Docs)
5.10. Provide a platform for families to have staff answer their questions or address their concerns about restricted visitation policies (E.g., website portal, email, number to call)
5.11. Provide a platform for patients and families to participate in clinical discussions when visitation is not possible (e.g., questions to ask the care team, information about the patient, etc.)

Are there any other recommendations for communication that are missing and should be included? (free text)

Appendix 3. Delphi Survey from Round 2 Sample Set

INSTRUCTIONS
Thank you for participating in Round 1 of the Delphi consensus survey. Your perspective is important in the development of national evidence-informed consensus statements on ICU restricted visitation policies.

This survey is Round 2 (of 2) of the multi-part consensus process. This survey contains the initial list of experiences and recommendations that were ranked in Round 1 and additional items that were suggested by participants in Round 1. This survey contains two parts:

- **Section 1: a weighted ranking of items that reached consensus in Round 1.**
- **Section 2: a 9-point Likert Scale to rescore items that did not reach consensus and to score additional items that were suggested in Round 1.**

Results from this survey will be used to generate national evidence-informed consensus statements on ICU restricted visitation policies during the National Stakeholder Meeting on April 7th and 8th, 2021.

We expect this survey to take approximately 30 to 45 minutes to complete. Qualtrics automatically saves your survey so you can return to the survey at any point during the 2-week window to complete. Please submit your survey by March 23, 2021 at 4:00pm MST.

Please email us directly if you have any questions.

Thank you for your participation.

TABLE OF CONTENTS

The following is an overview of themes within the key experiences and recommendations that you will be rating in this survey. We present them in a Table of Contents to give you a high-level overview. There are 2 sections with 2 categories: (1) Key experiences and (2) Recommendations. Each category has themes similar to Round 1, specified below. Within each theme, you will be ranking or rating items that are composed of consolidated statements from the previous round or newly suggested statements from participants.

KEY EXPERIENCES

1. Impact on patients and their families during restricted visitation
2. Impact of restricted visitation on patient and family-centered care (PFCC)
3. Impact of restricted visitation on healthcare professionals
4. Experiences with alternatives to in-person visitation (e.g. virtual visits, phone visits)

RECOMMENDATIONS

5. Ways to improve communication of restricted visitation policy and policy changes
6. Strategies for restricted visitation policy implementation and consistency
7. Facilitation of in-hospital visitation for family or visitors
8. End-of-life policy
9. Criteria for visitation exceptions if no visitation allowed
10. Facilitation of out of hospital communication with family or visitors

11. Technological supports to facilitate communication
12. Organizational supports

SECTION 1: PART 1

In Round 1, we identified 122 items that were identified to be essential or to have had a significant impact on patients, families or healthcare professionals. Due to the high number of items from Round 1, we have consolidated similar statements into themes. In this first section of the survey, we ask that you **provide a weighted ranking for each action item.**

Similar to Round 1, these items have been grouped into two categories: 1) key experiences; and 2) recommendations. **Please allocate a value to each item based on your experience, perceived understanding of the impacts of restricted visitation policies, and/or the importance for improving ICU restricted visitation policies during an infectious disease outbreak**. Allocated values may range for 0-100 however, the overall total allocated value for each theme of items **must total to 100**. You will receive an error message if your score does not total to 100. We suggest reading all items first before assigning a value to each item.

For example, if you wanted to allocate equal importance across 4 items, a value of 25 would be allocated to each item. Alternatively, the values could be dispersed to indicate greater variability in the item's importance. Scores of 0 are allowable.

*Please note that all items in this section have been recorded as essential or significant. This ranking process is to determine which items are of greater importance than other items. However, a lower ranking does not mean that the statement will be excluded from future policy considerations.

Priority Rankings Sample Set: Domain 1 (Experiences)

The first four themes ask you about **your experiences or perceived understanding of the impact of restricted visitation policies during the COVID-19 pandemic**. Please rate each item by assigning a weight value between 0-100 based on your experience of the impacts of restricted visitation policies. For example, if an item frequently occurred, or you experienced the statement as a significant impact, you should rank this as a higher score. If items are of equal occurrence or significance, you may rank them the same (e.g., 16.7-16.7-16.7-16.7-16.6-16.6). Scores of 0 are allowable.

Note: Allocated values may range from 0-100 but the overall total summed value must equal 100 points.

Theme 1: Impact on patients and their families during restricted visitation

1.1. Patients experienced isolation, loneliness or decreased interaction and connection with the healthcare team (e.g., staff only checked in on patients when it was medically necessary or communicated frequently via intercom devices).
1.2. Family was absent at the end-of-life or did not visit their loved one before they were sedated or intubated.
1.3. Families did not understand how sick the patient was (e.g., severity of critical illness).
1.4. Families were turned away from entering the hospital, had to wait outside on the sidewalks or in their cars.

1.5. Families experienced lack of compassion from security and healthcare staff or when requesting an exception for visitation.
1.6. Families needed reassurance and additional emotional support from healthcare staff when visitor restrictions were in place (e.g., to know that their loved one was not abandoned/forgotten, impact on coping and grief).

SECTION 1: PART 2

The next seven themes ask you about **recommendations for informing restricted visitation policies during future infectious disease outbreaks.** Please rate each element by assigning a weight value between 0-100 based on your perceived importance of each recommendation. Items with a lower score will indicate a lower priority, and items with a higher score will indicate higher priority.

Priority Rankings Sample Set: Domain 2 (Recommendations)

Please rate each element by assigning a weight value between 0-100 based on your perceived importance of each recommendation. Items with a lower score will indicate a lower priority, and items with a higher score will indicate higher priority. If items are of equal priority, you may rank them the same (e.g., 20-20-20-20-20). Scores of 0 are allowable.

Note: Allocated values may range from 0-100 but the overall total allocated value must equal 100 points.

Theme 5: Ways to improve communication of restricted visitation policy and policy changes

5.1. Provide a hardcopy of up-to-date restricted visitation policies at the hospital and on each unit (e.g., pamphlet, single page handout, communication board or posters on the unit that includes policy and resources and links to call for appeal and exemptions, further information).
5.2. Create a website with communication of current restricted visitation policies at each institution (e.g., options for electronic messaging subscriptions, a platform to share experiences across institutions, portal for families to ask questions or submit appeals to visitor restriction policies).
5.3. Integrate news and media to accurately communicate changes in restricted visitation policies to the public (e.g., daily provincial health updates, news segments, social media).
5.4. Incorporate in-person communication by management and leadership to communicate policy changes to staff, families and visitors (e.g., to answer questions about the policy, address family and visitors concerns and appeals).
5.5. Communicate policy changes to hospital staff during regular working hours and before the change becomes effective or is communicated to the public (i.e., all staff should know the policy change before the media, changes should be communicated during regular working hours).

SECTION 2: PART 1

In Round 1, we identified 30 items that did not reach consensus and 24 new items were suggested for consideration. **In this second section of the survey, we ask that you provide a score on a 9-point Likert Scale.**

Similar to Round 1, these items have been grouped by two categories: 1) key experiences; and 2) recommendations. For key experiences (themes 1-4) please assign a score from 1 to 9 indicating whether the statement applies to your experience with restricted visitation policies during the COVID-19 pandemic (1 = Not Significant, 9 = Significant). For recommendations (themes 5-12), please assign a score from 1 to 9 indicating whether you think the recommendation would be essential in informing restricted visitation policies during an infectious disease outbreak (1 = Not-Essential, 9 = Essential).

*Items in themes 5 and 12 all reached consensus in Round 1 and will not be re-ranked in this section.

Consensus Building: Sample Set Domain 1 (Experiences)

The first four themes ask you about your **experiences or perceived understanding of the impacts of restricted visitation policies during the COVID-19 pandemic.** Please rate each element based on your experiences or perceived understanding of the impacts of restricted visitation policies during the COVID-19 pandemic. Please use the full range of the 9-point scale to rank items from “not-significant” to “significant.”

*Please note, for some of the following statements, significant may not be the best rating anchor for some statements. Please frame some statements in the context of “strongly disagree (score 1)” to “strongly agree (score 9)”. For example, if an item occurred frequently at your institution and you felt it had a significant impact on your work, please assign a score of 9 to this item.

Theme 1: Impact on patients and families during restricted visitation

1.1. There were visitor and family concerns about COVID-19 exposure.
1.2. Family members were less present or refused to come visit even if it was allowed due to concern of contracting COVID-19 themselves.
1.3. Patients experienced a lack of spiritual care.
1.4. Families experienced decreased sleep.
1.5. Families were dissatisfied with the communication methods provided (e.g., feeling like an inconvenience to the bedside nurse when phoning for an update on the patient).
1.6. Geographical distance from the hospital limited family’s access to the patient during periods of rapid health decline (e.g., end-of-life).
1.7. Patients and families experienced increased financial burden due to visitation requirements (e.g., job loss or leave of absence, isolation requirements at a hotel, additional parking costs as families and visitors could not stay at the hospital when the patient was in treatment).
1.8. Restricted visitation policies were inconsistent with the community case numbers leading to anger and frustration amongst families and visitors.
1.9. There was an impact on children and siblings who were unable to visit (e.g., distressing, mental health concerns, isolation requirements).
1.10. There was animosity towards the healthcare team when visitors and families were told they could not physically touch their loved one due to physical distance requirements and PPE.
1.11. Policy changes distributed to the public were inaccurate or inconsistent across units and hospitals.

SECTION 2: PART 2

The next five themes ask you **about recommendations for informing restricted visitation policies during future infectious disease outbreaks**. Please assign a score from 1 to 9 indicating whether you think the recommendation would be essential in informing restricted visitation policies during an infectious disease outbreak (1 = Not-essential, 9 = Essential).

*Please note items in themes 5 and 12 reached consensus in Round 1 in the first survey, and thus, are not re-scored in this section.

Consensus Building: Sample Set Domain 2 (Recommendations)

The next five themes ask you about **recommendations for informing restricted visitation policies during future infectious disease outbreaks.** Please assign a score from 1 to 9 indicating whether you think the recommendation would be essential in informing restricted visitation policies during an infectious disease outbreak (1 = Not-essential, 9 = Essential).

Theme 6: Strategies for restricted visitation policy implementation and consistency
6.1. Ensure consistency in visitation policies across Canada.
6.2. Ensure consistency in visitation policies within provinces and territories.
6.3. Ensure consistency in visitation policies within hospitals (e.g., across units).

Supplementary Table 1. Re-prioritized strategies identified in Round 3[a]

DOMAIN 2: STRATEGIES		
Prioritized strategies identified in Round 3	**Theme Mean (SD)**	**Item Mean (SD)**
Theme 5: Ways to improve communication of restricted visitation policy and policy changes		
Communicate policy changes to hospital staff during regular working hours and at least 24-hours before the change becomes effective or is communicated to the public.	20.0 (3.3)	29.0 (14.9)
Create multiple vehicles of communication of current restricted visitation policies at each institution.		23.7 (14.3)
Theme 6: Strategies for restricted visitation policy implementation and consistency		
Implement a clear, straightforward, timely and accessible process to request exceptions and appeals to restricted visitation polices.	8.3 (1.4)	14.2 (16.6)
Create proactive and staged implementation of restricted visitation policies that are dependent on community COVID-19 caseload or hospital capacity, and patient circumstances. These policies may differ for essential care providers and visitors.		13.9 (12.0)
Include key stakeholders in policy development and adaption.		13.9 (10.5)
Permit hospitals to adapt provincial policies for their facilities and individual units.		11.2 (7.9)
Assign designated staff members to address questions regarding visitation and policy changes, address concerns, exceptions and appeals, and consistently applies the policy.		9.9 (9.5)
Theme 7: Facilitation of in-hospital visitation for families and visitors		
Designate unit-level “visitor advisors" if feasible. The role of these “visitor advisors" may include the following: communicate the policy, demonstrate donning and doffing of PPE, teach proper handwashing, answer questions, inform visitor what to expect on the unit, communicate consequences for non-compliance with hospital PPE policies, etc.	6.3 (0.4)	10.0 (9.0)
Implement a straightforward process to appeal the restricted visitation policy.		9.2 (6.9)
Do not exclude children from visitation if they visit with an adult who ensures they comply with public health recommendations.		7.5 (7.5)
Allow one designated visitor per patient at a time but allow the designated visitor to be changed to include multiple visitors throughout the patient's ICU stay.		7.1 (10.2)
Theme 8: End-of-life policy		
Create a clear visitation policy for end-of-life including clear rules on the number of people who can visit, consider end-of-life process for other cultural backgrounds, and when visitors are COVID positive. This end-of-life policy should include a clear definition of end-of-life, which allows visitors while patient is lucid and able to interact (i.e., not comatose at end-of-life)	14.3 (2.7)	26.2 (19.2)

Visitors are permitted at all times for end-of-life regardless of patient's COVID-19 status. If a patient is COVID-19 positive, this should be accompanied with a well-defined protocol (e.g., requiring PPE, self-isolation, etc.).		20.0 (13.1)
Theme 9: Criteria for visitation exceptions if no visitation is allowed		
Consider family caregivers as an integral member of the healthcare team, and a distinct entity from visitors.	16.7 (2.5)	23.6 (13.1)
Allow visitation for all critically ill patients regardless of patient's COVID-19 status.		20.6 (12.9)
Theme 10: Facilitation of out of hospital communication with family or visitors		
Designate one to two identified family spokespersons to be notified in advance of daily virtual rounds, participate in clinical decision-making, and to receive and disseminate family updates.	10.0 (1.8)	17.9 (13.1)
Provide videoconferencing options to family members and patients who are separated.		17.6 (14.5)
An effort should be made to provide frequent (medical) updates (including allied healthcare) to the family and provide opportunities for families to ask questions.		15.2 (11.3)
Theme 11: Technological supports to facilitate communication during restrictions		
Increase availability of technological devices to facilitate family involvement in daily rounds, family conferences, virtual visits, and communication of family messages to patient.	20.0 (4.7)	33.5 (16.1)
Theme 12: Organizational Supports		
Provide clear and consistent messaging to staff about visitation policy; clearly outline circumstances when policy exceptions can apply or defer designated visitor approvals to senior leadership.	16.7 (2.0)	22.0 (11.1)
Provide mental health supports for families, patients, and staff, including onsite support options for staff.		19.2 (10.7)

Abbreviation: SD=standard deviation.

[a]For full list of item rankings in Round 3, see Supplementary Table 6.

Supplementary Table 2: Round 1 modified Delphi consensus process results

DOMAIN 1: EXPERIENCES		
Item	**Consensus**	**Median (IQR)**
Theme 1: Impact on patients and families during restricted visitation		
1.1. Patient isolation, loneliness and/or sense of hopelessness	✓	8.0 (7-9)
1.2. Less connection between patient and healthcare	✓	7.0 (5-8)
1.3. Visitor and family risk exposure	×	6.0 (4-8)
1.4. Family members experience anxiety of COVID-19 exposure; family refused to come visit even if it was allowed	×	4.0 (2-7)
1.5. Family was absent at end-of-life	✓	8.0 (6-9)
1.6. Healthcare workers were concerned regarding the psychosocial impact on patients and their families	✓	8.0 (7-9)
1.7. Patients experienced lack of spiritual care	×	5.0 (3-7)
1.8. Families experienced decreased sleep	×	6.0 (4-7)
1.9. Families were in denial or did not understand the how sick the patient was (e.g., severity of critical illness)	✓	8.0 (6-9)
1.10. Families felt like they were an inconvenience to the bedside nurse when phoning for an update on the patient	×	5.5 (4-7)
1.11. Families were turned away from entering the hospital (E.g., felt like they are already in crisis, lack of compassion from security, etc.)	✓	7.0 (5-9)
1.12. Geographic distance from hospital limited family's access to the patient during periods of rapid decline (E.g., end-of-life)	×	6.5 (4-8)
1.13. Families needed reassurance that their loved one was not abandoned	✓	8.0 (6-9)
1.14. Families needed to be listened to or emotionally supported	✓	8.0 (7-9)
Theme 2: Impact on Patient and Family-Centered Care (PFCC) during restricted visitation		
2.1. Healthcare professionals had additional time available for the delivery of daily patient-centered care	×	5.0 (3-7)
2.2. There was no impact on delivery of patient-centered care	×	4.0 (2-7)
2.3. Healthcare professionals were able to build stronger rapport with patients	×	4.0 (2-6)
2.4. There were additional opportunities for families to communicate directly with the care team (E.g., physicians contacted the family directly about patient status)	×	5.0 (3-7)
2.5. Healthcare professionals were missing details about patient history usually provided by the family	✓	7.0 (5-9)

2.6. When patient care decisions were required, healthcare professionals did not have the opportunity to consult with family, or patient care decisions were delayed	×	6.0 (4-8)
2.7. Family was not present to take part in key elements of patient care (E.g., physiotherapy, feeding, delirium prevention/ management)	✓	8.0 (7-9)
2.8. During restricted visitation, family was not present to advocate for patient care needs	✓	8.0 (6-9)
2.9. There were added patient safety issues (E.g., increased code whites, patient falls, increased risk or prevalence of delirium)	×	6.0 (4-7)
2.10. There was an increase in sedative use	×	5.0 (3-7)
2.11. It was challenging to accurately convey the patient's clinical status and appropriateness of care to families (E.g., increased tension amongst families and healthcare professionals)	✓	7.0 (6-9)
2.12. Healthcare professionals were unable to develop close, personal and trusting relationships with family due to the reliance on virtual or phone call updates (E.g., loss of meaningful connection and rapport with patients and family)	✓	7.5 (6-9)
2.13. It was difficult to express compassion without body language (due to PPE)	✓	8.0 (6-9)
2.14. It was difficult to maintain trust between patients and families, and the healthcare team based on the misinformation that was presented in social media	×	6.0 (4-8)
Theme 3: Impact on healthcare professionals		
3.1. There was concern over staff exposure risk	✓	7.0 (6-9)
3.2. It was difficult to communicate rapidly changing visitation policies to family	✓	9.0 (7-9)
3.3. There was frustration with the timing or distribution of visitation policy changes (i.e., weekends, evenings, end of day on Friday)	✓	8.0 (7-9)
3.4. There were reports of discontent because of the frequent changes in visitation policies	✓	8.0 (7-9)
3.5. There was variation in the interpretation of visitation policy details	✓	9.0 (7-9)
3.6. There was a lack of support from the leadership team when developing restricted visitation policies	✓	7.0 (4-8)
3.7. During restricted visitation, policy makers took an active role in communicating with the healthcare team	×	4.0 (2-6)
3.8. During restricted visitation, the leadership team took a visible role in communicating with family members to offset healthcare professionals' workload	✓	3.0 (2-6)*

3.9. Healthcare professionals were conflicted between advocating against the policy (to prioritize patient well-being) and advocating for the policy (to protect the healthcare system)	✓	8.0 (6-9)
3.10. Healthcare professionals experienced an impact on job satisfaction	✓	8.0 (7-9)
3.11. Healthcare professionals experienced moral distress	✓	9.0 (8-9)
3.12. There was a lack of trust between healthcare professionals and visitors (e.g., visitors mis-identified themselves as the designated visitor, or lying about COVID-19 status)	✓	7.0 (4-9)
3.13. Frequent conversations with family members were required to develop and maintain trust (e.g., trust that the healthcare professionals were doing all that they could, giving adequate care, and for the acceptance of pandemic circumstances, etc.)	✓	8.0 (6-9)
3.14. There was a sense of tension and lack of trust amongst healthcare professionals and policy makers	✓	7.0 (5-8)
Theme 4: Alternatives to in-person visitation		
4.1. There were concerns regarding confidentiality breaches (E.g., showing a patient on video call without their consent)	×	5.0 (3-7)
4.2. There were limited communication options when there was a language barrier between patients and families and the healthcare team	✓	7.0 (5-9)
4.3. There was variability in the patients or families' familiarity or comfort with the technology used for communication	✓	7.0 (6-9)
4.4. Clinical circumstances limited the capacity for patients to communicate or interact with families (E.g., patient on breathing machine, proned patients, patients with delirium)	✓	8.0 (7-9)
4.5. Patients and families' socioeconomic status impacted their ability to access technology that supported virtual communication	✓	7.0 (6-9)
4.6. There were challenges with the number of available technological devices in the ICU	✓	7.0 (3-8)
4.7. Technology was used during patient rounds to communicate with families when restricted visitation polices were in place (E.g., virtual rounds)	×	5.0 (2-7)
4.8. End-of-life visits via technology were incorporated for COVID-19 positive patients	✓	7.0 (3-9)
DOMAIN 2: RECOMMENDATIONS		
Theme 5: Ways to improve communication of restricted visitation policy and policy changes		
5.1. Provide a pamphlet that includes information on reasons for restricted visitation; concise single page	✓	8.0 (6-9)
5.2. Website with brief communication of policy or clear location for policy changes	✓	8.0 (7-9)

5.3. Send electronic messages to staff and patient's families with periodic reminder of current policies (E.g., email, text message, page)	✓	8.0 (6-9)
5.4. Include policy changes in chief medical officer of health announcements	✓	8.0 (6-9)
5.5. Use news segments to provide updates on restricted visitation policies to the public	✓	7.0 (6-9)
5.6. Use social media as a resource for regional, up-to-date restricted visitation policies	✓	8.0 (6-9)
5.7 Implement hard copies of up-to-date restricted visitation policies at the hospital (E.g., posters and signage within the hospital, at entrances, and throughout the units)	✓	8.0 (7-9)
5.8. Incorporate in-person communication by management and leadership to healthcare team regarding policy changes (E.g., team huddles, at shift transitions, at handover)	✓	8.0 (7-9)
5.9. Create a shared online portal with up-to-date policy information (E.g., SharePoint, Google Docs)	✓	7.0 (4-8)
5.10. Provide a platform for families to have staff answer their questions or address their concerns about restricted visitation policies (E.g., website portal, email, number to call)	✓	8.0 (6-9)
5.11. Provide a platform for patients and families to participate in clinical discussions when visitation is not possible (e.g., questions to ask the care team, information about the patient, etc.)	✓	8.0 (7-9)
Theme 6: Strategies for restricted visitation policy implementation and consistency		
6.1. Real-time data linkage between frontline staff and hospital screening personnel to ensure updated visitor lists	✓	8.0 (6-9)
6.2. Decision making support from patient relations department	✓	7.0 (6-8)
6.3. Communicate policy changes to hospital personnel before the change becomes effective or is communicated to the public	✓	9.0 (8-9)
6.4. Ensure that policy changes are sent during regular working hours (e.g., start of the week, not end of day on Friday)	✓	9.0 (8-9)
6.5. Permit hospitals to adapt provincial policies for individual units (e.g., ICU)	✓	8.0 (6-9)
6.6. Permit regional hospitals to adapt provincial policies for their facilities	✓	8.0 (5-9)
6.7. Assign designated staff member(s) within each unit to specifically address questions regarding visitations and visitation policy changes	✓	8.0 (6-9)
6.8. Assign designated staff member(s) to decide exceptions to restricted visitation policies	✓	8.0 (6-9)

6.9. Ensure that the leadership team consistently applies the policy (e.g., leadership team supports the policy, does not allow special circumstances, etc.)	✓	8.0 (7-9)
6.10. Proactive and staged implementation of restricted visitation policies dependent on community COVID-19 case load or hospital capacity	✓	8.0 (7-9)
6.11. Maintain greater focus on patient and family centered care (e.g., rather than focusing on hospital capacity, managing caseloads, etc.)	✓	8.0 (6-9)
6.12. Improve documentation of patients' goals of care and preference for treatment prior to, or during the surge	✓	8.0 (6-9)
6.13. Create a process to request exceptions to restricted visitation policies	✓	8.0 (7-9)
6.14. Establish a rapid appeal process for declined exception requests during restricted visitation	✓	8.0 (6-9)
6.15. Ensure consistency in visitation policies across Canada	×	5.0 (1-7)
6.16. Ensure consistency in visitation policies within provinces and territories	×	6.5 (3-8)
6.17. Ensure consistency in visitation policies within health regions	✓	8.0 (6-9)
6.18. Ensure consistency in visitation policies within cities	✓	9.0 (7-9)
6.19. Pilot test restricted visitation policies to ensure they are ready for various scenarios (e.g., shortages in PPE, window visits, increased contagion rate) before they are needed	✓	7.0 (6-9)
6.20. Include key stakeholders in policy development (e.g., nurses, physicians, decision makers, patients and families)	✓	9.0 (8-9)
Theme 7: Facilitation of in-hospital visitation for families and visitors		
7.1. Designate visitor "greeters" and "navigators" throughout hospitals to communicate the policy, accompany visitors to unit, demonstrate donning and doffing of PPE, teach proper handwashing, etc.	✓	8.0 (7-9)
7.2. Enforce visitor identification during screening process (e.g., identify who is assigned as a designated visitor)	✓	8.5 (7-9)
7.3. Communication of consequences to visitors for non-compliance with hospital PPE policies (e.g., revoke visitation privileges)	✓	8.0 (7-9)
7.4. Allow only one designated visitor per patient throughout the patient's ICU stay	✓	3.0 (2-6)*
7.5. Allow two designated visitors per patient. Visitors must remain the same throughout the patient's ICU stay	✓	7.0 (5-9)

7.6. Allow one designated visitor per patient at a time but allow this visitor to be changed to include multiple visitors throughout the patient's ICU stay	×	5.0 (2-7)
7.7. Allow multiple visitors per patient as long as they are from the same household	×	5.0 (2-7)
7.8. Allow window visits (e.g., not entering patient's room) for critically ill patients who are COVID-19 positive	✓	7.0 (4-9)
7.9. When visitation restrictions are lifted, maintain that visitors must wear masks and comply with proper handwashing practices	✓	9.0 (8-9)
7.10. Restrict children (under a defined age) from visiting, to comply with public health recommendations (e.g., donning and doffing of PPE, wearing a mask, washing hands)	×	5.0 (3-8)
7.11. Schedule visitor time slots	×	6.0 (3-8)
7.12. Define visiting hours and create a staggered visiting schedule	✓	7.0 (3-9)
7.13. Limit the duration of visits	×	6.5 (2-8)
7.14. Do not allow overnight stays	×	5.0 (3-9)
7.15. Provide patient support stickers to identify visitors	✓	7.0 (5-9)
7.16. Allow religious and spiritual ceremonies (e.g., communion, sacraments, smudging, etc.)	✓	8.0 (7-9)
7.17. Lock unit to visitors who have not been pre-approved or identified as a designated visitor	✓	7.0 (6-9)
7.18. Ensure policies consider available physical space so that physical distancing is possible	✓	8.0 (7-9)
Theme 8: End-of-life policy		
8.1. Private rooms for end-of-life patients and their families	✓	9.0 (8-9)
8.2. Create a clear definition for end-of-life	✓	9.0 (7-9)
8.3. Consistent end-of-life policies across Canada	×	6.0 (3-7)
8.4. Consistent end-of-life policies within provinces	✓	8.0 (5-9)
8.5. Consistent end-of-life policies within health regions	✓	8.0 (7-9)
8.6. Consistent end-of-life policies within cities	✓	9.0 (7-9)
8.7. Visitors are permitted at all times regardless of patient's COVID-19 status	×	6.0 (2-8)
8.8. If imminent death or immediately after death occurs, allow single family member with PPE to visit regardless of COVID-19 status	✓	9.0 (7-9)
Theme 9: Criteria for visitation exceptions if no visitation is allowed		
9.1. Consider patients psychosocial needs as reason for visitation exceptions (e.g., anxiety, loneliness, long ICU stays)	✓	8.0 (7-9)

9.2. Consider patients that require cognitive, physical, or mobility assistance	✓	8.0 (7-9)
9.3. Include volunteers in circle of care (e.g., consider volunteers as part of the healthcare team to provide support for patients when families cannot visit)	✓	7.0 (5-8)
9.4. Consider spiritual care as part of the healthcare team to provide support for patients when family cannot visit or provide access to spiritual care (e.g., virtual)	✓	8.0 (7-9)
9.5. Allow visitation for all critically ill patients regardless of COVID-19 status	✓	7.0 (5-9)
9.6. Do NOT allow visitation for critically ill patients who are COVID-19 positive or a presumed COVID-19 case	×	4 (2-7)
9.7. Consider exceptions to restricted visitation policies on a case-by-case basis (e.g., always possible and this flexibility written into policy)	✓	8.0 (6-9)
9.8. Allow any healthcare team member to be able to initiate a request for visitation exceptions	✓	8.0 (5-9)
9.9. Allow families to undertake reasonable risks to visit dying loved ones – with understanding that this risk could result in potential illness or entail subsequent quarantine	✓	8.0 (7-9)
9.10. If exception occurs, implement a clinical follow up with the family members, who must agree to comply with confinement measures at home, and to alert the healthcare team if symptoms appear in the next 14 days	✓	8.0 (7-10)
Theme 10: Facilitation of out of hospital communication with family or visitors		
10.1. Notify family members in advance to take part in virtual rounds	✓	8.0 (7-9)
10.2. Designate additional individuals within the healthcare team to call and update family daily (e.g., allied health professionals, medical students, residents, etc.)	✓	8.0 (6-8)
10.3. Schedule times when families can call in to speak with healthcare team or patients	✓	8.0 (6-9)
10.4. Designate a family spokesperson to provide family updates	✓	9.0 (8-9)
10.5. Provide telephone and virtual guidance such as a tip sheet of suggestions and considerations when communicating with families (e.g., include how to give news of death over the phone or virtually)	✓	8.0 (7-9)
10.6. Offer families a follow-up call with healthcare team or a call from a palliative care team member if needed	✓	8.0 (7-9)

10.7. Enable video calling to connect patients with family members who are separated because of travel and visitor restrictions	✓	9.0 (8-9)
10.8. Provide access to translation services during videoconferencing and teleconferencing if family members do not speak same primary language as clinical team	✓	9.0 (8-9)
10.9. Create a virtual hotline for 24-hour specialty level advice and palliative care support	✓	7.0 (4-8)
10.10. Arrange night or weekend communication if families are unavailable during daytime hours	✓	9.0 (8-9)
10.11. Create alternative methods to get important patient information from family members (e.g., have families complete surveys regarding patient's background, likes, dislikes, pictures of patient before they were in the ICU, etc.)	✓	8.0 (6-8)
10.12. Allow healthcare professionals and family members to meet at designated outdoor locations (e.g., tent, designated picnic area)	×	5.0 (2-8)
10.13. Create rules for healthcare professionals and family members about meeting outside of the hospital	✓	7.0 (5-9)
Theme 11: Technological supports to facilitate communication during restrictions		
11.1. Designate technological support to set up virtual meetings to increase efficiency for healthcare team	✓	8.0 (7-9)
11.2. Increase technological support team for immediate assistance	✓	8.0 (7-9)
11.3. Have televisions in patient rooms that allow for online platforms of communication (e.g., Zoom, Skype) for virtual visits with families	✓	7.0 (6-9)
11.4. Have webcams in patient rooms to see patient status in real time	×	5.5 (2-7)
11.5. Increase availability of technological devices to facilitate family involvement in daily rounds, family conferences and virtual visits (e.g., iPads, tablets, phones etc.)	✓	9.0 (7-9)
11.6. Offset the costs of virtual- and tele-communication (e.g., free outgoing calls to families, free incoming calls to patients, prepaid calling cards, low cost or free internet program for patients and families)	✓	8.0 (6-9)
11.7. Provide free and reliable Wi-Fi access for patients	✓	9.0 (8-9)
11.8. Provide free access to television for patients	✓	8.0 (7-9)
11.9. Include public-facing and staff-facing training on virtual communication	✓	7.5 (6-9)
11.10. Provide a method for families to send messages that can be read or printed out for the patient	✓	8.0 (7-9)

Theme 12: Organizational Supports		
12.1. Provide mental health supports (e.g., self-care and coping strategies, bereavement, wellness, etc.) for families, patients and staff	✓	9.0 (8-9)
12.2. Provide consistent and transparent messages to staff about visitation policy; clearly outline circumstances when policy exceptions can apply	✓	9.0 (8-9)
12.3. Implement psychological supports for healthcare professionals at hospital or facility site	✓	9.0 (8-9)
12.4. Provide opportunities to debrief with colleagues or senior management team regarding events impacted by restricted visitation	✓	9.0 (8-9)
12.5. Create a location for staff to “unplug” during breaks (e.g., staff room or offices where staff can be off the patient floor)	✓	9.0 (8-9)
12.6. Implement frequent encouragement of healthcare professionals by divisional heads or senior leaders via emails, messaging apps, social media platforms (e.g., providing words of encouragement, sharing courageous stories)	✓	7.0 (5-8)
12.7. Create new ceremonies to celebrate patient recovery to increase healthcare team's morale	✓	7.0 (5-8)
12.8. Implement voluntary online psychological assessments to identify the emotional state of healthcare staff	✓	7.0 (5-9)
12.9. Provide guidance on choosing a designated visitor for patients unable to communicate with healthcare team	✓	7.0 (6-8)
12.10. Consider waiving legal considerations for Face Timing or Skype calling families (e.g., allow breach to accurately portray patient’s health status)	✓	7.0 (5-9)
12.11. Increase presence and availability of Infection, Prevention, and Control standards to address healthcare workers questions around infection risk and visitation	✓	8.0 (7-9)
12.12. Increase availability of clinician educators	✓	7.0 (5-8)
12.13. Include information on likelihood of survival along with symptoms, statistics and facts. Tool with prompt for decision point about advance directives	✓	7.0 (5-8)
12.14. Create clear definitions of what it is means to be critically ill or receiving palliative care	✓	8.0 (6-9)

Abbreviation: IQR=interquartile range; ✓=consensus, ×=non-consensus.
**Indicates items which were considered to be non-significant or non-essential, and were excluded in subsequent rounds*

Supplementary Table 3. Round 2 modified Delphi consensus process results

DOMAIN 1: EXPERIENCES		
Item	**Consensus**	**Median (IQR)**
Theme 1: Impact on patients and families during restricted visitation		
1.1. There were visitor and family concerns about COVID-19 exposure.	×	6.0 (4-7)
1.2. Family members were less present or refused to come visit even if it was allowed due to concern of contracting COVID-19 themselves.	×	4.0 (2-6)
1.3. Patients experienced a lack of spiritual care.	×	5.0 (3-6)
1.4. Families experienced decreased sleep.	×	5.0 (3-7)
1.5. Families were dissatisfied with the communication methods provided (e.g., feeling like an inconvenience to the bedside nurse when phoning for an update on the patient).	×	6.0 (5-8)
1.6. Geographical distance from the hospital limited family's access to the patient during periods of rapid health decline (e.g., end-of-life).	✓	7.0 (5-8)
1.7. Patients and families experienced increased financial burden due to visitation requirements (e.g., job loss or leave of absence, isolation requirements at a hotel, additional parking costs as families and visitors could not stay at the hospital when the patient was in treatment).**	×	5.0 (3-7)
1.8. Restricted visitation policies were inconsistent with the community case numbers leading to anger and frustration amongst families and visitors.**	✓	7.0 (6-8)
1.9. There was an impact on children and siblings who were unable to visit (e.g., distressing, mental health concerns, isolation requirements).**	✓	7.0 (6-8)
1.10. There was animosity towards the healthcare team when visitors and families were told they could not physically touch their loved one due to physical distance requirements and PPE.**	×	6.0 (3-8)
1.11. Policy changes distributed to the public were inaccurate or inconsistent across units and hospitals.**	×	6.0 (5-8)
Theme 2: Impact on Patient and Family-Centered Care (PFCC) during restricted visitation		
2.1. Healthcare professionals had additional time available for the delivery of daily PFCC (e.g., healthcare professionals were able to build stronger rapport with patients and there were additional opportunities for families to communicate directly with the care team).	✓	3.0 (2-5)*
2.2. There was no impact to PFCC.	✓	2.0 (1-4)*

2.3. When patient care decisions were required, healthcare professionals did not have the opportunity to consult with family, or patient care decisions were delayed.	×	6.0 (3-7)
2.4. There was an increase in the use of sedatives, and restraints (e.g., chemical and physical) when families were not present.	×	6.0 (4-7)
2.5. It was difficult to maintain trust between patients and families, and the healthcare team based on the misinformation that was presented in the media. This included family feeling confused and misinformed by hospital representatives or admitting staff.	×	6.0 (4-7)
2.6. Healthcare professionals had less time available for the delivery of PFCC due to increased clinical demand, patients on isolation precautions (e.g., donning/doffing PPE, patients with complex/multiple needs).**	✓	7.0 (6-8)
2.7. The lack of family presence had a more significant impact on patients with language barriers. Patients with language barriers may have suffered from lower quality of care due their difficulty in expressing their needs (e.g., patients may have had difficulty understanding goals of therapy, understanding verbal/manual cues, expressing their symptoms).**	✓	8.0 (6-9)
Theme 3: Impact on healthcare professionals during restricted visitation		
3.1. During restricted visitation, policy makers took an active role in communicating with the healthcare team.	✓	3.0 (2-5)*
3.2. Healthcare workers experienced reduced workload due to the lack of family and visitor presence on the unit.	✓	2.0 (1-4)*
3.3. There was a loss of educational opportunities for trainees since they could not be present in family meetings.**	×	5.0 (3-7)
3.4. There was a lack of continuity with standardized restricted visitation policies between different units within the same hospital or facility.**	✓	7.0 (5-8)
3.5. There was variation in the distribution of policy changes over time (i.e., the communication method for policy updates was inconsistent and unclear, or staff were unaware of the policy changes).	×	6.0 (5-8)
3.6. Exceptions occurred which were inconsistent with provided guidelines (e.g., staff made exceptions for some but not all patients).**	✓	7.0 (5-8)
3.7. Policy changes were inconsistent between hospitals and/or within hospitals.**	✓	7.0 (5-9)
Theme 4: Experiences with alternatives to in-person visits		

4.1. There were concerns regarding confidentiality breaches (e.g., showing a patient on a video call without their consent, family members taking photos or videos of their loved ones, families peeking in windows to try to see their loved one, etc.).	×	5.0 (2-7)
4.2. Technology helped to enhance communication with family members (e.g., multiple family members could take part in virtual rounds, translators were able to be incorporated, body language could be expressed better on video calls than on phone calls).	✓	7.0 (6-8)
4.3. Technology was used during patient rounds to communicate with families when restricted visitation policies were in place (e.g., virtual rounds).	×	4.0 (2-7)
4.4. Spiritual care ceremonies were facilitated virtually.**	✓	3.0 (2-5)*
4.5. Technology was NOT used often or at all, or the healthcare team had to initiate and implement technology use for communication with families.	×	5.0 (2-7)
4.6. There were challenges coordinating which clinical team members would attend virtual or tele-conferencing updates.**	×	5.0 (3-7)
DOMAIN 2: RECOMMENDATIONS		
Theme 6: Strategies for restricted visitation policy implementation and consistency		
6.1. Ensure consistency in visitation policies across Canada.	×	4.0 (2-6)
6.2. Ensure consistency in visitation policies within provinces and territories.	×	6.0 (3-8)
6.3. Ensure consistency in visitation policies within hospitals (e.g., across units).**	✓	9.0 (7-9)
Theme 7: Facilitation of in hospital visitation for families or visitors		
7.1. Allow one designated visitor per patient at a time but allow the designated visitor to be changed to include multiple visitors throughout the patient's ICU stay.	×	6.0 (3-7)
7.2. Allow multiple visitors per patient as long as they are from the same household.	×	6.0 (3-7)
7.3. Restrict children (under a defined age) from visitation who may have difficulty complying with public health recommendations (e.g., donning and doffing of PPE, wearing a mask, washing hands).	×	6.0 (3-8)
7.4. Schedule visitor time slots.	×	6.0 (5-8)
7.5. Limit the duration of visits except during end-of-life.	✓	7.0 (4-8)
7.6. Do not allow overnight stays.	×	5.0 (3-8)
7.7. Do not exclude children from visitation if they visit with an adult who ensures they comply with public health recommendations (e.g., PPE, hand washing, physical distancing).**	✓	7.0 (5-9)

7.8. Implement a straightforward process to appeal the restricted visitation policy.**	✓	8.0 (7-9)
Theme 8: End-of-life policy		
8.1. Consistent end-of-life visiting policies across Canada.	×	4.0 (2-7)
8.2. Visitors are permitted at all times for end-of-life regardless of patient's COVID-19 status. If a patient is COVID-19 positive, this should be accompanied with a well-defined protocol (e.g., informing families of risk, requiring PPE, self-isolation, hand washing, and COVID-19 testing).	✓	9.0 (7-9)
8.3. Work with families to create memories, mementos (e.g., record heart sounds, handprints, etc.).**	✓	7.0 (5-9)
8.4. Ensure the same end-of-life policies are applied across the hospital of facility (e.g., ICU versus medicine floor).**	✓	8.0 (7-9)
Theme 9: Criteria for visitation exceptions if no visitation is allowed		
9.1. Do NOT allow visitation for critically ill patients who are COVID-19 positive or a presumed COVID-19 case.	✓	3.0 (1-5)*
9.2. Allow visitation for all critically ill patients regardless of the family's COVID-19 status.**	×	5.0 (2-8)
9.3. Consider family caregivers as an integral member of the healthcare team, and distinct entity from visitors (e.g., consider family presence or families to be essential care partners).**	✓	8.0 (6-9)
Theme 10: Facilitation of out of hospital communication with family or visitors		
10.1. Facilitate healthcare professionals and family member meetings at designated outdoor locations on hospital property.	×	4.0 (2-6)
Theme 11: Technological supports to facilitate communication during restrictions		
11.1. Have secure webcam access available in a patient's room with consent from the patient or patient's alternative decision-maker for families to see patient status in real time.	×	5.0 (3-8)

Abbreviation: IQR=interquartile range; ✓=consensus, ×=non-consensus.
**Indicates items which were considered to be non-significant or non-essential, and were excluded in subsequent rounds*
*** Indicates items which were suggested in the free-text box during Round 1.*

Supplementary Table 4. Round 3 modified Delphi consensus process results

DOMAIN 1: EXPERIENCES		
Item	**Consensus**	**Median (IQR)**
Theme 1: Impact on patients and their families during restricted visitation		
1.1. There were visitor and family concerns about COVID-19 exposure	×	6.0 (3-7)
1.2. Family members were less present or refused to come visit even if it was allowed due to concern of contracting COVID-19 themselves.	✓	3.0 (2-3)*
1.3. Patients experienced a lack of spiritual care.	×	4.0 (2-7)
1.4. Families experienced decreased sleep.	×	5.0 (3-7)
1.5. Families were dissatisfied with the communication methods provided (e.g., feeling like an inconvenience to the bedside nurse when phoning for an update on the patient).	×	6.0 (3-8)
1.7. Patients and families experienced increased financial burden due to visitation requirements (e.g., job loss or leave of absence, isolation requirements at a hotel, additional parking costs as families and visitors could not stay at the hospital when the patient was in treatment).	✓	3.0 (2-7)*
1.10. There was animosity towards the healthcare team when visitors and families were told they could not physically touch their loved one due to physical distance requirements and PPE.	×	5.0 (3-7)
1.11. Policy changes distributed to the public were inaccurate or inconsistent across units and hospitals.	✓	8.0 (7-9)
Theme 2: Impact on Patient and Family-Centered Care (PFCC) during restricted visitation		
2.3. When patient care decisions were required, healthcare professionals did not have the opportunity to consult with family, or patient care decisions were delayed.	✓	7.0 (4-8)
2.4. There was an increase in the use of sedatives, and restraints (e.g., chemical and physical) when families were not present.	×	4.0 (3-7)
2.5. It was difficult to maintain trust between patients and families, and the healthcare team based on the misinformation that was presented in the media. This included family feeling confused and misinformed by hospital representatives or admitting staff.	✓	7.0 (4-8)
Theme 3: Impact on healthcare professionals		
3.3. There was a loss of educational opportunities for trainees since they could not be present in family meetings.	×	6.0 (3-8)
3.5. There was variation in the distribution of policy changes over time (i.e., the communication method for policy updates was inconsistent and unclear, or staff were unaware of the policy changes).	✓	8.0 (7-9)
Theme 4: Alternatives to in-person visitation		

4.1. There were concerns regarding confidentiality breaches (e.g., showing a patient on a video call without their consent, family members taking photos or videos of their loved ones, families peeking in windows to try to see their loved one, etc.).	✓	3.0 (3-7)*
4.3. Technology was used during patient rounds to communicate with families when restricted visitation policies were in place (e.g., virtual rounds).	✓	3.0 (3-7)*
4.5. Technology was NOT used often or at all, or the healthcare team had to initiate and implement technology use for communication with families.	✓	7.0 (3-9)
4.6. There were challenges coordinating which clinical team members would attend virtual or tele-conferencing updates.	✓	3.0 (2-6)*
DOMAIN 2: RECOMMENDATIONS		
Theme 6: Strategies for restricted visitation policy implementation and consistency		
6.1. Ensure consistency in visitation policies across Canada.	✓	2.5 (1-5)*
6.2. Ensure consistency in visitation policies within provinces and territories.	✓	7.0 (2-8)
Theme 7: Facilitation of in-hospital visitation for families and visitors		
7.1. Allow one designated visitor per patient at a time but allow the designated visitor to be changed to include multiple visitors throughout the patient's ICU stay.	✓	7.0 (5-8)
7.2. Allow multiple visitors per patient as long as they are from the same household.	✓	7.0 (6-8)
7.3. Restrict children (under a defined age) from visitation who may have difficulty complying with public health recommendations (e.g., donning and doffing of PPE, wearing a mask, washing hands).	✓	7.0 (3-8)
7.4. Schedule visitor time slots.	✓	7 (5-8)
7.6. Do not allow overnight stays.	×	3.5 (2-7)
Theme 8: End-of-life policy		
8.1. Consistent end-of-life visiting policies across Canada.	✓	3.0 (2-8)*
Theme 9: Criteria for visitation exceptions if no visitation is allowed.		
9.2. Allow visitation for all critically ill patients regardless of the family's COVID-19 status.	✓	2.0 (1-3)*
Theme 10: Facilitation of out of hospital communication with family or visitors		
10.1. Facilitate healthcare professionals and family member meetings at designated outdoor locations on hospital property.	✓	3.0 (1-7)*
Theme 11: Technological supports to facilitate communication during restrictions		
11.1. Have secure webcam access available in a patient's room with consent from the patient or patient's alternative decision-maker for families to see patient status in real time.	✓	3.0 (1-7)*

Abbreviation: IQR=interquartile range; ✓=consensus, ×=non-consensus.

Supplementary Table 5. Round 2 priority ranking results

DOMAIN 1: EXPERIENCES			
Consensus items identified in Round 1	**Theme: Mean (SD)**	**Item: Mean (SD)**	**Priority Ranking: ✓ = high priority × = low priority**
Theme 1: Impact on patients and their families during restricted visitation			
1.1. Patients experienced isolation, loneliness or decreased interaction and connection with the healthcare team (e.g., staff only checked in on patients when it was medically necessary or communicated frequently via intercom devices).	16.7 (2.7)	23.2 (15.4)	✓
1.2. Family was absent at the end-of-life or did not visit their loved one before they were sedated or intubated.		20.2 (12.6)	✓
1.3. Families did not understand how sick the patient was (e.g., severity of critical illness).		19.5 (11.8)	✓
1.4. Families were turned away from entering the hospital, had to wait outside on the sidewalks or in their cars.		10.5 (8.2)	×
1.5. Families experienced lack of compassion from security and healthcare staff or when requesting an exception for visitation.		7.6 (6.6)	×
1.6. Families needed reassurance and additional emotional support from healthcare staff when visitor restrictions were in place (e.g., to know that their loved one was not abandoned/forgotten, impact on coping and grief).		19.0 (11.2)	×
Theme 2: Impact on Patient and Family-Centered Care (PFCC) during restricted visitation			
2.1. Healthcare professionals were missing details about patient history usually provided by the family (e.g., knowing the patient's baseline prior to ICU admission).	16.7 (1.6)	13.2 (9.2)	×
2.2. Family was not present to take part in key elements of patient care (e.g., physiotherapy, feeding, delirium prevention/management, discharge planning), which may have impacted the health status of their loved one (i.e., families did not feel a part of the team caring for the patient).		19.4 (10.8)	✓
2.3. Family was not present to advocate for patient care needs or wishes.		17.3 (10.9)	×

2.4. It was challenging to accurately convey the patient's clinical status and appropriateness of care to families. It is important for family to understand treatment and therapy to be able to make appropriate choices.		20.7 (12.4)	✓
2.5. Healthcare professionals were unable to develop close, personal and trusting relationships with family due to the reliance on virtual or phone call updates (e.g., loss of meaningful connection and rapport with patients and family) which added responsibility to the care team (e.g., enforcing the restricted visitation).		18.0 (10.2)	×
2.6. It was difficult to express compassion without body language (e.g., due to personal protective equipment [PPE] or when speaking on the phone).		11.4 (8.8)	×
Theme 3: Impact on healthcare professionals			
3.1. There was concern over staff exposure risk or staff access to PPE (i.e., to COVID-19) or staff access to PPE.	10.0 (0.9)	8.6 (6.3)	×
3.2. It was difficult to communicate rapidly changing visitation policies to family, or when communication about changes to visitation policies were distributed on weekends, evenings, or end of day on Friday.		12.7 (8.5)	✓
3.3. There was a sense of tension and lack of trust amongst healthcare professionals and policy makers. This was often due to variation in the interpretation or application of restricted visitation policy details (e.g., healthcare providers circumventing the policies, unit managers making exceptions, inconsistency in enforcement of rules such as physical distancing).		11.4 (6.7)	✓
3.4. There was a lack of support from the leadership team when developing restricted visitation policies such as additional guidance when implementing or enforcing the policy or new structure of communication.		7.8 (7.0)	×
3.5. Healthcare professionals were conflicted between advocating against the policy (to prioritize patient well-being) and advocating for the policy (to protect the healthcare system).		11.8 (8.5)	✓
3.6. Healthcare professionals experienced an impact on job satisfaction. This included the lost sense of joy and pride that comes from being able to build successful supportive relationships with the families, pushing to discharge patients (to make room for other patients), and being limited to working on 1-2 wards (and unable to help out colleagues on other floors).		10.5 (6.2)	×

3.7. Psychosocial impact to healthcare professionals due to moral distress (e.g., gatekeepers to family visitation, patients dying alone) and anxiety due to ever changing restricted visitation policies.		14.4 (8.6)	✓
3.8. There was lack of trust between healthcare professionals and visitors (e.g., visitors from out of province not the following rules, visitors misidentifying themselves as the designated visitor, or lying about their COVID-19 status).		8.7 (6.7)	×
3.9. Increased workload. This included frequent conversations with family members that were required to develop and maintain trust (e.g., trust that the healthcare professionals were doing all they could, giving adequate care, and conversations for the acceptance of pandemic circumstances). This also included additional time to set up virtual visitation.		8.7 (6.7)	×
3.10. Broadening in responsibilities. This included other ICU care team members providing support or communicating patient updates with family (e.g., social workers taking initiative to incorporate families, friends, or community supports and bedside RNs or residents providing regular patient updates).		5.5 (5.6)	×
Theme 4: Alternatives to in-person visitation			
4.1. There was variability in patients, families and healthcare professional's comfort and access to technology that supported virtual communication (e.g., families and staff were unfamiliar with platforms such as Zoom and Skype, patients were not tech-savvy, families did not have access to Wi-Fi to communicate with their loved ones, etc.).	20.0 (2.8)	23.7 (13.9)	✓
4.2. There were technology issues which limited the ability to connect with family members (e.g., broken devices, batteries failing, poor Wi-Fi, limited number of devices).		16.0 (9.7)	×
4.3. There were limited communication options when there was a language barrier between patients and families and the healthcare team.		15.2 (10.3)	×
4.4. Clinical circumstances limited the capacity for patients to communicate or interact with families (e.g., patient on breathing machine, proned patients, sedated patients, patients with delirium).		27.9 (12.4)	✓
4.5. Technology was incorporated to facilitate end-of-life visits.		17.1 (13.6)	×
DOMAIN 2: RECOMMENDATIONS			
Theme 5: Ways to improve communication of restricted visitation policy and policy changes			

5.1. Provide a hardcopy of up-to-date restricted visitation policies at the hospital and on each unit (e.g., pamphlet, single page handout, communication board or posters on the unit that includes policy and resources and links to call for appeal and exemptions, further information).	20.0 (2.2)	15.8 (8.9)	×
5.2. Create a website with communication of current restricted visitation policies at each institution (e.g., options for electronic messaging subscriptions, a platform to share experiences across institutions, portal for families to ask questions or submit appeals to visitor restriction policies).		22.3 (10.5)	✓
5.3. Integrate news and media to accurately communicate changes in restricted visitation policies to the public (e.g., daily provincial health updates, news segments, social media).		17.1 (11.3)	×
5.4. Incorporate in-person communication by management and leadership to communicate policy changes to staff, families, and visitors (e.g., to answer questions about the policy, address family and visitors concerns and appeals).		18.1 (12.6)	×
5.5. Communicate policy changes to hospital staff during regular working hours and before the change becomes effective or is communicated to the public (i.e., all staff should know the policy change before the media, changes should be communicated during regular working hours).		26.7 (10.8)	✓
Theme 6: Strategies for restricted visitation policy implementation and consistency			
6.1. Permit hospitals to adapt provincial policies for their facilities and individual units (e.g., ICUs are permitted to make adjustments to their restricted visitation policies).	10.0 (1.1)	9.7 (9.2)	×
6.2. Create proactive and staged implementation of restricted visitation policies that are dependent on community COVID-19 caseload or hospital capacity (e.g., hospitals with no COVID-19 cases should be able to modify the policy).		11.4 (10.6)	✓
6.3. Assign designated staff members to address questions regarding visitation and policy changes, address concerns, exceptions and appeals, and consistently apply the policy (e.g., hospital liaison person/ team that families can contact, designated staff members that communicate outcome back to frontline staff, support from patient relations department, or authoritative decision-makers that do not allow for special circumstances to occur).		10.1 (7.3)	×
6.4. Allow any healthcare team member to be able to initiate a request for visitation exceptions.		8.5 (7.9)	×

6.5. Consider exceptions to restricted visitation policies on a case by case basis (i.e., allow the possibility to be flexible within the policy).		10.4 (7.9)	×
6.6. There should be no exception to the policy, or the exceptions must be well-defined and strictly adhered to.		5.4 (9.2)	×
6.7. Implement a clear and straightforward process to request exceptions and appeals to restricted visitation policies.		13.0 (8.5)	✓
6.8. Ensure consistency in visitation policies within health regions and cities (e.g., across hospitals).		10.2 (9.0)	×
6.9. Pilot test restricted visitation policies to ensure they are ready for various scenarios (e.g., shortages in PPE, window visits, increased contagion rate) before they are needed.		5.3 (5.7)	×
6.10. Include key stakeholders in policy development and adaption (e.g., patients and families, nurses, physicians, allied health professionals, decision-makers, infection prevention and control).		16.0 (9.4)	✓
Theme 7: Facilitation of in-hospital visitation for families and visitors			
7.1. Designate unit-level visitor "greeters "and "navigators." The role of these "greeters" or "navigators" may be to communicate the policy, accompany visitors to the unit, demonstrate donning and doffing of PPE, teach proper handwashing, answer questions, inform visitor what to expect on the unit, communicate consequences for non-compliance with hospital PPE policies.	10.0 (0.9)	13.4 (9.1)	✓
7.2. Require visitor identification during screening process (e.g., identify who is assigned as a designated visitor, ensure visitor has not been instructed to self-isolate, incorporate real-time data linkage system between frontline staff and hospital screening personnel to ensure updated visitor lists).		12.3 (7.8)	✓
7.3. Allow two designated visitors per patient throughout the patient's ICU stay. Allow the designated visitors list to change, but under predetermined circumstances.		10.8 (8.6)	×
7.4. Allow window visits (e.g., not entering the patient's room) for critically ill patients who are COVID-19 positive or presumed positive. This could include phone/video capability to communicate with the patient.		10.3 (7.3)	×
7.5. When visitation restrictions are lifted, maintain that visitors must wear masks and comply with public health guidelines, proper handwashing practices, physical distancing and wearing PPE.		12.0 (8.3)	✓

7.6. Define visitation hours and create a staggered visitation schedule, including times that are conducive to family members who work during the day. This will limit the number of visitors on the unit at any given time to manage physical distancing.		9.1 (8.0)	×
7.7. Provide patient support stickers to identify visitors.		4.1 (4.1)	×
7.8. Allow religious and spiritual ceremonies (e.g., communion, sacraments, smudging, etc.).		10.7 (8.7)	×
7.9. Lock unit to visitors who have not been pre-approved or identified as a designated visitor.		7.1 (6.6)	×
7.10. Ensure policies consider available physical space so that physical distancing amongst staff, patients, and visitors is possible.		10.2 (6.9)	×
Theme 8: End-of-life policy			
8.1. Private rooms for end-of-life patients and their families.	25.0 (2.8)	27.2 (12.1)	×
8.2. Create a clear policy for end-of-life. This should include clear rules on the number of people who can visit, allow culturally considerate end-of-life rituals for Indigenous families, and clear guidelines when visiting family is COVID-19 positive. These end-of-life policies should include a clear definition of end-of-life and should allow visitors while the patient is lucid and able to interact (i.e., not comatose at end-of-life).		30.3 (13.0)	✓
8.3. Consistent end-of-life policies within jurisdictions (i.e., cities, health regions, provinces).		18.8 (11.1)	×
8.4. Allow families to undertake reasonable risks to visit COVID-19 positive patients at end-of-life – with the understanding that this risk could result in potential illness or entail subsequent quarantine.		23.8 (12.7)	×
Theme 9: Criteria for visitation exceptions if no visitation is allowed			
9.1. Consider patients' and families' psychosocial needs as reason for visitation exceptions (e.g., anxiety, loneliness, long ICU stays).	20.0 (2.6)	25.8 (12.4)	✓
9.2. Consider patients that require cognitive, physical, or mobility assistance.		22.0 (9.0)	×
9.3. Include volunteers in circle of care (i.e., consider volunteers as part of the healthcare team to provide support for patients when families cannot visit).		12.0 (8.7)	×
9.4. Include spiritual care providers in circle of care (i.e., considered to be part of the healthcare team to provide support for patients when family cannot visit) or provide access to spiritual care (e.g., virtual).		18.1 (9.3)	×

9.5. Allow visitation for all critically ill patients regardless of patient's COVID-19 status (e.g., implement clinical follow up with the family members, who must agree to comply with confinement measures at home, and to alert the healthcare team if symptoms appear in the next 14 days).		22.2 (15.3)	×
Theme 10: Facilitation of out of hospital communication with family or visitors			
10.1. Designate one to two family spokespersons to be notified in advance of daily virtual rounds, provide the opportunity to participate in clinical discussions and to receive and disseminate family updates.	12.5 (2.0)	20.6 (10.4)	✓
10.2. Designate additional healthcare team members to call and update family daily (e.g., allied health professionals, medical students, residents, social workers).		13.5 (9.6)	×
10.3. Schedule designated times when families can call to speak with healthcare team or patients with additional follow-up calls, access to translation services, and alternative arrangements for nights and weekends with healthcare teams as needed.		14.1 (8.5)	×
10.4. Provide video conferencing options to family members and patients who are separated because of COVID-19 travel and visitation restrictions, or, ask the patient's alternative decision-maker for consent to connect with patients on video conferencing.		18.6 (10.3)	✓
10.5. Create alternative methods to acquire important patient background information from family members (e.g., have families complete surveys regarding patient's background, likes, dislikes, pictures of patient before they were in the ICU, improve documentation of patient's goals of care and preference for treatment, etc.).		11.1 (7.3)	×
10.6. Create designated meeting space outside of the hospital for family members and healthcare professionals to meet, following clear rules and guidelines.		5.9 (6.5)	×
10.7. Provide telephone and virtual guidance to the ICU care team such as a tip sheet of suggestions and considerations when communicating with families (e.g., include how to give news of death over the phone or virtually).		9.8 (6.8)	×
10.8. Create a virtual hotline for 24-hour specialty level advice and palliative care support.		6.3 (5.7)	×
Theme 11: Technological supports to facilitate communication during restrictions			
11.1. Designate additional technological support to assist healthcare teams to set up virtual meetings and address immediate technological concerns requiring assistance.	20.0 (2.4)	18.2 (10.0)	×

11.2. Have televisions or other technological devices in rooms with access to online platforms (e.g. Zoom, Skype) for virtual visits with families.		19.7 (8.8)	×
11.3. Increase availability of technological devices to facilitate family involvement in daily rounds, family conferences, virtual visits, and communication of family messages to patients (e.g., iPads, tablets, phones, etc.).		26.5 (13.1)	✓
11.4. Subsidize or provide free access to virtual and tele-communication including reliable Wi-Fi and television access for patients and their families.		22.0 (11.4)	×
11.5. Include public-facing and staff-facing training on virtual communication.		13.7 (8.6)	×
Theme 12: Organizational supports			
12.1. Provide mental health supports (e.g., self-care and coping strategies, bereavement care, wellness approaches) for families, patients, and staff.	12.5 (1.3)	15.9 (9.3)	✓
12.2. Provide consistent and transparent messages to staff about visitation policy; clearly outline circumstances when policy exceptions can apply or defer designated visitor approvals to senior leadership.		17.4 (10.0)	✓
12.3. Implement psychological supports for healthcare professionals at hospital or facility site with dedicated mental health professional with specialized knowledge of frontline healthcare. Have access to voluntary online psychological assessments (to identify the emotional state and burnout of healthcare staff) and access to break locations that facilitate mental health breaks for staff.		15.4 (8.7)	✓
12.4. Provide opportunities to debrief with colleagues or senior management team regarding events impacted by restricted visitation.		12.4 (7.3)	×
12.5. Implement frequent encouragement of healthcare professionals by divisional heads or senior leaders via emails, messaging, social media platforms (e.g., providing words of encouragement, sharing courageous stories) and encourage ceremonies to celebrate patient recovery to increase healthcare team morale.		7.9 (7.1)	×
12.6. Increase presence and availability of Infection, Prevention, and Control standards and clinician educators to address healthcare workers questions around infection risk and visitation.		10.3 (7.8)	×

12.7. Provide families with information and educational videos on choosing a designated visitor for patients, common ICU procedures, day-to-day care, common patient symptoms and common ICU statistics. Include tools for prompting decisions around advance directives.		11.6 (8.0)	×
12.8. Create clear definitions of what it means to be critically ill or receiving palliative care.		9.2 (8.0)	×

Abbreviation: SD=standard deviation.

Supplementary Table 6. Round 3 priority ranking results

DOMAIN 2: RECOMMENDATIONS			
Consensus items identified in Round 2 and 3	**Theme: Mean (SD)**	**Item: Mean (SD)**	**Priority Ranking: ✓ = high priority × = low priority**
Theme 5: Ways to improve communication of restricted visitation policy and policy changes			
Incorporate communication (e.g., phone call, video, podcast, automated messaging) implemented by management and leadership to communicate policy changes to families, and visitors	20.0 (3.3)	16.0 (14.5)	×
Communicate policy changes to hospital staff during regular working hours and at least 24-hours before the change becomes effective or is communicated to the public (e.g., all staff should know the policy change before the media)		29.0 (14.9)	✓
Create multiple vehicles of communication of current restricted visitation policies at each institution (e.g., website, electronic messaging subscriptions, portal for families to ask questions or submit appeals to visitor restriction policies)		23.7 (14.3)	✓
Provide a succinct hardcopy of up to date (i.e., by unit clerk) restricted visitation policies at the hospital and on each unit with addition resources listed (e.g., pamphlet, single page handout, communication board or posters on the unit that includes policy and resources and links to call for appeal and exemptions, further information, etc.). This should include an "effective date."		17.0 (9.9)	×
Incorporate communication (i.e., phone call) by management and leadership to communicate policy changes to staff (e.g., hospital liaison person who could answer questions about the policy, address family and visitors concerns and appeals)		14.3 (9.4)	×
Theme 6: Strategies for restricted visitation policy implementation and consistency			
Ensure consistency in visitation policies within provinces and territories	8.3 (1.4)	2.9 (6.2)	×
Ensure consistency in visitation policies within hospitals (e.g., across units).		8.4 (8.0)	×

Pilot test restricted visitation policies to ensure they are ready for various scenarios (e.g., shortages in PPE, window visits, increased contagion rate) before they are needed		5.6 (6.8)	×
Ensure consistency in visitation policies within health regions and cities (e.g., across sites)		4.3 (5.0)	×
There should be no exception to the policy, or the exceptions must be well-defined and strictly adhered to		1.3 (3.4)	×
Consider exceptions to restricted visitation policies on a case-by-case basis (e.g., always possible, and this flexibility should be written into the policy)		8.0 (6.2)	×
Allow any healthcare team member to be able to initiate a request for visitation exceptions		5.8 (4.9)	×
Assign designated staff members to address questions regarding visitation and policy changes, address concerns, exceptions, and appeals, and consistently applies the policy (e.g., authoritative decision makers that does not allow for special circumstances to occur, support from patient relations department, hospital liaison individual or team that families can contact, designated staff members communicate outcome back to frontline staff)		9.9 (9.5)	✓
Permit hospitals to adapt provincial policies for their facilities and individual units (e.g., ICUs are permitted to make adjustments to their restricted visitation policies).		11.2 (7.9)	✓
Include key stakeholders in policy development and adaption (e.g., nurses, physicians, spiritual care, allied health professionals, decision makers, patients and families, infection prevention and control)		13.9 (10.5)	✓
Implement a clear, straightforward, timely and accessible process to request exceptions and appeals to restricted visitation polices (e.g., end-of-life, other adults that would benefit from being present)		14.2 (16.6)	✓
Create proactive and staged implementation of restricted visitation policies that are dependent on community COVID-19 caseload or hospital capacity, and patient circumstances (e.g., hospitals with no COVID-19 cases should be able to modify the policy). These policies may differ for ECPs and visitors.		13.9 (12.0)	✓
Theme 7: Facilitation of in-hospital visitation for families and visitors			
Schedule visitor time slots.	6.3 (0.4)	5.6 (6.4)	×

Require visitor photo identification during screening process (e.g., identify who is assigned as a designated visitor, ensure visitor has not been instructed to self-isolate, ensure communication policies have been shared with visitors, incorporate real-time data linkage system between frontline staff and hospital screening personnel to ensure updated visitor lists).		4.6 (5.4)	×
When visitations restrictions are liberalized, at a minimum adhere by public health measures which may be augmented by local hospital policy.		5.1 (4.9)	×
Do not exclude children from visitation if they visit with an adult who ensures they comply with public health recommendations (e.g., PPE, hand washing, physical distancing).		7.5 (7.5)	✓
Implement a straightforward process to appeal the restricted visitation policy.		9.2 (6.9)	✓
Allow up to two designated visitors per patient throughout the patient's ICU stay. Allow the designated visitors list to change, but under special circumstances.		5.6 (7.6)	×
Allow window visits (e.g., not entering patient's room) for critically ill patients who are COVID-19 positive or presumed positive. This could include phone/video capability to communicate with the patient.		5.5 (5.7)	×
Consider scheduling visiting hours and create a staggered visiting schedule, including times that are conducive to family members who work during the day. This will limit the number of visitors on the unit at any given time to manage physical distancing.		6.4 (7.5)	×
Designate unit-level "visitor advisors" if feasible. The role of these "visitor advisors" may include the following: communicate the policy, demonstrate donning and doffing of PPE, teach proper handwashing, answer questions, inform visitor what to expect on the unit, communicate consequences for non-compliance with hospital PPE policies, etc.		10.0 (9.0)	✓
Provide patient support stickers to identify visitors		5.1 (5.2)	×
Accommodate religious and spiritual ceremonies (e.g., communion, sacraments, smudging, etc.) whenever possible and safe in line with public health guidelines.		6.5 (5.9)	×
Do not allow visitors who have not been pre-approved or identified as a designated visitor		5.2 (5.1)	×

Ensure policies consider available physical space so that physical distancing is possible		5.9 (7.0)	×
Allow one designated visitor per patient at a time but allow the designated visitor to be changed to include multiple visitors throughout the patient's ICU stay		7.2 (10.1)	✓
Allow multiple visitors per patient as long as they are from the same household.		5.2 (6.0)	×
Restrict children (under a defined age) from visitation who may have difficulty complying with public health recommendations (e.g., donning and doffing of PPE, wearing a mask, washing hands).		3.4 (5.3)	×
Theme 8: End-of-life policy			
Consistent definitions or triggers and thresholds for end-of-life policies within jurisdictions (i.e., cities, health regions, provinces), yet flexibility to respond to local COVID activity or risk assessment		8.1 (9.0)	×
Allow families to undertake reasonable risks to visit COVID-19 positive patients at end-of-life – with understanding that this risk could result in potential illness or entail subsequent quarantine)		13.3 (8.9)	×
Visitors are permitted at all times for end-of-life regardless of patient's COVID-19 status. If a patient is COVID-19 positive, this should be accompanied with a well-defined protocol (e.g., informing families of risk, requiring PPE, self-isolation, hand washing, and COVID-19 testing).		20.0 (13.1)	✓
Create a clear policy for end-of-life. This should include clear rules on the number of people who can visit, consider end-of-life process for other cultural backgrounds, and when visitors are COVID positive. This end-of-life policy should include a clear definition of end-of-life, which allows visitors while patient is lucid and able to interact (i.e., not comatose at end-of-life)	14.3 (2.7)	26.2 (19.2)	✓
Work with families to create memories, timelines of patient progress, or mementos (e.g., record heart sounds, handprints, etc.).		9.7 (8.1)	×
Ensure the same end-of-life policies are applied across the hospital or facility (e.g., ICU versus medicine floor).		10.5 (10.0)	×
Privacy for end-of-life patients and their families and, where available, private rooms		12.3 (8.9)	×
Theme 9: Criteria for visitation exceptions if no visitation is allowed			

Allow visitation for all critically ill patients regardless of patient's COVID-19 status (e.g., implement clinical follow up with the family members, who must agree to comply with confinement measures at home, and to alert the healthcare team if symptoms appear in the next 14 days)		20.6 (12.9)	✓
Consider family caregivers as an integral member of the healthcare team, and a distinct entity from visitors (e.g., consider family presence or families to be essential care partners).		23.6 (13.1)	✓
Consider patients that require cognitive, physical, or mobility assistance	16.7 (2.5)	18.7 (7.7)	×
Consider each patient and family's specific psychosocial needs as reason for visitation exceptions (e.g., anxiety, loneliness, long ICU stays)		15.3 (10.2)	×
Include volunteers in circle of care (e.g., consider volunteers as part of the healthcare team to provide support for patients when families cannot visit)		8.2 (7.4)	×
Consider spiritual care as part of the healthcare team to provide support for patients when family cannot visit or provide access to spiritual care (e.g., virtual)		13.5 (10.0)	×
Theme 10: Facilitation of out of hospital communication with family or visitors			
Create a virtual hotline for 24-hour specialty level advice and palliative care support		6.6 (9.0)	×
Have a robust process for consent to connect the patient with visitors via videoconferencing		8.1 (7.5)	×
Provide videoconferencing options to family members and patients who are separated		17.6 (14.5)	✓
To secure background information (e.g., have families complete surveys regarding patient's background, likes, dislikes, pictures of patient before they were in the ICU, improve documentation of patient's goals of care and preference for treatment, etc.)	10.0 (1.8)	10.9 (9.9)	×
An effort should be made to provide frequent (medical) updates (including allied healthcare) to the family and provide opportunities for families to ask questions		15.2 (11.3)	✓
Designate one to two identified family spokespersons to be notified in advance of daily virtual rounds, participate in clinical decision-making, and to receive and disseminate family updates		17.9 (13.1)	✓

Provide times when families can call to speak with healthcare team or patients with additional follow-up calls, access to translation services, and alternative arrangement for nights and weekends with healthcare teams as needed		10.2 (9.2)	×
Communicate with family members to acquire important patient background information (e.g., have families complete surveys regarding patient's background, likes, dislikes, pictures of patient before they were in the ICU, improve documentation of patient's goals of care and preference for treatment, etc.)		2.7 (6.2)	×
Create rules and designated meeting spaces for healthcare professionals and family members about meeting outside of the hospital		3.7 (6.1)	×
Provide telephone and virtual guidance such as a tip sheet of suggestions and considerations when communicating with families (e.g., include how to give news of death over the phone or virtually)		6.3 (6.0)	×
Theme 11: Technological supports to facilitate communication during restrictions			
Subsidize or provide free access to virtual and tele-communication including reliable Wi-Fi and television access for patients and their families	20.0 (4.7)	21.5 (11.3)	×
Have televisions or other technological devices in rooms that allow for scheduled access to online platforms (e.g., Zoom, Skype) for virtual visits with families, while protecting the privacy of the patient.		19.0 (11.4)	×
Increase availability of technological devices to facilitate family involvement in daily rounds, family conferences, virtual visits, and communication of family messages to patient (e.g., iPads, tablets, phones, etc.) including tech support for staff and family.		33.5 (16.1)	✓
Designated role (i.e., new member of ICU care team) to set up virtual meetings and address immediate technological concerns requiring assistance.		17.9 (10.5)	×
Include different modes of public-facing and staff-facing training on virtual communication (e.g., YouTube, video, brochure).		7.9 (7.2)	×
Theme 12: Organizational Supports			

Provide families with information and educational videos on choosing a designated visitor for patients, common ICU procedures, day-to-day care, common patient symptoms and common ICU statistics. Include tools for prompting decisions around advance directives		17.4 (14.2)	×
Provide clear and consistent messaging to staff about visitation policy; clearly outline circumstances when policy exceptions can apply or defer designated visitor approvals to senior leadership		22.0 (11.1)	✓
Provision of accessible Infection, Prevention, and Control standards and educators to address healthcare workers questions around infection risk and visitation		14.8 (8.2)	×
Provide mental health supports (e.g., self-care and coping strategies, bereavement, wellness, etc.) for families, patients, and staff, including onsite support options for staff	16.7 (2.0)	19.2 (10.7)	✓
Provide opportunities to debrief with colleagues or senior management team regarding events impacted by visitation policies/family presence		17.0 (9.1)	×
Implement frequent encouragement of healthcare professionals by divisional heads or senior leaders via emails, messaging, social media platforms (e.g., providing words of encouragement, sharing courageous stories) and encourage new ceremonies to celebrate patient recovery to increase healthcare team's morale		9.2 (7.8)	×

Abbreviation: SD=standard deviation.