ELECTRONIC SUPPLEMENTARY MATERIAL

Fiest KM *et al.*: Evidence-informed consensus statements to guide COVID-19 patient visitation policies: results from a national stakeholder meeting

Disclaimer: *Electronic Supplementary Material (ESM) is supplied by the authors for the benefit of readers. This feature is intended to provide additional information, context, and/or dimension to complement articles. Readers should be aware that unlike the main print manuscript, ESM may not undergo extensive peer review and typically is posted as supplied by the authors without editing, proofreading, accuracy checking, copyediting, or typesetting; it is published online only.*

TABLE OF CONTENTS

eAppendix 1 National Stakeholder Meeting agenda and day 1/day 2 methods

Time	Day 1: Wednesday, April 7, 2021
	Aim: Discuss themes & construct policies
8:00	Opening remarks & introductions (Dr. Kirsten Fiest)
8:10	Overview of national stakeholder meeting (Dr. Kirsten Fiest)
8:20	Results of Delphi consensus process (Dr. Karla Krewulak)
8:35	Polling non-consensus items
8:50	Break
9:00	Breakout groups - [create visitation policies for assigned themes]
10:15	Group discussion
10:45	Adjournment & closing remarks
Time	**Day 2: Thursday, April 8, 2021**
	Aim: Discuss practical implications (i.e., barriers and facilitators) of policies
8:00	Opening remarks (Dr. Jeanna Parsons Leigh)
8:10	Revisit policies from Day 1
8:30	Break
8:40	Breakout groups - [implementation considerations]
10:15	Group discussion
10:45	Summary of discussion & plan for next steps
11:00	Adjournment

Day 1

The aim of day 1 of the meeting was for stakeholders to discuss and refine consensus statements (prioritized and ones that did not meet the cut-off to be considered a priority) created from the Delphi consensus process. Following introductions of all participants and an overview of meeting objectives, the principal investigator (KMF) presented the results of the research program and senior research associate (KDK) presented on the Delphi consensus process. During the breakout session (70 minutes) on day one, each group was assigned two (of 12) themes and related consensus statements to discuss. Each theme included consensus statements from the modified Delphi process that either 1) met the threshold to be considered a priority; 2) reached consensus (i.e., median score of 7-9) but did not meet the threshold to be considered a priority; or 3) were new items (i.e., suggested by Delphi participants) that reached consensus (i.e., median score of 7-9) but were not yet ranked by order of perceived importance (**Supplementary Table**

3). Participants first discussed prioritized consensus statements and the importance of each for improving restricted visitation policies. Second, participants discussed whether any modifications would be required to improve the relevance and meaningfulness to the current issues experienced by ICU patients, families, and healthcare professionals. Last, participants discussed the items that did not meet the priority threshold or were not yet ranked, based on how important it might be for improving restricted visitation policies. Research assistants recorded key points of the discussion on MURAL (www.mural.co), a digital workspace, for all participants to review and make further comments. After day 1 discussions ended, attendees were given the opportunity to modify the MURAL outside of the meeting and provide feedback to any other themes discussed. Their access remained open for day 2, to provide feedback to discussions the next day.

Day 2

The aim of day 2 of the meeting was for participants to discuss implementation of the consensus statements. The principal investigator (KMF) presented to the full group a high-level summary of the consensus statements that were refined from day one to inform the second breakout session. During the breakout session (70 minutes) on day 2, participants discussed implementation centered on the facilitators and barriers of consensus statements, implementation considerations, and how the consensus statements should be measured and monitored.

eAppendix 2 Day 1 Breakout Session Guide.

Introduction

Welcome to break out room [#], my name is <facilitator's name>. I work as a <role> with [PI name]. This is <note taker's name> who works as a <role> with [PI name] and will be taking notes throughout today's discussion and managing our chat and mural dashboard. I will be the facilitator, and I am here to help move the discussion on our assigned themes.

In today's group discussion, we will be using MURAL to:

- Discuss our assigned theme(s)
- Discuss the results of the themes
- Build a visitation policy together

Housekeeping

Before we start our discussion, does anyone have any questions?

Let's start our discussion, I will start recording now <press record>.

<Record the session on zoom to your computer or a handheld recorder – we will be only using audio>
Instructions on saving are at the end of discussion section

Facilitated Discussion

Brainstorming policymaking

This morning's breakout group session will focus on brainstorming and compiling items to create a policy for each of the two themes we were assigned.

We will be focusing on reflecting what is **important** and **applicable** to the critical care community based on your experience. Our group has been assigned the following themes [title of themes].

We can make any modifications we want to these items/strategies, including additions if we feel that key elements are missing or deletions. You can add context (e.g., who the strategy should be directed towards, what institutional level it should be carried out in, etc.) to the strategy to make them more understandable or more applicable.

During the conversation, I will write notes on MURAL.

**Notetaker: once discussion begins, please encourage participants to use the chat box. For example, "Hi everyone. Feel free to unmute and add to the discussion verbally. If not, I will monitor the chat so please add your ideas."*

**Facilitator: During the discussion, try your best verbalize changes so they are recorded on the audio.*

Discussing themes for policy & building policies (75 mins): 9:00-10:15 MDT

Discuss theme items (30 mins)

[Facilitator reads out theme items one by one; themes/items will already be on mural]

Let's think about why this item/strategy is **important** for improving restricted visitation policies and whether any modifications should be made to make it more **applicable and meaningful** to the current issues experienced by ICU patients, families, healthcare providers and decision-makers.

[Note: we want to work through each item and see if the participants think any modifications are necessary. Write out the item on MURAL and ask how participants would change the wording. Write it again with the updated wording so we can see the evolution. Read it out. Ask "is there a different way to say this?" Some of the items on MURAL are in grey boxes. This means that they were not ranked high when participants were asked to prioritize them and don't meet the cut-off. You will see that their mean scores are lower than the others. Ask participants if they think these items should be included in the policy statement?]

Other phrases you can say:

- Is there anything to add or change to this item?
- Is this inclusive of all groups possibly affected?
- If there's a proposed change, why do you think this change is merited?
- Does this new item fall under this theme?
- Could any of these items be combined?
- Do you think this is applicable to the critical care community?
- Which items should be included in the policy and why?
- Are there any items or sections missing that would make this more applicable and meaningful to the impact of restricted visitation/ critical care?

Constructing a policy (40 mins)

Now that we've discussed important strategies for improving restricted visitation policies, we will be constructing a policy focusing on each theme discussed.

Putting together all our discussed items, what should the policy be? Please be specific and construct a policy while considering how it impacts different stakeholders in the ICU community.

1. Which items should be included in the policy and why?
2. Are there any items missing?
3. In what situations does this policy apply? Are there exclusions or exceptions? When would these apply?
4. Are there existing policies that would support the construction of this new policy?

Conclusion (5 mins)

Does anyone have any additional thoughts or questions before we conclude our breakout group discussion? [or add, or does anyone have a "take home message" from this breakout session or anything that they would like to share with the research team?]

Thank you everyone for your excellent contributions to our discussion, we will continue with our large group discussion shortly. **Please note the conversation doesn't end here**. **We will be sending out the link to this MURAL to everyone after today's meeting. If you have anything to add, please write it on the MURAL or feel free to contact a member of the study team.**

eAppendix 3 Day 2 Breakout Session Guide.

Introduction

Welcome to break out room [#], my name is <facilitator's name>. I work as a <role> with [PI name]. This is <note taker's name> who works as a <role> and will be taking notes throughout today's discussion. I will be the facilitator, and I am here to answer any questions you have and to help move the discussion along.

Housekeeping

Does anyone have any questions?

Let's start our discussion, I will start recording now <press record>.

<Record the session on zoom to your computer or a handheld recorder – we will be only using audio>
Instructions on saving are at the end of discussion section

Facilitated Discussion

Today we will be considering the consensus statements we are developing and reflecting on their implementation. We will be focusing on potential barriers and facilitators that may arise while you reflect on your experience as a member of the critical care community.

Review policies from day 1 & discuss implementation, barriers & facilitators (~65mins)
9:10-10:15 MDT
Discuss policies & implementation (30 mins)

Dr. Fiest reviewed the consensus statements from yesterday [display on screen if you think helpful, but DO NOT go through themes or items. Consider the consensus statements as a whole.]

Let's discuss how we would implement our consensus statements.
Probes for implementation:

1. How should these consensus statements be implemented?
2. Who should be in charge of implementing these into the current system? What roles do each of the stakeholders have?
   Probes: Families/Decision-makers/healthcare providers
3. What would need to happen for these consensus statements to be implemented at your institution?
   Probes: Cultural change/ buy in from leadership/ collaboration between stakeholders/ financial considerations?
4. What resources would be necessary to implement these consensus statements?

5. How should the consensus statements deal with unexpected changes during an outbreak situation?

Discuss barriers & facilitators (40 mins)

Let's discuss what might be potential barriers and facilitators to these consensus statements.

1. What existing factors might prevent these consensus statement from being successful? What do you perceive to be barriers?
    a. Resources/ beliefs/ expectations/ communication/ acceptability/ support/ clinical workflow
2. Do policies exist that present institutional, regulatory barriers to these consensus statements?
3. How do you think these barriers can be addressed?
4. For whom do you think there are barriers? Probe different stakeholders
5. What are things that would facilitate the making of these consensus statements?
6. What would be the best method to monitor and evaluate the implementation of these consensus statements

Revisit the example policies & conclude main points (5 mins)

Are there any changes that we should make to these consensus statements? Do we feel we have addressed all areas while constructing these consensus statements?

How should the consensus statements be reworded or reformatted to fit our implementation strategies and considerations of potential barriers and facilitators?

Conclusion

Does anyone have any additional thoughts or questions before we conclude our breakout group discussion?

Thank you everyone for your excellent contributions to our discussion, we will continue with our large group discussion shortly.

eTable 1 Consolidated criteria for Reporting Qualitative research (COREQ) Checklist

Topic	Item No.	Description	Reported on Page No.
Domain 1: Research team & reflexibility			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	8,17
Credentials	2	What were the researcher's credentials? E.g., PhD, MD	1
Occupation	3	What was their occupation at the time of the study?	1
Gender	4	Was the researcher male or female?	NR (female)
Experience and training	5	What experience or training did the researcher have?	8
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	7
Participant knowledge of the interviewer	7	What did the participants know about the researcher? E.g., personal goals, reasons for doing the research	NR
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? E.g., Bias, assumptions, reasons and interests in the research topic	NR
Domain 2: Study design			
Theoretical framework			
Methodological orientation and theory	9	What methodological orientation was stated to underpin the study?	NR (qualitative description design under a naturalistic methodological assumption that was informed by a constructivist perspective)
Participant selection			
Sampling	10	How were participants selected? E.g., purposive, convenience, consecutive, snowball	7
Method of approach	11	How were participants approached? E.g., face-to-face, telephone, mail, email	NR (emailed)
Sample size	12	How many participants were in the study?	7

Non-participation	13	How many people refused to participate or dropped out? Reasons?	NA
Setting			
Setting of data collection	14	Where was the data collected? E.g., home, clinic, workplace?	7
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	NA
Description of non-participants	16	What are the important characteristics of the sample? E.g., demographic data, date	7,Supplementary Table 1
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Supplementary Files 1 & 2
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	NA
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	8
Field notes	20	Were field notes made during and/or after the interview or focus groups?	8
Duration	21	What was the duration of the interviews or focus groups?	Supplementary File 1
Data saturation	22	Was data saturation discussed?	NA
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	Supplementary File 1
Domain 3: Analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	8
Description of the coding tree	25	Did authors provide a description of the coding tree?	9-13
Derivation of themes	26	Were themes identified in advance or derived from the data?	8
Software	27	What software, if applicable, was used to manage the data?	8
Participant checking	28	Did participants provide feedback on the findings?	Supplementary File 1
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g., participant number?	9-13, Supplementary Tables 3 & 4
Data and findings consistent	30	Was there consistency between the data presented and the findings?	9-13

Clarity of major themes	31	Were major themes clearly presented in the findings?	9-13
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	9-13

Abbreviations: Not Reported, NR; Not Applicable, NA

eTable 2 Original and refined consensus statements (n = 99) from the modified Delphi Consensus process

Items presented for discussion on Day 1	»	***Revised items after Day 1 (changes in bold)***
Theme 1: Impact on patients & their families during restricted visitation		
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).	»	Patients **may experience** 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).
Family was absent at the end-of-life or did not visit their loved one before they were sedated or intubated.	»	Family **may have been** absent at the end of life or **missed an opportunity to** visit their loved ones before they were sedated or intubated.
Families did not understand how sick the patient was (e.g., severity of critical illness).	»	Families **could not visualize how critically ill** the patient was (e.g., **lack of family presences, family cannot see the level of care provided, overnight change of patient status**).
Families were turned away from entering the hospital, had to wait outside on the sidewalks or in their cars.	»	*No changes made*
Families experienced lack of compassion from security and healthcare staff, or when requesting an exception for visitation.	»	*No changes made*
Families needed reassurance and additional emotional support form healthcare staff when visitor restrictions were in place (e.g., to know that their loved one was not abandoned/forgotten; there was a significant impact on coping and grief).	»	*No changes made*
Geographical distance from the hospital limited family's access to the patient during periods of rapid health decline (e.g., end-of-life).	»	Geographical distance **(e.g., flights)** from the hospital **impacted family's ability to** access **their family member** during periods of rapid health decline (e.g., end of life).

Restricted visitation policies were inconsistent with the community case numbers leading to anger and frustration amongst families and visitors. Policy changes distributed to the public were inaccurate or inconsistent across units and hospitals.	» »	**Communication of restricted visitation policies were inconsistent. This led to rapidly changing policy without rationale (e.g., if policy changed based on what is happening in the provinces), which led to** anger and frustration amongst families and visitors **who couldn't visit**.
There was an impact on children and siblings who were unable to visit (e.g., distressing, mental health concerns, isolation requirements).	»	There was an impact on children **(under the age of 16 years old)** who were unable to visit (e.g., distressing, mental health concerns, isolation requirements).
Theme 2: Impact on patient & family-centered care during restricted visitation		
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).	»	Family **is unable to participate** in key elements of patient care (e.g., physiotherapy, feeding, delirium prevention/management, discharge planning, recovery), 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).
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.	»	It was challenging to accurately convey the patient's clinical status and appropriateness of care to families over the phone or Zoom. It is important for family to understand treatment and therapy **(e.g., hear alarms, and frequency and variety of staff who enter the room)** to be **informed** to make appropriate **decisions**.
Healthcare professionals were missing details about patient history usually provided by the family (e.g., knowing the patient's baseline prior to ICU admission). When patient care decisions were required, healthcare professionals did not have the opportunity to consult with family, or patient care decisions were delayed.	» »	Healthcare professionals were missing a **complete picture of the** patient's history usually provided by the family (e.g., knowing the patient's pre-ICU baseline, **understanding them as a person**).

Family was not present to advocate for patient care needs or wishes.	»	*No changes made*
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).	»	*No changes made*
It was difficult to express compassion without body language (e.g., due to personal protective equipment [PPE] or when speaking on the phone).	»	It was difficult to express compassion **and empathy** without body language or eye contact (e.g., due to personal protective equipment (PPE) or when speaking on the phone).
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)	»	Healthcare professionals had less time available for the delivery of patient and family-centered care (PFCC) due to increased clinical demand, patients on isolation precautions (e.g., donning/ doffing PPE, patients with complex/ multiple needs, **entering patient's rooms less frequently**).
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).	»	The lack of family presence had a more significant impact on patients with **communication barriers (i.e., language, cognitive difficulties, hearing)**. Patients with **communication barriers** may have suffered from lower quality of care due their difficulty in expressing their needs or **advocating for themselves** (e.g., patients may have had difficulty understanding goals of therapy, understanding verbal/manual cues, expressing their symptoms).

Theme 3: Impact on healthcare professionals during restricted visitation		
It was difficult to communicate rapidly changing visiting policies to family, or when communication about visitation policy change were distributed on weekends, evenings, or end of day on Friday. 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).	» »	It was difficult to communicate the rapidly changing visiting policies to family **when distributions of visiting** policy change occurred on weekends, evenings, or end of day Friday.
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 visitation policy details (e.g., healthcare providers circumventing the policies, unit managers making exceptions, inconsistency in enforcement of rules such as physical distancing).	»	There was a sense of tension **(e.g., between the policy and its application)** and lack of trust amongst healthcare professionals and policy makers. This was often due to variation in the interpretation or application of visiting policy details (e.g., healthcare providers circumventing the policies, unit managers making exceptions, **inconsistencies** in enforcement of rules such as physical distancing).
Healthcare professionals were conflicted between advocating against the policy (to prioritize patient well-being) and advocating for the policy (to protect the healthcare system).	»	*No changes made*
Psychosocial impact to healthcare professionals due to moral distress (e.g., gatekeepers to family to visit, patients dying alone) and anxiety due to ever changing restricted visitation policies.	»	Psychosocial impact to healthcare professionals due to moral distress (e.g., gatekeepers to family to visit, patients dying alone), **fear (e.g., fear of catching COVID-19, uncertainty around PPE)**, and anxiety due to ever changing policies.
There was concern over staff exposure risk or staff access to PPE.	»	There was concern over staff exposure risk **(i.e., during visitation)** or staff access to PPE **on top of caring for critically ill patients.**

There was a lack of support from the leadership team when developing restricted visitation policies. This included no help from the policy maker or administration when implementing or enforcing the policy or new structure of communication.	»	**Query staff if they feel there was adequate** support from the leadership team when developing restricted visitation policies. **This includes** help from the policy maker or administration when implementing or enforcing the policy or new structure of communication.
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 colleagues on other floors).	»	Healthcare professionals experienced impact on job satisfaction **and moral distress**. 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 (**making them** unable to help colleagues on other floors).
There was a lack of trust between healthcare professionals and visitors (e.g., visitors from out of province not following rules, visitors misidentified themselves as the designated visitor, or lying about their COVID-19 status).	»	*No changes made*
Increased workload for healthcare professionals, decision makers, and hospital administrators. This included frequent conversations with family members that were required to develop and maintain trust (e.g., trust the healthcare professionals were doing all they could, giving adequate care, and for the acceptance of pandemic circumstances etc.) and additional time to set up virtual visitation.	»	*No changes made*

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).	»	*No changes made*
There was a lack of continuity with standardized restricted visitation policies between different units within the same hospital or facility.	»	There was a lack of continuity **and rationale** with standardized restricted visitation policies between units in the same hospital.
Exceptions occurred which were inconsistent with provided guidelines (e.g., staff made exceptions for some but not all patients).	»	*No changes made*
Policy changes were inconsistent between hospitals and/or within hospitals.	»	*No changes made*
Theme 4: Experiences with alternatives to in-person visits		
There was variability in patients, families and healthcare professionals' comfort and access to technology that supported virtual communication (e.g., families and staff were unfamiliar with platforms such as Zoom and Skype, loved ones were not tech-savvy, families did not have access to Wi-Fi to communicate with their loved ones, etc.).	»	There was variability in **patient's, family's** and healthcare **provider's** comfort and access to technology that supported virtual communication (e.g., **inequitable access to devices**, families and staff were unfamiliar with platforms such as Zoom and Skype, loved ones were not tech-savvy, families did not have access to Wi-Fi to communicate with their loved ones, etc.), **and access may have been limited upon ICU discharge.**
Technology was NOT used often or at all, or the healthcare team had to initiate and implement technology use for communication with families.	»	
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).	»	Clinical circumstances **or geographical distance** limited the capacity for patients and families to communicate or interact (e.g., patient was on breathing machine, proned patients, patients were sedated, patients with delirium**, etc.**).

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, etc.).	»	*No changes made*
There were limited communication options when there was a language barrier between patients and families and the healthcare team.	»	*No changes made*
Technology was incorporated to facilitate end-of-life visits.	»	*No changes made*
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).	»	Technology helped to enhance communication between **healthcare professionals and 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) **in most circumstances, with the exception of issues with access to technology and knowledge of how to operate.**
Theme 5: Ways to improve communication of policy & policy changes		
Communicate policy changes to hospital staff during regular working hours and before the change becomes effective or is communicated to the public (e.g., all staff should know the policy change before the media, changes should be communicated during regular working hours).	»	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).
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).	»	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).

Provide a succinct 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, etc.).	»	Provide a succinct hardcopy of up-to-date **(i.e., by unit clerk)** restricted visitation policies at the hospital and on each unit **with additional 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.**
Incorporate in-person communication by management and leadership to communicate policy changes to staff, families, and visitors (e.g., hospital liaison person who could answer questions about the policy, address family and visitors concerns and appeals).	»	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 visitor concerns and appeals).
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).	»	Incorporate communication **(e.g., phone call, video, podcast, automated messaging) implemented by management and leadership to communicate policy changes to family and visitors.**
Theme 6: Strategies for policy implementation & consistency		
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).	»	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 from essential care providers and visitors.**
Include key stakeholders in policy development and adaption (e.g., nurses, physicians, allied health professionals, decision makers, patients and families, infection prevention and control).	»	Include key stakeholders in policy development and adaptation (e.g., nurses, physicians, **spiritual care,** allied health professionals, decision makers, patients and families, infection prevention and control).

Implement a clear and straightforward process to request exceptions and appeals to restricted visitation polices.	»	Implement a clear and 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).**
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).	»	*No changes made*
Allow any healthcare team member to be able to initiate a request for visitation exceptions.	»	*No changes made*
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).	»	*No changes made*
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).	»	*No changes made*
There should be no exception to the policy, or the exceptions must be well defined and strictly adhered to.	»	*No changes made*
Ensure consistency in visitation policies within health regions and cities (e.g., across cities).	»	*No changes made*
Ensure consistency in visitation policies within provinces and territories.	»	*No changes made*

Ensure consistency in visitation policies within hospitals (e.g., across units).	»	*No changes made*
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.	»	*No changes made*
Theme 7: Facilitation of in-hospital visitation for families or visitors		
Designate unit-level visitor "greeters "and "navigators." The role of these "greeters" or "navigators" may include the following: 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 noncompliance with hospital PPE policies, etc.	»	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.
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).	»	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).
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.	»	When visitations restrictions are **liberalized**, **at a minimum adhere** by public health **measures which may be augmented by local hospital policy.**
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.	»	*No changes made*

Allow two designated visitors per patient throughout the patient's ICU stay. Allow the designated visitors list to change, but under pre-determined circumstances.	»	*No changes made*
Allow multiple visitors per patient as long as they are from the same household.	»	*No changes made*
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.	»	*No changes made*
Define 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.	»	**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.
Schedule visitor time slots.	»	*No changes made*
Provide patient support stickers to identify visitors.	»	*No changes made*
Allow religious and spiritual ceremonies (e.g., communion, sacraments, smudging, etc.).	»	**Accommodate** religious and spiritual ceremonies (e.g., communion, sacraments, smudging, etc.) **whenever possible and safe in line with public health guidelines.**
Lock unit to visitors who have not been pre-approved or identified as a designated visitor.	»	**Do not allow** visitors who have not been pre-approved or identified as a designated visitor.
Ensure policies consider available physical space so that physical distancing is possible.	»	*No changes made*.
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).	»	*No changes made*

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).	»	*No changes made*
Implement a straightforward process to appeal the restricted visitation policy.	»	*No changes made*
Limit the duration of visits except during end-of-life.	»	*Participants agreed to remove item as it was difficult to define.*
Theme 8: End-of-life		
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 Indigenous families, and when visiting family is 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).	»	*No changes made*
Private rooms for end-of-life patients and their families.	»	**Privacy for** end-of-life patients and their families **and, where available, private rooms.**
Consistent end-of-life policies within jurisdictions (i.e., cities, health regions, provinces).	»	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-19 activity or risk assessment.**
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.	»	*No changes made*
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).	»	*No changes made*

Work with families to create memories, mementos (e.g., record heart sounds, handprints, etc.).	»	Work with families to create memories, **timelines of patient progress,** or mementos (e.g., record heart sounds, handprints, etc.).
Ensure the same end-of-life policies are applied across the hospital of facility (e.g., ICU versus medicine floor).	»	*No changes made*
Theme 9: Criteria for visitation exceptions if no visitation is allowed		
Consider patients and families psychosocial needs as reason for visitation exceptions (e.g., anxiety, loneliness, long ICU stays).	»	Consider **each** patient and family's **specific** psychosocial needs as a reason for visitation exceptions (e.g., anxiety, loneliness, long ICU stays).
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).	»	*No changes made*
Consider patients that require cognitive, physical, or mobility assistance.	»	*No changes made*
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).	»	*No changes made*
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).	»	*No changes made*
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).	»	*No changes made*

Theme 10: Facilitation of out of hospital communication with family or visitors		
Designate one to two identified competent family spokespersons to be notified in advance of daily virtual rounds, participant in clinical discussions and to receive and disseminate family updates.	»	*No changes made*
Provide videoconferencing options to family members and patients who are separated because of COVID-19 travel and visitor restrictions or, ask the patient's alternative decision maker for consent to connect with patients on videoconferencing.	»	Provide videoconferencing options to family members and patients who are separated.
	»	**Have a robust process for consent to connect the patient with visitors via videoconferencing.**
Designate additional healthcare team members to call and update family daily (e.g., allied health professionals, medical students, residents, social workers, etc.).	»	**An effort should be made to provide frequent (medical) updates (including allied healthcare) to the family and provide opportunities for families to ask questions.**
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 arrangement for nights and weekends with healthcare teams as needed.	»	**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.
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.).	»	**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.).
	»	**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.)

Create rules and designated meeting spaces for healthcare professionals and family members about meeting outside of the hospital.	»	*No changes made*
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).	»	*No changes made*
Create a virtual hotline for 24-hour specialty level advice and palliative care support.	»	*No changes made*
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 (e.g., iPads, tablets, phones, etc.).	»	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.**
Subsidize or provide free access to virtual and tele-communication including reliable Wi-Fi and television access for patients and their families.	»	*No changes made*
Designate additional technological support to assist healthcare teams to set up virtual meetings and address immediate technological concerns requiring assistance.	»	**Designated role (i.e., new member of ICU care team)** to set up virtual meetings and address immediate technological concerns requiring assistance.
Have televisions or other technological devices in rooms that allow for access to online platforms (e.g., Zoom, Skype) for virtual visits with families.	»	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.**

Include public-facing and staff-facing training on virtual communication.	»	Include **different modes of** public-facing and staff-facing training on virtual communication **(e.g., YouTube, video, brochure).**
Theme 12: Organizational supports		
Provide mental health supports (e.g., self-care and coping strategies, bereavement, wellness, etc.) for families, patients, and staff.	»	
Implement psychological supports for healthcare professionals at hospital or facility site with dedicated mental health professionals competent with specialized knowledge of frontline healthcare, access to voluntary online psychological assessments (to identify the emotional state and burnout of healthcare staff), and access to locations to facilitate staff mental health breaks during work.	»	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.**
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.	»	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.
Provide opportunities to debrief with colleagues or senior management team regarding events impacted by restricted visitation.	»	Provide opportunities to debrief with colleagues or senior management team regarding events impacted by **visitation policies/family presence.**
Increase presence and availability of Infection, Prevention and Control standards and clinician educators to address healthcare workers questions around infection risk and visitation.	»	**Provision of accessible** Infection, Prevention, and Control standards and educators to address healthcare workers questions around infection risk and visitation.
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.	»	*No changes made*

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.	» *No changes made*
Create clear definitions of what it means to be critically ill or receiving palliative care.	» *No changes made*

eTable 3 Consensus statements and exemplary quotations related to the clarity, accessibility, and feasibility of consensus statements

Quotation (Q) Number [participant]	Exemplar quotation	Delphi consensus statement	Refined consensus statement
Clarity			
Q1 [Participant 1 - Nurse]	"I agree with that. I think it's important. The essential care partner is so important to the patient's care where a visitor for the sake of visiting might not be as essential."	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)	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 essential care providers and visitors.**
Q2 [Participant 2 - Nurse]	"…family's not always who we are just related to. As we know with many indigenous families also, it's not just your blood relation, it's who you consider family, which I don't know if that's captured in this somehow. But it's also your chosen family, not your given family."	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 (e.g., families did not feel a part of the team caring for the patient).	*No refinement*
Q3 [Participant 3 - Attending Physician]	"…the word children, siblings, is pretty ambiguous and that there could be maybe ways to make that	There was an impact on children and siblings who were unable to visit (e.g., distressing, mental	There was an impact on **children (under the age of 16 years old)** who were unable to visit (e.g.,

	more specific. Certainly, in terms of if we thought of policies that siblings are very different than children potentially. And children, if we're thinking of that as under legal age, then that's a huge range. We could think about a 16-year-old coming into the ICU is quite different than an infant or toddler."	health concerns, isolation requirements) -	distressing, mental health concerns, isolation requirements). -
Q4 [Participant 4 - Attending Physician]	"I know that we had to navigate a few end-of-life cases where there were children specifically involved in there. It seemed to be age rather than relationship because of the fear that a three-year-old would be running around uncontrollably in the hallway. And we had to make a policy that said children could visit if accompanied by a responsible adult and following all of the other restrictions that were in place. I think capturing the visits of a minor is important."		
Q5 [Participant 5 - Attending Physician]	"…having the patients able to interact. Again, that's really, really important in my view, so it's very good."	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 indigenous families,	*No refinement* -
Q6 [Participant 6 - Attending Physician]	"… I had an individual admitted to		

	the ICU during the early stages of COVID, but still with all the COVID restrictions, where he had a period of lucidity, but nobody could visit except one visitor, which was his wife. He then became delirious, and we were moving towards end-of-life care. And so, his children who were teenager to young adult children only had a chance to visit after he was delirious or intubated. And I think that had a very negative impact around the experiences of death for those children. Whereas if they had a chance to visit while he was still lucid and not intubated, it would have been quite a bit different.“	and when visiting family is 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) -	
Accessibility			
Q7 [Participant 7 - ICU Patient/Family Member]	“…there's Wi-Fi in the actual ICU. My husband would have to go down a hall and close to a window to get anything…Wi-Fi can be pretty bad” “	There was variability in patients, families and healthcare providers comfort and access to technology that supported virtual communication (e.g., families and staff were unfamiliar with platforms such as Zoom and Skype, loved ones were not tech-savvy, families did not have access to	There was variability in patient's, family's and healthcare provider's comfort and access to technology that supported virtual communication (e.g., **inequitable access to devices,** families and staff were unfamiliar with platforms such
Q8 [Participant 8- Attending Physician]	“…we had a solution of iPads, which was actually really helpful to us to have always available. I know a lot		

	of other institutions and people have mentioned that a major limitation is exactly as you're highlighting there, is inequitable access to devices. Fortunately, we didn't experience that on my site, but it's definitely a very real issue."	Wi-Fi to communicate with their loved ones, etc.) -	as Zoom and Skype, loved ones were not tech-savvy, families did not have access to Wi-Fi to communicate with their loved ones, etc.), **and access may have been limited upon ICU discharge.** -
Q9 [Participant 9 - Attending Physician/ Researcher]	"And this is part of the whole multimodal way or fashion to disseminate this information. If you don't have a phone or a computer, anyone can... Hopefully you can pick up a pamphlet, and that can get the message across and even if you're illiterate. Hopefully, you can bring that pamphlet to someone who can help you to decipher it as well, because that's another piece that we just found out how many of our patients or family members are actually illiterate, which is surprising in this day and age."	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).	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)**.
Q10 [Participant 10 - Resident/ Family Member]	"Increasing is a very…in some ways a very ambiguous term, because there might be some institutions out there that already have a really robust system…maybe just saying, "provision of	Increase presence and availability of Infection, Prevention and Control standards and clinician educators to address healthcare workers questions around	**Provision of accessible** Infection, Prevention, and Control standards and educators to address healthcare workers questions around infection risk and visitation.

	accessible infection prevention and control standards, and educators to address healthcare workers questions about infection risk and communication."	infection risk and visitation. Implement a clear and straightforward process to request exceptions and appeals to restricted visitation polices	Implement a clear, **timely and accessible** and straightforward process to request exceptions and appeals to restricted visitation polices **(e.g., end-of-life, other adults that would benefit from presence)**
Q11 [Participant 8 - Attending Physician]	"I read a study where one institution actually had a communications team... I'm not sure if they were composed of... I think they're composed of med students. They would actually call the seniors and try to train, if they didn't have a younger individual to help them, they would actually train them on how to access technology. I thought that was really interesting. But yes, I think they key issues here are access to the devices. And then the second is capacity to actually use the devices."	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	**With the exception of issues with access and knowledge**, technology helped to enhance communication **between healthcare professionals and 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
Q12 [Participant 10 - Resident/ Family Member]	"I think that would shape some of our language use. For example, 'competent family spokesperson' I think may not land well with every	Designate one to two identified competent family spokespersons to be notified in advance of daily virtual rounds, participant in clinical	Designate one to two **identified** family spokespersons to be notified in advance of daily virtual rounds, participate

	family. It's a bit of a value judgment, like: "What does it mean to be a competent family spokesperson?"	discussions and to receive and disseminate family updates.	in clinical decision-making, and to receive and disseminate family updates.
Q13 [Participant 1 - Nurse]	“We also had quite a few adults with developmental delays. And I think those are also special populations, again, coming from pediatrics, having either their parents or care provider there, especially for communication is really important.”	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).	The lack of family presence had a more significant impact on patients with **communication barriers (i.e., language, cognitive difficulties, hearing)**. 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).
Q14 [Participant 11 - Attending Physician]	“I think end of life is context specific for many different peoples with different religious, spiritual, social, cultural backgrounds. And so we've highlighted indigenous, which is clearly important. But I think there's also some sensitivity to the fact that end of life care practices can vary across these as well. And so I think we need to be more	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 indigenous families, and when visiting family is 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	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 visiting family is COVID positive. This end-of-life policy should include a clear definition of end-of-life, which allows visitors while

	inclusive, is my point."	interact (i.e., not comatose at end-of-life)	patient is lucid and able to interact (i.e., not comatose at end-of-life
Feasibility			
Q15 [Participant 12 - Nurse]	"I feel like the frustration is just from the inconsistency. Not so much from community case numbers. I think the frustration came from inconsistency. Even within [province], depending on which hospital you're at, the policies were different. If they were transferred from another hospital, for example, the rules kept changing. It became a bit of frustration for families, for us as well."	-	-
Q16 [Participant 13 - Attending Physician/Researcher]	"I do like that the fact that there is some advanced warning, it goes out across all available media, social outlets, and then the announcement is widely disseminated 24 hours later, still during business hours, I think is important."	Communicate policy changes to hospital staff during regular working hours and before the change becomes effective or is communicated to the public (e.g., all staff should know the policy change before the media, changes should be communicated during regular working hours)	Communicate policy changes to hospital staff during regular working hours and before the change becomes effective **(at least one days' notice before implementation)** or is communicated to the public (e.g., all staff should know the policy change before the media, changes should be communicated during regular working hours)

Q17 [Participant 9 - Attending Physician/Researcher]	"If the ultimate goal is to create some policy statements or guidelines, then as per a guideline, it may be useful to suggest that units consider having a greeter or navigator if feasible. And that could be the caveat that we placed there, that it would be our recommendation but with the acknowledgement that it's not possible in every single site."	Designate unit-level visitor "greeters "and "navigators." The role of these "greeters" or "navigators" may include the following: 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, etc.	Designate unit-level "**visitor advisor" if feasible**. The role of these **"visitor advisor"** 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.
Q18 [Participant 14 - Attending Physician]	"…that would've been so unrealistic. We were run off our feet day and night, and just to leave to go meet somebody... we couldn't even find time to meet to go for lunch. So, to me, this was in the unrealistic category, but again, that may be just in our experience with COVID and the volume."	Create rules and designated meeting spaces for healthcare professionals and family members about meeting outside of the hospital	*No refinement*
Q19 [Participant 15 - Attending Physician]	"…thinking about how outbreaks in this pandemic have been patchy temporally and geographically, and what's happening in [city name] might not at all reflect what's happening in [city name] and vice versa.	Consistent end-of-life policies within jurisdictions (i.e., cities, health regions, provinces)	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**

	And so it'd be nice if there was some consistency around triggers and thresholds."		**COVID activity or risk assessment.**
Q20 [Participant 16 - Nurse/ Researcher]	"I mean, I guess the theme that we had talked about around that, although there's not going to be one policy that governs an entire health authority, to have agreed upon principles of valuing family presence, trying to maximize family presence, and also preserving staff safety…"	-	-

eTable 4 Exemplary quotations related to implementation of prioritized consensus statements

Quotation (Q) Number [participant]	Subtheme	Exemplar Quotation
Facilitators and barriers		
Quotation 21 [Participant 17 - Physiotherapist]	Consensus statement-related factors	"I agree that they have to be plain and simple, maybe bullet points or something, so that you can read them really fast and understand what's going on."
Quotation 22 [Participant 10 - Resident/Family Member]	Consensus statement-related factors	"I think having realistic expectations to access to both staff and technology in those things, because I remember that was something that came up in some of the places I was working as, on the one hand we were saying that we could do these things for the families that we didn't actually have iPads or the Wi-Fi, or other types of those logistical supports in place. Or if we were saying, "Oh, talk to this person, talk to that person." I'm like, we didn't actually have in our staffing, or I think just we can put forward these are the best practices and the best way to recommend it as much as we want. But if there isn't some degree of flexibility or some ability to have adapt this toolkit or adapt these policies based off of what you have available locally, or the funding or the support, or the staffing, then I don't think it's going to be very useful, because what we have in [province name] might be

		different from what we have in [province name] or even within the same city, different hospitals may have different resources available to them."
Quotation 23 [Participant 18 - Attending Physician]	External factors	"We haven't pivoted today to change our visitation policy as part of the stay home. Because I think we've learned from one and wave two that that family presence, whatever way we can do it, if the family the one thing is it's a single household now, and it's a limited amount of time. It's not the free reign because there's no visitors lounge or anything like that anymore. But it is come in have your visit, it's a single household, aligning with what public health wants. We're trying to balance that off, but I hadn't heard today with the stay-at-home order that we were changing our visitation policy"
Quotation 24 [Participant 19 - Decision Maker]	External factors	"Well, wouldn't you know that Thursday afternoon, unbeknownst to anyone in [the provincial health authority organization], our government announced that there is no longer outdoor visits of any kind. So we had to really be aware and pivot in big ways. So sometimes there's challenges that are higher level than we know. So is this a barrier to consider of how can we partner with our government or authorities around when they make these

		changes similar to, I think what we had in the first bullet, at least 24 hours' notice because for me to get a policy change in [the provincial health authority organization] to get up to our senior leaders, it's 24 to 48 hours at the very, very quickest. And then to get it down to our 100,000 employees, let alone just our ICU staff, that's a week. And when you look at some knowledge translation, sometimes people would say it could be three months, six months before we're comfortable with these pieces. So I just want to be mindful of that that sometimes there are constraints that are really challenging around public health or maybe I'll say it politics I guess but I'll leave it at that."
Quotation 25 [Participant 20 - Family Member]	External factors	"So this committee, this group, and lots of others have all levels, all the stakeholders, right? So I'm advocating for patients and family members and someone needs to be on that committee that's making those changes that advocates for the facility or the healthcare facility that actually has to implement those. Because if the right people were at that table, they could say unless otherwise governed by [the provincial health authority organization]

		facility. And then that would still allow the hospital situation to be exempt from that. Because sometimes when they make those rules, they haven't considered that fact. We'd like to assume they did but that's not real."
Quotation 26 [Participant 2 - Nurse]	Individual factors	"…the amount of change fatigue that happens, as a registered nurse, sitting there. I don't have just new COVID policies. I have new studies that we're involved in. I have new pumps that are coming in. I have new meds that are now on back-order. I have new masks. This is now how we're doing this. This thing has happened. This is how we're changing, right? Every day, there's so much change. And what happens is you get to have change fatigue. And it's similar to alarm fatigue in the ICU, right, that people just get so sick of the sheer amount of changes in one day."
Quotation 27 [Participant 21 - Attending Physician/ Researcher/ Decision Maker]	Resources	"I think the single most important thing with all the items that has been proposed is that, it should be quite easy to implement. It should be low human cost as well, because people are just currently overwhelmed. The staff is tired, the administrators are tired because they have hard time to find staff to take care of patients. So to ask them to implement something very

		complex, would probably just not work at this point.”
Quotation 28 [Participant 16 - Nurse/Researcher]	Resources	“I guess the one thing I would like to highlight and it's hard to know because I know this is specific to COVID-19. And again, kind of in reflection to the second and third wave being different than the first wave, is that I would say initially, there was a lot of staff fear around catching COVID-19, and that was a motivating factor behind limiting family. In the hospital that I work in, there's a lot of multi-generational homes, and so the entire household has COVID-19, which would then limit the visitation in the initial part of the ICU stay. And that was for I know, for my unit specifically, that was the motivating factor behind us putting really strict family visitation in, is because the staff were feeling unsafe at work, and the management wanted to feel or wanted the staff to feel like they were listening to their valid concerns of catching. I feel personally, specific to COVID-19, although with variance, is but, our staff population for the vast majority is now vaccinated. And so that internal fear that was there, in the beginning of the pandemic, I don't know if it's still as present, and as a motivating factor to have

		staff actually advocate for family not to visit, which was a weird place to be in to hear my nursing colleagues advocate to stop family visiting, because normally, that's not the side of that argument that we're on."
Quotation 29 [Participant 16 - Nurse/Researcher]	Resources	"I guess the one thing I would like to highlight and it's hard to know because I know this is specific to COVID-19. And again, kind of in reflection to the second and third wave being different than the first wave, is that I would say initially, there was a lot of staff fear around catching COVID-19, and that was a motivating factor behind limiting family. In the hospital that I work in, there's a lot of multi-generational homes, and so the entire household has COVID-19, which would then limit the visitation in the initial part of the ICU stay. And that was for I know, for my unit specifically, that was the motivating factor behind us putting really strict family visitation in, is because the staff were feeling unsafe at work, and the management wanted to feel or wanted the staff to feel like they were listening to their valid concerns of catching. I feel personally, specific to COVID-19, although with variance, is but, our staff population for the vast

		majority is now vaccinated. And so that internal fear that was there, in the beginning of the pandemic, I don't know if it's still as present, and as a motivating factor to have staff actually advocate for family not to visit, which was a weird place to be in to hear my nursing colleagues advocate to stop family visiting, because normally, that's not the side of that argument that we're on."
Implementation considerations		
Quotation 30 [Participant 22 - Nurse/Researcher/Decision Maker]	Structure	"So I think this is where it goes back to who is the audience and how does this fit with maybe any other direction that people are getting, and I do like personally, I like clear simple statements. I don't like statements with lots of parts, where one piece is actually connected to another piece, or one piece depends on the other piece…some of these are really crisp and clean and easy to interpret, and some of them are double barreled and there's lots of different parts and I think we have to be conscious of addressing that reality for people that some of these things are going to be difficult or potentially infeasible. And so how do we actually convey that you're not in violation of the consensus statement, or not, not delivering good care because you can't actually

		meet that, I don't want to say standard, because I don't actually think these are standards, I think they're suggestions or guideposts, but sometimes they can feel that way."
Quotation 31 [Participant 23 - Social Worker]	Structure	"Clear and direct and concise and just as practical as we can. That would be super helpful."
Quotation 32 [Participant 10 - Resident/ Family Member]	Structure	"I think having realistic expectations to access to both staff and technology in those things, because I remember that was something that came up in some of the places I was working as, on the one hand we were saying that we could do these things for the families that we didn't actually have iPads or the Wi-Fi, or other types of those logistical supports in place. Or if we were saying, "Oh, talk to this person, talk to that person." I'm like, we didn't actually have in our staffing, or I think just we can put forward these are the best practices and the best way to recommend it as much as we want. But if there isn't some degree of flexibility or some ability to have adapt this toolkit or adapt these policies based off of what you have available locally, or the funding or the support, or the staffing, then I don't think it's going to be very useful, because what we have in [province name] might be

		different from what we have in [province name] or even within the same city, different hospitals may have different resources available to them."
Quotation 33 [Participant 17 - Physiotherapist]	Structure	"Right now in [city name], it's relatively quiet compared to [city name], but I just wanted to say [city name] is divided in multiple health regions, and right now the one that I'm in, there are different hospitals, three different hospitals. And here in [city name], we have a lot of COVID patients still, but in other hospitals, there are no COVID patients right now. So, I think the policy should be adaptable to different hospitals regarding the context of COVID and what's going on in the different ICUs."
Quotation 34 [Participant 11 - Attending Physician]	Structure	"There's another sort of, I think, layer, that's critically important. And it's probably going to feed into whether there's widespread buy-in, or the policy which is understanding the rationale and why this has been adopted, whether you agree with or not, at least providing a firm sort of rationale for why this is being instituted, at this particular time, in this particular place, for these particular people."
Quotation 35 [Participant 11 - Attending Physician]	Process	"I think, generally speaking, implementation of a huge array of potential policies and

		procedures like this is going to require a variety of different strategies, to ensure their success, right, and their sustainability, to some extent, and your adherence, too, once implemented. So I mean, I'm not sure. We can discuss some of that, the methods and mechanisms by which you might try to reinforce that, but I think it's going to be a multi-prong sort of multi-disciplinary sort of approach if you're going to implement some of these things. And one of the strategies, also, might be you don't implement them all carte blanche. You might have stagger and prioritize some of the ones that you think are going to have different impacts on different stakeholders, at different times, so to speak."
Quotation 36 [Participant 24 - Attending Physician/ Researcher/ Decision Maker]	Process	"Well, I think the simplest way is to ask for and give people an opportunity to provide feedback. I mean, I think, again, that was probably one of the frustrations from frontline staff. You don't need to send out a fancy survey or anything. It is just to simply, can you provide feedback to your unit manager and can the unit manager then bring that back to their executive and so on and so forth?"
Quotation 37 [Participant 9 - Attending Physician/ Researcher]	Process	"I don't think that any of these would be most suitable or appropriate for in-hospital

		dissemination. These would probably be most suitable for some sort of publication for people to be able to digest and utilize as deemed appropriate.”
Measuring & monitoring		
Quotation 38 [Participant 25 - Respiratory Therapist]	Measuring	“The stories will work faster than the analytical quantitative data that we're getting, but it's the quantitative data that's going to work to help us push policy with government or make certain changes that are safer, more beneficial for the patient and to create funding even for these processes that we want to put in place”
Quotation 39 [Participant 10 - Resident/Family Member]	Measuring	“Because I think that would hopefully tease apart which parts of these policies and the way they're implemented are most meaningful and important to keep doing moving forward, and which might actually not be a good use of resources.”