A project spearheaded by Planetree International, with funding from the American Nurses Foundation

FAMILY PRESENCE POLICY DECISION-MAKING TOOLKIT FOR NURSE LEADERS

Released May 25, 2021
FAMILY PRESENCE POLICY DECISION-MAKING TOOLKIT
FOR NURSE LEADERS

1. **Introduction** to the Decision-Making Framework

2. **Discussion Guide**: Questions to Guide Evidence-Informed, Data Driven and Person-Centered Decision-Making

3. **Decision-Making Aid**, designed to generate a recommended course of action based on responses

4. **Summary of Evidence Base About Family Presence**

5. **Resources**

6. **Acknowledgements**

7. **Endorsements**
INTRODUCTION

“As nurses, we know that family presence is critical to generating and continuing the healing process. We must recognize it as fundamental to our obligation in the healing continuum and the healing environment to be advocates for that. My hope, as a nurse, is that this now moves to something definitive, so that it becomes a part of our deliberation whenever we establish standards of nursing practice.”

– Tim Porter-O’Grady, DM, EdD, ScD (h), APRN, FAAN, FACCWS, Clinical Professor, Nell Hodgson Woodruff School of Nursing at Emory University

The COVID-19 outbreak has exposed the fragility of partnerships with patients, residents and families* during times of crisis in our healthcare system. This has been particularly evident as it pertains to engaging family caregivers – or Care Partners – as essential members of their loved one’s care team. Since the onset of the crisis, healthcare systems have attempted to manage the spread of transmission by enacting restrictive policies that limit family members’ physical presence in care settings. These policies have compromised Care Partners’ abilities to participate actively in supporting and caring for their loved ones and have contributed to growing moral distress among nurses and other staff.1

These restrictions have largely focused on mitigating infection control risks associated with family members’ physical presence in facilities. They have largely overlooked, however, the risks to patient/resident safety and well-being when individuals are separated from those who know them best at times of heightened vulnerability. Notably, many of these policy changes have been implemented with little input from those who would ultimately be most affected by them – patients, residents, family members and nurses whose professional obligations call on them to advocate for the best interests of those in their care.

The risks associated with restrictive family presence policies are well documented, and include risks to patient safety, cognitive functioning, psychosocial well-being, preparedness for discharge, and moral distress among caregivers.2–9 These unintended consequences underscore that in many instances, limiting connection to family to only virtual visits is often not in the best interest of patients/residents and can further social and health inequities.

The potential for adverse outcomes when Care Partners are distant observers versus engaged members of the care team is considerable, including preventable harm, physical and cognitive decline, poor transitions of care and communication gaps. Given this, in many cases the risks of restricting family presence may very well outweigh the risk of virus transmission. The long-term consequences of these policies on patient/resident, family and staff outcomes are unknown but are likely to be significant.

At the onset of the outbreak, there was limited knowledge and little guidance to support healthcare systems in making fact-based adjustments to their family presence guidelines. We believe the unfortunate unintended ramifications of those early decisions can be prevented in the future with an evidence-informed, transparent, data-driven and person-centered decision-making framework that nurse

---

* Family as defined by the patient/resident. Family members may include relatives and non-relatives.

©Planetree International 2021
leaders and other decision-makers can use to support safe family presence in any health care setting, including (but not limited to) hospitals, long-term care communities, inpatient rehabilitation facilities, assisted living and behavioral health settings.

I am an integral part of the care team working with you and the team for a common goal – the health, safety and comfort of my son. I am the consistent part through shift changes, noting treatments and medications and watching for irregularities. I have key information and insights to share. I rephrase or translate the medical information into a form that is best understood by my son. I am the extra set of eyes. In all these ways, I support my son’s safety and yours as you accomplish your vital work with greater effectiveness, efficiency and safety.” – Lisa Keitel, Care Partner

About the Toolkit
This Family Presence Policy Decision-Making Toolkit was developed by a coalition of nurse leaders, patients/family/elder advocates and other clinical and non-clinical partners. Its foremost intent is to appropriately support family presence in healthcare settings through an evidence-informed, transparent, data driven and person-centered process of decision-making. The framework is meant to drive organizational dialogue to better understand the benefits and risks of family presence. This dialogue then positions decision-makers to establish and modify policies in consideration of a broad range of factors, including local conditions, current evidence and equitable impact. The toolkit was created to be used:

- **By nurse leaders and other decision makers** – with the understanding that the evaluation of the factors will include input from key stakeholders, including nurses at the point of care and patients/residents and families.

- **To guide a process for assigning levels of Care Partner access across the organization** as conditions change. Teams are encouraged to use the tool proactively to establish family presence policies that respond to current conditions independent of individual cases. This minimizes the influence of more subjective judgments in case-by-case family presence determinations. When decisions about family presence vary from one case to another, it may heighten disparities and add to staff burden.

- **During any time of crisis that may strain the healthcare system**, not just during this current crisis.

“We have an obligation to prioritize relational care as reflected in our code of ethics by respecting the uniqueness and dignity of every person and treating everyone fairly.” – Cynda Hylton Rushton PhD, RN, FAAN, Anne and George L. Bunting Professor of Clinical Ethics, Berman Institute of Bioethics/School of Nursing, Johns Hopkins University

Underlying Assumptions

1. As members of the leadership team, nurse executives are organizational decision-makers with the authority and responsibility to act in the best interest of patients/residents, families and their organization. It is incumbent on nurse leaders to use their influence and authority to advocate for the importance of family presence to the healing process.
2. Care Partners are essential members of the care team who partner with (and do not replace) paid caregivers. They are integral to patient/resident care. Care Partners are distinct from casual visitors. Because they know their loved one best, they are uniquely attuned to subtle changes in their behavior or status. This makes the presence of Care Partners an important strategy for reducing the risk of preventable physical, emotional and/or psychological harm. A balanced approach for safely integrating Care Partners rests on the expectation that Care Partners will conform to evidence-based safety precautions and infection control guidelines.

3. Virtual visitation platforms alone are not sufficient replacements for the in-person presence of Care Partners and may increase inequities in care for those less able to use and/or access technology.

4. The safe establishment of family presence must take into consideration not only the safety and well-being of patients/residents and family, but also the safety and well-being of nurses and other staff. This requires sufficient resources to support the transition to broader access to Care Partners in ways that are not disproportionately shouldered by nurses at the point of care.

References

FAMILY PRESENCE POLICY DECISION-MAKING FRAMEWORK

The Family Presence Decision-Making Toolkit presents a framework that guides decision-makers in a wide-ranging dialogue with a broad stakeholder group. Together, stakeholders consider the impact of changes to family presence policies based on the four areas seen here. Decision-makers then draw on this dialogue to determine appropriate family presence guidelines for current realities.

To facilitate an evidence-informed, transparent, data-driven and person-centered decision-making process, teams begin with the discussion guide. This set of questions (see page 8) is provided to generate evidence and broaden the risk/benefit analysis of Care Partner presence under current conditions. Teams are encouraged to use the discussion guide to explore the issues and collect the data necessary to complete the decision-making aid (pictured here), which incorporates an abbreviated set of questions. (See recommended workflow.)

The decision-making aid features 8 questions. They are distributed across the four impact areas. This safeguards against decision-making unilaterally focused on just one impact area.

Direct link to download the decision-making aid: https://resources.planetree.org/wp-content/uploads/2021/04/PlanetreeFamilyPresencePolicyDecisionAid-2021.xlsm
Decision-Making Aid Instructions for Use

Once you download the tool, for each question select the most fitting response for your organization. Each response is associated with a risk/benefit score indicating the degree to which the safety, quality and well-being benefits of the in-person presence of Care Partners outweigh potential risks. Higher numbers equate to conditions that support higher levels of access for Care Partners. Based on responses, a total score will be calculated. The score will generate a recommendation for the level of in-person Care Partner presence indicated based on all the factors addressed in the tool.

*Note: the link provided here will take you to an Excel file to download. (If prompted, enable the macro.) The file is designed to generate a recommendation based on your responses. This functionality, however, requires that you complete the tool digitally rather than printing it out and completing a hard copy version.*

Recommended Workflow

1. Engage a multi-stakeholder group in reviewing and collecting current data & evidence.*
   RESOURCE: Family Presence Decision Making Companion Discussion Guide

2. Use the data collected to complete the decision tool.
   RESOURCE: Family Presence Decision-Making Aid

3. Receive a recommendation for the level of in-person Care Partner presence indicated within the organization, along with additional recommendations for addressing areas of greatest risk in order to move toward greater in-person Care Partner presence.
   RESOURCE: Guidelines for Preserving Family Presence

4. Engage a group separate from the decision-makers to examine any potential unrecognized bias or inequity in the decision prior to finalizing any policy changes.

5. Broadly share the findings. Clearly lay out how the factors informed the updated policy. Make the decision-making guidelines readily accessible to staff, patients/residents, families and community members to promote transparency and enhance public trust.

*What Applies as Evidence for Making Evidence-Informed Decisions?*

Evidence informed decisions around family presence take into consideration:

- Local conditions
- The “lived experience” and expressed needs of patients/residents, family and staff
- Expertise from local, federal, and other authorities, and
- The best available evidence from research.

These questions are provided to guide organizational dialogue and data collection with a broad stakeholder group when family presence policies are under review. As a first step in the decision-making process, teams are encouraged to use this discussion guide to explore these issues and collect the data that will be necessary to complete the decision tool, which incorporates an abbreviated set of questions.

<table>
<thead>
<tr>
<th>1. Evidence-Informed Analysis.</th>
<th>2. Local Conditions Analysis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What evidence supports restrictions to Care Partner presence to benefit patients/residents and/or staff?</td>
<td>- What is the current state of community spread (e.g., % of positive tests within past 14 days or increase in number of cases above accepted levels)?</td>
</tr>
<tr>
<td>- How strong is the benefit likely to be under current conditions?</td>
<td>- Has the local health department determined there has been a sudden increase in the number of infections in the local community or geographic area?</td>
</tr>
<tr>
<td>- Is there any evidence that restricting Care Partner presence (either generally or for a specific population) could result in preventable harm to patients/residents and/or staff?</td>
<td>- What is the current rate of vaccination in the community?</td>
</tr>
<tr>
<td>- How severe is the risk of harm likely to be under current conditions if Care Partner presence is restricted - either generally or for a specific population? (Consider, for instance, morbidity and mortality, harms of respect and dignity, compromised communication or decision-making, isolation, safety, patient/resident distress, lack of decisional capacity, end of life experiences, comprehension of treatment or diagnostic results, etc.)</td>
<td>- Can risk of spread within the facility be effectively managed with PPE and infection prevention and control measures?</td>
</tr>
<tr>
<td>- Are the proposed changes consistent with organizational practices and policies already in place to limit risk of transmission for other highly transmissible viruses spread in the same way (for example, via respiratory droplets or aerosols)?</td>
<td>- Does the proposed policy align with state and local mandates? If not, is there an opportunity to influence those mandates to align with evidence-based guidelines?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- What is the availability of personal protective equipment (PPE)?</td>
<td>- Does restricting in-person Care Partner presence disproportionately benefit or burden some patients/residents/families more than others? (Consider, for instance, access to technology, language and cultural factors, cognitive barriers, age-related issues, mental health-related issues, complexity of health needs, etc.)</td>
</tr>
<tr>
<td>- What is the availability and accessibility of rapid testing?</td>
<td>- Does restricting in-person Care Partner presence disproportionately benefit or burden some staff roles/departments/locations more than others?</td>
</tr>
<tr>
<td>- Are there sufficient material resources to support evidence-based safety and infection control measures?</td>
<td>- If yes, how can we lessen the discrepancies between the benefits and burdens created by these policy changes?</td>
</tr>
<tr>
<td>- What is the availability of nursing staff to help manage and coordinate family presence?</td>
<td>- What support mechanisms are available to lessen the physical and emotional burden on nurses during the crisis? (e.g., leader rounding, adequate breaks, etc.)</td>
</tr>
<tr>
<td>- What is the availability of non-nursing staff, including chaplains, patient/resident advocacy personnel, patient/resident experience staff and security, to help manage family presence and address non-compliant visitors?</td>
<td>- Have we involved stakeholders who may most benefit and/or be most burdened by these policy changes in this consideration process?</td>
</tr>
<tr>
<td>- What resources will be needed to adequately communicate the policy change to the patients/residents/families and the community?</td>
<td></td>
</tr>
</tbody>
</table>
Sources of COVID-19 Guidance on Family Presence


- State & Territorial Health Department Websites:
  [https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html](https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html)
## Summary of the Evidence Policy Base Related to Family Presence During the COVID-19 Pandemic

<table>
<thead>
<tr>
<th>Reference</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altarum. (October 2020). <em>Experiences of Nursing Home Residents During the Pandemic: What we learned from residents about life under Covid-19 restrictions and what we can do about it.</em> <a href="https://altarum.org/sites/default/files/uploaded-publication-files/Nursing-Home-Resident-Survey_Altarum-Special-Report_FINAL.pdf">https://altarum.org/sites/default/files/uploaded-publication-files/Nursing-Home-Resident-Survey_Altarum-Special-Report_FINAL.pdf</a></td>
<td>“The broader evidence in the literature, as well as our survey findings detailed in this report, suggest that social isolation has produced a devastating emotional impact on many residents—and that this has also translated into accelerated physical and mental health decline.”</td>
</tr>
<tr>
<td>Hado, E., &amp; Friss Feinberg, L. (2020). Amid the COVID-19 Pandemic, Meaningful Communication between Family Caregivers and Residents of Long-Term Care Facilities is Imperative. <em>Journal of aging &amp; social policy, 32</em>(4-5), 410–415. <a href="https://doi.org/10.1080/08959420.2020.1765684">https://doi.org/10.1080/08959420.2020.1765684</a></td>
<td>Older adults residing in long-term care facilities are especially vulnerable for severe illness or death from COVID-19. To contain the transmission of the virus in long-term care facilities, federal health officials have issued strict visitation guidelines, restricting most visits between residents and all visitors, including family members. Yet, many older adults rely on family care for social support and to maintain their health, well-being, and safety in long-term care facilities, and therefore need to stay connected to their families. The federal government, state and local leaders, and long-term care facilities should take further actions to enable the relationship between residents of long-term care facilities and families during the COVID-19 pandemic.</td>
</tr>
<tr>
<td>Jones-Bonofiglio, K., Nortjé, N., Webster, L., &amp; Garros, D. (2021). A Practical Approach to Hospital Visitation During a Pandemic: Responding With Compassion to Unjustified Restrictions. <em>American journal of critical care: an official publication, American Association of Critical-Care Nurses</em>, e1–e10. Advance online publication. <a href="https://doi.org/10.4037/ajcc2021611">https://doi.org/10.4037/ajcc2021611</a></td>
<td>No circumstance, even a global public health emergency, should ever cause health care providers to deny their ethical obligations and human commitment to compassion. The lack of responsive protocols for family visitation, particularly at the end of life, is an important gap in the current recommendations for pandemic triage and contingency planning. A stepwise approach to hospital visitation using a tiered, standardized process for responding to emerging clinical circumstances and individual patients’ needs should be considered, following the principle of proportionality. A contingency plan, based on epidemiological data, is the best strategy to refocus health care ethics in practice now and for the future.</td>
</tr>
<tr>
<td>Oseroff, B. (June 18, 2020). Hospital Delirium and the Long Tail of COVID-19. <em>Harvard Medical Student Review.</em> <a href="https://www.hmsreview.org/covid/hospital-delirium">https://www.hmsreview.org/covid/hospital-delirium</a></td>
<td>Hospitals and post-acute care facilities should consider how to develop new strategies to mitigate the delirium-related impact of COVID-19 in a way that is safe for health care workers, volunteers, families, and patients… Allowing limited family and caregivers to visit would be an important step to reduce patient isolation and manage delirium. However, required personal protective equipment may limit the quality of in-person interactions and will likely contribute to further sensory impairment and disorientation for patients… Virtual visiting should only be a temporary substitute.</td>
</tr>
<tr>
<td>Reference</td>
<td>Findings</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>Verbeek, H., Gerritsen, D. L., Backhaus, R., de Boer, B. S., Koopmans, R., &amp; Hamers, J. (2020). Allowing Visitors Back in the Nursing Home During the COVID-19 Crisis: A Dutch National Study Into First Experiences and Impact on Well-Being. <em>Journal of the American Medical Directors Association</em>, 21(7), 900–904. <a href="https://doi.org/10.1016/j.jamda.2020.06.020">https://doi.org/10.1016/j.jamda.2020.06.020</a></td>
<td>These results indicate the value of family visitation in nursing homes and positive impact of visits. Based on these results, the Dutch government has decided to allow all nursing homes in the Netherlands to cautiously open their homes using the guidelines.</td>
</tr>
<tr>
<td>Voo, T. C., Senguttuvan, M., &amp; Tam, C. C. (2020). Family Presence for Patients and Separated Relatives During COVID-19: Physical, Virtual, and Surrogate. <em>Journal of bioethical inquiry</em>, 1–6. Advance online publication. <a href="https://doi.org/10.1007/s11673-020-10009-8">https://doi.org/10.1007/s11673-020-10009-8</a></td>
<td>This paper will examine ethical issues with three modes of “family presence&quot; or &quot;being there or with&quot; a separated family member during the current COVID-19 pandemic: physical, virtual, and surrogate. Physical visits, stays, or care by family members in isolation facilities are usually prohibited, discouraged, or limited to exceptional circumstances. Virtual presence for isolated patients is often recommended and used to enable communication. When visits are disallowed, frontline workers sometimes act as surrogate family for patients, such as performing bedside vigils for dying patients. Drawing on lessons from past outbreaks such as the 2002-2003 SARS epidemic and the recent Ebola epidemic in West Africa, we consider the ethical management of these modes of family presence and argue for the promotion of physical presence under some conditions.</td>
</tr>
</tbody>
</table>
Evidence in Support of Family Caregiver Presence


RESOURCES

- [Person-Centered Guidelines for Preserving Family Presence in Challenging Times](#)
- [Sample Care Partner Program Brochure](#) (Hospital)
- [Sample Care Partner Agreement & Safe Visiting Practices](#) (Long-Term Care)
- [Sample Care Partner Education on Safe Visiting Protocols](#)
CONTRIBUTORS

**Convener**

Connie Barden, MSN, RN, CCRN-K, FAAN  
Chief Clinical Officer  
American Association of Critical-Care Nurses

Robyn Begley, DNP RN NEA-BC FAAN  
Chief Executive Officer  
American Organization for Nursing Leadership

Kathleen C. Buckwalter, PhD, RN, FAAN  
Reynolds Center of Geriatric Nursing Excellence  
University of Oklahoma Health Sciences Center

Jane Carmody, DNP, MBA, RN  
Senior Program Officer  
The John A. Hartford Foundation

Rita B. Choula, MA  
Director, Caregiving, AARP Public Policy Institute  
AARP

Sarah Delgado, MSN RN ACNP  
Clinical Practice Specialist, Strategic Advocacy  
American Association of Critical-Care Nurses

Jeff Doucette, DNP, RN, NEA-BC, FACHE, FAAN  
Senior Vice President & Chief Nursing Officer  
Thomas Jefferson University Hospitals

Susan Frampton, PhD  
President  
Planetree International

Terry Fulmer, PhD, RN, FAAN  
President  
The John A. Hartford Foundation

Sara Guastello  
Senior Vice President, Person-Centered Care Standards  
Planetree International

Holly Harmon, RN, MBA, LNHA, FACHCA  
Vice President Quality, Regulatory & Clinical Services  
AHCA/NCAL

Helen Haskell, MA  
Mothers Against Medical Error  
Consumers Advancing Patient Safety

Lisa Keitel  
Minnesota Alliance for Patient Safety

Cherie Lytle, MHA, CPXP  
Patient Experience Manager  
Children's Hospital & Medical Center

Ellen V. Makar, DNP, RN-BC, NPD-BC, CENP  
Vice President, Patient Safety & Care Improvement  
Griffin Health Services

Gabriella Malagon-Maldonado, PhD, DNP, RN, NEA-BC  
Vice President of Patient Care Services and CNO  
Sharp Chula Vista Medical Center

**Funder**

Patricia McGaffigan, RN, MS, CPSP  
VP, Safety; President, CBPS  
Institute for Healthcare Improvement

Phebe McKay, RN, BSN, MBA, FACHE  
Chief Nursing Officer  
Merit Health Wesley

Gloria J. McNeal, PhD, MSN, ACNS-BC, FAAN  
Associate Vice President Community Affairs in Health  
National University

Marcia Nelson, MD, MMM, FAAFP, FAAPL  
Chief Medical Officer  
Enloe Medical Center

Christine Pabico, PhD, RN, NE-BC, FAAN  
Director, Pathway to Excellence Programs  
American Nurses Credentialing Center, Pathway to Excellence Program

Jennifer Pettis, MS, RN, CNE, WCC  
Acting Director, Programs  
Nurses Improving Care for Healthcare System Elders (NICHE)  
NYU Rory Meyers College of Nursing

Tim Porter-O’Grady, DM, EdD, APRN, FAAN, FACCWS  
Senior Partner, Health Systems, TPOG Associates  
Clinical Professor, SON, Emory University, Atlanta GA.  
Board, American Nurses Foundation

Sharon Quinlan, RN, MSN, MBA, NEA-BC  
System VP Ambulatory Nursing & Professional Practice  
Advocate Aurora Health

Michael Radosta, MA, MS, RN, NEA-BC, FACHE Chief Nursing & Quality Officer  
Gracie Square Hospital - Member of NewYork-Presbyterian Hospital Network

Valeria Ramdin, PhD  
Assistant Clinical Professor  
Northeastern University Bouvé College of Health Science

Marilyn Rantz, RN, PhD, FAAN  
Curators’ Professor Emerita  
Sinclair School of Nursing  
University of Missouri

Karen Reifenstein, PhD, RN  
Senior Associate Dean for Student Affairs & Diversity  
Oregon Health & Science University School of Nursing

Susan C. Reinhard, RN, PhD, FAAN  
Senior Vice President and Director  
AARP Public Policy Institute  
Chief Strategist, Center for Champion Nursing in America and Family Caregiver Initiatives

Connie Rowe, RN, MHA, FACHE  
Chief Nursing Officer  
Enloe Medical Center
We would like to acknowledge the following sites for pilot testing a prototype version of this toolkit:

Cedars-Sinai
CHI Health Good Samaritan
Children’s Health Queensland Hospital and Health Service
Elmhurst Hospital
Gracie Square Hospital - Member of NewYork-Presbyterian Hospital Network
Hennepin Healthcare
ISMETT UPMC Italy
Johns Hopkins Medicine
Lenox Hill Hospital, Northwell Health
Long Island Jewish Medical Center, Northwell Health
Merit Health Wesley
North Shore University Hospital, Northwell Health
Northern Westchester Hospital, Northwell Health
NYC Health + Hospitals/Coler
Phelps Hospital, Northwell Health
South Shore University Hospital, Northwell Health
Webco Nursing