Implementation of a Phase I Caregiver Visitation Program for a Specialized Pediatric Population

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Phase I caregiver visitation practice has been endorsed and encouraged by the American Society of PeriAnesthesia Nurses, yet implementation has not been widespread. Literature has described benefits of visitation for patients and their caregivers. This article reports on a Phase I caregiver visitation program at a specialty care hospital. The steps of implementation and guidelines for both the health care team and the patient's caregivers are outlined. Visitation is recognized as promoting patient safety during Phase I recovery. A discussion of additional benefits and obstacles is addressed.

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FAMILY VISITATION REFERS to the practice of allowing the presence of family members with hospital patients. This practice has been recommended for some time but it is not widely implemented among pediatric patients during Phase I recovery in the postanesthesia care unit (PACU). In this article, we describe the successful implementation of a program that reunites parents with children in the PACU.

While family visitation has been considered a key component of family-centered perioperative care, we report on our experience of visitation as a practice that also augments patient safety in the PACU. We describe the results of evaluations, as well as lessons learned over the 5 years since the program was formally implemented.

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Significance of PACU Visitation

Today, family visitation is recommended as a key element of family-centered care of the hospitalized child.[1] Parents and other family members commonly visit and even stay overnight with their children during hospital admissions, even in pediatric intensive care units (PICUs). Yet it was not long ago that children were separated from their families throughout any hospital experience.[2] For years, the prevailing attitude was that hospitalized children were best managed by professional staff, and that—aside from short visits—parents' presence was likely to upset children and otherwise interfere with hospital routine.[3]

The topic of family visitation in the PACU was first addressed in the literature in the 1980s, usually in support of this emerging practice, although nurses were also outspoken against visitation.[4] In 2003, American Society of PeriAnesthesia Nurses (ASPAN) published a position statement in support of family visitation in Phase I recovery.[5] This document acknowledged that visitation advances both the patient's and the family's well-being.

Studies from the 1980s and 1990s found that family visitation was associated with lower anxiety levels

among adult PACU patients. In a randomized controlled study, family members who were allowed to visit adult patients in the PACU had significantly less anxiety than those who were not brought into the PACU.[6] Similar results have been found among pediatric patients. When parents were reunited with their children in the PACU, parents' postoperative anxiety was lower when compared with standard care; however, no difference was found among pediatric patients' postoperative anxiety.[7-9] A bundle of interventions that included parental presence in the PACU (as well as parental education and presence during induction) was associated with lower postoperative anxiety among children, when compared with standard care.[10]

Family visitation in the pediatric PACU is more widely allowed than in the past, but it is not universally adopted in the United States. In the most recent survey of ASPAN members (2008, N = 2,225), more than 75% of respondents reported that family visitation in Phase I was routinely allowed for children under 12. However, about 50% of the nurses reported that the practice was less established with older children.[11] Deleskey concluded that family visitation was not well understood or consistently implemented.[11] This impression has been supported by the first author's communication with colleagues at regional and national meetings of perianesthesia nurses.

Nurses' reluctance to engage in family visitation stems from concerns that the presence of family members can interfere with the PACU nurse's primary responsibility to the patient's well-being.[12] Questions of safety and privacy are not easily countered with appeals to values such as family-centered care. We will next describe how the implementation of a caregiver visitation program at Gillette Children's Specialty Healthcare has been successful largely because the psychosocial benefits of family presence appears to contribute to nurses' safe care of the PACU patient. Throughout the article, the term *caregiver visitation* is used to include those adults who are not parents who are primary caregivers and/or guardians, for example, extended family members and foster parents.

Caregiver Visitation Contributes to Safety and Comfort

Most investigations of the clinical benefits of caregiver visitation have included patient anxiety as a primary outcome. Patient anxiety is of particular importance during recovery because anxiety can intensify pain.[13] Patient anxiety complicates pain assessment because patients experiencing severe anxiety often exhibit signs and symptoms of distress associated with pain. When a PACU nurse is unable to distinguish a patient's pain from anxiety or distress, there is an increased likelihood that additional medications will be administered in an effort to keep the patient comfortable.

When a patient lacks the capacity for clear and reliable self-report, pain assessment becomes extremely challenging.[14] A high proportion of patients at Gillette Children's Specialty Healthcare have communication or cognition limitations due to developmental disabilities (DD) such as cerebral palsy (CP). It has been estimated that between 30% and 50% of children with CP experience dysarthria or cognitive deficits that make verbal expression difficult or impossible.[15,16]

At Gillette Children's Specialty Healthcare, the Faces, Legs, Arms, Cry, Consolability scale had been used routinely with all PACU patients during Phase I recovery. While this observational pain assessment tool is validated among children with DD,[17] Gillette Children's Specialty Healthcare PACU nurses have found that it does not adequately distinguish between pain and other sources of distress. Pain-related behaviors of those with DD are often idiosyncratic and difficult to recognize.[18] Caregivers are usually quite familiar with the patient's unique communication and behavior patterns related to pain and can assist nurses to perform pain assessments more effectively during recovery. So in addition to providing reassurance, caregivers can support PACU nurses in providing optimum symptom management.

At the time this project began in 2008, caregiver visitation in the Gillette Children's Specialty Healthcare PACU was permitted but was practiced infrequently and sporadically, depending on the initiative of individual nurses. There was no guideline or policy to support consistent and safe caregiver visitation in the PACU.

The Director of Pediatric Anesthesiology had many years of experience managing sedation for patients with a variety of developmental and physical disabilities. He had become convinced that PACU staff

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