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Children visit to intensive care unit

Visita de crianças em unidade de terapia intensiva

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ABSTRACT

Most hospitals only allow children above 12 years-old to visit adult intensive care unit patients. However, younger children participating in the hospitalization process manifest, through their family members, their willingness to visit their hospitalized relatives. This raises different health care team members' opinions on how to manage their visits to the intensive care unit and prevent psychological

harm. Aiming to expand and support this practice, a literature review was conducted, and the children's cognitive and emotional development phases related to understanding of death studied. From this, a routine for children's visits to adult intensive care unit is proposed.

Keywords: Intensive care units; Child; Attitude of health personnel; Adaptation, psychological; Visitors to patients/psychology

INTRODUCTION

Children visits to adult intensive care units (ICU) raises different opinions among health care team members, as even today this field has plenty of controversy and myths.

According to the Brazilian Child and Adolescent Statute,⁽¹⁾ a child is considered a person below 12 years-old, and adolescent someone between 12 and 18 years-old. Most of the hospitals regulations only allow adolescents' visits, however some healthcare professionals are more sensitive to this matter and during their shifts allow children to see their loved ones. This decision is sometimes disliked by other team members, who can argue that the child will be exposed to hospital infection, can be emotionally traumatized or harmed,^(2,7) and that he/she is not yet able to understand either disease or death.

These may be plausible arguments, however they should not pose an obstacle to allow a child entering an adult ICU, as it would preclude the opportunity to face a real life situation experienced by the family when a family member is admitted to the ICU.⁽⁸⁾ Additionally, children psychology scholars emphasize the child's cognitive, intellectual, affective and emotional abilities, demystifying the idea that children are not capable to deal with pain and suffering. By visiting a critically ill patient, the child takes part in the family reality, and will be able to understand the family

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routine and behavior changes.⁽⁷⁾

There is a consensus that children experience fear and anxiety, frightened by their relative possible death in the ICU, and there is evidence that these symptoms intensity is reduced when a visit is allowed.⁽⁹⁾ Therefore, this article is intended to present a literature review and propose a routine for children visits to adult ICU.

Review on children visiting intensive care unit

Children visits to adult ICU is not usual either in Brazil or in other countries, and when allowed, always comes from analysis the health care team and the psychologist (when part of the team) of the entire picture. Few institutions have policies for children visits to adult ICU;^(5,6,10,11) in some, this analysis depends on individual circumstances and common sense.⁽¹¹⁾

Two recent studies conducted in Italy found similar results. The first identified that from 104 ICUs, only 22% allowed children below 12 years-old visits.⁽⁵⁾ In the second study, 69% of the ICUs didn't allow children visits.⁽¹⁰⁾ In France, 54% allowed children from eight years-old on, and in Swiss, 66% of the ICUs had no restrictions.⁽⁵⁾

The restrictions to children visits to adult ICUs are often based on the fear of exposing the child to hospital infection,⁽²⁻⁷⁾ However there is no literature evidence of this. In a multicenter quantitative trial⁽¹¹⁾ aimed to understand the reasons provided by the teams for restricting children visits to adult ICUs, 36% answered that their main reason was fear of infection. However, some of these respondents mentioned that both physicians and nurses use this explanation to disguise a certain emotional unpreparedness to deal with children who have severely ill relatives in the unit. Other authors,^(3,7,11) mention that the team is not able to deal with these visits emotional requirements.

These restrictions approach the visit's emotional aspect, as some team members limit children visits believing the emotional consequences to be negative, such as anxiety, psychological traumas and fear.^(3,6,7,11) On the other hand, other studies conducted by nurses show that explaining to the child what he/she is about to see and experience would prevent eventual traumas.^(3,7,8,11,12)

Several studies^(2,3,5,11) have shown that a child's visit to a relative in ICU is fundamental, as the child's anxiety, abandonment and fear of death feelings are found reduced after the visit; in addition, having a notion of the disease, the child becomes participant in the

hospitalization process.^(7,8)

Nicholson et al.^(2,3) studied a sample of 20 children, divided in two groups. For the intervention group, the children were allowed to visit their relatives using the children visitation intervention.* The other group visits were restricted. In the first group the feelings of abandonment, fear and anxiety were reduced. In the second group, these feelings increased. In another trial,^(2,8) it was emphasized that not accompanied children visits to an adult ICU may be as harmful as restricting visits.

As in our ICUs patients are progressively more lucid and awaken, the families are more involved in the patient's recovery process, and sometimes voice their children's requests to be allowed to participate too.⁽⁷⁾

According to the Children Rights Convention, issued in 1990: "It is recommended that a child is made part of all events around him/her, as well as within the family; a child is entitled to be informed, have his/her questions answered and have an opinion; thoughts and beliefs should be respected, and the best for the child, done."⁽¹¹⁾ Protecting a child from unpleasant situations may limit the experience, and delay or spoil his/her emotional development.⁽⁸⁾

The child and death

Based on infantile psychology and development, the human being, since tender age, faces losses such as: uterus loss, weaning, pacifier removal, brothers/sisters birth, teeth losses, school changes, toys loss and pet animals' death, parents divorce, etc., among others, inherent to the human being development. These experiences allow the child to experience and face loss pain, suffering and frustration. Before this, and particularly when facing imminent real beloved death, he/she will try to understand the facts.

However, the adult tends to do not recognize the child's ability to understand, and acts wrong as when not explaining what is going on, trying to minimize his/her own feelings to spare the child, or even lying. These attitudes render the child confused and insecure, as his/her sensorial perception is sharper than in adults, and thus he/she is able to capture feelings from non-verbal language.⁽¹³⁾

The child realizes sadness, pain, but without mean-

*Children visitation intervention is a systematic visit support using the behavior notion within the child's development age, based on Piaget (1969) and Pigeon (1977).

ing, can't understand, and feels deserted. He/she needs explanations appropriate to his/her cognitive and intellectual level, and needs to find a meaning for the experience.

Torres,⁽¹⁴⁾ a psychologist and a Brazilian Thanatology pioneer, conducted a detailed study on children in face of death and emphasizes that his/her ability to understand this issue is related to his/her cognitive development. Generally speaking, and based on the Piaget's cognitive development, the author remarks:

- before 2 years old, death is perceived as absence; the child will look for the dead person and experience a sensation of loss, however will not be able to intellectually understand this loss permanency;
- between 3 and 5 years, they understand death as a temporary and revertible phenomenon;
- between 6 and 9 years, with the predominance of concrete thinking, they understand the death causality, but not irreversibility;
- from 10 years on, until the adolescence, the concept of death becomes more abstract, and they understand death as unavoidable and universal.⁽¹⁴⁾

Other studies,^(7,11) corroborate these results, stating that since 6 months-old children miss their caregivers. Thus, their visit to the ICU is recommended even if the patient looks ill. They also alert that intending to protect the child from an unpleasant situation, the health care team may contribute to limit his/her experience, and delay or impair his/her emotional development. They also emphasize that adults are more shocked to see ill people than children.⁽⁴⁾

Some authors^(3,7,12) emphasize the relevance of the team knowledge of the child's cognitive and psychological development, particularly for the nursing team, as they have direct contact with the family and patient. This knowledge will help an improved approach to the child's needs and appropriate counseling to family members.

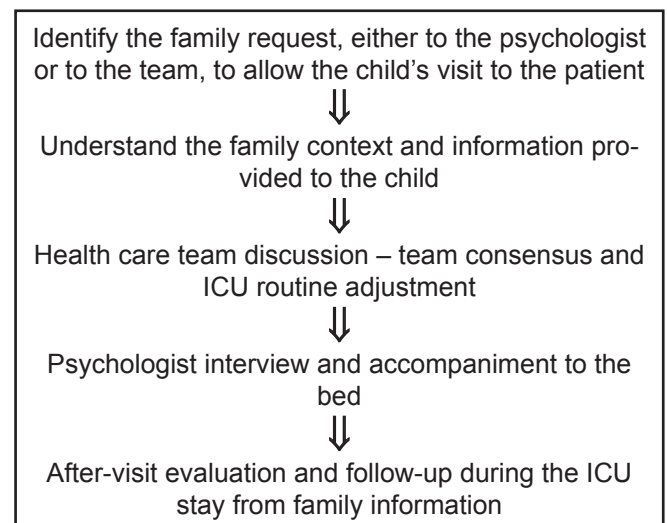
Additionally, a child's visit may bring diversion, hope and sense of normality to the hospitalized relative, when allowed by his/her clinical status.^(2,7) If well conducted, this can be a beneficial experience for the patient, the family and the child him/herself, who will be able to take part and share this remarkable time in his/her family life, thus preventing later psychological issues.

Below we suggest some relevant steps to allow and receive a child in an adult ICU, based on our service routine.

A child visit to an adult intensive care unit step by step

The request to allow a child's visit to the ICU is often voiced by the legal guardian and is directed to the health care team, usually either to the nursing or the medical team. In our institution, as the Hospital Psychology Service is part of our ICU routine assistance, the families bring this request during the psychological interviews.

The flowchart (Figure 1) described below considers the child's and family psychological follow-up as fundamental for this process. However, it is known that not all ICUs have available psychologists, and this may difficult children visits. In this case, the decision will be up to the medical and nursing team on duty, who are probably busy and will not be able to pay appropriate attention to the child. This can be an argument to do not allow the visit, as they are worried with the child's emotional situation.



ICU – intensive care unit.

Figure 1 – Flowchart.

Many other variables should be considered for the decision making process to allow a child's visit, including: the patient's clinical status and severity, degree of relationship, intensity of the affectional relationship, child's emotional maturity, family support, understanding of the disease and hospitalization processes, and specially the child's will (as not always the child wants the visit, but his/her parents).

The first step is to identify the family request regarding the child's visit. It is important that this request come from the family or the child him/herself, and is considered by the health care team. Understand-

ing the family context and request motivation is crucial. Ideally the visit should be scheduled, except in cases of worsened clinical status with imminent death, when every minute counts for the family.

Some points must be clarified before the visit is allowed, such as: the child's age, his/her relationship to the patient and specially his/her degree of knowledge of the disease and progression. Collected these data, the request is communicated to the medical and nursing team, and the child's visit management and reception are discussed. Frequently the team's opinions are not unanimous, but it is necessary to reach a consensus, as the entire team cooperation is indispensable, as the ICU routine will be broken to receive the child (extra visit time, not impairing the patient's care and not coinciding with tests, baths, curatives, etc.). A special visit time is recommended, in order to assure the necessary privacy and attention.

Once scheduled day and time for the child's visit, a psychologist interview will evaluate the child's understanding on the hospitalization and disease process, his/her emotional maturity and confrontation resources. During the interview an ICU model is shown (Figure 2) so that playfully the child has a general physical space idea. The main questions are answered, as well his/her ideas demystified. Children often have fantasies about the explanations received (about tubes, probes, monitors, catheters) and normally these are much scarier than real life.



Figure 2 – Intensive care unit model.

After the evaluation, the psychologist accompanies the child to the bed along with the guardian, and explains the visit procedures (hands wash, use of gloves

and coat when required). Other doubts may show up, and their clarification is important. Ended the visit, the child is again interviewed out of the ICU, to evaluate his/her impressions. The child is invited to make a drawing or write a letter to be given to the patient or affixed to the box, as a way to make the child feel included and participating. During the hospitalization process the psychology team will normally continue the family care, always asking for information about the child. If necessary, he/she may return for other interviews.

In situations when the patient's death is imminent, the flowchart steps may not be complied with, as death can happen at any time, and the psychologist may be absent. In this case, an exception may be allowed, and the child's visit allowed without previous evaluation, as not all health care team members will be prepared for this. It is important in these situations the team's sensitivity to identify the availability of a family member with emotional structure to support the child, as well as if he/she manifested willingness to see or say farewell to the beloved one. Additionally, it is important to identify if the team has a professional able to support the child. It should be remarked that after this, it is fundamental a team discussion, so this situation may be instrumented to provide ability to deal with such situations.

FINAL REMARKS

The patient-family-team relationship is highly valuable in the currently ongoing Brazilian ICUs humanization process, and requires from the institution, and mainly from the health care team, abilities and competencies to manage these children's visits to severely ill patients.

The literature search has shown diversified results, identifying that, undoubtedly, a careful health care team approach is required in a case by case basis, and founded on the child's emotional structure and development phase and family system evaluations. For this, a psychologist in an ICU team is relevant to follow and evaluate this process, providing guidance to the team on family dynamics, emotional structure and the meaning of a child's visit for him/herself.

The interdisciplinary work is fundamental to use the flowchart, requiring a health care team aligned with its aims, and above all, sensitive to the essence of the bioethical principle of autonomy, ruled by the patient's and family member's will.

The use of this flowchart, always adjusted to each case requirements, has been very useful in our institution's practice. We could perceive that the health care team feels more serene and confident with this guidance and that the families feel more relieved and assured by sharing their afflictions related to their children. However, due to this subject relevance and sensitiveness, new discussions are required to deepen the studies and therefore systematize children's visits to ICUs.

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RESUMO

A maioria dos hospitais estabelece idade mínima de 12 anos para a entrada de crianças nas unidades de terapia intensiva de adultos, porém, crianças menores participativas do processo de hospitalização têm manifestado, por meio de seus familiares, o desejo de visitar seus entes hospitalizados. Essa situação suscita diferentes opiniões entre os membros da equipe de saúde, principalmente no que diz respeito a pouca orientação sobre como manejar a entrada de criança na unidade de terapia intensiva sem causar danos psicológicos. Com objetivo de ampliar e fundamentar essa prática realizou-se revisão bibliográfica sobre o tema, alinhada ao estudo das fases do desenvolvimento cognitivo e emocional da criança em relação à compreensão da morte para, em seguida, sugerir proposta para rotina de entrada de crianças em unidade de terapia intensiva adulto.

Descritores: Unidades de terapia intensiva; Criança; Atitude do pessoal de saúde; Adaptação psicológica; Visitas a pacientes/psicologia

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