Family Presence and Open Visiting Hours for Pediatric, PICU, & NICU Patients

*A Literature Review of the Evidence*

**Clinical Question:** For pediatric, PICU, and NICU patients, what is the quantity, quality, and consistency of the evidence for family presence and/or open visiting hours in the acute care setting?

**Conclusions:** Consistent evidence exists to support the positive benefits of family presence (FP) for parents and close relatives in pediatric units, PICU and NICU. The literature endorses an integrated family centered care (FCC) model and liberal 24/7 open visiting hours. Open family presence at the bedside is defined as: No or minimal restrictions on presence at the bedside. Family presence needs of patients, parents/families, and nurses may differ, as do attitudes, and preceptions (Table 1, Page 3; Table 2, Page 4). Families want and need close access to their children and assurance from staff. Parents and siblings value being at the patient’s bedside; they feel a need to be vigilant and safeguard their loved one. Clinical concerns of increased infection rates and breach of confidentiality are unfounded and raise significant barriers for the implementation of evidence-based FP programs. Well designed monitoring programs that report infection/colonization rates have the potential to assure physicians and nurses that FP is a safe healthcare practice. A well-designed FP program with flexible visiting policies opens the door to a unified FCC model that supports the needs of the patient, the family, and the nurse.

**Historical Background:** Family presence in pediatric settings continues to be debated. The 2001 Institute of Medicines (IOM) report, *Crossing the Quality Chasm*, concluded that FCC addresses many concerns within the still evolving United States healthcare system. Open visiting hours and family presence is but one element of this complex care model. Professional organizations endorsing FCC/FP include:

- Agency for Healthcare Research and Quality (AHRQ)
- American Academy of Pediatrics (AAP)
- American Association of Critical-Care Nurses (AACN)
- American College of Critical Care Medicine, (ACCM)
- Institute for Patient-Family-Centered Care
- Society of Critical Care Medicine (SCCM)

Despite these endorsements, many pediatric, PICU, and NICU settings retain restrictive parental and family visitation policies that permit only brief parental visits; multiple family members and siblings are not allowed to visit at all. Justification for clinician resistance to open visiting hours include possible infection spread of infection, privacy/confidentiality issues, emotional trauma to the child, siblings, and families, lack of space, distraction from nursing care and limited nursing staff to address family needs. Past attempts at resolving the visiting policy conundrum can result in undesired outcomes, such as pitting nurses and parents against each other. Restrictive visitation may create additional nurse-family tensions concerning actual visiting hours, number of visitors at the bedside, and erratic adherence to current policies.

**Key Summary of the Evidence:**

- FCC recognizes the uniqueness of individual families and respects varied parental coping methods.
- Healthcare organizations play a key role in encouraging FCC by providing structured staff/patient/family education and comprehensive policies and guidelines that support to nurses, patients, and families.
- FCC education programs and family bedside engagement have demonstrated improved outcomes such as:
  - Reassure and reduce child’s anxiety
  - Fulfil parents’ safeguarding role
  - Reduce need for formal information as parent develop a sense of “what is happening”
  - Parent move from spectator role to partners role
  - Reduce parental anxiety and dissatisfaction
  - Build trusting nurse/family/patient relationship
  - Nurses see visitors as active partners, not a burden
  - Decrease visiting hour tensions
- Open FP is beneficial for patients, parents, and families, and can significantly impact clinical decisions.
- Nurses are the change agents/champions needed to build collaborative nurse/family partnerships, encourage family involvement, and advocate for families to be present as they desire.
- PICU/NICU environments are adopting open visiting policies that include parental involvement, 24/7 visiting, parent sleeping areas, and private/semi-private family rooms.
- Evidence does not support the notion that parental/sibling visitation increases NICU patient infection rates and/or has negative physiologic effects on the child.

Cecelia L Crawford, DNP, RN; ©Kaiser Permanente Southern California, Regional Nursing Research Program, March 2017
Evidence-Based Recommendations:
- Deconstruct previous fears, traditions, and myths to ensure the creation of a FCC philosophy and culture
- Use the term “family presence” rather than “open visiting” to reflect alignment with a FCC model
- Create a comprehensive evidence-based FP program with a FCC model that includes:
  - *Organizational/Nurse/Family Assessments*[^2^,^4^,*^5^]
  - *Policies, procedures, guidelines, guidance*[^2^,^4^,*^5^] (design & review by family advisory groups)[^6^]
  - Colonization/infection surveillance program[^3^,*^7^]
- Staff/Patient/Family education programs with activities and videos[^2^,^4^,*^5^]
- *Staff/Family pocket guides describing how to work together as a team[^4^]
- Analyze organizational, nursing, and family assessment results to systematically guide the creation and revisions of staff/patient/family educational programs[^5^]
- Evaluate/update policies and procedures with a FCC framework in order to reduce nurse-parent tensions and build effective nurse, patient, and family partnerships[^2^,^4^,*^6^]
- Develop evidence-based systems and processes that encourage nurses to provide patient care without asking parents to leave their child's bedside[^6^]
  - Provide nurses with FP specific mentoring, skills, education, and role-playing opportunities[^6^]
  - Plan visiting guidelines that are individualized for each patient and family[^6^]
  - Ensure nurses share consistent interpretation and adherence of the FP policies to decrease conflict between staff and families and alleviate perceptions of preferential treatment[^6^]
- Implement a colonization/infection surveillance program to assure clinicians that FP is a safe and positive practice for pediatric settings, including PICU[^3^,*^7^] and NICU[^3^]

*Resources:
Family Presence and Open Visiting Hours for Pediatric, PICU, & NICU Patients
A Literature Review of the Evidence

Table 1.

Family Presence Needs for Pediatric Patients, Parents, and Nurses

<table>
<thead>
<tr>
<th>Children</th>
<th>Parents/Families</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives have a major impact on the pediatric patient’s condition by:⁷</td>
<td>• Prefer honest, intelligible and timely information, and liberal visiting policies⁷</td>
<td>• Caring for families can be stressful⁵ and often perceived as additional work and emotional labour⁷</td>
</tr>
<tr>
<td>• Assisting patient to remain in touch with reality⁷</td>
<td>• Open visiting meets family needs by:⁷</td>
<td>• May lack knowledge and/or time needed to properly meet families’ emotional and psychosocial needs⁷</td>
</tr>
<tr>
<td>• Giving the child hope and strength during critical illnesses or injury⁷</td>
<td>o Enabling participation in child’s care⁷</td>
<td>• Integrating family members’ visits into daily care plan can be difficult for many nurses⁷</td>
</tr>
<tr>
<td>• More important in child’s recovery than care givers⁷</td>
<td>o Providing support⁷</td>
<td>• Visitors' needs for information and open access to a loved one may conflict with nurses’ need to safely manage the child’s care⁷</td>
</tr>
<tr>
<td>Visitors include parents, siblings, school friends, or any relative⁸</td>
<td>o Safeguarding the patient⁵,⁷</td>
<td>o Take up much nursing time and may interrupt/interfere with direct nursing care⁷</td>
</tr>
<tr>
<td>Staff encouragement for visitation makes visitors feel welcome⁸</td>
<td>o Assisting in coping with the hospitalization experience⁷</td>
<td></td>
</tr>
</tbody>
</table>

Strategies to Balance the Needs of Pediatric Patients, Families, and Nurses

Needs of patients, parents, families, and nurses should be clearly defined with an established balance between these needs⁷

Resolve the discrepancy between nurse/parent roles and family presence needs by:¹
• Viewing parents as partners in care rather than “visitors”²
• Recognizing that the family is a constant in the child's life, while healthcare systems and nursing staff fluctuate⁶
• Accepting that healthcare delivery systems must be flexible⁶ to meet patient, families, and nurses needs⁶,⁷
• Creating flexible policies that provide guidelines, not rules, to best meet the needs of patient, families, and nurses⁶
• Determining and implementing a flexible open visiting¹ on a case to case basis⁷
• Initiating a collaborative discussion between the family and the nurse in order to collectively determine the visitation schedule⁷
  o Allowing parents to define the time needed and how they wish to be involved in the child's care⁶
  o Ensuring all collaborative visiting decisions are geared towards the patient’s best interests⁷
• Allocating a 1 hour break during the day¹
• Providing a place for parents to sleep⁹
### Attitudes and Perceptions of Parents and Nurses related to Family Presence/Open Visiting Hours

<table>
<thead>
<tr>
<th>Parents</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Natural caregivers for their children^9</td>
<td>• Some see FP as comforting for patient and involve parents in simple care activities^5</td>
</tr>
<tr>
<td>• Opposed to restricted visiting hours &amp; contact with child^10</td>
<td>• May be ambivalent in enacting FP^5</td>
</tr>
<tr>
<td>• Transfer of caregiving role to nurses and alteration of parental role is great source of stress^9</td>
<td>• Frustrated when parents sit vigil if child is not defined as critical^6</td>
</tr>
<tr>
<td>• Authority inequality between nurse and parent^1</td>
<td>• Constant parental presence may indicate a lack of trust in staff^6</td>
</tr>
<tr>
<td>• Change from protector to helpless watcher; often asked to leave due to confidentiality or crowd control issues^1</td>
<td>• Allowing family/visitors to visit whenever they wish is not overwhelmingly acceptable^5</td>
</tr>
<tr>
<td>• Loss of control over caregiving role^1</td>
<td>• Parents seen as distracting and in the way; sometimes they should leave due to a lack of space and if child is unstable^1</td>
</tr>
<tr>
<td>• Must ask permission to interact with their child^1</td>
<td>• Impact ability to deliver care, particularly during high census and acuity^6</td>
</tr>
<tr>
<td>• Frustrated, angry, undervalued when denied access to child^6</td>
<td>• Answering family questions may be challenging for novice nurses^6</td>
</tr>
<tr>
<td>• Wish more participation than they are allowed^1</td>
<td>• May affect nurse perception of workload;^2 however, nurse attitudes/behaviors are generally favorable during routine care^5</td>
</tr>
<tr>
<td>• Preference for parental presence, participation with open and honest communication^1</td>
<td>• Prefer visitation rules so policy is blamed rather than the nurse^6</td>
</tr>
<tr>
<td>• Sibling visitation may help both the child and sibling cope with hospitalization experience^9</td>
<td></td>
</tr>
<tr>
<td>• Uses diverse coping methods with varied degrees of involvement and care^6</td>
<td></td>
</tr>
<tr>
<td>• FP not perceived as an obligation to stay or long visits^7</td>
<td></td>
</tr>
<tr>
<td>• Visitation patterns may vary due to work/home responsibilities and transportation issues^6</td>
<td></td>
</tr>
<tr>
<td>• Personality characteristics can influence involvement in decision making and time parents spend at the bedside^6</td>
<td></td>
</tr>
<tr>
<td>• Participate in developing FP policies^6</td>
<td></td>
</tr>
</tbody>
</table>
Family Presence and Open Visiting Hours for Pediatric, PICU, & NICU Patients

A Literature Review of the Evidence

References

Family Presence and Open Visiting Hours for Pediatric, PICU, & NICU Patients
A Literature Review of the Evidence

Evidence Search Strategies: A literature review on the selected clinical question was conducted from January to March 2017. This review examined the evidence for the quantity, quality, and consistency of the evidence for the open visiting hours and/or family presence for pediatric, PICU, and NICU patients in the acute care setting. An electronic database search from 2000-2017 and/or Open Years search was conducted via CINAHL, PubMed, Science Direct, and the Cochrane Library. Professional organization website searched included AACN, AHRQ, IHI, NAPNAP, AWHONN, NAN, and AAP. Search terms were broad and included “open visiting hours,” “family presence,” “pediatric,” “PICU” and “NICU,” either alone or in combination. Searches were individualized for each database. (See Database Search Methodology, Pages 8-9).

This review yielded 38 relevant hits and 1 contextual manuscript. Four duplicates were eliminated during the database search. Thirty-four articles were selected for inclusion. After careful examination, 25 articles were eliminated as they did not answer the clinical question, were outside the acute care environment, and/or focused on components other than family presence and/or open visiting hours. 1 additional article via contextual linkage was included, for a total of 10 relevant articles that pertained to the clinical area of inquiry. The articles were ranked using the Academy of Evidence-Based Practice Evidence Leveling System and graded using the Johns Hopkins Evidence Appraisal tools (See Page 7). The strength of the evidence was graded as low quality.

Evidence Review Results: The evidence consisted of 2 quantitative descriptive research studies,5,10 one integrative review,1 three literature reviews,3,7,9 one professional organizational guideline,2 one performance improvement project,8 and 2 articles ranging expert opinion commentaries4,6 There was overwhelming consistency concerning open access visiting hours and family presence in pediatric units, PICU, and NICU1-10 (See Tables 1 & 2, Pages 3-4). Result limitations include small sample size, use of untested tools, and various methodological issues. An additional limitation is the lack of randomized control trials examining this clinical issue, particularly for the effect on family-centered outcomes. The majority of the literature is descriptive and/or observational. Some evidence was generated in other countries and may not be generalizable to the United States. Finally, the current evidence is dated, with two articles published in the early 1980s,8,10 one article in 2003,6 2 articles between 20085 and 2010,7 four articles between 20131,3,9 to 20154 and a recent article in 2017.2

New knowledge and information regarding family presence and opening visiting hours is needed in order to address the emerging and ever-evolving needs of patients, families, and nurses. Future research is needed to strengthen the level of evidence for FP.3 Key research focus areas include evaluating FCC strategies, comparing care models, integrating family partnerships, and quantifying effective FP interventions, risks, and benefits.1,2 However, the information in this review provides the best available evidence to date for nursing leaders and families to consider when addressing open visiting hours and/or family presence for hospitalized pediatric patients.
<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
<th>RELEVANT ARTICLES</th>
<th>EVIDENCE TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Meta-analysis of multiple large sample or small sample* randomized controlled studies, or meta-synthesis of qualitative studies with results that consistently support a specific action, intervention, or treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Well-designed controlled studies, both randomized and nonrandomized, prospective or retrospective studies, and integrative reviews with results that consistently support a specific action, intervention, or treatment</td>
<td>#1</td>
<td>#1: Integrative review with consistent results</td>
</tr>
<tr>
<td>C</td>
<td>Qualitative studies, descriptive or correlational studies, concept analyses, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results</td>
<td>#5,#10,</td>
<td>#5: Quantitative Descriptive #10: Quantitative Descriptive</td>
</tr>
<tr>
<td>D</td>
<td>Peer-reviewed professional organizational standards, with clinical studies to support recommendations</td>
<td>#2</td>
<td>#2: American College of Critical Care Medicine (ACCM) Guidelines</td>
</tr>
<tr>
<td>E</td>
<td>Theory-based evidence from expert opinion or multiple case reports, case studies, consensus of experts, and literature reviews</td>
<td>#3,#4,#6, #7,#8,#9</td>
<td>#3: Literature Review #4: Expert Opinion #6: Expert Opinion #7: Literature Review #8: Performance Improvement Project #9: Literature Review</td>
</tr>
<tr>
<td>MA</td>
<td>Manufacturer’s recommendation; Anecdotes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LR</td>
<td>Laws and Regulations (local, state, federal; licensing boards; accreditation bodies, etc.)</td>
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</tbody>
</table>
| *A large sample has adequate power to detect the observed effect with confidence (as seen in significant Confidence Intervals). A small sample may lack confidence in the power of the desired effect (Polit & Beck, 2008)*

**Designated by Emma M. Cuenca and Cecelia L. Crawford, Academy of EBP; ©Kaiser Permanente SCAL Regional Nursing Research Program, May 2011**

Adapted from AACN Evidence Leveling System (2009) and Canadian Medical Association & Centre for Evidence-Based Medicine, Levels of the Evidence (2001)

**High Quality: 0**
(Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence OR expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader in the field)

**Moderate Quality: #1,#2**
(Reasonably consistent results; sufficient sample size for the study design; some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence OR expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions)

**Low Quality: #3,#5,#6,#7,#8,#9,#10**
(Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn OR expertise is not discernable or is dubious; conclusions cannot be drawn.

**Final Summary of the Body of Evidence = Low Quality**
Family Presence and Open Visiting Hours for Pediatric, PICU, & NICU Patients  
A Literature Review of the Evidence  
Electronic Database Search Methodology

**Date(s):** January to February, 2017

**Literature search topic/clinical question:** For pediatric, PICU, and NICU patients, what is the quantity, quality, and consistency of the evidence for family presence and/or in the acute care setting?

<table>
<thead>
<tr>
<th>Database or Website</th>
<th>Key Word(s) and/or Controlled Vocabulary Terms #</th>
<th>Total References Identified (hits)</th>
<th>No. of Relevant References</th>
<th>No. of Total Duplicate Articles</th>
<th>No. of Articles Selected for Review</th>
<th>No. of Articles Excluded</th>
<th>No. of Relevant References</th>
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</thead>
<tbody>
<tr>
<td>Name: CINAHL</td>
<td>Family presence + children; Open visiting hours</td>
<td>56</td>
<td>12</td>
<td>0*</td>
<td>12</td>
<td>5</td>
<td>7</td>
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<td>Years: Open Year</td>
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<tr>
<td>Name: PubMed #1</td>
<td>Family presence + pediatrics + PICU + NICU</td>
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<td>2</td>
<td>0</td>
<td>2</td>
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<td>2</td>
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<tr>
<td>Years: 2000-2016</td>
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<tr>
<td>Name: PubMed #2</td>
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<td>8</td>
<td>3</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Name: Science Direct</td>
<td>Open visiting hours + pediatrics + family presence</td>
<td>19</td>
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<td>1</td>
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<tr>
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</tr>
<tr>
<td>Name: Cochrane Lib.</td>
<td>Family presence OR opening visiting hours + children</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Name: AHRQ; IHI; NAPNAP; AAP, AWHONN; NAN</td>
<td>Family presence OR opening visiting hours + children</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
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<tr>
<td><strong>TOTALS</strong></td>
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<td>2056</td>
<td>38</td>
<td>4</td>
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</tr>
</tbody>
</table>

#Controlled vocabulary (subject terms, MESH terms, tagged terms specific to database)

*First database used as the main comparison for subsequent database searches and identifying duplicate articles

**Reference/Contextual Links**

**Citation:** Davidson JE, Aslakson RA, Long AC, et al. (2017). Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult ICU. *Critical care medicine*, 45(1):103-128.

**Total Articles Included in Literature Review: Database (9) + Contextual Links (1) = 10**

*Additional articles/information found in references lists and/or article review
# Family Presence and Open Visiting Hours for Pediatric, PICU, & NICU Patients

A Literature Review of the Evidence

## Clinical Question

<table>
<thead>
<tr>
<th>Population and/or Patient(s)</th>
<th>Intervention/Interest Area</th>
<th>Comparison Intervention (Often current practice)</th>
<th>Outcome</th>
<th>Time Period (If Applicable; Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P: Pediatric patients; pediatric intensive care patients; neonatal intensive care patients</td>
<td>I: • Open visiting hours • Family presence</td>
<td>C: • Restricted visiting hours • No family presence</td>
<td>O: • Patient perceptions and attitudes • Family perceptions and attitudes • Staff perceptions and attitudes • Patient/family Satisfaction • Staff satisfaction</td>
<td>T: Hospitalization period</td>
</tr>
</tbody>
</table>

**Final Clinical Question:** For pediatric, PICU, and NICU patients, what is the quantity, quality, and consistency of the evidence for family presence and/or open visiting hours in the acute care setting?

## Searchable Question

- **Key Search Terms:** Open visiting hours; family presence; pediatric; PICU; NICU
- **Inclusion Criteria:** Visiting hours; family presence; pediatric; PICU; NICU
- **Exclusion Criteria:** CPR; DNR; resuscitation; invasive procedures; emergency department; settings other than acute care
- **Limitors (Open year or year ranges, age ranges, and language, etc.):** Open year or 2000 to 2017; English; birth to 18 years
- **Databases:** PubMed; CINAHL; Science Direct; Cochrane Library
- **Websites:** American Association of Critical Care Nurses (AACN); Agency for Healthcare Research & Quality (AHRQ); Institute for Healthcare Improvement (IHI); National Association of Pediatric Nurse Practitioners (NAPNAP); Association of Women’s Health, Obstetrics, and Neonatal Nurses (AWHONN); National Association of Neonatal Nurses (NAN), American Academy of Pediatrics (AAP)
Purpose/intended Audience

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Kaiser Permanente's documents were created using an evidence-based process; however, the strength of the evidence supporting these documents differs. Because there may be differing yet reasonable interpretations of the same evidence, it is likely that more than one viewpoint on any given healthcare condition exists. Many reviews will include a range of recommendations consistent with the existing state of the evidence.

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Family Presence and Open Visiting Hours for Pediatric, PICU, & NICU Patients
A Literature Review of the Evidence

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