From Open to Closed: COVID-19 Restrictions on Previously Unrestricted Visitation Policies in Adult Intensive Care Units

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Background In March 2020, rising numbers of COVID-19 infections contributed to changes in intensive care unit visitation policies, with some facilities allowing no visitors.
Objective To compare visitation policies of Magnet and Pathway to Excellence hospitals with prepandemic open visitation in adult intensive care units.
Methods A mixed-methods study was conducted from January through March 2021. Quantitative data on visitation policies were extracted from websites of 96 Magnet and Pathway to Excellence hospitals that had allowed unrestricted visits in adult intensive care units before the pandemic. Qualitative data were collected via semistructured interviews with 9 nurse leaders from these hospitals.
Results More than 1 year after the start of the pandemic, all of the hospitals had instituted restricted visitation policies. The policies varied, with little to no evidence-based justification. Restrictions included 83% of hospitals (n=80) allowing just 1 visitor per day and 69% of hospitals (n=50 of 72) allowing no visits at all for patients with COVID-19 in the intensive care unit. Five themes were found when nurse leaders' interviews were analyzed: visitors not welcome, doing harm, external decisions at system level, visiting within limits, and changes in critical care nursing work.
Conclusion Results of the study suggest that despite the vast amount of evidence supporting the benefits of visitation and the harms of restricted visitation and expert recommendations for returning safe visitation to hospitals, Magnet and Pathway to Excellence hospitals continue to enforce restricted visitation policies in intensive care units. Patients, families, and nursing and health care staff must partner to create pandemic-proof visitation policies.
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Close contact between patients, their families, and the health care team is critical during hospitalization. Specifically, patients in the intensive care unit (ICU) benefit from family-centered care, and a staple of family-centered care is unrestricted visitation.[1] In times of public health emergencies, such as the COVID-19 pandemic, maintaining family-centered care is difficult. To protect public health, the rights of patients to have in-person contact with family visitors can be challenged.[2]

Decades of research have provided evidence for the benefits of unrestricted visitation and the harms of restricted visitation policies on patients and their families.[3-5] Several studies of hospitals in the early stages of the pandemic documented great variability in visitation policies with little transparency into decision-making processes communicated to the public.[6-10] Existing evidence does not support the complete restriction of family visitation in the ICU and other hospital units, especially beyond the initial crisis response to the COVID-19 pandemic.[6] Studies are needed that describe the variability and decision-making associated with adult ICU visitor restrictions to inform policy changes during subsequent COVID-19 waves and future infectious disease outbreaks.

Evidence does not support complete restriction of family visitation.

Visitation in US Hospitals During Initial Wave of COVID-19 Pandemic

In March 2020, rising rates of community transmission of SARS-CoV-2 infection and the declaration of a national emergency in the United States sparked drastic changes in hospital-based care to help mitigate the COVID-19 pandemic.[11-13] Although the emergency declaration contained no federal policy change or mandate for hospital visitation, the uncertainty around disease transmission and progression, risks of overburdening the health care system, concerns for the safety of health care workers, and a limited supply of reliable testing and personal protective equipment contributed to widespread visitation restriction to reduce the number of people on hospital grounds.[9,11] Many health care systems reacted to the initial crisis by banning all visitors from entering their hospitals.[11,14,15] Intensive care units, admitting the first wave of critically ill patients with COVID-19, were the most restrictive. Several environmental scans of hospital visitation policies during spring 2020 indicated that between 93% and 98% of hospitals were enforcing no-visitation policies in their ICUs.[11,16]

On September 15, 2020, the Centers for Disease Control and Prevention (CDC) released recommendations to non-US health care systems on the safe management of visitors during COVID-19.[17] These recommendations included a designated visitor entrance with signs instructing visitors not to enter if they had a fever or respiratory illness symptoms. Visitors were to adhere to national personal protective equipment standards. Visitors were strongly discouraged from visiting patients at increased risk for severe illness from COVID-19.[7,8,18] For high community transmission periods, the CDC recommended that visitation be facilitated for those who were essential to providing care to a patient, and in COVID-19 isolation units, 1 essential visitor per patient could be permitted.[17] These CDC recommendations, in essence, allowed at least 1 healthy visitor for all hospitalized patients.

Risks of Restricted Visitation Versus Risks of Transmission During Pandemic

Despite recommendations and guidance from the CDC, The Joint Commission, and Medicare Conditions of Participation that support adapting policies and allowing visitors to return to hospitals, facilities have a wide variety of visitation policies, with some US hospitals continuing to enforce no-visitation policies even for patients at the end of life.[7,8,16-18] For some hospital systems, the continuation of restricted visitation policies beyond the initial COVID-19 crisis response suggests that decision makers may not have fully considered the risks of restricted visitation to patients, families, and staff versus the risk of COVID-19 transmission.

A large body of evidence documented the positive impact of family presence on patients' psychological

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and physical well-being before the pandemic.[5,19-22] Reports of patients' distress and trauma due to the absence of family members during the pandemic have been well documented.[7,23-25] Patients who experienced visitation restrictions during the pandemic were more likely to have delays in response time for requests for care,[13,15] errors in medication management,[18] more incidences of falls and sepsis,[15] less understanding of medical status,[11,26] and increased anxiety due to hospitalization and separation from their families.[6,13,23]

Numerous effects of visitation restrictions on families have also been documented, including decreased involvement in care,[6] delays in goals-of-care conversations,[27,28] lower levels of family understanding of disease progression, and inadequate preparation for end-of-life decision-making, such as withdrawing life-sustaining measures or making decisions about do-not-resuscitate or do-not-intubate status.[29,30] Families developed a heightened sense of distrust of medical staff,[31] traumatic response to separation,[23] and complex bereavement responses for those who could not see or touch their loved ones before they died.[32]

Numerous effects on frontline health care workers associated with visitation restrictions have also been documented. Workers reported symptoms of posttraumatic stress disorder,[16,33] regret about restricted visitation policies,[33,34] burnout,[35] and intention to leave their jobs because of their roles enforcing no-visitation policies.[35] Enforcing restricted visitation rules also contributed to an increase in violence directed at hospital workers during the pandemic.[36] Barriers to timely medical decision-making,[6] advance care planning delays,[37,38] and lower-quality patient care outcomes[13,15] also were reported in the research on restricted visitation in hospitals.

Continued restricted visitation policies in US health systems appear to place more value on the risk of COVID-19 transmission from visitors to patients and health care workers and on community transmission that is not supported by evidence. Much research shows that hospital visitors do not play a large role in the transmission of SARS-CoV-2.[6,39] In a systematic review and meta-analysis before the pandemic, no difference existed in ICU-acquired airborne infections with flexible vs restricted visitation, meaning that limiting visitors in ICUs does not affect virus transmission.[5] Early in the pandemic, before any widespread implementation of public health or infection prevention and control measures, a meta-analysis of 40 studies from Wuhan, China, demonstrated that only 2% of acquired COVID-19 cases in the city were from hospital visitors.[40] In a sample of US hospitalized patients from March to May 2020, researchers found low rates of hospital-acquired SARS-CoV-2 and concluded that this could not be attributed solely to visitor restrictions, as that practice started in April 2020.[41] In another study in a Singapore hospital from June to August 2020 when visitor restrictions were relaxed, there was no statistically significant difference in nosocomial cases of SARS-CoV-2 between a period with no visitors and a period with 1 to 2 visitors.[42] Research documenting the transmission from 2 asymptomatic visitors to 2 patients in a Brazil hospital in August 2020 was not able to rule out that these transmissions may have occurred before hospitalization.[43] At the time of this study, the only infection prevention and control policy was for visitors to wear masks, with no monitoring of other recommended protection measures (eg, screening, vaccination availability, or hand hygiene) that became common practice in hospitals.[43]

> Many adverse effects of visitation restrictions on patients, their families, and nurses have been documented.

Visitation Policy in Magnet and Pathway to Excellence Hospitals During Pandemic

In ICUs, nurses facilitate visitation and nurse leaders are accountable for changing rule-based policies that are barriers to family presence.[1] Recognition as a Magnet or Pathway to Excellence health care organization represents exemplary nursing professional practice and the delivery of the best patient care.[44] In the initial COVID-19 wave, some suggested that Magnet organizations were better prepared to cope with challenges caused by the pandemic.[45] It is unclear if evidence was used to inform decisions to restrict visitation, especially in these organizations that had unrestricted visitation before the pandemic.[46] Thus, studies that document changes in visitation and the related decision-making in Magnet and Pathway to Excellence hospitals may help to inform visitation policies in subsequent waves of the pandemic and future infectious disease outbreaks.

The purpose of this study was to better understand how a sample of hospitals with nursing excellence recognition and previously unrestricted visitation policies in their adult ICUs have restricted or facilitated visitation during the COVID-19 pandemic.

The research questions for this mixed-methods study were

1. What visitation policies due to the COVID-19 pandemic were implemented by Magnet and Pathway to Excellence facilities with previously unrestricted visitation in their adult ICUs?

2. How did nurse leaders perceive the transition from unrestricted visitation to restricted visitation?

3. How do the qualitative and quantitative data improve understanding of decision-making processes related to visitation restriction differences between hospitals?

Methods

Design

This study used an exploratory concurrent mixed-methods design, which was a follow-up to prepandemic studies on unrestricted visitation policies in adult ICUs across the United States.[46,47] Because of changes in ICU visitation policies caused by the pandemic, the researchers conducted this additional inquiry to better understand how Magnet and Pathway to Excellence facilities implemented and experienced changes in their ICU visitation policies. The Sacred Heart University Institutional Review Board approved the overarching study and the current study.

Design Rationale

A mixed-methods design is a procedure for collecting, analyzing, and reporting a combination of quantitative and qualitative data within the same study to achieve an improved understanding of a complex issue.[48,49] The rationale behind this chosen design was that the combination of both quantitative and qualitative research methods has been found to be particularly useful to capture the complexities of emerging research content areas[48] and difficult-to-contextualize research topics[50] and has been used frequently in early-stage exploratory studies with health care workers during the COVID-19 pandemic.[31,51]

Sample

For the quantitative portion of this study, the target population was Magnet and Pathway to Excellence hospitals with unrestricted visitation policies in adult ICUs before the pandemic. This sample (N = 99) was created in an earlier study that examined the prevalence of unrestricted visitation policies in adult ICUs in Magnet and Pathway to Excellence hospitals.[46] For the qualitative portion of this study, the researchers sampled nurse leaders from these same Magnet and Pathway to Excellence hospitals.[47]

Sampling and Data Collection

Quantitative. From January through March 2021, research assistants conducted an internet search of US hospital and ICU visitation policies of 99 Magnet and Pathway to Excellence facilities with previous unrestricted visitation policies. At the time of this study, 3 hospitals had no current visitor information listed on their websites and were thus excluded. Variables regarding restricted visitation policies were identified on the basis of the visitation information available on hospital websites (eg, number of visitors, visiting hours, visitation to patients with COVID-19, age of visitors, virtual visitation options).

The method of extracting data from hospital websites was used before the pandemic to understand national trends in open visitation[46] and during the initial stages of the pandemic to understand initial crisis visitation policies.[8,9,11] Additionally, visitor information on websites is described as public facing and is the primary method that health care facilities use to communicate with the community.[9]

Qualitative. Purposive sampling was used to invite nurse leaders' participation in this study. In this sample, the researchers sought to interview informants who would be able to provide, as Patton[52] describes, "information rich" data about the goals of the study. Therefore, the researchers invited nurse leaders who had experienced working in adult ICUs with prepandemic unrestricted visitation, had experienced the initial transition to restricted visitation, and were in nurse leadership positions (eg, ICU nurse manager, clinical director or patient care director, or clinical nurse specialist or advanced practice nurse) 9 months after the start of the pandemic. In total, 9 nurse leaders agreed to participate in semistructured interviews; because the informants met the inclusion criteria, this meets the acceptable qualitative sample size for mixed-methods design.[53] In a mixed-methods study, the aim of qualitative data collection is not always saturation. Rather, in-depth interviews provide an opportunity for further exploration into the richness and integration of the data to yield an understanding into further contextual information that could not be provided by single-method data collection alone.[49,53] After agreeing to participate in the study, nurse leaders were scheduled for interviews with the research team. The researchers created a semistructured interview that was vetted by Sacred Heart University nursing faculty for clarity (see Table 1). Interviews were conducted by telephone or video conferencing. The nurse leaders who participated in the interviews were from diverse regional hospitals, including in

Table 1
Interview questions

1. I want you to recall back to when the decision was made to begin placing restrictions on intensive care units (ICUs). What was that experience like?
   a. When was the decision made?
   b. Who made this decision?
   c. How was this decision communicated to staff? Patients? Community and families?
2. Since the start of the coronavirus pandemic, what visitor restrictions have you had to put in place?
   a. How have these changed with time?
   b. Are there differences between units? What are they?
   c. Did the restrictions change with time?
3. What kind, if any, of unit restrictions were placed on ancillary staff (eg, social workers, chaplains, therapists, housekeeping, dietary, psychiatry, phlebotomy)?
4. Now I want to specifically ask about your experience as an ICU that has a philosophy of open visitation. How did your unit manage with restricted visitation?
   a. How was this for you personally as a nurse leader in the ICU?
   b. How did your nurses manage with restricted visitation?
   c. How about other disciplines? Physicians? Social workers? Chaplains? Therapists?
5. For what reasons did you allow family into the ICU after visitation was restricted?
6. Can you tell me about any practices that have been initiated by ICU staff to improve family contact with patients during restricted visitation?
   a. What sort of technology was used to increase virtual visitation?
   b. Who oversaw making sure that technology was available to patients?
7. How did nurses cope with patients who died alone in the ICU?

the Northeast, West, Midwest, and Southeast regions of the United States, that were part of larger health systems, ranging in size from large academic hospitals to smaller community hospitals.

Data Analysis

All quantitative data (eg, number of visitors, visiting hours, visitation of patients with COVID-19, age of visitors, and virtual visitation options) were analyzed in Microsoft Excel. Univariate statistics were obtained by calculating frequency distributions (reported as percentages).

The audio files for qualitative data were transcribed verbatim into Microsoft Word. Interview transcripts were evaluated using inductive content analytical methods.[54] Data were imported into ATLAS.ti, version 7.5.4 (ATLAS.ti Scientific Software Development) for data management and analysis. Latent pattern content analysis was chosen as the method of analysis.[52,55] This method allowed the researchers to establish a pattern of characteristics in the text of the data.[55] Step 1 involved having both researchers read the text several times to immerse themselves in the data and detect emergent codes through identification of meaning units related to the shared experience of nurse leaders' understanding of ICU visitation policies during the pandemic. In step 2, to check for consistency, each researcher independently coded 15% of transcript excerpts to establish intercoder agreement and label textual codes for the codebook.[56] Initial intercoder agreement was 85.0%. After reconciliation, intercoder agreement was 93.2%. In step 3, second-level coding and first-level meaning units were sorted and placed in categories of similar codes, separating dissimilar codes to create distinct categories. In step 4, these categories were then analyzed for themes and patterns, comparing and contrasting within and across groups, allowing for categorization of themes and the discovery of similarities and differences in the data.[55,57] Both researchers iteratively reached consensus on the list of 5 finalized themes and representative quotes.

> The future of open visitation as a strategy to support family-centered care and engagement is in jeopardy.

Results

A review of 96 Magnet and Pathway to Excellence hospital websites in the quantitative sample indicated that at the time of data collection (January-March 2021), all of the hospitals (100%) had some form of restricted visitation. Table 2 displays these restrictions. These data reflect 4 hospitals (4%) with no visitation to any unit in the hospital and 6 hospitals (6%) that had no visitation in the ICUs. Only 10 of 72 hospitals (14%) allowed visits to patients with COVID-19 in the ICU. Most of the adult ICUs (n = 65 [68%]) did not allow children younger than age 18 years to visit.

Table 2
Visitation restrictions in 96 Magnet and Pathway to Excellence hospitals with prepandemic unrestricted visitation

Category	No. (%)
Hospital visitation policy	
1 Visitor per day (different allowed)	33 (34)
1 Visitor in room at a time	20 (21)
1 Visitor per day (same visitor each day)	18 (19)
2 Visitors per day	12 (12)
1 Support person only (patient is dependent)	9 (9)
No visitors allowed	4 (4)
Intensive care unit visitation policy	
Visitors allowed, restricted hours	70 (73)
Open visitation hours, restricted number of visitors	20 (21)
No visitors allowed	6 (6)
Visitation policy for patients with COVID-19 (n=72)	
No visitors allowed	50 (69)
Visitors allowed for comfort care only	12 (17)
Visitors permitted	10 (14)
Age of visitors (n=65)	
No children <18 years	48 (74)
No children <16 years	13 (20)
No children <12 years	4 (6)
Virtual visitation	
Options not listed on website	64 (67)
Virtual visitation options listed on website	32 (33)

In the qualitative strand of the study, latent pattern content analysis revealed 5 distinct themes associated with restricted visitation policies in adult ICUs because of the pandemic. These themes included visitors not welcome, doing harm, external decisions at the system level, visiting within limits, and changes in critical care nursing work. Table 3 displays participant quotes for each theme.

Visitors Not Welcome

This theme was the most common, representing a shift away from the prepandemic culture of unrestricted visitation. Participants discussed the suddenness of this change and the lack of knowledge about the transmission and treatment of COVID-19. Participants reflected on the previous culture of open (eg, unrestricted) visitation, with most nurse leaders predicting a future that will not return to open visitation and will always include some visitor restrictions in their ICUs.

Doing Harm

Data revealed a theme of doing harm, reflecting direct harm caused by restricted visitation policies. Harm was described as affecting patients, patients' families, and ICU nurses and was distinguished from the harm caused by COVID-19 infection. Nurse leaders discussed strategies to reduce harm caused by restricted visitation policies, including making exceptions to visitation rules, coordinating virtual visitations, and supporting nursing staff.

External Decisions at System Level

A universal theme expressed by all participants was that decisions to restrict visitation and changes to those restrictions were external decisions, not within nurses' influence or under their direct responsibility. Decisions were described at the system, local, and state or federal level, with no nursing ownership for decision-making. Most participants described a top-down management style to organizational decision-making but no clear understanding if decision-making was being driven by infection control or risk management departments or the administration or if available evidence was used to inform decision-making. Methods of communication within their systems were described by some as efficient for advising staff, patients, families, and communities via email, media, websites, and direct communication. Others described challenges within larger system communication. These challenges at times caused inconsistencies in implementation of visitation policy and confusion for family members who were not informed of changes in visitation policies until they arrived at the hospital to visit.

Visiting Within Limits

This theme reflected both exceptions and restrictions to visitation policies. The most common exception discussed by participants was for end-of-life care. However, certain hospitals remained fully restricted, even for patients at the end of life, specifically if the patients were diagnosed with COVID-19. Conversely, several participants were committed to finding ways to facilitate safe end-of-life visitation for patients and for visitors diagnosed with COVID-19. Participants reported restrictions on the number of visitors and the amount of time allowed for visits, and they were not aware of any evidence used to support these restrictions. No participant reported that overnight visitation was allowed unless the visitor was essential to the patient's care. Most participants described restrictions to visitation as a reaction to both rising and decreasing COVID-19 transmission rates in their regions.

Changes in Critical Care Nursing Work

This theme was specifically related to changes in critical care nursing work caused by changes in visitation policy, with subthemes of technological and nontechnological adaptations to nursing work.

Table 3
Themes related to visitation restrictions

Theme	Sample quotes
Visitors not welcome	In April, that was the end of normal visitation. When it got busy, and we were really in the thick of things, they completely restricted visitors for all patients. Since they put in visiting restrictions, we've never allowed visitors for COVID-positive patients; that's probably the thing that's been the same throughout the entire process.
Doing harm	Patients were by themselves, and really sick patients in the ICU, not having anybody to hear a voice that they're familiar with, or see a familiar face is very hard. I will say that I'm proud that my nurses never let anybody die alone, so they were always in the room when it happened. But if . . . they were not . . . that is not something that you want to remember in your career; it is devastating. It just felt like we could never do enough. You know you don't realize how much the family members do, when we used to teach them a little bit of oral care, or how to do range of motion, and now, not even have that help. I would just challenge health care systems to really think about the pros and cons of visitors—are we being more detrimental to our patients, and to their emotional and mental well-being, by completely restricting visitors.
External decisions	
System level	These decisions were always made at a system level; there was never a local level decision. We determine appropriate visitation for all our hospitals at the same time. And then they [hospital system] announce the changes to the visitor policy on social media and on other media outlets, so on our NPR local news station, to help let the community know.
Local level	Our county actually gives us restriction [recommendation] based on our tier level, so that some of the things that were enacted were based on that.
State or federal level	Recommendations are from our state on visitors. The [state] Department of Health really sets forth guidelines regarding visitation and the expectation around visitation. There are CDC guidelines we use.
Visiting within limits	I'll be super honest with end-of-life stuff: you know in our guidelines throughout this whole process we had a little extra leeway, so we really have been able to have more than 1 or 2 people at bedside. They did add discharge teaching as a reason for a visitor to be able to come in, on the day of discharge or prior to discharge, and for care planning. One designated visitor could visit . . . and we needed to have 1, so like it couldn't be a different designated visitor the next day and a different designated visitor the next day. What we have recognized is we have not had any exposures from a family member in our facility. With universal masking and source control, and ensuring hand hygiene, you know, we've had visitors in our COVID patient rooms and haven't had any issues. But just knowing that that family member has that opportunity to see their loved one, I think is incredibly important, and that is something that we truly believe in as an organization is important.
Changes in critical care nursing work	
Technological	I mean the nurses did the best that they could using iPads and iPhones, and whatever they had, inside of a plastic bag to be able to initiate the communication. We have a real robust telehealth group, and they were really connected to nursing; they were really our primary IT support for all . . . they are very patient-centric. Nurses dealing with a patient's end-of-life situation, and now having to talk the family through how do you work an iPad, or how do I do this on my phone when they haven't done that before.
Nontechnological	When this first happened, we got calls like crazy, because the family couldn't visit, so they called. And we couldn't even talk to them because we were in the isolation rooms all day. So that was hard. And you know if we did pick up a phone call it wouldn't be like a 5-minute phone call, it would be like a 30-minute phone call. Staff have enjoyed extra time, you know they can take their time and give their medications and not be interrupted without 5 family members in the room, but I think overall it's the part that probably will haunt people the longest is just knowing that they couldn't have those crucial conversations in person. I think that's still the hardest part. To be transparent, I think sometimes the nurses appreciated not having family at the bedside, only because they could focus totally on the patient and the patient's needs.

Abbreviations: CDC, Centers for Disease Control and Prevention; ICU, intensive care unit; IT, information technology; NPR, National Public Radio.

Technological virtual visitation offered some constructive changes, including connecting patients with family members who were able to visit and offering opportunities to have family meetings and important discussions regarding care planning via video conferencing, which was usually preferred

over telephone conferencing. However, providing video calls, locating devices for communication, and coordinating virtual meetings often were added responsibilities for nursing staff, in addition to caring for patients who needed high-acuity critical care. Nontechnological changes included needing more time to focus on patient care without having family members there to help and needing more time to communicate with absent family members and provide updates on patients' status. Nurse leaders recognized the contributions of other team members, such as social workers and chaplains, along with the value of interdisciplinary teamwork to best support patients and families. However, some facilities had periods during which other staff members were not permitted to enter patients' rooms or the ICU, creating additional nursing work, including conducting family phone consultations, coordinating technology, delivering meals to patients' rooms, and coordinating physician consultations with patients.

Discussion

This research is the first national study to our knowledge to use a mixed-methods design to examine visitation practices in adult ICUs in Magnet and Pathway to Excellence Hospitals that had unrestricted visitation before the COVID-19 pandemic. Using a mixed-methods design helped integrate the public-facing visitation policies with actual nursing practices as described by nurse leaders. This comparison was important because it has been reported in the literature that nurses make their own exceptions to visitor restrictions depending on patient and family needs and unit culture.[58-60] Overall, none of the hospitals had unrestricted visitation policies at the time of the study, and visitation policies in adult ICUs varied widely, from no visitation at all to visitation with restrictions.

> With proper screening and PPE, the benefits of visitation far outweigh the risks, and going forward, families must be allowed to be near their loved ones.

Data integration of quantitative and qualitative results in this study showed several similarities and provided additional context and meaning. The hospitals included in the study had no restrictions on the number of visitors, hours of visitation, age of visitors, or visitor type before the COVID-19 pandemic. However, data analysis revealed a wide range of visitation restrictions in these hospitals at the time of the study. This finding was corroborated in the qualitative data, as different nurse leaders described a wide variety of visitation policies in adult ICUs, such as visitation only at the patient's end of life, 1 visitor at the bedside with different visitors permitted during the same day, 1 visitor for the entire hospital stay, only 1 visitor at the bedside, 2 visitors permitted per day, no children younger than age 18 years, or only essential visitors whom the patient relied on for care. Most hospitals at the time of the study reported a no-visitation policy for patients in COVID-19 isolation; however, exceptions were made for comfort care at some hospitals, with no criteria for this exception noted on hospital websites. A content analysis of 13 Michigan hospital visitation policies showed similar variability in individual policies, with 5 hospitals having no end-of-life exceptions and 3 having case-by-case visitor exceptions.[8] As noted in other studies, the lack of clear criteria for exceptions to these restrictions has contributed to inequitable access for families who may not be able to advocate for end-of-life care visits or to engage in end-of-life decision-making.[7,29]

Additional findings in the qualitative strand included nurses' perceptions of the decision-making process for visitation restrictions; overwhelmingly, the nurse leaders seemed to perceive visitation restrictions as a decision-making process that occurred outside the realm of their nursing practice or influence, and they were not able to specify which entities in the hospital were driving the visitation decision-making process. This finding is particularly relevant because traditionally, visitation policies have been under the control of nursing staff as one of the key stakeholders for visitation.[61] Most nurse leaders seemed to feel removed from these decisions and unsure if decisions were made by infection control or risk management departments, but they were clear that these decisions occurred separately from nurses' daily work responsibilities in the ICU. This finding was corroborated during data extraction in the quantitative strand of the study, as it was noted that larger health care systems often set the same visitation policy for multiple hospitals within the larger health care organization, regardless of differences in location or local transmission rates.

Although some participants acknowledged an improvement in workflow and an ability to focus on direct patient care without patients' family members present, they described restricted visitation policies as placing an emotional strain on nursing staff, such as nurses witnessing patients' suffering from being separated from their families and experiencing challenges in finding time to properly communicate with families. Nurse leaders described how nurses would make sure that no patient died alone, but it was

stressful keeping that standard. Most nurse leaders discussed awareness of the importance of visitation to isolated patients and described how often, visitation was facilitated at the discretion of staff for critically ill patients in COVID-19 isolation. Differences between officially communicated visitation policies and end-of-life staff discretion for comfort care have also been noted in the research literature.[28,62]

Evidence to justify organizational decision-making regarding restricted visitation policies was noticeably absent in both the quantitative and qualitative data. Current evidence contradicts the decisions made by health systems that have enacted no-visitation policies in ICUs, and decision makers may not be integrating evidence of the beneficial effects of having families present on patients' recovery. This presence is even more important in times of uncertainty like the pandemic. Further, there is little evidence of in-hospital transmission of COVID-19 from visitors.[63] With proper screening, use of personal protective equipment, and monitoring, most experts agree that the benefits of family visitation far outweigh the risks.[14,16,44,64] Moreover, the Society of Critical Care Medicine's prepandemic recommendation for family-centered care during an outbreak is to have respect for family presence and engagement by allowing family members to be near the patient.[2]

Implications

This study captures a culture shift from unrestricted or open to restricted visitation in hospitals known for open visitation and for the use of evidence-based practices to improve patient care outcomes. The experiences of nurse leaders regarding visitation are noteworthy and should be used to inform an evidence-based visitation policy moving forward. A shared decision-making model can help establish a safe visitation policy that includes and respects the perspective and needs of patients, families, and staff while also maintaining infection control and precautions.[64] As visitation restrictions lessen, hospitals need to conduct quality monitoring plans for the related transmission of disease in hospitals and communicate these results to concerned staff and other organizations. Decision-making tools, such as those developed by the Institute for Patient- and Family-Centered Care[65] and the Canadian Foundation for Healthcare Improvement,[66] can aid in establishing a transparent process for any future visitation policy restrictions and can be conducted in tandem with a collaborative decision-making team of relevant stakeholders, including patients, care partners, staff, clinicians, hospital administrators, ethicists, community members, and infection control staff.[39] Patient and family-centered care can be assisted by a set of consistent national visitation guidelines, relative to current knowledge in the context of the pandemic. Critical care organizations and all ICU health care disciplines can advocate for these standards in legislative statutes and in their disciplines. Furthermore, visitation policies should reflect and respond to a patient's need to feel safe while in the hospital and a "family's instinct to protect the patient from harm."[1(p3)]

Limitations

This study has limitations. First, only public-facing or publicly available ICU visitation policies from hospital websites were collected. It is possible that some policies were internal and not communicated externally and hence were not identified by our review. Second, regional differences exist in how each state has been affected by and responded to the COVID-19 pandemic; however, purposive sampling yielded representation from each US region, and facilities ranged from small community hospitals to large academic medical centers. Given that policies were collected during 1 point in time only, this study does not consider temporal differences within each state as the pandemic continues to evolve. Third, it is well known that visitation policies are not always followed and that nursing staff bend the rules on the basis of patient, family, and health care worker needs.[58,59]

> Visitation policies must be based on best available evidence, risk-benefit analysis, and input from key stakeholders like nurses, social workers, patients, and families.

Conclusion

This research adds to the knowledge base about the vast variability in visitor restrictions among Magnet and Pathway to Excellence hospitals. Initial strict restrictions helped mitigate the risks placed on nursing and health care workers who bravely continued working during a time of uncertainty, lack of personal protective equipment, and minimal knowledge about transmissibility. A sustained policy for safe visitation should be based on only the best available evidence and risk-benefit analysis of both positive and negative influences on patient and family outcomes. Since the start of the pandemic, new guidelines and evidence on the proper use of personal protective equipment, greater availability of multimode testing and vaccines, and proof of low visitor-to-community

transmissibility have made space for reintroducing safe visitation in hospitals. However, many unjustified restrictions remain.

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SEE ALSO

For more about family visitation and COVID-19, visit the *AACN Advanced Critical Care* website, **www.aacnacconline.org**, and read the article by Copley and Morley, "Virtual Visitation and Microethical Decision-making in the Intensive Care Unit During COVID-19" (December 2021).

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