Journal of Patient Experience
Volume 8: 1-5

DOI: 10.1177/23743735211049646
journals.sagepub.com/home/jpx
SAGE

A Patient-Centered Environmental Scan of Inpatient Visitor Policies During the COVID-19 Pandemic

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Abstract

Researchers and patients conducted an environmental scan of policy documents and public-facing websites and abstracted data to describe COVID-19 adult inpatient visitor restrictions at 70 academic medical centers. We identified variations in how centers described and operationalized visitor policies. Then, we used the nominal group technique process to identify patient-centered information gaps in visitor policies and provide key recommendations for improvement. Recommendations were categorized into the following domains: 1) provision of comprehensive, consistent, and clear information; 2) accessible information for patients with limited English proficiency and health literacy; 3) COVID-19 related considerations; and 4) care team member methods of communication.

Keywords

COVID-19, quality improvement, patient perspectives/narratives, communication

Introduction

Hospital visitor restriction policies in response to the novel coronavirus (COVID-19) pandemic have received widespread attention because of their adverse impact on patient- and family-centered care (1–4). Describing and comparing how hospitals have implemented COVID-19 visitor policies presents an opportunity to reduce inconsistencies and promote equitable care (5).

The aims of this study are to 1) conduct an environmental scan of policy documents and websites describing COVID-19 adult inpatient visitor restrictions at 70 academic medical centers and 2) partner with patients and caregivers to use these data to identify gaps and generate recommendations for improvement of these policies and resources.

Patient Stakeholder Engagement

The Hospital Medicine Reengineering Network (HOMERuN) Patient and Family Advisory Council (PFAC) has met monthly

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since 2018 and comprises a group of 11 patient and caregiver advocates. Each member has experienced hospitalization and represents different medical centers and geographic areas across the United States (6). All HOMERuN PFAC members are collaborators and part of the study team.

Methods

We conducted an environmental scan of internal policy documents and public-facing websites describing visitor restrictions in response to COVID-19 between August and October 2020. Environmental scanning in health care is an established, effective, and widely used approach for gathering and synthesizing information that identifies gaps and opportunities and enables understanding of a specific topic (7). Data from environmental scanning efforts can be used proactively by organizations to inform policy and impact operations (7).

The study took place within a 70-site North American Hospital Medicine research collaborative—HOMERuN (8,9). We invited collaborative participants to submit protocols on COVID-19 visitor restrictions from their hospitals. In addition, we identified public-facing websites of centers that described adult inpatient visitor restriction policies.

We created a data abstraction tool to ensure consistency in data collection, which contained closed and open-ended items asking: number of visitors allowed, categories of restriction exceptions, details of how rules are operationalized, end-of-life policies, rules for visitors, accommodations for visitors (e.g., parking), and care team-to-family communication practices. Data was managed in Qualtrics (Provo, UT). We used descriptive statistics to summarize quantitative data and at least two reviewers independently abstracted and interpretated open-ended items to ensure accuracy (10).

Following data synthesis, all 11 PFAC members of the study team met to identify gaps in policies and create a set of patient-centered COVID-19 hospital visitor recommendations. This was achieved using the nominal group technique (NGT) process—an established and structured methodology for consensus-building (11,12). The NGT process was facilitated by JDH and RW during two 1-hour virtual consensus-building sessions. Prior to the first session, PFAC members were asked to review the results of the data abstraction and website review. Then during the first session, they were asked to discuss any gaps that they perceived and/or any concerns with information contained within the policy documents and/or websites. Standard NGT practices were followed including the opportunity for all PFAC members to share their views, allowing adequate time for discussion, enabling members to comprehend each other's point of view, and ensuring that no perspectives were excluded (11,12). The session was digitally recorded and transcribed. Transcripts summarizing the first session were sent to PFAC members for review before a second consensus-building session. During the second session, again through facilitated discussion and consensus-building, PFAC members were asked to identify the most salient gaps and topics from those discussed in the first session—these gaps and topics informed a set of patient-centered recommendations for COVID-19 hospital visitor policies.

Table 1. Summary of n = 70 Sites and COVID-19 Visitor Policies.

Number of visitors allowed	
0	12 (17)
1	51 (73)
Not described	7 (10)
Exceptions to visitor restrictions by hospital area or patient population*	
Admission	0
Behavioral health issues	9 (13)
Disability	34 (49)
Discharge	8 (11)
Emergency Department	39 (56)
End-of-Life	43 (61)
Infusion Center	10 (14)
Limited English Proficiency patients	3 (4)
Maternity/Labor and Delivery/Obstetrics	52 (74)
Neonatal ICU	28 (40)
Pediatric	59 (84)
Surgery and Procedures	36 (51)
Contact information for patients and caregiver with visitor policy questions?	
Yes	13 (19)
Visitor screening elements *	
Check for COVID-19 symptoms	40 (57)
Fever screening / temperature check	20 (29)
Masks required	49 (70)
Negative COVID-19 test	1 (1)
≥18 years old only	22 (31)
Restrictions and accommodations for hospital visitors*	
On-site food options	21 (30)
Bathrooms open	4 (6)
Bathrooms restricted	1 (1)
Cafeteria open	7 (10)
Cafeteria restricted	9 (13)
Chapel open	1 (1)
Food not allowed	5 (7)
General restriction for public meeting places / hallways	7 (10)
Gift shop open	2 (3)
Gift shop restricted	4 (6)
Recommendation to stay in patient's room	34 (49)
End-of life visitor exceptions	
Stated policy exception exist and details provided	31 (44)
Stated policy exception exist but no details provided	12 (17)
Not described or provided	27 (39)
Number of visitors allowed at end of life	
≤2	5 (7)
2	19 (27)
≥2	5 (7)
"exceptions for family"	3 (4)
Definition of end-of-life provided	
Yes	12 (17)

*sites can provide multiple responses meaning denominator is 70 for each category.

Results

Seventy public-facing websites and 18 local protocols were reviewed (Appendix 1). Twelve (17%) centers did not allow any visitors, 51 (73%) centers allowed one visitor, and 7

Provision of comprehensive, consistent and clear information

- ◊ Ensure website and policy information is consistent, clear and complete
- ◊ Ensure website is updated, dated, with the rationale for policy decisions and changes
- ◊ Indicate rules for allowed visitors (i.e., number allowed, rules for rotation or coming/going from facility, how visitors are identified, visiting hours, and screening policies on arrival)
- ◊ Provide a contact for questions about visitor policies and a clear chain-of-command for escalations
- ◊ Provide information on accommodations including parking, food, and housing
- ◊ Provide a clear definition for "end-of-life"

Accessible information for patients with limited English proficiency and limited health literacy

- ◊ Consider health literacy, ensuring information is at the appropriate reading level.

COVID-19 related considerations

- ◊ Ensure visitors are aware of different visitor restriction policies based on inpatient's COVID-19 status
- ◊ Specify exceptions to visitor policy relating to vulnerable patient populations, including those:
  - o with intellectual impairments/dementia/delirium
  - o who are unable to make healthcare-related decisions without assistance
  - o with Limited English Proficiency
  - o at "end-of-life"
  - o at time of admission and discharge from hospital
- ◊ If Personal Protective Equipment (PPE) are required for visitors, specify details prior to visitor arrival or have hospital-provided PPE available
- ◊ Communicate which hospital facilities are available for visitors and if restrictions on movement have been implemented.

Care team member methods of communication

- ◊ Provide expectations on how, and when, families should expect communication and updates from inpatient care teams
- ◊ Be prepared to facilitate communication between inpatients and their family/advocates who are unable to come to the hospital, either with hospital-provided technology, or provision of detailed instructions for use of alternative communication methods (e.g., video conferencing tools) with hospital staff/resources to assist as able; specifically address patient populations who are not able to use these technologies

Figure 1. Nominal group technique findings: patient-and-family centered recommendations for developing, implementing and communicating inpatient COVID-19 visitor policies.

(10%) centers did not describe the actual number of visitors that were allowed (Table 1). For hospitalized patients with COVID-19, 44 (63%) centers outlined visitor policies that were different than those for patients without COVID-19. Exceptions to general visitor restriction policies varied by area of the hospital or department. The majority of hospitals required masks for visitors (n = 49, 70%), with 14 (20%) specifying that masks would be provided by the facility if visitors did not have their own. The majority of hospitals did not provide information regarding visitor accommodations.

Forty-three (61%) centers noted they would allow end-of-life exceptions, with 32 providing details of the number of visitors allowed at end of life (Table 1). Twelve (17%) centers provided a definition for end-of-life time period, however these definitions varied across centers.

Thirty-one (44%) centers provided information about alternate visitation and communication strategies. Twenty-three (33%) centers described virtual platforms or gave detailed instructions of how to communicate with inpatients. Six (9%) centers specified that hospital resources, including iPads, would be provided if otherwise unavailable to a patient. Five (7%) institutions specified expectations for how inpatient teams would be communicating with advocates/family.

The NGT process identified patient-centered information gaps in visitor policies and provided several key recommendations (Figure 1). These recommendations have been categorized into the following domains: 1) provision of comprehensive, consistent, and clear information; 2) accessible information for patients with limited English proficiency and limited health literacy; 3) COVID-19

related considerations; and 4) care team member methods of communication.

Discussion

Medical center descriptions of COVID-19 visitor policies were highly variable. For patients and caregivers, information overall—and particularly on public-facing websites—were found to be unclear, inconsistent and lacked details most important to them. Our national study provides a broader view consistent with single-site research and guidelines suggesting that centers use clear and consistent publicly available information (5,13–15). We found the lack of attention to health literacy and accessibility for patients with limited English proficiency to be particularly concerning. While these issues have been reported previously (16–19), the COVID-19 pandemic has amplified these problems at a time when the public requires accessible information. Few hospitals provided details of alternative communication options or expectations of how inpatient teams would communicate with families during a time period when visitor restrictions were firmly in place. Patient and family members on our study team expressed concerns that the insufficient consideration of both topics had the potential to reverse gains in patient- and family-centered care that have evolved over the last decade (20).

Given the rapid changes that had to be made in the early days of the COVID-19 pandemic, it is understandable that hospitals had to implement visitor policies quickly. However, now that the pandemic continues to evolve, there are opportunities to learn from this last year to enhance patient- and family-centered policies using the recommendations reported in this study. Several recommendations are tailored to COVID-19 itself, but some also relate to how centers can communicate with patients and families who are isolated for other infection control purposes, providing lessons of lasting importance. Other recommendations such as updating websites to ensure information is complete and consideration of health literacy are critical lessons learned during the pandemic and are cross-cutting issues for the future.

Limitations

Our study included academic medical centers, meaning findings may not accurately reflect community hospital settings. The cross-sectional study design means our findings are a snapshot and may not reflect current visitor policies that have since been adjusted based on local needs and surges in COVID-19 infections. We only included local protocols and websites as data sources, meaning we did not include visitor policy information communicated by other methods such as print media, signs, and telephone. We also did not grade websites for health literacy using validated health literacy measures, rather we relied on the lived experiences and opinions of patient and caregiver advocates.

Acknowledgments

We would like to thank all HOMERuN COVID-19 collaborative members who provided their local COVID-19 visitor policy documents.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article:

James Harrison is supported by the Agency for Healthcare Research and Quality under Award Number K12HS026383 and the National Center for Advancing Translational Sciences of the NIH under Award Number KL2TR001870. The content is solely the responsibility of the authors and do not necessarily represent the official views of the NIH. Andrew Auerbach and Tiffany Lee report that research reported in this publication was supported by the Gordon and Betty Moore Foundation. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Gordon and Betty Moore Foundation.

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Ethical Approval

Ethical approval is not applicable to this article.

Statement of human and animal rights

This article does not contain any studies with human or animal subjects.

Statement of informed consent

There are no human subjects in this article and informed consent is not applicable.

Supplemental Material

Supplemental material for this article is available online.

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