

The case for relaxing no-visitor policies in hospitals during the ongoing COVID-19 pandemic

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In an attempt to mitigate excess transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), Canadian hospitals adopted “no visitor” policies during the first wave of the pandemic. A reflexive and almost complete restriction of visitors occurred across all hospitals surveyed in a pan-Canadian study involving 35 hospitals.¹ Such policies were designed to balance the interests of patients and their caregivers against society’s utilitarian responsibility to mitigate transmission into and within hospitals, with the secondary objective of preserving personal protective equipment (PPE) when concerns existed surrounding its supply. In the midst of a second wave, it is prudent to consider whether visitor restrictions should be kept stringent to fulfill infection prevention and control (IPAC) concerns and the precautionary principle, or whether they should be relaxed to mitigate harms to patients and families.

Visitor restrictions in hospitals are not unique to the coronavirus disease 2019 (COVID-19) pandemic and have existed for many decades. Lessons learned from seasonal influenza suggest that preventing outbreaks of respiratory viruses in the acute care hospital sector is vital to ensure that hospitals can provide needed care for all.² However, a progressive relaxation of hospital rules for visitors began after mounting evidence of the beneficial effect of family or designated support persons being present for patients admitted to hospital.^{3,4} Before the COVID-19 pandemic, a systematic review that evaluated liberal versus restrictive visitation policies in adult intensive care unit (ICU) settings found no increase in acquired infections or septic complications with more liberal visitation policies.³ A 2020 review (before the pandemic) found that 73% of hospitals had adopted accommodating visitation policies compared with only 32% in 2015.¹

At present there is limited evidence to support visitors having an important role in hospital-related transmission of COVID-19. Early in the pandemic, before the widespread implementation of public health and IPAC measures, a systematic review of nosocomial acquisitions of COVID-19 from case series in Wuhan, China, reported that only 2% were from people other than medical staff (e.g., visitors).⁵ A more recent study of 9149 patients admitted to hospital in the United States from Mar. 7 to May 30, 2020, found low rates of hospital-acquired COVID-19.⁶ Only 1.7% (12/697) of patients

KEY POINTS

- Restrictive “no-visitor” policies were adopted in Canada during the first wave of the pandemic in an attempt to mitigate introduction and spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) within hospitals, and to preserve personal protective equipment (PPE) for health workers.
- Available literature does not support a substantial role for family members and designated support persons in the transmission of SARS-CoV-2 in hospitals.
- Extensive evidence has shown that family members or designated support persons are important in the delivery of patient-centred care, particularly for patient advocacy, feeding, mobility, orientation, emotional support in settings of delirium, cognitive impairment, language barriers, end-of-life care, labour and delivery, and transitions to critical care.
- We argue that in the current wave of the coronavirus disease 2019 (COVID-19) pandemic, hospitals should adopt more accommodating visitor policies with careful use of PPE and monitoring, paying careful attention to community prevalence of COVID-19 and, in the future, immunization status.

with COVID-19 were defined as having a positive test result 3 days after admission or within 14 days of discharge and 10 of the 12 were most likely late identification of community-acquired cases. Only 1 was deemed to be acquired from a presymptomatic visitor before restrictions were implemented. The low rates cannot be attributable solely to visitor restrictions because restriction policies were implemented at the midpoint of this study time period.

Widespread, indiscriminate policies restricting visitors are associated with multiple risks for patients, families and health care providers.^{3,4,7-10} Although the term visitors generally includes any person who has a relationship with a patient, it is important to distinguish general visitors from “family” or “designated support persons” (also known as care partners). Family or designated care partners are increasingly recognized as being key to the delivery of patient-centred care (e.g., assisting with feeding, mobility, hygiene, orientation, emotional support). Accommodating visitation policies have been shown to improve communication and

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build trust between families and care providers, especially when patients do not speak the same language as their health care workers.⁷ Family members are essential in communication about escalation of care in the event a patient is incapable and often act as patient advocates.

Preliminary research has suggested that delirium is common among acute and critically ill patients with COVID-19.⁸ Patients with delirium have longer hospital stays and increased risk of death. In the ICU setting, family participation and flexible visitor policies have been shown to be associated with reduced delirium and improved longer-term psychological recovery.³ In general, family-centred care interventions have shown decreased ICU length of stay and improved patient experience and patient and family mental health.⁴

A recent observational study evaluated the effect of visitor restrictions on postoperative experiences of patients undergoing surgery during the COVID-19 pandemic.⁹ Patients exposed to visitor restrictions had delays in receiving medications, greater social isolation, difficulty in getting out of bed and were more likely to not have their discharge preferences adequately considered compared with patients who did not have restrictions on visitors before visitor restriction policies were initiated.

Data are limited regarding the impact of restrictive visitation policies on families. However, a 2017 observational study found that a dying patient's inability to say goodbye to their family was associated with complicated grief for the family.¹⁰ Dying alone is distressing and confusing for patients and psychologically distressing for loved ones. Health care workers have reported substantial distress associated with being a "placeholder" for families at the end of life.¹¹ Participants in a study of health care providers across ICUs in France from April to May 2020 expressed deep regret and symptoms of anxiety or depression about the COVID-19 visitor restrictions.¹²

How can we balance these risks as the pandemic continues? To ensure adequate IPAC measures as the community prevalence of COVID-19 rises, some restrictions will be needed. Higher visitor numbers will increase challenges to maintaining adequate physical distancing (e.g., in elevators and entrances). Nosocomial outbreaks have been seen in both waves of the pandemic in Canada. Some may have originated from asymptomatic health care workers infected in the community using shared spaces for breaks and meals, whereas others could have originated from asymptomatic visitors without sufficient education in PPE use or who did not articulate symptoms on entry screening.

In the second wave of the pandemic, many institutions in Canada have begun to adopt a less restrictive policy that recognizes the importance of family and care partners after reflecting on their experiences in the first wave. For example, some institutional contexts that should make exceptions for family members or designated care partners include hospices and palliative care, ICUs, labour and delivery suites, and surgical recovery wards. Patients transitioning to critical or end-of-life care, as well as patients with delirium, cognitive impairment, language barriers or severe psychiatric conditions, could also benefit from relaxed visitation policies.

How different visitation policies affect the risk of acquiring COVID-19 is unknown. Community prevalence of infection, including rate of asymptomatic infection, mode of transmission and quality of contact tracing, will affect rates of transmission to a hospital setting. However, rigorous IPAC measures (e.g., masks, handwashing and screening upon hospital arrival) and a well-performing, rapid COVID-19 test could mitigate the risk of transmission substantially. Data are needed to better determine the balance between these competing factors. The substantial between-jurisdiction variation in prevalence of COVID-19 means that risks should be assessed at the regional or hospital level and visitation policies tailored accordingly. Steps to reduce transmission risk include enhanced visitor screening and education, limiting visitors to a specified number of family members or designated care partners per patient, limiting the duration of the visit, selected use of point-of-care testing (if available), contact tracing by the region (if feasible) and ensuring appropriate PPE for visitors.

Safe visitation is anchored on visitors accurately and honestly reporting their symptoms, and their availability and compliance with PPE. A 2018 survey of visitors to patients with *Clostridium difficile* infection found that nurses are fundamental in educating visitors in the effective use of PPE.¹³ There may be a need for additional staffing and visitor education to ensure appropriate use of PPE. Given the greater challenges of ensuring appropriate PPE use for those visiting patients with COVID-19, tighter restrictions on visitation may be required for this subgroup of patients.

If visitors must be kept away, easy access to video conferencing can reduce the risks associated with patient isolation. A study that evaluated the feasibility and acceptability of e-communication for palliative care family meetings during the pandemic found that video conferencing was scheduled successfully across 97% of cases, and 80% of family members felt comfortable articulating questions and expressing thoughts throughout the meeting.¹⁴ However, video conferencing requires access to devices and facilitation by health care staff, increasing their work load. It does not allow for impromptu conversations, is often challenging when escalation or end-of-life care must be discussed, and it is not clear that patient information is being shared only with people that the patient would consent to involving in such discussions. Furthermore, the use of mobile communication could be associated with fomite transmission, and, therefore, IPAC measures should guide disinfection of these devices.¹⁵ Where feasible, some centres have used outdoor spaces to facilitate visits between patients and families.

The existing literature does not support any scenario where a complete restriction of visitors across all patient subtypes from hospitals is required. Although the evidence is not conclusive, we believe that restrictive visitor policies may do more harm than good in specific settings, and there are specific circumstances where hospital visitation policies should be relaxed with careful use of PPE and monitoring, paying careful attention to community prevalence of COVID-19 and community immunization status in the future. A Canadian study is currently underway to evaluate the pandemic's impact on visitation policies across Canadian hospitals (<https://cumming.ucalgary.ca/research/calgary-critical-care-research-network/research/COVID-19>).

References

1. Re-integration of family caregivers as essential partners in care in a time of COVID-19. Ottawa: Canadian Foundation for Healthcare Improvement; 2020. Available: www.cfhi-fccss.ca/about/news-and-stories/news-detail/2020/07/08/re-integration-of-family-caregivers-as-essential-partners-in-care-in-a-time-of-covid-19 (accessed 2020 Oct. 17).
2. Salgado CD, Farr BM, Hall KK, et al. Influenza in the acute hospital setting. *Lancet Infect Dis* 2002;2:145-55.
3. Nasser Junior AP, Besen BAMP, Robinson CC, et al. Flexible versus restrictive visiting policies in ICUs: a systematic review and meta-analysis. *Crit Care Med* 2018;46:1175-80.
4. Goldfarb MJ, Bibas L, Bartlett V, et al. Outcomes of patient- and family-centred care interventions in the ICU: a systematic review and meta-analysis. *Crit Care Med* 2017;45:1751-61.
5. Zhou Q, Gao Y, Wang X, et al. Nosocomial infections among patients with COVID-19, SARS and MERS: a rapid review and meta-analysis. *Ann Transl Med* 2020;8:629.
6. Rhee C, Baker M, Vaidya V, et al. Incidence of nosocomial COVID-19 in patients hospitalized at a large US academic medical center. *JAMA Netw Open* 2020;3: e2020498.
7. Hurst H, Griffiths J, Hunt C, et al. A realist evaluation of the implementation of open visiting in an acute care setting for older people. *BMC Health Serv Res* 2019;19:867.
8. Helms J, Kremer S, Merdji H, et al. Delirium and encephalopathy in severe COVID-19: a cohort analysis of ICU patients. *Crit Care* 2020;24:491.
9. Zeh RD, Santry H, Monsour C, et al. Impact of visitor restriction rules on the postoperative experience of COVID-19 negative patients undergoing surgery. *Surgery* 2020;168-770-76.
10. Otani H, Yoshida S, Morita T, et al. Meaningful communication before death, but not present at the time of death itself, is associated with better outcomes on measures of depression and complicated grief among bereaved family members of cancer patients. *J Pain Symptom Manage* 2017;54:273-79.
11. Najeeb U. 2020. COVID-19 reflections: Phone call [blog]. *CMAJ* 2020 July 3. Available: <http://cmajblogs.com/phone-call/> (accessed 2020 Nov. 18).
12. Azoulay E, Cariou A, Bruneel F, et al. Symptoms of anxiety, depression and peritraumatic dissociation in critical care clinicians managing COVID-19 patients: a cross-sectional study. *Am J Respir Crit Care Med* 2020;202:1388-98.
13. Seibert G, Ewers T, Barker A, et al. What do visitors know and how do they feel about contact precautions? *Am J Infect Control* 2018;46:115-7.
14. Kuntz JG, Kavalieratos D, Esper G, et al. Feasibility and acceptability of inpatient palliative care e-family meetings during COVID-19 pandemic. *J Pain Symptom Manage* 2020;60:e28.
15. Brady RR, Verran J, Damani NN, et al. Review of mobile communication devices as potential reservoirs of nosocomial pathogens. *J Hosp Infect* 2009;71:295-300.

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