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Impact of COVID-19 visitation restrictions on hospitalized patients and their families – a dual perspective

Wpływ ograniczeń odwiedzin w szpitalach podczas pandemii COVID-19 na hospitalizowanych pacjentów i ich rodziny – perspektywa dwustronna

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ABSTRACT

INTRODUCTION: To slow the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) during the pandemic, healthcare institutions worldwide implemented rules to restrict hospital visitation, poising significant challenges for the entire healthcare system. The presence of relatives often facilitates communication and exchange of information between patients and healthcare professionals.
MATERIAL AND METHODS: The study involved 203 adult, independent patients and 198 relatives. Conducted in a rehabilitation outpatient clinic between November 2021 and March 2022, the study aimed to evaluate how patients and their relatives perceived visitation restrictions in hospitals during the coronavirus disease 2019 (COVID-19) pandemic. Patients and their relatives were divided into two groups based on their positive or negative assessment of the restrictions.
RESULTS: Among the patients, 44% (N = 90) evaluated the visitation restrictions positively, while 56% (N = 113) viewed them negatively. Among relatives, 41% (N = 82) gave a positive assessment, while 59% (N = 116) expressed dissatisfaction with the restrictions.
CONCLUSIONS: The study found that the hospital visitation ban during the pandemic primarily evoked negative emotions among both patients (56%) and their relatives (59%). Despite the restrictions, most patients and their families maintained daily contact through alternative communication methods, highlighting the need for further development of remote communication options in hospitals. Additionally, hospitals provided effective procedures for delivering personal belongings and sharing information about patients' conditions, which was positively evaluated by respondents. In the future, a more flexible approach to visitations should be considered, for example, allowing visits in exceptional cases.

KEYWORDS

patients, coronavirus, relatives

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STRESZCZENIE

WSTĘP: Aby spowolnić rozprzestrzenianie się wirusa SARS-CoV-2 (*severe acute respiratory syndrome coronavirus 2*) podczas pandemii, instytucje opieki zdrowotnej na całym świecie wprowadziły zasady mające na celu ograniczenie odwiedzin pacjentów przebywających na oddziałach szpitalnych, co stworzyło ogromne wyzwania dla całego systemu zdrowotnego. Obecność bliskich często ułatwia komunikację i wymianę informacji między pacjentami a pracownikami służby zdrowia.

MATERIAŁ I METODY: W badaniu wzięło udział 203 pełnoletnich, samodzielnych pacjentów oraz 198 osób bliskich. Badanie prowadzono w jednej placówce medycznej, tj. w poradni rehabilitacyjnej, od listopada 2021 r. do marca 2022 r. i miało na celu ocenę, jak pacjenci i ich bliscy postrzegali ograniczenia odwiedzin w szpitalach w trakcie pandemii COVID-19 (*coronavirus disease 2019*). Pacjentów i ich osoby bliskie podzielono na dwie grupy – na podstawie pozytywnej lub negatywnej oceny ograniczeń.

WYNIKI: Spośród pacjentów 44% (N = 90) pozytywnie oceniało wprowadzenie ograniczeń, podczas gdy 56% (N = 113) postrzegało je negatywnie. Z kolei spośród osób bliskich pozytywną ocenę wystawiło 41% (N = 82), a 59% (N = 116) wyraziło niezadowolenie z ograniczeń.

WNIOSKI: Badanie wykazało, że zakaz odwiedzin w szpitalach podczas pandemii wywoływał głównie negatywne emocje zarówno u pacjentów (56%), jak i ich bliskich (59%). Mimo restrykcji większość pacjentów i ich rodzin utrzymywała codzienny kontakt za pomocą alternatywnych metod komunikacji, co podkreśla potrzebę dalszego rozwoju zdalnych form kontaktu w szpitalach. Ponadto szpitale zapewniły skuteczne procedury dostarczania rzeczy osobistych oraz udostępniania informacji o stanie pacjentów, co zostało pozytywnie ocenione przez respondentów. W przyszłości należy rozważyć bardziej elastyczne podejście do odwiedzin, na przykład zezwalając na wizyty w wyjątkowych przypadkach.

SŁOWA KLUCZOWE

pacjenci, koronawirus, osoby bliskie

INTRODUCTION

During the coronavirus disease 2019 (COVID-19) pandemic, in order to contain the spread of the virus, hospitals around the world introduced visiting restrictions for patients staying in wards, which created huge challenges for medical staff as well [1]. Although some restrictions on visitors have long existed, such as the introduction of specific visiting hours in hospitals and are a recognised common practice, the extent of restrictive restrictions, including a complete ban on the presence of patients' relatives, introduced especially at the beginning of the pandemic, was unprecedented [2,3,4].

On the one hand, the use of restraints reduced the risk of transmission of infections to hospitalised patients and thus to the wider community, protected patients from increased morbidity, especially those with comorbidities or immunocompromised patients, and safeguarded the health of staff [3]. Patient- and family--centered care, on the other hand, includes, in addition to ongoing communication, visits, the participation of the family directly in the care of the patient, accepting that this approach improves medical and psychological outcomes in patients [5]. For healthcare providers, the introduction of visitation restrictions may have caused anxiety and difficulties in ensuring patient autonomy or holistic patient-centered care [6].

The exact extent and nature of the support provided by a close relative depends on the patient's clinical situation, degree of independence, age, and the nature of the relationship between the close relative and the patient [3]. According to Article 3(1)(2) of the Act on Patients' Rights and the Patients' Ombudsman (*Ustawa z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta*) [7], a close relative is a spouse, a relative up to the second degree, or a relative up to the second degree in a straight line, a legal representative, a person in cohabitation, or a person indicated by the patient.

The study aimed to find out the evaluation among patients and their relatives of the introduction of visitation restrictions in hospitals during the COVID-19 pandemic.

The lack of access to personal care and support provided by visitors to patients negatively affected the well-being of those hospitalised and the overall experience of the attention they received [8,9]. Some patients, to prevent separation from their loved ones, may have made decisions that adversely affected their health, such as refusing or delaying medical care, which may have accelerated the deterioration of their health, both physically and psychologically [3,8].

In turn, patients' use of technology to communicate (video calls, phone calls, social media) with loved ones depended on the hospitalised patients' access to these devices, experience, skills, and familiarity with using them. During the pandemic, medical staff had to adapt to other ways of communicating with patients' loved ones and supporting patients, families to access and use technology [4,10], but phone or video calls were often not a sufficient substitute for direct contact with loved ones [11]. The psychological impact of the introduced restrictions on hospitalised patients and their families is still poorly understood [4].

MATERIAL AND METHODS

Participants

A total of 203 adult, independent patients and 198 relatives took part in the survey. Participation in the study of patients and relatives was voluntary and anonymous. Only independent patients and their relatives participated in the study, i.e. patients who do not require care from other people, e.g. in the areas of mobility, nutrition, or care. Patients and their relatives were divided into two groups: related to both positive and negative assessments of the introduction of visitation restrictions at the hospital during the pandemic. Respondents who rated the introduction of visitation restrictions as definitely good and rather good were assigned to the group that rated the introduction of restrictions positively. In contrast, respondents who assessed the introduction of visitation restrictions strongly badly, rather badly or had no opinion on the subject were assigned to the group that assessed the introduction of restrictions negatively.

In the patient group, 65% (N = 132) were female and 35% (N = 71) were male. On the other hand, among relatives, 52% (N = 102) were women and 48% (N = 96) were men (Table I). The mean age of the patients was 55.5 years (19.0–87.0 years), among women, the mean age was 55.0 years, and among men 56.5 years. The mean age of relatives was 49.5 years (23.0–78.0 years), among women the mean age was 47.0 years, and among men 52.0 years.

Among the patients surveyed, most respondents had secondary education – 44.4% (N = 90), 3% (N = 6) of people had primary education, 25.6% (N = 52) had vocational education, and 27% (N = 55) had tertiary education. On the other hand, among relatives, 51% (N = 101) of respondents had secondary education, 1.5% (N = 3) of respondents had primary education, 14.2% (N = 28) had vocational education, and 33.3% (N = 66) had tertiary education.

Most patients resided in a medium-sized city (20,000––100,000 inhabitants) – 53.7% (N = 109), in a large city (> 100,000 inhabitants) 20.2% (N = 41), in a small city 19.2% (N = 39) and in a village 6.9% (N = 14). Among relatives, the largest number of respondents also lived in a medium-sized city – 59.6% (N = 118), in a large city 21.2% (N = 42), in a small city 13.1% (N = 26) and in a village 6.1% (N = 12; Table I).

Table I. Characteristics of studied group of patients and relatives

Variable		Group	
		patients N = 203 (%; N)	**relatives** N = 198 (%; N)
Gender	women	65%; 132	52%; 102
	men	35%; 71	48%; 96
Education	professional	25.6%; 52	14.2%; 28
	basic	3%; 6	1.5%; 3
	medium	44.4%; 90	51%; 101
	higher	27%; 55	33.3%; 66
Place of residence	village	6.9%; 14	6.1%; 12
	city up to 20,000	19.2%; 39	13.1%; 26
	city of 20,000–100,000	53.7%; 109	59.6%; 118
	city over 100,000	20.2%; 41	21.2%; 42

Patients were hospitalized in various hospital wards in Silesia (98%; N = 199), 2% (N = 4) of respondents were hospitalized in Opole, Lesser Poland, Subcarpathian, and Lower Silesian. 18% (N = 36) were treated in the orthopaedic ward, 14% (N = 29) in the gynaecological ward, 14% (N = 29) in the cardiology ward, 11% (N = 23) in the neurological ward, 9% (N = 18) in the general surgery ward, 7% (N = 14) on the rehabilitation ward, 6% (N = 12) on the urology ward, 6% (N = 13) on the internal medicine ward, 3% (N = 7) on the rheumatology ward, 3% (N = 7) on the pulmonology ward. Otherwise, single hospitalisations were in otolaryngology (ENT), ophthalmology, nephrology, diabetology, psychiatry, dermatology, endocrinology, oncology, and pregnancy pathology departments.

Regarding the degree of relatedness of the relatives to the hospitalised patient, most respondents 64% (N = 127) were spouses, 28% (N = 55) were children, 4.5% (N = 9) were siblings, 1.5% (N = 3) were parents, partner 1% (N = 2), guardian 0.5% (N = 1), daughter-in-law 0.5% (N = 1).

According to the Statistics Poland (Główny Urząd Statystyczny), in 2022 there were 6,895,900 people hospitalised in Poland, after calculating a fraction size of 0.9, a maximum error of 5%, and the minimum sample size with a confidence level of 95% a sample size of 138 people was obtained, which justifies that

a sample size of 203 and 198 is appropriate to conduct research.

Study design

It should be noted that the greatest increase in incidence in the fourth wave of the pandemic occurred in the second half of November 2021, admission to hospitals was restricted during this period for outsiders. The study was conducted in one medical facility, i.e. a rehabilitation clinic, from November 2021 to March 2022, to which patients and their relatives reported. Respondents in the study indicated the date and hospital department where they were hospitalized during the pandemic. The dynamics in the rehabilitation clinic differ from those in the hospital, as patients from different hospital wards are referred to the rehabilitation clinic, making it easier to collect data and assess the introduction of visitation restrictions among patients and their relatives.

Ethical consideration

The study design did not require the approval of the local bioethics committee (Decision of the ŚUM Bioethics Committee No. PCN/CBN/0052/KB/187/22), and the study was conducted in accordance with the provisions of the Declaration of Helsinki.

Instrument

The present study was a cross-sectional study in which the authors used specially designed questionnaires aimed at patients and their relatives as the data collection method (Appendix 1). Patients and their relatives gave informed consent to participate in the study. The primary criteria for inclusion in the study were health status to participate and being over 18 years of age.

The first part of the questionnaires consisted of questions on demographic data, including gender, age, place of residence. The second part of the questionnaires consisted of individual factors such as level of education, hospital wards in which patients stayed, provinces in which people were hospitalised, periods in which patients were hospitalised, chronic diseases accompanying the patients, or the relationship that the patient had with the relative.

The last part of the questionnaire consisted of 26 closed questions addressed to patients and nine questions addressed to relatives. The questionnaires consisted mainly of single-choice questions and were formulated on the basis of the patient's rights under the Act on Patients' Rights and the Patients' Ombudsman.

Statistical analysis

Statistical analysis was performed with Statistica version 13.3 (TIBCO Software Inc.). The chi-square test was used to compare the frequency of occurrence of a trait across groups, or subgroups. In turn, the frequency of occurrence of traits, qualitative variables, was expressed as percentages and N significant values. Microsoft Excel was used for data collection.

To assess the internal consistency of the questionnaire, the Cronbach's alpha test was used in the section evaluating the introduction of visitation restrictions. The Cronbach's alpha value was 0.84, which indicates high reliability of the tool. This value falls within the acceptable range for social research, where a value of 0.7 or higher is considered sufficient to establish question consistency. This means that the questions included in the questionnaire were internally consistent and measured the same construct, which was the evaluation of the introduction of visitation restrictions.

RESULTS

56% (N = 113) of respondents were hospitalised due to a planned procedure, 39% (N = 80) due to a sudden deterioration in health, 4% (N = 8) due to rehabilitation, and one case each of risk of premature birth and liver disease were the reasons for hospitalisation.

91.4% (N = 181) of visitors indicated that they had the opportunity to contact the patient daily, 5.6% (N = 11) of visitors contacted the patient once a week, 2.5% (N = 5) of respondents did not contact the patient, 0.5% (N = 1) of visitors contacted the patient less than once a week. Among patients, 93.5% (N = 190) of respondents had daily contact with a relative, 2.5% (N = 5) of people contacted a relative once a week, and 4% (N = 8) of patients did not contact a relative.

In the group of visitors, 88% (N = 175) of the respondents did not need help to contact the patient, 8% (N = 15) of the respondents indicated that the medical staff helped to contact the patient, 2% (N = 4) of the relatives did not contact the hospitalised person, 1% (N = 2) of the respondents had no opinion on the subject and 1% (N = 2) of the respondents indicated that the medical staff did not help to contact. In contrast, 89% (N = 180) of patients also did not need help to contact the visitor, 6.5% (N = 13) of respondents felt that medical staff helped to contact, 3% (N = 7) of respondents did not contact the visitor and 1.5% (N = 3) of respondents had no opinion on the subject.

94.5% (N = 187) of visitors indicated that they had the possibility to give personal items necessary during hospitalisation to the patient, which was negated by 4% (N = 8) of respondents, and 1.5% (N = 3) of respondents had no opinion on the subject. In contrast, 93% (N = 189) of patients indicated that they had the possibility to receive personal items necessary during hospitalisation, which was negated by 3.5% (N = 7) of respondents, and 3.5% (N = 7) of respondents had no opinion on the subject.

Although the survey included respondents who were hospitalised at different times, most, 97% (N = 192) of visitors, indicated that patient visits were prohibited due to the pandemic, 2% (N = 4) of people did not visit the hospitalised person, 0.5% (N = 1) of respondents indicated that visits were allowed, another 0.5% (N = 1) of people that visits were possible but on presentation of a certificate of vaccination. Among patients, 94% (N = 191) of respondents indicated that visits were prohibited due to the pandemic, 3% (N = 6) of people indicated that they were not visited by relatives, 1% (N = 2) of respondents indicated that visits were allowed and 2% (N = 4) of respondents that visits were possible but only in special situations.

The authors conducted a study on the same study group regarding the evaluation of the introduction of restrictions on visiting patients by relatives and the well-being of hospitalised patients during the pandemic [9,12]. 57% (N = 113) of respondents, in the visitor group, rated the introduction of hospitalised visiting restrictions badly, 41% (N = 82) of respondents rated the introduction of these restrictions well and 2% (N = 3) had no opinion on the subject. In the patient group, 52% (N = 105) of people rated the introduction of in-patient visiting restrictions badly, 44% (N = 90) of respondents rated the introduction of these restrictions well and 4% (N = 8) of people had no opinion on the subject (Figure 1).

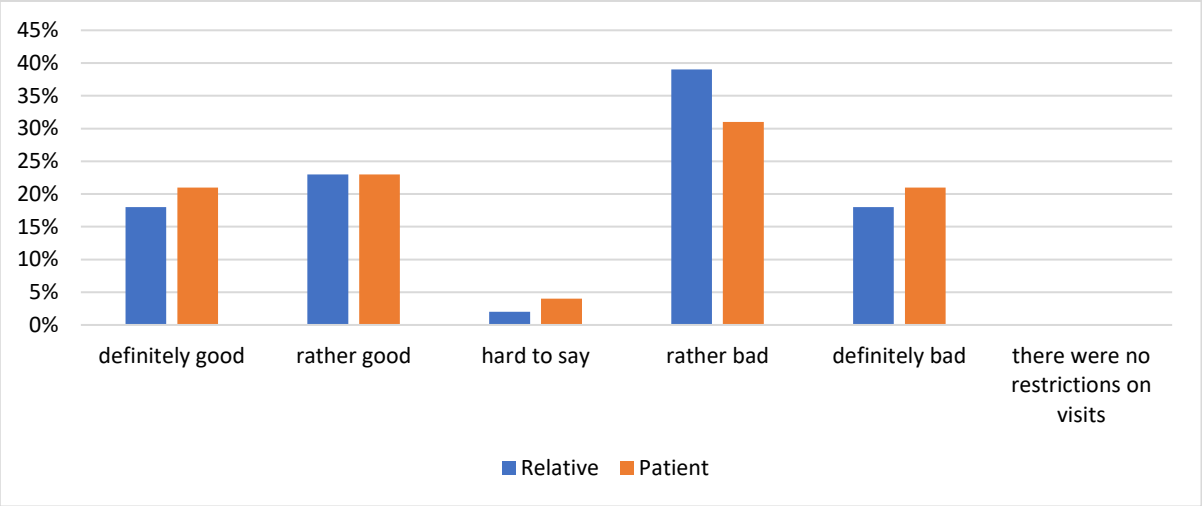

Fig. 1. Assessment of visitation restrictions in hospital wards by relatives and patients.

Regarding the way medical staff communicate information about the patient, 58% (N = 115) of people did not contact medical staff in this regard, 39% (N = 77) of people gave a good assessment of the way medical staff communicate this information and 3% (N = 6) of respondents gave a bad assessment of the way medical staff communicate this information.

The frequency of obtaining patient information from medical staff was also analysed among the respondents. Most visitors did not contact medical staff – 57.6% (N = 114), 24.2% (N = 48) of respondents received patient information from medical staff once a day, 13.6% (N = 27) of respondents received such information several times a day and 4.6% (N = 9) of respondents received such information less than daily.

In addition, 58.1% (N = 115) of relatives did not contact medical staff about receiving patient information over the phone, 40.4% (N = 80) of respondents received such information after verifying the identity of the person calling the medical facility, 1.5% (N = 3) of respondents did not receive information about the hospitalised person, because medical staff did not provide it over the phone.

The positive and negative evaluation of the introduction of visiting restrictions among patients was influenced by factors such as gender: more women – 65% (N = 73) than men – 35% (N = 40) negatively evaluated the introduction of restrictions; education: 32% (N = 36) of patients with a vocational education negatively evaluated the introduction of restrictions in hospitals, compared to patients with a higher education – 22% (N = 25), the highest proportion of patients with a secondary education negatively evaluated the introduction of restrictions – 41% (N = 46); place of residence: patients from a small city – 28% (N = 32) evaluated the introduction of restrictions worse than patients living in a large city – 15% (N = 17), the highest proportion of patients living in a medium-sized city negatively evaluated the introduction of visit restrictions – 50% (N = 56; Table II).

Furthermore, in the group of patients who negatively assessed the introduction of visitation restrictions, 91% (N = 103) of them had the possibility of daily contact with relatives, 82% (N = 93) of them did not need help to contact relatives, 93% (N = 105) of the respondents indicated that visitation was prohibited due to the

pandemic and, according to 89% (N = 101) of the respondents, relatives were able to give them personal items necessary during hospitalisation. In contrast, in the group of patients who were positive about the introduction of visitation restrictions, up to 97% (N = 87) of them were able to have daily contact with relatives, 97% (N = 87) of the respondents did not need assistance in contacting relatives, 96% (N = 86) of the respondents indicated that visits were prohibited due to the pandemic and according to 98% (N = 88) of the patients, relatives were able to give them personal items necessary during hospitalization (Figure 2).

Table II. Characteristics of surveyed group of patients divided into groups with positive and negative opinions of introduction of visitation restrictions

Variable		Total N = 203 (%; N)	Patient group	
			positive assessment of visitation reduction N = 90 (%; N)	negative assessment of reduction in visits N = 113 (%; N)
Gender	women	65%; 132	66%; 59	65%; 73
	men	35%; 71	34%; 31	35%; 40
Education	basic	3%; 6	0%; 0	5%; 6
	professional	25.6%; 52	18%; 16	32%; 36
	medium	44.4%; 90	49%; 44	41%; 46
	higher	27%; 55	33%; 30	22%; 25
Place of residence	village	6.9%; 14	7%; 6	7%; 8
	city up to 20,000	19.2%; 39	8%; 7	28%; 32
	city of 20,000–100,000	53.7%; 109	59%; 53	50%; 56
	city over 100,000	20.2%; 41	26%; 24	15%; 17

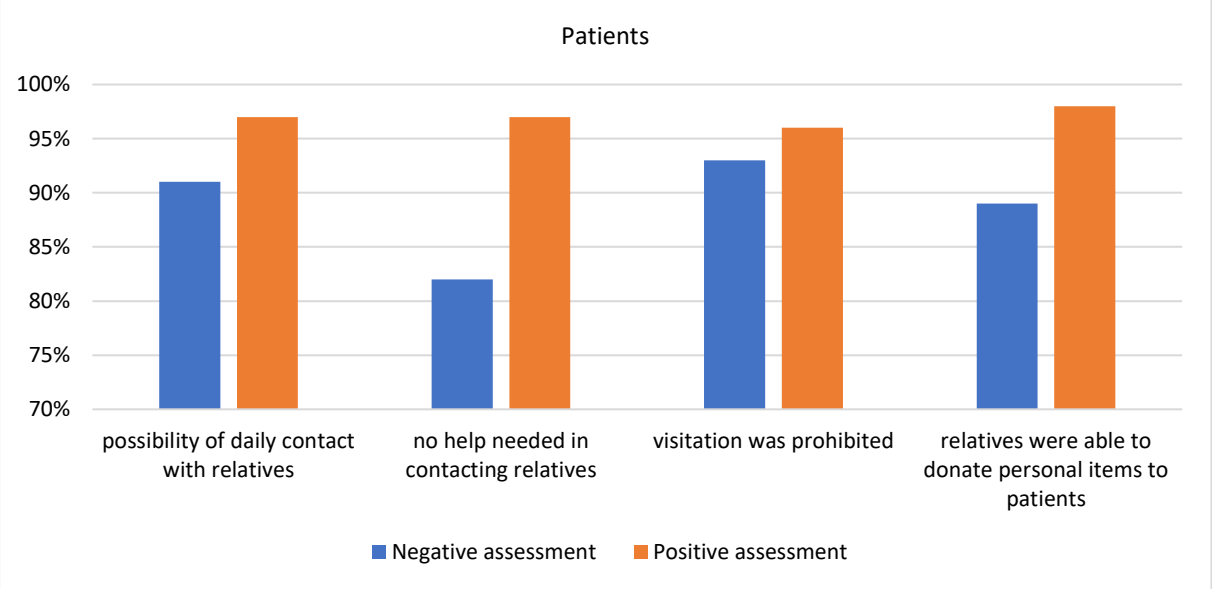

Fig. 2. Characteristics of surveyed group of patients divided into groups positively and negatively assessing introduction of visitation restrictions.

Positive and negative evaluations of the introduction of visiting restrictions among relatives were also influenced by factors such as gender: more women – 55% (N = 64) than men – 45% (N = 52) negatively evaluated the introduction of restrictions; education: the highest number of relatives with a secondary education negatively evaluated the introduction of hospital restrictions – 58% (N = 67), while the highest number of respondents with a tertiary education positively evaluated the introduction of these restrictions – 48% (N = 39); place of residence: relatives living in a medium-sized city evaluated the introduction of visitation restrictions the worst – 62% (N = 72; Table III).

Furthermore, in the group of relatives who negatively assessed the introduction of visitation restrictions, 90% (N = 104) of them had the possibility of daily contact with the patient, 84% (N = 98) of them did

not need help to contact the hospitalised person, 92% (N = 107) of the respondents in this group had the possibility to give the patient personal items necessary during hospitalisation, 97% (N = 113) of the respondents indicated that visiting the hospitalised person was prohibited due to the pandemic. In contrast, among the relatives who viewed the visitation restrictions positively, 94% (N = 77) were able to maintain daily contact with the hospitalised patient, and the same proportion – 94% (N = 77) did not require assistance in establishing this contact. Additionally, 99% (N = 81) were able to deliver personal items needed during the hospital stay. According to 96% (N = 79) of respondents, hospital visits were prohibited due to the pandemic (Figure 3).

Table III. Characteristics of surveyed group of relatives with division into groups positively and negatively assessing introduction of visitation restrictions

Variable		Total N = 198 (%;N)	Group of relatives	
			positive assessment of visitation reduction N = 82 (%; N)	negative assessment of reduction in visits N = 116 (%; N)
Gender	women	52%; 102	46%; 38	55%; 64
	men	48%; 96	54%; 44	45%; 52
Education	basic	1.5%; 3	1%; 1	2%; 2
	professional	14,2%; 28	10%; 8	17%; 20
	medium	51%; 101	41%; 34	58%; 67
	higher	33.3%; 66	48%; 39	23%; 27
Place of residence	village	6.1%; 12	9%; 7	4%; 5
	city up to 20,000	13.1%; 26	6%; 5	18%; 21
	city of 20,000–100,000	59.6%; 118	56%; 46	62%; 72
	city over 100,000	21.2%; 42	29%; 24	16%; 18

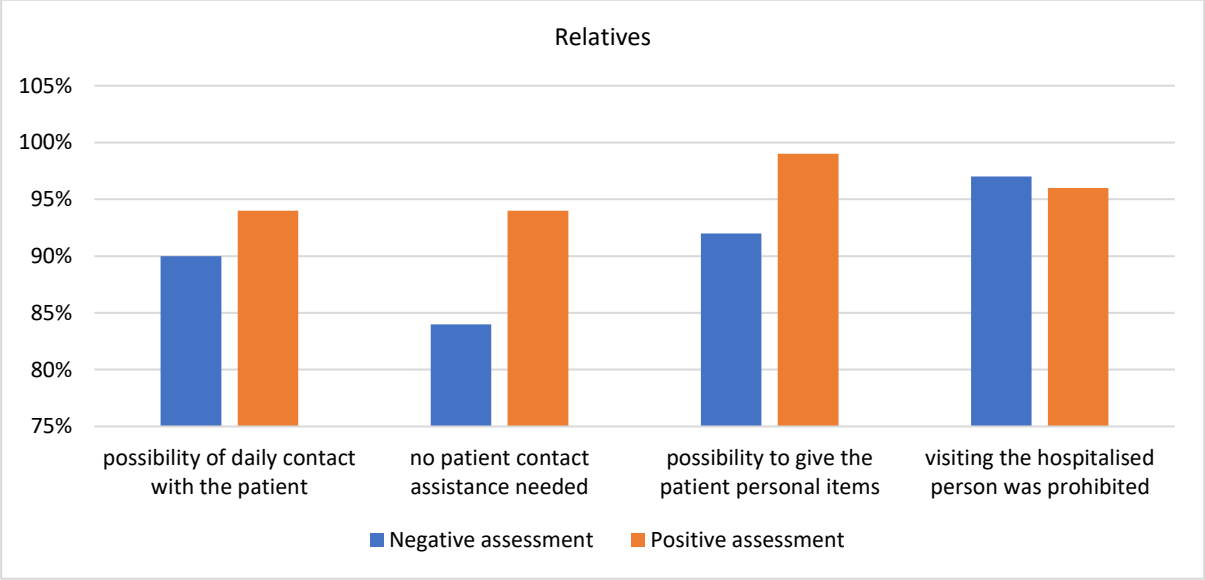

Fig. 3. Characteristics of surveyed group of relatives divided into groups positively and negatively assessing introduction of visitation restrictions.

DISCUSSION

Most countries, during the COVID-19 pandemic, introduced temporary restrictions on visiting patients in hospital wards, due to the potential for visitors to transmit the disease [13,14]. To understand the concept of visitation restriction, it is important to discern the mechanisms of relatives' involvement in the care of the hospitalised person and the impact of visitation on patient outcomes [13].

An overwhelming number of patients and their relatives understood the necessity of the visitation restriction, but the consequences of its introduction may have had an impact on the psychological state of hospitalised patients and their relatives [4]. The very contact with the healthcare system is often a source of great stress for the patient and their relatives, and the introduction of restrictions on patients' visitation could have significantly exacerbated their anxiety [1]. Greater psychological stress among relatives may also have resulted from the fact that they were unable to form their own opinion about the patient's health due to their absence from the patient [4].

As indicated in Article 33(1) of the Act on Patients' Rights and the Patients' Ombudsman [7], a patient of a health care entity that performs therapeutic activity of 24-hour and inpatient health care services within the meaning of the regulations on health care activity has the right to personal, correspondence, telephone contact with other persons. The so-called right of visitation, i.e. the right of contact with other persons, is part of the patient's broader right, i.e. the right to respect for family and private life, and is assumed to cover not only patients but also their relatives. Furthermore, the legislator has guaranteed patients the right to contact other persons without specifying the meaning of the term 'other persons', so that only the patient has the right to decide on the persons who visit him or her [15]. On the other hand, according to Article 5 of the Act on Patients' Rights and the Patients' Ombudsman [7], the head of an entity that provides health services or a doctor authorised by him or her may restrict the exercise of a patient's right in a situation where an epidemic threat arises or for reasons of patients' health safety and, in the case of the right to contact other persons, also for reasons of the entity's organisational capacity. During the pandemic, there were recommendations issued by the Ministry of Health and the Chief Sanitary Inspectorate on visiting relatives [16,17].

When introducing visitation restrictions, it was crucial to maintain the principle of proportionality, so that the harm to visitors and patients that might result from implemented restrictions was commensurate with the expected public health benefits, which could be influenced by a number of factors, such as the possibility, mode of transmission, severity of illness, incubation period and duration of infectivity, or community burden of disease [3,18]. Also, exemptions for visitation restrictions should be justified by the benefit-harm ratio, which in some countries has included, for example, pediatric patients, newborns, infants in intensive care units, people with disabilities, or people at the end of life [3,19,20,21]. Regardless of the circumstances, rules regarding visitation restrictions should be transparent and clear, with clear justification for their application, and decisions and exceptions for visitors should be based on general ethical principles such as trust, autonomy, proportionality, or minimisation of harm, in turn, a number of local factors should also be taken into account when making these decisions, including the current burden of infection in the community, new variants of the virus, vaccination rates, or available resources to combat it in the community [3,18,21]. Determining the benefits and burdens of restrictions on visitors is an important issue in view of the still rapidly spreading viruses, or the potential for further outbreaks in the future [1].

A study conducted in a hospital in the Valais region (Switzerland) found that visitation restrictions were not well received by either relatives or patients, especially those at the end of life or with cognitive impairment, with whom conversations other than face-to-face, including video, were difficult or impossible [13,22]. Families of some patients noted psychological as well as physical regression in these patients, which was also due to the lack of stimulation usually guaranteed by direct contacts. For other patients, especially those who were independent, it was welcome to compensate for the prohibition of visits with conversations, e.g. by telephone or video [13]. Virtual visits have been shown to have a positive effect on patients' recovery, reduce distress for relatives, and may also improve morale among medical staff. It seems responsible and rational for hospitals to continue to invest in telehealth, digital tools regardless of the circumstances [23].

Although the efforts of healthcare professionals and digital solutions that led to maintaining adequate distance between family members and patients were appreciated, these methods cannot replace the direct presence of loved ones [14,24,25]. Alternative means of visits, such as multimedia and digital applications, limited the ability to maintain social relationships, as well as often failing to allow loved ones to understand the patient's overall condition. The need to trust medical facilities, the inability to see what care was actually being offered to patients, and the often unclear and inconsistent rules for implementing restrictions may have caused discouragement in relatives, especially in the elderly, and contributed to their search for effective communication, especially face-to-face communication [13,22]. The presence of relatives

facilitates communication and the exchange of information between patients and health professionals, which increases the satisfaction of hospitalised patients, their families and the restriction of these visits may put more of a workload on medical staff, who often wanted to compensate patients during the pandemic for the care that visitors provided, also decision-making and communication with relatives is more difficult and time-consuming when visitors cannot be present with patients [3,4,13,26].

According to the self-reported survey, which included only independent patients and their relatives, the majority of hospitalised patients and relatives were able to contact each other on a daily basis, the respondents did not need assistance in this contact from the medical staff, and they were also able to hand over personal items necessary during hospitalization. Furthermore, respondents reported that hospital ward visits were prohibited due to the pandemic, a measure that generated considerable dissatisfaction among many. In addition, most visitors did not reach out to medical staff for updates on the patient's condition.

A study conducted during the first wave of the COVID-19 pandemic among patients in a hospital in Valais found that the lack of physical presence of relatives resulted in anxiety, decreased mood, and a greater need for up-to-date information about the patient's condition. A significant proportion of the relatives participating in the study felt that they were well informed by the medical staff, but some respondents expressed concerns about the limitations of visiting and felt less or no involvement in the patient care provided. Significant differences were observed in some wards, most notably in gynaecology or obstetrics. In the study, 69% of respondents acknowledged that they had regular contact with hospitalised patients (at least once a day), but the attempt to replace physical visits by digital means was associated with clear limitations, related to reduced understanding by those close to the patient of the patient's overall condition, which was also a source of emotional distress and a greater burden for medical staff [13]. The authors of the referenced study recommend a more flexible, tailored, and patient-centered approach to visit limitations depending on the patient's clinical situation [13].

The results of a study of the consequences of visitation restrictions in health care services during the COVID-19 pandemic, based on a literature review [24], indicate that they had many negative consequences for patients as well as family members, despite efforts made to use technical solutions to replace face-to-face visits. Restrictions on visitation have increased mental health problems and caused distress among patients as well as relatives. Despite this, other studies have shown that family members approved of and adhered to visitation restrictions to inhibit the spread of COVID-19, even when their well--being may have been affected [14,24,27].

A study that included hospitalised patients and their relatives, carried out at the outpatient clinics of the University Medical Centre Rostock, found that the reduction in hospital visits to control the COVID-19 pandemic was an additional stress factor for both patients and their relatives. This study showed that relatives were more psychologically stressed than hospitalised patients, and the desire to visit hospitalised patients was more pronounced among relatives than among patients [4].

A study conducted among relatives of patients hospitalized during the COVID-19 pandemic in general surgery and internal medicine departments across three hospitals in northern and central Portugal found that visitation restrictions led to a detachment of families from the hospital environment. This, in turn, negatively impacted the healthcare process by hindering the involvement of family members in patient care. This study also showed that medical teams often went to great lengths to ensure the well-being of hospitalised patients [28]. Patients' families know their health history best, are attentive to emerging needs, and have the opportunity to collaborate with medical staff in the observation and supervision of the patient. As these studies indicate, assessing each circumstance in detail and making the decision to allow visits on this basis, despite the visitation restrictions in place, demonstrates a patient- and family-centered approach and, according to emerging evidence, the presence of the family alongside the patient positively influences patient outcomes and the overall process of care involved [28]. It is difficult to determine whether visit restrictions have effectively prevented the spread of COVID-19. It is reasonable to argue that these restrictions have slowed the spread of the disease [13], although other studies indicate that the family has not played a significant role in the transmission of SARS-CoV-2 virus [1], undoubtedly in the future, should further threats arise, consideration of the introduction of visit restrictions should be done with consideration of the potential benefits and harms to patients and their relatives.

CONCLUSIONS

1. Almost all visitors and patients indicated that hospital ward visits were prohibited due to the pandemic. For more than half of the respondents in both groups, this was a source of dissatisfaction, emphasizing the importance of physical contact with loved ones for both groups surveyed. The inability to receive visitors may have negatively affected patients' emotional well-being, causing

feelings of loneliness and stress, especially among elderly and chronically ill individuals.
2. Despite the pandemic restrictions, most independent patients and their relatives had daily contact with each other through alternative communication methods, without requiring assistance from medical staff in this regard. The ability to maintain daily contact via phone or online was crucial for preserving family bonds and mitigating the negative effects of visitation restrictions. This may indicate the need for further development and improvement of remote communication methods in hospitals.
3. The majority of patients and their relatives believed that despite visitation restrictions it was possible to deliver essential personal items to the hospitalized individual, highlighting that hospitals provided appropriate means for their transfer.
4. More than half of the relatives did not contact the medical staff to obtain information about the patient's condition. However, those who took advantage of this opportunity positively assessed the way the information was provided. Most often, the information was conveyed by the medical staff over the phone once a day, after prior verification of the caller's identity by the medical facility. Positive feedback on the way medical staff communicated information may indicate that hospitals successfully adapted to new challenges.
5. Differentiating patients and their relatives into two groups in relation to a positive or negative assessment of the introduction of visitation restrictions, in both groups more women than men negatively assessed the introduction of visitation restrictions, with most respondents with a secondary education and living in a medium-sized city giving negative assessments of the introduction of restrictions.
6. In the future, in the event of new epidemics, it may be worth considering a more flexible approach to visitations, such as allowing them in exceptional cases (e.g. for critically ill patients) or implementing protective measures that enable safe contact.

Limitations

The amount of evidence related to the impact of the introduction of visiting restrictions in hospitals on patients' and relatives' assessment of the implementation of these restrictions is low, and further research is definitely needed in this area, in view of the still dynamic spread of new diseases and the viruses that cause them, including dependants. Given the small number of studies conducted on this topic, it was not easy to compare the results of our own study with other available results. Limitations of the study were the collection of results in a single medical facility, i.e. a rehabilitation clinic, the sample size, the smaller number of relatives (198) than patients (203) surveyed, the study's focus on independent persons only, the failure to distinguish between relatives and patients infected with COVID-19 and patients hospitalised for another reason and visitors. The delay between the hospitalisation of the patients and the completion of the questionnaire by them and their relatives was also a limitation.

Practical implementation

In the event of further outbreaks occur in the future, the development of the next hospital ward visitation policies should take into account the already known benefits and burdens of the previously implemented visitation restrictions for patients and their relatives and the exemptions regarding these restrictions and the families or essential carers of the patients could be involved in the development of the strategies [1].

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Institutional Review Board Statement

This research complies with the provisions of the Helsinki Declaration and local regulations of the Bioethical Commission of the Medical University of Silesia, Katowice, Poland; the Committee on Publication Ethics (COPE) regulations were followed in the study.

Data Availability Statement

Not applicable.

Conflict of interest

The authors declare no conflict of interest.

Authors' contribution

Study design – K. Jaroń, M. Grajek, J. Kobza
Data collection – K. Jaroń
Data interpretation – K. Jaroń, M. Grajek, J. Kobza
Statistical analysis – K. Jaroń, M. Grajek
Manuscript preparation – K. Jaroń, M. Grajek, J. Kobza
Literature research – K. Jaroń

Appendix 1

DEPARTMENT OF PUBLIC HEALTH
FACULTY OF PUBLIC HEALTH IN BYTOM
MEDICAL UNIVERSITY OF SILESIA, KATOWICE, POLAND

Dear Sirs,

I kindly request you to participate in a survey on medical staff-patient communication in the context of patient rights during the COVID-19 pandemic. Participation in the survey is voluntary and completely anonymous. The material collected will be used for research purposes only. We kindly ask for your assistance in the survey. The survey consists of 2 parts. The first part of the survey consists of 26 short questions, will take approximately 15–20 minutes to complete and is aimed at hospitalised patients. The second part of the survey is aimed at the patient's relatives and consists of 9 short questions, it will take approximately 10–15 minutes to complete.

The term 'hospital' as used in the survey includes hospitals and other inpatient units.

The term 'COVID-19', as used in the survey, refers to the respiratory disease caused by the SARS-CoV-2 coronavirus.

QUESTIONNAIRE FOR PATIENTS' RELATIVES

AGE: ..... years

GENDER: ☐ K (woman) ☐ M (man)

EDUCATION:
a) primary
b) vocational
c) secondary
d) higher

PLACE OF RESIDENCE:
a) rural area/village
b) small town up to 20,000 inhabitants
c) medium town with 20,000 to 100,000 inhabitants
d) large city with more than 100,000 inhabitants
e) very large city with more than 200,000 inhabitants

RELATIONSHIP TO THE PERSON HOSPITALISED
.....

HOSPITAL WARD WHERE YOUR CLOSE RELATIVE IS STAYING
.....

VOIVODESHIP WHERE YOUR RELATIVE IS STAYING IN THE HOSPITAL WARD
.....

PERIOD WHERE YOUR NEARLY RELATIVE STAYED IN HOSPITAL SITUATION (please give the approximate time of the beginning and end of stay in hospital ward, day/month/year)
☐☐-☐☐-☐☐☐☐ -- ☐☐-☐☐-☐☐☐☐

1. **For what reason was your loved one admitted to hospital?**
   a) planned operation and/or treatment
   b) sudden deterioration of health
   c) rehabilitation after illness or injury
   d) complications after an illness
   e) other (which?) .....
2. **Did you have any opportunity to contact your loved one (including by telephone) during your stay in hospital?**
   a) YES, every day
   b) YES, once a week
   c) YES, less than once a week
   d) I have not contacted my relative

3. **Did the medical staff assist you in contacting (also by phone) your loved one?**
   a) definitely yes
   b) rather yes
   c) hard to say
   d) rather no
   e) definitely not
   f) I did not need help to contact a relative
   g) I did not communicate with my relatives
4. **Were you able to give your personal items necessary for your hospitalization to your relatives?**
   a) definitely yes
   b) rather yes
   c) difficult to say
   d) rather no
   e) definitely not
5. **Were you allowed to visit your relative during his/her stay in the hospital ward?**
   a) YES, visits to your relatives were allowed
   b) YES, visits to a relative were possible but only in special situations
   c) NO, visits of a relative were forbidden due to the pandemic
   d) I did not visit a relative
   e) other (which ones?) .....
6. **How would you rate the restriction on visiting a loved one in hospital during the pandemic?**
   a) definitely good
   b) rather well
   c) difficult to say
   d) rather bad
   e) definitely bad
   f) there were no restrictions on visiting a relative
7. **How would you rate the way in which medical staff provided information about your relative staying in hospital?**
   a) definitely good
   b) rather well
   c) hard to say
   d) rather bad
   e) definitely bad
   f) I did not contact medical personnel
8. **How often have you been able to get information about your loved one from medical personnel?**
   a) several times a day
   b) once a day
   c) less than daily
   d) I have not been in contact with medical personnel
9. **Did you receive information about a loved one over the phone from medical personnel?**
   a) YES, always
   b) YES, after the medical staff had verified the identity of the person calling the medical facility
   c) NO, the medical personnel did not give information about a relative over the phone
   d) I did not contact the medical personnel
   e) other (which?) .....

THANK YOU VERY MUCH FOR FILLING IN THE QUESTIONNAIRE

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