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Research

The influence of COVID-19 visitation restrictions on patient experience and safety outcomes: A critical role for subjective advocates

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Abstract
With the emergence of the coronavirus (COVID-19) pandemic in the United States in early 2020, hospitals across the country made the difficult decision to alter visitation policies, by either limiting visitations or restricting visitations altogether by closing access to family, friends and care partners in an effort to reduce further spread of the virus. While there is foundational research on the impact of family and care partner presence on the experience of patients and patient safety outcomes, the actions driven by the pandemic allowed for a real-time comparison of the impact of family or care partner presence or lack thereof. Patient and family engagement has long been a part of patient experience scholarship where the role of family members and care partners as patient advocates and a presence of support has been reinforced. Scholarship and practice have also encouraged movement from restricted visiting hours to having open visitation based on findings that, in addition to better patient outcomes, there is a benefit in nurse job satisfaction and communication when visitations are unrestricted. The purpose of this study is to examine the degree to which hospital visitation restrictions in U.S. hospitals during the COVID-19 pandemic help to explain changes in patient experience and patient safety outcomes. To examine this relationship, patient experience and safety outcomes of a national sample of hospitals (n=32) during the pandemic is compared to previous corresponding performance. The results indicate that hospital performance was negatively impacted on average during the pandemic for hospitals in the sample. However, differences in hospital performance during the pandemic were driven by hospitals that disallowed patient visitations. Hospitals with closed visitations saw most pronounced deficits in their performance with regard to patient ratings of medical staff responsiveness, fall rates and sepsis rates. Performance in hospitals that either remained unrestricted or partially limited their visitations was not appreciably different from pre-pandemic performance, and in some cases performance even improved marginally. The findings of this study indicate that the policy to allow for visitors, or subjective advocates, individuals with a vested interest in the well-being of the patient, is beneficial not only for the patient, but also in sustaining high quality of care. Recommendations are given for how hospitals might achieve improved quality and safety outcomes even in instances when organizations believe visitation needs to be disallowed or restricted. The results of this study suggest those decisions should be made with great care and in only the most extreme circumstances.

Keywords
Visitation, patient experience, patient safety, HCAHPS, AHRQ, COVID-19, subjective advocate

Introduction

When the coronavirus COVID-19 (COVID) arrived in the United States, it immediately impacted various aspects of medical care delivery. One aspect of care delivery that was directly disrupted by COVID was patient visitations. Heeding international calls to "Stop the Spread,"[1] hospital administrators across the country decided that one manner in which they could control the rate of infections in their community was to limit or restrict access to hospital campuses to essential personnel, and in the process many hospitals decided to disallow visitors for all patients in the hospital. This decision to protect communities in this manner meant that patients in many instances would be dying alone, and a great many patients were made to heal in the absence of their primary support networks.

Thankfully, this period of great change was also met with rapid development and deployment of innovations in telehealth and remote visitations which aided in the ability to meet the demands of both social distancing guidelines as well as patient needs for social support.[2] Like many difficult decisions, what made this decision particularly difficult is there has only been a limited amount of research conducted to appreciate the influence of visitors on a patient's experience of care and on care quality and

safety outcomes, though it should be noted in those pieces there are well-substantiated conclusions suggesting claims to the positive value and impact and the lack of negative consequences, such as infection, due to visitation.[3-5]

The history of patient visitation policies dates back to the late 1800s when non-paying patients were denied visitor access.[6] Paying patients, however, were granted open access for visitation until the 1960s when hospitals began to specify visiting hours for all patients to ensure that patients were able to rest and that staff were able to conduct their clinical work without interruptions.[7,8] Previous scholarship finds that patients' families, physicians, and nurses hold differing views in their beliefs about visitations,[9] wherein patients and their visitors have historically shown positive response to open visitation policies while clinicians have had mixed or negative responses to open visitation policies. While many hospital administrations ended up deciding to either restrict access to no visitors, others decided to limit the number of visitors along with establishing hygiene protocols, while other hospitals had no restrictions on the number of visitors instead choosing to maintain open visitations. The variation in hospital visitation policies implemented during the COVID-19 pandemic has created a nearly natural experiment in which to understand the value of patient visitors on care quality outcomes and the role of subjective advocates.

The purpose of this study is two-fold. The first goal is to examine the degree to which performances in patient experience outcomes (as reported via the Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS] survey) and patient safety (via AHRQ patient safety indicators) were influenced by the COVID pandemic. In addition, this study will examine the degree to which any changes in performance in patient care quality outcomes are associated with changes to hospital visitation policies. To examine these questions, a national sample of hospitals (n=32) was recruited to report monthly quality performance from January 2019 through December 2020 (n_m=768). Average performance in these hospitals on patient safety and patient care quality outcomes was first compared, and then a subsequent analysis looked at variation in quality performance in hospitals that decided to keep their visitations open and those that decided to restrict visitation during 2020. The results find that, on average, performance in 2020 across the hospitals examined in the study was worse than in 2019. However, hospitals that maintained some level of patient visitation (either open visitation or limiting to one or two persons) outperformed hospitals that elected to close visitations. Furthermore, performance in hospitals that maintained some level of visitation either maintained or improved upon 2019 performance. The findings show that the closing of visitations was detrimental for both patient experience and patient safety outcomes and were particularly detrimental to ratings for the responsiveness of staff with regard to patient experience and sepsis rates and patient falls with regard to patient safety.

The findings of this study suggest that the decision to limit visitations in hospitals, while potentially beneficial for slowing the pandemic, had far-reaching effects germane to patient care quality. Namely, patients who were unable to have family members or visitors present while in the hospital found that hospital staff was not as responsive and had a substantial increase in the risk for sepsis and falls compared to hospitals that maintained open visitations. These findings suggest that hospitals that have some level of open visitation policy sustain a higher quality of care. It may be that visitors, or the ability to have visitors, serves as a functional role in the care process. From this perspective, it is suggested that visitors are primarily family members or care partners who are more consistently present with a patient, and these individuals can and do serve as extended support for what a patient may need and, to a greater extent, as subjective observers or advocates during the care process itself. Suggestions are discussed for how the role of subjective advocates can be expanded in medical care delivery in instances when patients do not have visitors or when visitors need to be disallowed, as was the case during COVID-19.

Background

The influence of visitation policies on patient care quality has rested mainly on the influence of visitor presence on clinical staff and on patients themselves. Patients and their visitors, often family members, have long considered open visitations to be a net positive. For patients, this is somewhat unsurprising, as open visitation is among the defining elements of a patient-centered approach.[10] It has been shown that open visitation (as opposed to restricted hours) is viewed as beneficial for 88% of families and has decreased anxiety for 65% of patients.[9] Primarily, visitations offer patients an opportunity for support in their recovery as well as the ability to offload any anxieties they may be feeling with regard to their healthcare needs.[7,9]

Visitors want a better relationship with the patient's physician and more interaction with them, recognizing that there could be numerous physicians involved in the care of their loved one.[11] Visitation also allows for a sense of familiarity as patients are in a strange environment and helps to engender trust between family members (or other visitors) and the hospital staff.[7] Patient visitors are increasingly viewed as critical to the care process, most especially in the recovery process, and during the administration of inpatient care, visitors can serve an important role as advocates on behalf of patients.[8,11] Engagement with visitors has the propensity to improve care, as visitors can provide feedback to nurses and

physicians more effectively than even the patient in some instances when the patient is critically ill. [12] Visitors may play the role of surrogate decision-makers and become active participants in the care process as well, [11,13,14] as they often have first-hand insight into patients' preferences and can make important contributions to care decisions.[11]

The findings of one visitation study suggest that family members want to be involved in the specific task of safeguarding the patient,[15] and family presence is seen a way of helping patients' family members meet the need to provide support and safety.[11] Logically, then, meeting the need of a patient's family members to participate, support, and protect the patient would help family members to cope with the situation. The Institute of Medicine further supports the concept of allowing family presence in an effort to improve safety and recommends that healthcare delivery systems become patient-centered in an effort to improve patient safety.[16] Families felt panicked if patient's health status was not reported in a timely manner and scared when making caregiver decisions without a recent update.[17]

While patients and families prefer to have access to visitation, previous studies have found that they understand the need for nurses and physicians to perform procedures or medical routines without the presence of visitors.[17] Despite this, hospital staff prefer to have limited visitations, as visitors are viewed by clinicians as disruptive to their clinical work.[18] Clinical staff center their concerns on three major concerns: increased physiologic stress for the patient, interference with the provision of care and physical and mental exhaustion of family and friends.[7] The evidence, however, suggests that visitors not only do not distract from the delivery of high-quality care, they might even offer a quality advantage.

With regard to physiologic stress for the patient, clinicians' assumption that family presence at the bedside causes patients undue stress is refuted by the empirical literature which suggests that visitor presence tends to reassure and soothe the patient.[7, 11,18] Visits of family and friends do not usually increase patients' stress levels, as measured by blood pressure, heart rate, and intracranial pressure, but may in fact lower them.[12,19] The second concern of clinical staff, that the presence of visitors at the bedside will make it more difficult for nurses and physicians to do their jobs and will interfere with the delivery of care, is also refuted by the evidence.[11] The findings of several studies suggest that visitors more often serve as a helpful support structure, increasing opportunities for patient and family education and facilitating communication between the patient and clinicians. [7,12] Furthermore, if exposed to a medical procedure, visitors might understand patient medical needs better and be more able to assist with activities of daily living.[11]

While both nurses and physicians are in agreement with patients and visitors about the need and value that visitations have with regard to information-sharing about patient health status and prognoses,[11, 17] clinical staff's perspectives maintain that dealing with visitors increases their workload.[6] There may be some credence to this perspective for nurses, as physicians shared beliefs that patients' families should receive detailed information about patients; however, many physicians believe that this distracts from physicians' primary obligation, patient care.[11, 17] Physicians suggest that they have no time to spare for communicating with patients' families, and communication with visitors and families could be delegated to other members of the healthcare team (e.g., resident physicians, nurses).[17]

The final concern for clinicians about hospital visitation policies is that visitors themselves will get exhausted and fail to recognize their needs to pace themselves.[11] On this, the literature reveals mixed evidence. It finds that while that does sometimes happen, it is also true that visitations help alleviate the anxiety of the visitors, as it allows them to spend time with the patient and to feel more secure and relaxed during the time they are not with the patient.[7, 9,12,19] The conflict between how patients and their visitors view hospital visitation policies and how clinical staff view them puts visitation policies firmly at the border between provider-centric care and patient-centric care. The implication being that care that prioritizes the experience, needs and preferences of patients and their families would orient towards maintaining open visitations in the interest of patients and their families.[20]

Hypothesis

Visitations have been shown to be beneficial for both patient and staff measures. Despite the viewpoint of clinical staff that visitations are disruptive, studies show that visitations contribute to improved psychological measures and lower stress for patients as well as increased job satisfaction for nurses.[7,10,11,19,21-28] While research studies have not heretofore measured the effect of family presence on patients' safety,[11] visitors may play a role in reducing medical errors by alerting staff to issues such as new changes in the patient's level of consciousness, previous response to medications and medications taken at home.[29,30] During the COVID-19 pandemic, hospital visitations were nearly universally ceased at the onset of the pandemic in the U.S. (March 2020) as seen in the sample explored in this study. However, as more information was gained about the nature of the disease, some hospitals began to open visitation. The opening of visitation in the midst of a pandemic would require new protocols and visitor guidelines in addition to the reappropriation of staff to ensure that opening visitation did not put hospital patients and staff at increased risk. The decision to open visitation in the midst of a pandemic

Figure 1. Participant FTE and Bed Size

Facility FTEs (count)		Facility Bed Size (count)	
<1000	11	<100	9
1000-5000	13	100-500	16
> 5001-10000	8	> 500	7

is certainly not an easy one to make philosophically or logistically; however, hospital administrators that decided to do so necessarily were prioritizing patient experiences and the experiences of their families and friends. The literature has shown that visitations offer an opportunity for healthcare workers to demonstrate empathy.[17] Given the positive influence that visitation has historically shown for patients, visitors and even clinical staff, *it is hypothesized that the results of the closing of visitations during the pandemic are likely to have had a negative relationship to experience outcomes and, specifically, hospital quality and patient safety outcomes.*

Methods

Sample

Data was collected from senior level executives from 32 U.S. hospitals within The Beryl Institute community. The participants self-identified in volunteering to submit data and were not randomly selected. Hospital organizational characteristics and quality performance metrics were provided by each facility for each month over the two-year period of January 2019 to December of 2020. The hospitals in the sample represent organizations from nine states across the country. They were all part of non-profit healthcare systems or organizations. Six of the 32 hospitals contributing data represented Academic Medical Centers. Facilities ranged significantly in size from 240 to 35,000 FTEs and 35 to 2,400 beds. The breakdown of size is reflected in Figure 1. Our sample participants skew slightly larger in size than the average size found in the U.S. hospital system.

Hospital quality metrics reviewed included five domain measures of the Hospital Consumer Assessment of Healthcare Providers and Systems (*HCAHPS*) survey (overall recommendation, responsiveness, transition to post-hospital care, communication with nurses, and communication with doctors), and three of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI) Composite Measures (pressure ulcer rate, in-hospital fall with hip fracture rate, and postoperative sepsis rate). The measures collected are reflected in Figure 2.

To determine overall points of comparison for this study, the average score of all participating hospitals was compiled for each measure collected in 5 key segments. Scores were pulled from the sample to create an average score on each of the 8 indicators being examined for all of 2019 and all of 2020, respectively. Scores were also averaged for 2020 in two key segments across all participating hospitals. The first was for the months in which those organizations identified as having open or limited visitation (1 or even 2 visitors allowed). The second was for the months in which those organizations identified as having fully closed visitation.

Results

Comparing Performance Year-to-Year

The first data set explored the comparative results of top-box scores across all of 2019 and 2020. This view was intended both to gauge a baseline for the sample group as well as see if there were any general changes from the year prior to the COVID-19 pandemic to 2020.

Figure 2. HCAHPS Domain and PSI Composite Measures collected

HCAHPS Domain Measures	PSI Composite Measures
Overall Rating of Hospital	Pressure Ulcer Rate (PSI 3)
Responsiveness of Hospital Staff	In-Hospital Fall with Hip Fracture Rate (PSI 8)
Transition to Post-Hospital Care	Postoperative Sepsis Rate (PSI 13)
Communication with Nurses	
Communication with Doctors	

HCAHPS Results

In first looking at the 2019 baseline top-box scores for the HCAHPS survey, the sample collected was at or just above the reported 50th percentile score of the HCAHPS survey in 2019,[31] except for in the responsiveness domain. What we found in comparing 2019 to 2020 was that while HCAHPS scores were slightly impacted, the change was subtle at best in most domains. The greatest net change in results was in the domains of responsiveness, a reduction of 2 points, and care transitions, a reduction of 1.2 points. It should be noted that even with those reductions, our sample, specifically as it related to care transitions, remained above the comparative 2019 50th percentile mark, as did all other measures except for responsiveness. (Figure 3)

Safety Results

Similarly, in the review of safety results, we framed performance around the reported AHRQ benchmark data released in 2020 (noting these benchmarks are based on 2017 data).[32] What we again found was that the sample in this study outperformed the benchmarks in the three measures explored in the baseline 2019 data collected. In looking at the changes to 2020, interestingly, what we found was a decrease in pressure ulcer rates in our sample year-to-year and a slight increase in sepsis rates (but still reporting under the benchmark). Of greatest interest was the increase in fall rates as reported. Not only did the fall rate jump from well below the benchmark to above it, but it also increased by 253% from 2019 to 2020. (Figure 4)

Open/Limited Visitation to No Visitation Allowed

Once the general changes over the two-year period were explored, the question turned to the impact of changes in visitation policy overall. As noted, all participants in the study indicated for all 24 months in 2019 and 2020 whether they had open visitation (no restrictions on visitation), limited visitation (allowing 1 or 2 designated visitors) or no visitation. "No visitation" is defined as a policy that disallows visitors from entering a healthcare facility. It should be noted that even with "no visitation" policies, some organizations do make exceptions for certain circumstances, such as at end-of-life or during childbirth.

In reviewing the data comparing these different states of visitation, a clear story began to emerge. First of note is that the 32-facility sample reported having a "no visitor" status for 127 of the 384 collectively reported months in 2020, or 33% of the time overall (and noting there were no months in 2019 reported as having "no visitor" status). More specifically, the trend of when and to what extent these policies were implemented mirror the surges in COVID-19 cases reported overall. You will see a surge in no visitor status in the March and April timeframe with a return to initial 2020 numbers in August and September

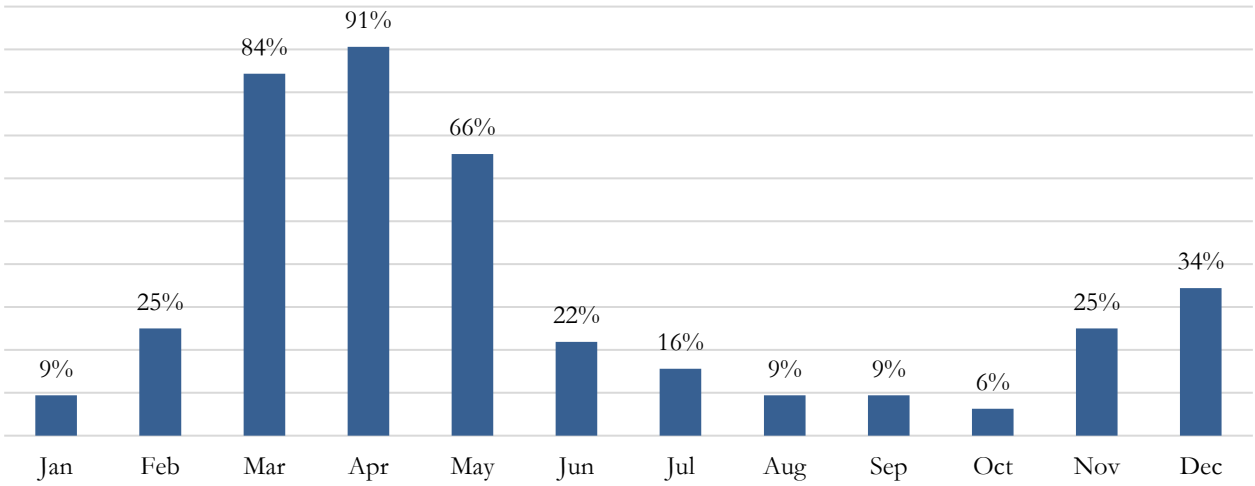
Figure 3. Comparative HCAHPS Scores 2019 to 2020

HCAHPS Domain Measures	HCAHPS 50th Percentile 2019	2019 Overall Sample Score	2020 Overall Sample Score	Net change 2019 to 2020	% Change 2019 to 2020
Overall Rating of Hospital	73%	73.6%	73.5%	- 0.1	- 0.1%
Responsiveness of Hospital Staff	69%	67.8%	65.9%	**- 1.9**	**- 2.9%**
Transition to Post-Hospital Care	53%	57.5%	56.3%	**- 1.2**	**- 2.1%**
Communication with Nurses	81%	82.1%	81.5%	- 0.6	- 0.8%
Communication with Doctors	81%	82.5%	82.1%	- 0.4	- 0.6%

Figure 4. Comparative Safety Scores 2019 to 2020

PSI Composite Measures	AHRQ Benchmark (July 2020)	2019 Overall Sample Score	2020 Overall Sample Score	Net change 2019 to 2020	% Change 2019 to 2020
Pressure Ulcer Rate (PSI 3)	0.65	0.44	0.38	- 0.06	-13%
In-Hospital Fall with Hip Fracture Rate (PSI 8)	0.07	0.03	0.11	**.08**	**253%**
Postoperative Sepsis Rate (PSI 13)	3.97	2.93	3.47	0.54	18%

Figure 5. Percent of Facilities Reporting "No Visitation" Per Month in 2020



with the start of a second surge reflected at the end of the year. At the high point of the crisis, over 90% of all facilities had "no visitation" policies in place, but you can see there was some extent of this restriction throughout the year. (Figure 5)

HCAHPS Results

As in comparing year-to-year shifts, we delineated HCAHPS results over three defined periods for this comparison: 2019 scores (which represented only open visitation), 2020 scores reflecting open/limited visitation and 2020 scores when no visitation was allowed. What we found was that again most changes were not substantive, but in comparison, the differences between these measures reflected a much greater impact on responsiveness which dropped by almost 3 times over the next item, care transition. (Figure 6) Again, the difference in HCAHPS scores even with a shift in visitation was minimal at best, but the shift in responsiveness should garner some attention.

Safety Results

In looking at the safety results with the same comparative framing, the greatest impact is seen. This is not only reflected in the fall rate increase found in the year-to-year comparison, but now helps to pinpoint possible causality for that result as well. In looking at the impact of no visitation on safety, there is a substantive increase in pressure ulcer rates in the sample, though still holding under the benchmark score. Where the most significant impact of no visitation is found is in both fall rates and sepsis rates. The rates reported in those organizations at the time of no visitation well exceed the benchmark rates as well as show over a 100% increase from those reporting open or limited visitation. (Figure 7)

Figure 6. Comparing HCAHPS Performance Relative to Visitation Policy

HCAHPS Domain Measures	HCAHPS 50th Percentile 2019	Open Visitation 2019	Open/ Limited Visitation 2020	No Visitation 2020	Net Difference (Open/Limited to No 2020)	% Difference (Open/Limited to No 2020)
Overall Rating of Hospital	73%	73.4%	73.6%	73.3%	-0.3	-0.4%
Responsiveness of Hospital Staff	69%	67.6%	66.3%	64.7%	**-1.7**	**-2.5%**
Transition to Post-Hospital Care	53%	57.3%	56.6%	56.0%	-0.5	-0.9%
Communication with Nurses	81%	82.0%	81.7%	81.2%	-0.4	-0.5%
Communication with Doctors	81%	82.5%	82.2%	81.9%	-0.3	-0.3%

Figure 7. Comparing Safety Results Relative to Visitation Policy

PSI Composite Measures	AHRQ Benchmark (July 2020)	Open Visitation 2019	Open/ Limited Visitation 2020	No Visitation 2020	Net Difference (Open/Limited to No 2020)	% Difference (Open/Limited to No 2020)
Pressure Ulcer Rate (PSI 3)	0.65	0.45	0.39	0.49	0.11	**28%**
In-Hospital Fall with Hip Fracture Rate (PSI 8)	0.07	0.03	0.07	0.14	**0.07**	**104%**
Postoperative Sepsis Rate (PSI 13)	3.97	2.93	2.65	5.39	2.74	**104%**

Discussion

The intent of this study was inspired by the observation of members of The Beryl Institute's Experience Leaders Circle who were seeing an impact on safety scores during the latter half of 2020 particularly related to the decisions to limit visitation in their facilities. There were also healthcare executives across the U.S. expressing concern that their HCAHPS scores were suffering due to the impact of the COVID-19 pandemic. The data reviewed tell a very interesting story and reflect something born out in earlier literature but made apparent through the opportunity for a natural experiment caused by the pandemic itself.

While it has long been suggested that the presence of family members or care partners was an important part of the care process, and studies have shown this presence has limited negative impacts and even positive influence on outcomes, this study helps to reinforce this point in real time as healthcare organizations made the difficult decisions to establish significant visitation restrictions in the face of a new and unknown virus. The impact of these restrictions as seen in the sample here is now clear: the presence of a family member or care partner matters.

In reviewing the data, the impact of all that was taking place in 2020, primarily driven by the rapid arrival and sustained presence of COVID-19, had an impact on scores. This impact varied in some noteworthy ways. First, the overall impact on HCAHPS domain scores was much less than on the reported safety outcomes. In looking at 2019 compared to 2020 results, HCAHPS scores only reduced slightly, with the overall rating score across the two years in our sample group remaining relatively the same. The greatest changes, still less than a three-percent change overall, were in the responsiveness of staff and care transition domains. Of interest to this discovery is that the areas most impacted year-to-year were those where the presence of a care partner or "subjective advocate" could be seen as potentially influential. This is before any further exploration of having a family or care partner present.

Meanwhile, in comparing 2019 to 2020 in the performance related to safety scores, one major increase is noted specifically as it related to fall rates. Fall rates in 2020 increased 253%, jumping from below the AHRQ benchmark score to well above it. In that same comparative period, pressure ulcers actually decreased and sepsis rates slightly increased. In this simple year-to-year comparison, again, it seems the area most impacted is mostly related to having the presence of a care partner to assist a patient when care staff cannot be present. In a year where staff was stressed to significant limits due to the sheer volume of care and in many cases staff absence due to infection or the need to follow quarantine protocols, the lack of more consistent support at the bedside was clear in the data alone.

These observations are only further highlighted in looking at the direct impact of a lack of family member or care partner presence when comparing months during 2020 when visitation was allowed, or even slightly restricted, versus when no visitation was allowed whatsoever. Again, it is important to note that while HCAHPS was impacted by these comparative periods, it was by very small rates. The greatest difference seen in the months with limited visitation itself was primarily in responsiveness of staff, reflected in a drop in score in the sample by 2.5%. All other changes as a result of visitation restrictions were under 1%, which makes the change in responsiveness something that stands out. The consideration here is that responsiveness – especially as it relates to the items of toileting or call light response – can be connected to having someone present with you. If a care partner is present, they can often address minor requirements including helping a loved one or friend to the toilet, avoiding the need to call a nurse or care provider to help. Also for consideration is the time perception of waiting when one is alone versus when one has someone to wait with. This perception of responsiveness can also be altered. This is not to say that due to all that was suggested

above regarding staffing at a time of crisis, that the pure burden and stress on staff and their ability to be available either due to volume, PPE limitations or access or other reasons may have also delayed perceived responsiveness, but it is clear that care partner presence could play a role here.

In exploring the impact of visitation changes on safety, the conversation gets more interesting and significant. As seen in the data, both in-hospital fall rates and sepsis rates took a significant leap of 100% in those months without visitation versus those with open or some presence allowed. More so, these numbers moved in our sample from at or below AHRQ benchmarks to well above. The data here again show that the presence of a care partner made a difference in both instances. While sepsis rates could be supported by someone at the bedside more consistently monitoring a patient to address any postoperative clinical needs earlier, the real interest here continues to be fall rates, where it is evident due to lack of care partner presence or lack of staff due to the issues identified above, people attempted to do things alone that they might not otherwise have to. The need to use the toilet, access something not in easy reach or other reasons that might have a patient need to move and risk a fall are all real issues made more evident in the data. In reviewing the data, it is clear that while even having some limited visitation was a positive for patient safety, when no visitation was allowed, things just simply got worse.

These observations are not a critique of staff or of policy decisions, noting tough choices had to be made hastily to react to an ongoing series of unknowns. What it does reveal is that in making some decisions, especially as it relates to care-partner presence in not only times of crisis but at all times, serious considerations need to be made. First, as evidence prior to the crisis showed and as the data from our sample reveal, having the presence of a care partner makes a difference. While COVID-19 may have been the "x-factor" in the last year, the reality is the minimal implications on HCAHPS scores and the significant impact on safety scores were not just due to COVID itself. The impact seen was related to the policies implemented to address a moment of crisis. The data help us to see how we may want to consider making decisions in the future.

While little evidence has been presented showing that visitor presence during this crisis impacted infection rates and previous studies prior to the COVID-19 pandemic support this notion,[5] the decisions made are understandable based on circumstance. The power of hindsight now in this natural experiment is that we could have found ways to address this differently. What the data reveal and what is asserted here is that there is direct and positive impact for having "someone in the room, be they a family member, friend or care partner; what we suggest is a "subjective advocate." A subjective advocate would ideally be someone that knows the patient and can advocate and even communicate on their behalf as an active part of the care team. In the most extreme circumstances, such as those just encountered and where difficult choices may have to be made, organizations must consider with great seriousness why restricting visitor presence is scientifically (or operationally) necessary.

It is important to restate this is not a critique of choices made in a moment of crisis, but the observational power of hindsight of how we can and must act in the future. If a moment such as this should arise again and extreme choices must be made to restrict access to visitors (though the data suggests this may not be the best decision), organizations should consider how they themselves can provide this advocate as a means to alleviate the negative change in outcomes reflected in this study. This type of support is not simply completed through occasional staff or leader rounding, as those individuals are still most likely perceived as the care provider to the patient. Rather, it is suggested that healthcare organizations consider a cadre of advocates, not unlike the key role Child Life Specialists play in pediatric settings where individuals on the team build more personal relationships with patients and families.[33] In the most recent crisis, as staff were reassigned or reallocated to roles such as screeners at hospital entrances, perhaps this reassignment could also include a "SWAT team" of sorts comprised of advocates to be there for patients in a more personal and supportive way. While these individuals could not be present all the time as could a family member or care partner, nor is it suggested they could ever fully play the role that a family member or care partner could, would the presence of this subjective advocate, a personal partner in care, change how people act, respond and actually support better outcomes? The evidence provided by this study suggests that, yes, patients should not and must not be allowed to travel a care journey alone.

This also suggests that even when times of crisis subside, we must also be aware of the needs of those patients that do not have family or care partners at their side. While visitation restrictions revealed this significant issue, we must be cognizant that there are people in hospitals at all times who do not have the support or presence of family or other care partners, and the data reveal they are at much greater risk because of this. The results of the natural experiment around hospital visitations that COVID offers is that all healthcare organizations should consider heavily the notion of providing patients with a care partner or subjective observer in instances when patients are not able to have this support. Based on the findings of this study, both patients and the care providers stand to benefit from such an effort.

Conclusion

There are significant lessons learned for healthcare organizations to consider as a result of this crisis, a crisis which we will be reflecting on for some time. Organizations had to make quick and difficult choices, supplies were strained, staff was pushed to the edge and beyond, hospital units overflowed with the sick and dying. We were forced to reflect on our humanity and the human realities of healthcare in ways we have not before.

This has been a moment that has never been experienced before. It is truly unprecedented. The choices forced by the pandemic revealed great lessons about our strengths and opportunities for improvements as well. The implications of restrictions on visitation on care quality may be one of the most important learning opportunities. The void of family or care partner presence - the lack of subjective advocates - has garnered the attention of leaders and clinicians alike. It spurred heroic actions by staff to connect people to those they loved through technology and inspired news stories and commentaries from around the world that moved our hearts. The many stories of patients having to undergo medical treatment and recovery without the physical presence of care partners or loved ones with them in their time of need has garnered an emotional reaction, but now it is clear that this change in care delivery is associated with tangible deficits in care quality and patient experience as well. Given this evidence, we find that there is an opportunity to build new processes and consider new actions as a result of what we have all learned.

That may be our biggest lesson of all. In an industry grounded in the idea that we are human beings caring for human beings, it is only fitting that the human connection needed at its core was revealed to be so essential. It will drive all the outcomes we aspire to, and we must continue to do all we can to ensure those we care for have the support they need.

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