EMPIRICAL RESEARCH QUALITATIVE

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# The lived experiences of health care professionals regarding visiting restrictions in the emergency department during the COVID-19 pandemic: A multi-perspective qualitative study

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## Abstract

**Aims:** To explore the lived experiences of emergency department (ED) healthcare professionals regarding visiting restrictions during the COVID-19 pandemic.

**Design:** A qualitative phenomenology study.

**Methods:** Semi-structured interviews were undertaken. Participants consisted of 10 physicians, 20 clinical nurses, and three managers, who were purposefully selected from two EDs in China between April and July 2021. Colaizzi's approach guided data analysis.

**Results:** Four themes arose: (i) burden moral injury, (ii) higher workload to provide and support patient- and family-centered care, (iii) dissatisfied and unsafe healthcare service for patients and families, and (iv) tailoring strategies to provide family-centered care.

**Patient or Public Contribution:** This study explored the lived experiences of ED health care professionals regarding visiting restrictions during the COVID-19 pandemic. Noted challenges included communicating with families and ethical decision making. Strategies that support ED clinician welfare, and communication with families are warranted if visiting policy restrictions are continued or re-introduced.

KEYWORDS
COVID-19, emergency departments, moral injury, nurses, pandemic, qualitative study, visiting restrictions

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# 1 | INTRODUCTION

The outbreak of COVID-19 in 2020 compelled health care settings worldwide to implement visiting restriction policies to align with World Health Organization (WHO) recommendations: "numbers of visitors and visiting periods should be highly restricted" (World Health Organization, 2020, p. 10). These policies were applied in different ways in different countries and regions, ranging from an absolute ban on all visits in all kinds of care facilities to comparatively liberal visiting policies, allowing visitors during certain circumstances (Hugelius et al., 2021). Such policies have significantly changed health care delivery approaches in hospitals (Maaskant et al., 2021; Murray & Swanson, 2020), especially in the highly stressful setting of the emergency department (ED).

# 2 | BACKGROUND

A growing number of studies from the pre-COVID-19 pandemic era have emerged showing that in family-centered care facilitates, there is a mutually beneficial partnership in the planning, delivery, and evaluation of care among patients, family members. And healthcare professionals (Institute for Patient-and Family-Centered Care, 2020). Family involvement is important in the provision of information about patients (such as pre-admission condition, daily habits, and self-management status); supporting patients physically, emotionally, and cognitively; and invariably improving the quality of care (Mackie et al., 2018). For patients who are critically ill, family and caregivers play an especially important role in decision-making; their input can inform the development of care plans, and in some cases, they provide motivation for some patients to stay alive and recover (Engström & Söderberg, 2007).

During a pandemic, the capability to deliver family-centered care can be challenging. Literature has emerged highlighting dilemmas healthcare providers have experienced in care provision during the COVID-19 pandemic in settings such as nursing homes, intensive care units, and COVID-19 hospital wards (Maaskant et al., 2021; Murray & Swanson, 2020; Sizoo et al., 2020). Such dilemmas included balancing visiting restriction rules to minimize the possibility of nosocomial transmission of COVID-19 and the provision of best health care (Murray & Swanson, 2020; Sizoo et al., 2020). However, it is unclear how visiting restriction policies have impacted family-centered care provision in the ED setting. Such understanding is required to gain insights and inform future policy making efforts to support patients, their families, and ED staff in their ability to provide best care in the event of subsequent situations where visitor restriction requirements are implemented.

# 3 | THE STUDY

## 3.1 | Aim

This study aimed to explore the lived experiences of ED healthcare professionals (physicians, nurses, and managers) regarding visiting restrictions in China during the COVID-19 pandemic. Of particular interest were the challenges and strategies surrounding these experiences.

## 3.2 | Design

We conducted a qualitative phenomenology study, using semi-structured interviews. The research is presented according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist for qualitative research (Tong et al., 2007).

## 3.3 | Setting and participants

The study was conducted in two EDs in Beijing, China. These two EDs are both public tertiary hospitals, located in a central area in the city. ED one spans 8000 square meters, with 250,000 patient presentations per annum and has 35 physicians and 150 registered nurses. ED two spans 5500 square meters, with 200,000 patient presentations per annum and consists of 65 physicians and 145 registered nurses.

A purposive sampling approach was used to recruit the sample of 10 physicians, 20 clinical nurses, and three managers. Inclusion criteria for participation were (i) physicians, clinical nurses, or managers who worked in one of the two EDs during the study period (between April 5 and July 26, 2021); (ii) able to provide informed consent; and (iii) able to speak and understand Mandarin. During the recruitment period, visiting restrictions were in place.

Sample size estimates for phenomenological studies have been suggested to be around 10 interviews; however, it is noted that these numbers are very tentative, with bigger sample sizes required in larger qualitative studies (Moser & Korstjens, 2018) such as ours that includes two professional groups from two EDs. While it has been suggested that sample size is based on when data saturation is reached (i.e., no new analytical information arises anymore and the study provides maximum information on a phenomenon) (Moser & Korstjens, 2018), there are varying perspectives around data saturation and its application to various types of qualitative research, including phenomenology, warranting further depth in reporting of sample size sufficiency (Vasileiou et al., 2018). Other phenomenological studies that have also used Collizzi's data analysis method have reached data saturation with sample sizes of 14 (Sheng et al., 2020) and 20 (Liang et al., 2020) nursing participants. Malterud et al. (2016) proposed reporting on five items that impact upon 'information power' of a study sample (i.e., the larger information power the sample holds, the lower *N* is needed, and vice versa). Upon considering these five items, our aim was narrow (focused on experiences regarding visiting restriction policies); our sample was specific (to ED health care professionals working during a specific time period; but covered more than one discipline); based on established concepts (patient and family-centered care); relatively strong quality of dialogue (interviews undertaken in person, by a nurse with ED, management, and qualitative research experience); and a cross-case analysis strategy (different challenges and strategies

regarding visiting restrictions). While our sample size was determined by data saturation, other noted considerations provide depth to the ascertainment of information power of our sample size.

## 3.4 | Data collection

Semi-structured interviews were undertaken. Questions guiding the interview are presented in Table 1. Questions were developed by members of the research team, based on existing literature (Murray & Swanson, 2020; Sizoo et al., 2020). Interview questions were piloted with two ED physicians, two ED clinical nurses, and one ED manager who were not part of the formal study. After following this pilot run through of the interview, one probing question was added (is there anything you want to share/talk about? such as cases/circumstances/stories) to guide and help remind the participant of a typical and detailed case(s).

Informed written consent and demographic data were obtained from participants prior to conducting interviews. All interviews were conducted individually and face-to face by the first author (YL) who has had qualitative research education and training. Interviews were conducted in Mandarin, Chinese (first author and all participants' first language). The interviews took place in a private room in the ED and lasted approximately 30–40 min. During the interview process, the interviewer kept neutral regarding the content of what the participants said to be a sensitive, nonjudgmental, and nonthreatening listener. Interviewees were encouraged to share their personal experiences regarding providing healthcare for patient with their own words. Probing questions, such as "Can you tell me more about that?" and "What does that mean to you?" clarified the participants' responses and elicited detailed information during each interview. Meaningful facial and body expressions were also recorded when necessary.

TABLE 1 Outline of semi-structured interview questions

| Question |
| --- |
| 1. Could you please share the impact of the policy of visitation restrictions on your clinical work on the patient, family, and clinical operation? (Is there anything you want to share/talk about? such as cases/circumstances/stories)? How do you make decisions and explain to family members the rule of restricted visitation? |
| 2. Have you ever encountered some specific scenarios, such as language barrier, deathbed, delirium, and the implementation of invasive rescue of patients? How do you choose between clinical ethics and strict implementation of the visiting system? |
| 3. Do you have any suggestions or strategies about the visitation requirement? How do you consider the principle of "patient-centered care, family-centered care, humanistic care, and medical ethics" based on the existing strict prevention and control system? |
| 4. Do you think it is necessary to completely remove visitation or partially open visitation to some patients? If partially open, what do you suggest are the criteria or circumstances for this open visitation? |

## 3.5 | Data transcription and translation

The interviews, original transcriptions, coding processes, and data analysis were in Mandarin, Chinese to ensure that the information provided by the participants was not taken out of context and that meaning from the raw data was not lost (Zhou et al., 2011). During data analysis, core members of the research team (YL, HY, FLG, and XHH) were also involved in coding, clarifying themes, and selecting quotations that best reflected the themes and findings. All quotations were translated into English by YL and back translated by HY to ensure that meaning was retained. YL and HY were both professional, qualified translators who have a medical background and are bilingually competent, features that supported accurate and reliable translations of the data.

## 3.6 | Data analysis

While several phenomenological approaches to data analysis exist (Phillips-Pula et al., 2011), we applied that of Colaizzi's (1978) which is used in nursing and interprofessional research (Liang et al., 2020; Lin et al., 2020; Sheng et al., 2020; Wirihana et al., 2018) and found to be a rigorous and robust approach that ensures credibility and reliability of its results (Wirihana et al., 2018). Colaizzi's (1978) approach involves (i) reading of the interview transcripts several times while listening to the tape recordings; (ii) extracting essential elements and meaningful statements from the transcripts; (iii) coding the same elements and statements of the data; (iv) arranging the formulated meanings into several clusters of themes; (v) ensuring that detailed descriptions were stated and merged for every extracted theme; (vi) undertaking a repeated reading by the researchers of the themes and the descriptions; (vii) returning the data to the participants to obtain their views and to be verified.

Data analysis was undertaken in conjunction with data collection. Specifically, Colaizzi's (1978) method was applied to this study, with two researchers independently reading and rereading all the transcripts in Chinese for immersion of the data. Key quotes were highlighted, and initial codes were developed based on participants' verbatim statements. Codes were grouped according to similarity into subthemes and then themes based on common threads throughout the data. Any disagreement or contested theme/subtheme was discussed among several other members of the team until consensus was reached. Interview transcripts were returned to participants for comments and further clarifications to ensure their verbatim expressions supported the subthemes.

## 3.7 | Ethics

The Human Research and Ethics Committee approved the study. Informed written consent from each participant was sought prior to the interview. All the interviewees were assured that participation was entirely voluntary and had the right to withdraw at

any time and at any stage of the research. Every interviewee was given a subject code which was used for all transcripts of interviews and for identifying recordings so that all information obtained from the participants was treated in a non-identifiable and confidential manner. Audiotapes and other documents were kept in a locked cabinet in interviewers' office in the ED until each interview was transcribed and verified by checking for accuracy against the tapes.

Confidentiality, privacy, and anonymity of all participants were ensured. The interview records are stored as de-identified files in a password-protected computer that only the research team can access. The interview records will be retained for 5 years from the publication date and then deleted from the computer.

## 3.8 | Trustworthiness

In this study, several techniques were utilized to support the trustworthiness by implementing measures for credibility, dependability, confirmability, and transferability (Graneheim & Lundman, 2004). Credibility was achieved by undertaking the in-depth interviews followed by peer debriefing. Two researchers analyzed the transcripts independently by bracketing data on preconceived ideas and strictly following Colaizzi's approach, as described. Furthermore, quotes were translated into English back and forth by two bilingual researchers. Dependability of the findings was met by this team providing a step-by-step description of the process of data collection and analysis, enabling replicability. As for confirmability, a paper trail was kept recording significant ideas or incidents emerging from the conversation with participants. The interviewer also undertook member checking with participants to enable checking and offer opportunity for further clarification. Transferability was established by considering variations of participant characteristics and sufficient quotations collected through in-depth interviews. The audit trail was maintained to ensure all analysis steps could be traced back to original interviews.

## 4 | RESULTS

There were 10 physicians, 20 clinical nurses, and three managers who volunteered to be interviewed. Among the 33 participants, 12 were male and 21 were female. The average age was 36.8 years, with a median of 10.5 years of clinical experience in ED (ranging from 1 to 32 years of experience).

The analysis of the participant narratives uncovered four main themes and 11 subthemes reflecting the experience of healthcare professionals regarding visiting restrictions in the ED during the COVID-19 pandemic (Table 2). The four themes were (i) burdened moral injury, (ii) higher workload to provide and support patient and family-centered care, (iii) dissatisfied and unsafe healthcare service for patients and families, and (iv) tailoring strategies to provide family-centered care.

**TABLE 2** Themes and subthemes arising from participant interviews

| Themes | Subthemes |
| --- | --- |
| Burdened moral injury | Emotional pressure |
| | Balance and decision |
| | Rethinking the meaning of career |
| Higher workload to provide and support patient- and family-centered care | Increase in time required for basic daily care patient needs |
| | Increased efforts required to provide emotional support for patients |
| | Increased complexity regarding communicating with patients and their families |
| Dissatisfied and unsafe healthcare service for patients and families | Difficulty in obtaining comprehensive patient information from family members |
| | Encountering conflict with potential complications (e.g., delirium, unexpected events) |
| Tailoring strategies to provide family-centered care | Shifting boundaries to meet patient and family needs |
| | Alternate measures to support patients and staff |
| | Advocate for tailored strategies for ED |

## 4.1 | Burdened moral injury

The visiting restriction policy brought an evident change that separated families and patients. Healthcare professionals felt emotional pressures, especially in terms of balancing family-centered-care with the strict implementation of visiting restriction. This moral injury meant that some healthcare workers reflected on the value of their career. These subthemes and related quotes are elaborated upon next.

### 4.1.1 | Emotional pressure

When asked about the impact of the visiting restriction policy, all healthcare professionals interviewed indicated that they felt a sense of burdened moral injury and emotional pressure reflected in terms of feeling guilty, powerless, depressed, helpless, sympathetic, and even angry. Their challenge was evident in the following quotes.

> I felt guilty, in the ED, you definitely know how important the role of the family members [is] to the patients. Sometimes, they [families] are the hope to the patients, but the infection control was the priority. What you can do was quite limited, [I] felt sorry about that.
>
> [Physician 3]

> Hmmm, sometimes, family members have indicated that they are not afraid to be infected, they have

a close relationship with patients, especially in some circumstance [like end of life], they strongly required being in the company with patients, you really are touched by their relationship, but you have to obey the policy [sign]; so sympathetic and powerless.

[Nurse 5]

### 4.1.2 | Balance and decision

The visiting restriction policy put healthcare professionals (despite clinical/managerial position) in a dilemma balancing family-centered care and policy requirements. This was especially difficult in patient with language barriers and for those where end-of-life decision making was required.

I want to help my patient and provide family centered care, but firstly, I have to obey the hospital rules, that was too hard to balance.

[Physician 5]

I have to make the decision, how to do the family care during this COVID-19 pandemic, especially in patients with end-of-life phase, or with language problem, which is really hard to make.

[Manager 3]

### 4.1.3 | Rethinking the meaning of career

The constant weighing up of ethical principles arising from the change of routine healthcare service model during the COVID-19 pandemic made some healthcare staff rethink and reflect upon the value and meaning of their career, which was evident in the statement below.

Sometimes, I think over the meaning and value of the job. From the family's own opinion, do they really think [the restriction] protects them [patients and relatives] to avoid being infected or hurts them? To what extent, could we help them or comfort them?

[Physician 4]

### 4.2 | Higher workload to provide and support patient and family centered care

Because families were not allowed to visit patients, some work (physical and psychological) usually assisted by families was transferred to ED staff, increasing their workload. This change is reflected in the three following subthemes and quotes.

### 4.2.1 | Increase in time required for basic daily care patient needs

All nurses reported a vast increase in their workload, especially in basic daily care. This was evident in the following quote.

Previously, family members could help do some basic daily care, like bathing, feeding for patient, exercise, and early movement, but now, no family members are allowed to visit. We have to do all the basic daily things by ourselves. This really added much workload.

[Nurse 6]

### 4.2.2 | Increased efforts required to provide emotional support for patients

Presenting to the ED was usually an unpredictable event for patients and families, which brought emotional pressure for families. With the visiting restriction, the physical distance between patient and their family meant that health care professionals were taking on the added role of providing more emotional support that family members historically would have provided, as supported by the following quote.

Usually, during the visiting period, family members could help encourage, comfort and support patients, which was really helpful. However, because of the [visiting restriction] policy, our physicians or nurses had to do this [emotional supporting work] by themselves in addition to their daily work.

[Manager 1]

### 4.2.3 | Increased complexity regarding communicating with patients and their families

Most physicians and clinical nurses reported an impact on how they communicated with families about the patients' condition. An increased use of telephone, need for more detailed information, and more regular updates were reported. These sentiments are illustrated by the following quotes.

Family members cannot see the patient's face and conditions, so it took more time to describe the information about the patient.

[Physician 8]

Every afternoon, I have to call every relative of the patient, to explain the condition of the patient in detail. We have 20 patients in our observation room, this really cost me plenty of time on communication.

[Physician 4]

## 4.3 | Dissatisfied and unsafe healthcare service for patients and families

By separating patients and families, the visiting restrictions led some families to be dissatisfied with the healthcare service. The visiting restriction policy also brought distance between the patients' families and ED staff, largely due to challenges in obtaining comprehensive information about the patient which sometimes compromised care. This was evidenced through the following two subthemes and quotes.

### 4.3.1 | Difficulty in obtaining comprehensive patient information from family members

Because of the visiting restriction policy, ED healthcare providers were challenged in some cases in being able to obtain sufficient information about the patient's lifestyle, medication history, or family relationships. This is evident in the following quotes.

> Usually, there are 30 mins open for family to visit, we could receive some important information for the patient regarding daily habits, for food, prescription history, and preference. We can provide more personalized care, but now, this is really challenging.
>
> [Physician 12]

> During the physical presence between the patients and families, we can observe and obtain more potential and comprehensive information about the patients and their families.
>
> [Nurse 6]

### 4.3.2 | Encountering conflict with potential complications (e.g., delirium and unexpected events)

The routine visits from families were important, especially for elderly patients who depended on their caregivers in daily life, and patients with mental health problems. Potential conflicts and risks arose because of insufficient information as reflected in the following quotes.

> We really noticed that because of the [physical] absence of relatives, the incidence of delirium was higher than before COVID-19.
>
> [Nurse 10]

> Last month, a woman attempted to commit suicide in the ED. We only knew that she had [mental health] history when this bad thing [attempted suicide event] happened. Actually, before the [visiting

> restriction] policy, we could get more detailed information and observe more subtle conditions on patients from daily visits from families' communications. I think the policy brought some patients into risky circumstance.
>
> [Physician 5]

Because of the visiting restriction policy, family members had some complaints, which was of concern to the healthcare manager, as supported by the following quote.

> … during this month, we have been complained about three times due to the visiting restriction policy, which was more than before [pre COVID-19]. We had to acknowledge that family-centered care could not be provided as before.
>
> [Manager 3]

## 4.4 | Tailoring strategies to provide family centered care

Facing visiting restrictions, ED healthcare staff considered and tried to tailor care delivery to continue efforts to provide family-centered care; however, efforts were somewhat limited in the ED context. The sentiment of this theme is elaborated through three subthemes and quotes.

### 4.4.1 | Shifting boundaries to meet patient and family needs

In daily practice, ED healthcare providers were required to consider the boundary between infection control and family-centered care and adapt care delivery as a result. Conditions and circumstances where this were most challenging included end-of-life care, patients with delirium, patients who refused treatment or examination, and when there were language barriers, as illustrated by the following quote.

> For some patients [with language barriers] who really need the families' support, or assisting with explanations, the families can communicate with the patient more frequently. I think we should open the door for families. We had to decide, but where is the boundary? I mean which situation(s) should allow the patients to be accompanied. Who sets the rules? I think this is quite important.
>
> [Physician 6]

During the time when the visiting restriction policy was being implemented, physicians explained how they had to change their treatment strategies, for example:

An 88-year-old patient who had delirium. Usually, we will let the family members come into the department to accompany them, which helped [relieved the symptoms] a lot, generally, we try not to use medication, but now we are more likely to use sedatives earlier…

[Physician 9]

### 4.4.2 | Alternate measures to support patients and staff

Physicians and nurses attempted to use a variety of alternative measures to support family centered care. An example is evident in the following quote:

One elderly patient had gastrointestinal bleeding and needed a gastroscope and colonoscopy, but [she] rejected any examination and any communication with us. We tried to provide video and telephone ways to let her communicate with her husband, children, and grandchildren, but this did not work, you know, she just wanted to see her family face to face. So eventually, we had to transfer this patient to a private ward, all family members wore PPE, etc., after short communication, she agreed [to do the examination and treatment].

[Physician 4]

Other strategies to support family-centered care included taking some digital solutions like iPads to provide family visits through video. Even though digital solutions and efforts by health care professionals to maintain appropriate distances between patients and family members were appreciated by clinicians, video visits could not always substitute for the physical presence of family members in the ED. Therefore, some participants suggested that while such solutions were effective in some locations, they were somewhat limited in the ED context. This was evident in the following quotes.

The role of families as an intervention to prevent delirium and relieve cognitive confusion was widely acknowledged. The video visit was really limited…the alternative measures used are very difficult/inadequate for the ED patients.

[Manager 3]

Frankly speaking, the visiting by telephone or video is not helpful enough in ED. It may be helpful in the general ward, or other [healthcare] settings, because the patients were awake, and the condition of patients were stable and predictable. However, in the ED, the conditions of the patients are too complex, there are many circumstances that need decision-making in a short time. The families mean too much

for the patients. Sometimes, patients who committed suicide, had cardiac arrest or accident admitted to ED, their families were not able to see them before they died.

[Physician 10]

### 4.4.3 | Advocate for tailored strategies for ED

Participants reported a strong willingness to call for more tailored strategies within ED to assist healthcare professionals provide family-centered care. The following quotes indicate the advocacy for such tailored strategies.

In the peak of the COVID-19 crisis, I think the policy operated by the government is quite necessary to guarantee safety and infection control. When the situation is not at high risk, I think the tailored measurement should be taken by government or public health institute.

[Nurse 6]

We really advocate to add more volunteers or assistants to help us do some non-professional work, like help patients bath, wash body, help patients connect video with their relatives, and transfer patients to private room.

[Nurse 18]

## 5 | DISCUSSION

To our knowledge, this is the first study to describe the lived experienced of healthcare professionals regarding visiting restrictions in EDs in China during the COVID-19 pandemic. The interviews depicted a vivid and elaborate picture of dilemmas from multiple perspectives. Our findings are reflective of findings (Preti et al., 2020) where that the response to COVID-19 brought clinically significant psychological burdens and mental health problems for healthcare providers around the globe.

First, the most overwhelming issue expressed by healthcare professionals in our study was the moral injury and ethical dilemmas, which was consistent with results from Williamson et al. (2021) and the UK National Health Service where moral injury has been found to be one of the greatest challenges by frontline health-care staff in the context of COVID-19 (Lamb et al., 2021). This may occur when healthcare professionals cannot fulfill their moral obligation to patients, such as delivering the best medical service, or fail to pursue what they believe to be the correct course of action caused by forces that are out of their control (Mehlis et al., 2018). In our study, physicians and nurses reported they witnessed acts that transgressed deeply held moral beliefs. Moral injury carries a sense of guilt, powerlessness, and insufficiency that can lead to job burnout

in health care professionals (Ruotsalainen et al., 2015). In this study, ED physicians and nurses were brought to rethink and reflect upon the meaning of their career. Therefore, the need for open communication with and support for staff in periodical screening for and obtaining psychological support and evidence-based treatments for mental health problems (such as moral injury) is required (Lamb et al., 2021) to minimize the potential for negative impacts on staff.

The delivery of end-of-life care during the COVID-19 visiting policy restrictions was challenging for participants in our study. This finding was also reflected in a UK national survey conducted among 217 ICUs (Rose et al., 2021), where end-of-life was the most common reason for which family presence was permitted. In our study, healthcare professionals reported dilemmas between ethical principles and policy requirements; they were left wanting for further guidance in their capability to tailor visiting requirement to meet the patient's needs. These findings highlight the need to consider a tailored approach to visitor restrictions so that ethical dilemmas can be minimized and quality of life outcomes optimized.

Second, the added complexity of visiting restrictions appeared to place extra burdens on staff particularly regarding workload and communication with patients and family members. When families were not able to visit patients, an increased need for information and regular updates from health care professionals on patients' conditions was reported. This finding is consistent with studies undertaken in different settings and different countries including nursing homes in the Netherlands (Verbeek et al., 2020) and one neurology intensive care unit in the United States (Creutzfeldt et al., 2021) where visiting restrictions added extra workload, especially in terms of communication and support virtually during the COVID-19 crisis. The strict visitation policy meant that the distance between patients, families, and staff required a more detailed, frequent, and proactive communication from clinicians when compared to how information was able to be gained through physical visits and face-to-face communication (Creutzfeldt et al., 2021). This finding highlights the need for additional support services, such as social workers or volunteers, to help support communication pathways between healthcare staff, the patient, and their family when there are restrictions placed on visiting.

The challenges with communication between clinicians, patients, and their families were especially evident with certain vulnerable population patient groups such as people with language barriers, dependent older people, people with mental health problems, and people at the end-of-life. In these vulnerable groups and situations, the presence of family in a critical care setting has been suggested as a means to achieve better pain control to reduce the use of sedatives and to contribute to the reorientation and cognitive stimulation for patients (Rosa et al., 2017).

Third, the visiting restriction challenged the ability of ED staff to provide family-centered care. The distance between patients, families, and ED staff led to difficulty in obtaining comprehensive patient information from family members. The limited information may have placed some patients (e.g., those with delirium) in potentially unsafe circumstances. The situation in our study has been reflected

elsewhere. A retrospective single-center observational cohort study in Japan showed the odd ratios (OR) for incidence of delirium after visitation restriction was 3.79 (95% CI 2.70–5.31) compared with before visitation restriction among emergency inpatients (Kandori et al., 2020). Moreover, a Scandinavian cross-sectional study presented that the COVID-19-related visiting restrictions resulted in nurses compromising on their usual standards of family care (Jensen et al., 2022). This emerging body of research highlights the importance of considering broader implications from visiting restrictions.

Finally, in order to compensate for the absence of physical visits, some alternatives (such as video or telephone meetings) have been effectively utilized during the COVID-19 pandemic in other healthcare settings, including nursing homes and general wards (Jiménez-Rodríguez et al., 2020). In this study, these digital measures were also utilized by ED staff to meet families' needs and try to improve the involvements of families. However, the findings from our study provide a new point that these strategies have certain limitations in the ED setting. From the participants' perspectives, the conditions of ED patients were complicated, fluctuated, and changed quickly, which required frequent communication and decision-making between family members and healthcare providers. Besides, it is difficult to provide and implement the involvement of family-centered care because of the extra cost on time and staff during the COVID-19 crisis, which echoes the finding by Rose et al. (2021) where the most common barrier to virtual visiting in the ICU related to insufficient staff time. Moreover, the visiting restriction reduced the possibilities to provide consensus between families and healthcare providers. Digital methods were not able to comprehensively meet the needs of patients, their families, and staff in the emergency care setting; a finding reflected elsewhere (Muniraman et al., 2020). Although there is no "one-size-fits-all" solution for the complex dilemmas faced by ED clinicians and managers, our findings provide several insights worth considering in future visiting policies. The need for an ED-specific and tailored visiting policy, such as added social worker or volunteers, warrants consideration to support clinicians with their decision-making and capability to deliver quality healthcare that best meets the needs of the patient and their families.

## 6 | LIMITATIONS

There are several limitations to this study. First, participants were from two EDs in Beijing in China and their experiences and our findings might not be generalized to other healthcare settings in other countries. The semi-structured interview guide used in our study, although based on the literature, was developed by researchers, and although pre-tested, the questions could be further developed.

## 7 | CONCLUSIONS

Emergency department healthcare professionals were impacted by the visiting restriction policies implemented during the COVID-19

pandemic. Themes that emerged centered around the moral balance and the increased workload, especially with communication, and the challenges in providing family-centered care. Despite these challenges, ED staff made concerted efforts to accommodate the policies and tailor strategies to support family-centered care. Our findings shed some light on informing future visitation considerations that are cognizant of vulnerable people who require emergency care, especially in situation of delirium, end-of-life, and language barriers. Nationally supported and guided approaches to help maintain connections between patients and families and tailored approaches for the ED context that consider both infection prevention and quality of life during a pandemic are warranted.

## DATA AVAILABILITY STATEMENT

Data openly available in a public repository that issues datasets with DOIs.

## ETHICS STATEMENT

The Human Research and Ethics Committee of the hospital have approved the study.

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