Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Women's and Nurses' Perceptions of Visitor Restrictions After Childbirth During the COVID-19 Pandemic

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ABSTRACT

Objective: To examine the perceptions of labor and delivery (L&D) nurses and childbearing women in the postpartum period regarding a restricted visitor policy during the COVID-19 pandemic.

Design: Descriptive mixed-methods survey and open-ended questions.

Setting/Local Problem: One hospital in the southwestern United States. There is limited evidence regarding recently imposed visitor restrictions related to COVID-19.

Participants: Individuals who were pregnant and self-identified as women who gave birth during October 2020 through March 2021 ($n = 674$) and L&D nurses ($n = 47$).

Intervention/Measurements: Participants who had given birth with visitor restrictions completed an online survey, and L&D nurses completed a paper survey.

Results: Childbearing women had positive and negative views; they valued a more intimate familial bonding and recovery without visitors and appreciated decreased pressure to accommodate family/friends. They were also disappointed with sibling restrictions and were sad and frustrated with visitor limitations, especially in special circumstances (e.g., NICU admission or extended stays). Nurses expressed that visitor restrictions allowed more time for higher-quality nursing care/patient teaching and decreased distractions in emergencies, leading to safer care. Women and nurses reported that visitor restrictions allowed women more rest and relaxation as well as less worry and strain from juggling family and friends who wanted to visit, but they also identified that there was decreased family support when it was needed.

Conclusion: Women's responses were mixed, with some preferring support from many visitors, while others appreciated the intimate focus of just their partner. Most nurses preferred fewer visitors but could empathize with women.

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KEYWORDS: childbirth, COVID-19, hospital, labor and delivery, newborn, pandemic, perception, postpartum, pregnancy, visitation, visitor restriction

CLINICAL IMPLICATIONS

- Women differ in their social support preferences during and after birth, and a rigid visitation policy may impede women's perceptions of a successful birth experience.
- Health care providers' clear communication and education regarding the importance of restricted visitation to childbearing individuals and their families will allow for better understanding and tolerance for restricted visitor policies.
- In this study, nurses' and women's comments were similar on the advantages and desirability for an intimate experience with limited visitors that enhanced bonding and breastfeeding.
- The importance of sibling visitation warrants policies that allow sibling visitation under special precautions.
- Adminstrators and management must use both nurses' and women's views when developing or revising visitor policies.

The novel coronavirus (COVID-19) pandemic presents significant risks to public health, including mental health, and can increase risks for maternal morbidity and mortality (Saccone et al., 2020). Many labor and birth units in the United States have implemented a restricted visitor policy to limit the spread of COVID-19 (Arora et al., 2020). Giving birth is a unique and emotional experience for pregnant individuals and families. Health care professionals must take appropriate precautions to protect themselves and those they care for from infection and ensure social and emotional support during pregnancy and childbirth (Jago et al., 2020).

Health care providers and pregnant women are concerned about contracting COVID-19 (Cronin et al., 2020). In one study, despite their concerns about COVID-19, only a minority of health care providers (in agreement with pregnant individuals) were in favor of excluding all support people during labor, birth, and the immediate postpartum period (Cronin et al., 2020). Therefore, having support persons present during labor and birth is expected and encouraged (Ecker & Minkoff, 2020).

Labor support is well documented to decrease the length of labor, reduce surgical and instrumental births, decrease the use of analgesics, promote higher Apgar scores and breastfeeding rates, and promote greater birth satisfaction (American College of Obstetricians and Gynecologists, 2014; Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], 2018; Bohren et al., 2017; World Health Organization [WHO], 2018). For these reasons, professional health care organizations strongly recommend continuous labor support, and it is considered an essential aspect of childbirth. However, women's preferences for specific support persons vary depending on interpersonal relationships, culture, values, or birth environment (Lunda et al., 2018). Although women often want and benefit from the presence of selected members of their social network (e.g., family members, doulas), some women may welcome a more restrictive visitation policy to allow them to experience the moment of birth with only their partner (Bohren et al., 2017). Having only one visitor during labor and birth may increase rest, promote bonding and breastfeeding, and allow for less worry and family tension.

Visitor restrictions may exacerbate existing racial and ethnic disparities by limiting avenues for support and advocacy (Norton et al., 2020). Women with lower income and/or from historically marginalized populations are less likely to have the financial and transportation resources to have a single person with them continuously or to allow different visitors to swap out. These women may be more likely to be essential workers or caregivers and, thus, are more likely to be exposed to COVID (Norton et al., 2020). Policies limiting visitors, especially for laboring women who are diagnosed with COVID, mean that this population is more likely to be deprived of labor support, which is known to improve outcomes. These policies may inadvertently contribute to structural inequality and increase health disparities (Norton et al., 2020). Indigenous, Hispanic, and Black women are twice as likely to be mistreated by health care workers (e.g., being shouted at, receiving delayed care, or being ignored; Vedam et al., 2019). Support persons are often considered advocates who protect individuals from discriminatory behavior from health care providers. By losing the ability to have support persons present during labor and birth, individuals may be at a greater risk for mistreatment (Altman et al., 2021).

The benefits of support persons during labor and delivery (L&D) have been well documented. However, less is known about the perceptions of women and nurses concerning restricted visitation during L&D because of the COVID-19 pandemic. Therefore, the purpose of this study was to explore the perceptions of women in the postpartum period and L&D nurses on visitor restrictions during childbirth.

Study Design and Methods

Design and Setting

This descriptive cross-sectional study provided quantitative and qualitative data from participants at one medium-size hospital in the southwestern United States. This hospital has approximately 150 to 200 births per month and approximately

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4,000 births per year. Our system institutional review board reviewed and approved the study.

We used two investigator-developed surveys to describe the following: (a) women's perceptions of restricted visitors on the birth experience and (b) L&D nurses' perceptions of the restricted visitor policy on patient care.

Sample

Our sample included individuals who were pregnant and self-identified as women, as well as all L&D nurses who were employed at the hospital during the study. Between October 2020 and March 2021, 890 women gave birth. Inclusion criteria were (a) able to read and speak English, (b) gave birth during the time period of the study, and (c) age of 17 years or older. Exclusion criteria were (a) non–English speaking, (b) no e-mail address listed or undeliverable e-mail address, and (c) age less than 17 years. Women who experienced significant complications and/or a fetal demise were also welcomed to participate and were not excluded. See Table 1 for women's demographics and Table 2 for nurses' demographics.

Procedures

Research team members e-mailed women who gave birth during a 6-month period of visitor restrictions from October 2020 to March 2021 using the software system RedCap. A total of 674 women received the e-mail after the exclusion of women who were not fluent in English, women who had no e-mail listed, and those that were returned as undeliverable. The e-mail described the research project and invited participants to complete a survey of their perceptions of the restricted visitation policy. The surveys were anonymous and explained that participants' informed consent was implied by completion of the survey. There were 118 completed surveys returned, which was an 18% response rate.

The primary investigator sent an e-mail to the L&D nurses' e-mail distribution list describing the research study, inviting participation, and explaining the voluntary, optional, and anonymous nature of the survey. All 47 L&D nurses were invited to participate. After sending the e-mail, the primary investigator placed a paper survey in each nurse's unit mailbox. Nurses were asked to place their completed surveys in a slotted sealed box located on the unit. The data were imported into the IBM SPSS statistical software program by a nurse-scientist on the team. Two nurses declined to answer the question related to age, but all other questions were answered by all 33 nurses who completed the survey, which was a 70% response rate.

Measures/Instruments

No previous similar surveys were available related to nurses' or women's perceptions of visitor restrictions during a pandemic. Lacking existing surveys, the research team used the literature, recommendations, and a systematic review on labor support to create the surveys (AWHONN, 2018; Bohren et al., 2017). Both surveys used response options from 1 to 10, where 1 = *strongly disagree* and 10 = *strongly agree*. The survey of women in the postpartum period had 11 questions in the Likert scale format to describe their perceptions related to COVID-19 visitor restrictions during their birth and postpartum experiences (see Table 3). The L&D nurses' survey had 9 questions in the Likert scale format on nurses' perceptions of caring for women with restricted visitors (see Table 4).

Both surveys had open-ended items for respondents to elaborate on their views. Postpartum respondents were asked to "Please share your thoughts on how restricted visitation affected your birth experience." Nurses provided qualitative responses by replying to the statement, "Please share your thoughts on how restricted visitation affects patient care and women's birth and postpartum experiences."

> Nurses indicated that they know from their experiences observing and promoting optimal bonding that excessive numbers of visitors can diminish and detract from that ideal

Analysis

We followed a content analysis methodology to determine themes from nurses' and women's open-ended comments. The team individually read all content to develop codes, categories, and preliminary themes and then came together to determine agreement on the final themes. The themes were reviewed and defined (Nowell et al., 2017). Data for postpartum women and nurses were entered into the SPSS statistical software program by a nurse scientist on the research team. Descriptive statistics were used to report means and percentages. Linear regression was used to examine the association between demographic characteristics and the survey items.

Results

Women's Survey Results

Demographic characteristics are represented in Table 1. Multiple considerations predicted women's satisfaction with pandemic-related visitor restrictions during labor and birth. Age range was transformed to 30 years and younger or 31 years and older because of very small numbers in the tails of the distribution. Race/ethnicity was transformed to White and minority because of the disproportionate distribution (67% White). Associations were investigated using a linear regression outcome of Item 9 ("I am glad there was a restricted visitor policy in labor and delivery"). The outcome was regressed on items other than Item 9 (outcome) and on age, race, and birth month. Age, race, and birth month did not

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TABLE 1 DEMOGRAPHIC CHARACTERISTICS OF WOMEN

Characteristics	Participants (N = 118)	
	n	%
Month women gave birth		
December	29	24.6
January	23	19.5
February	27	22.9
March	21	17.8
Missing	18	15.3
Race		
Hispanic/Latino	21	18
Asian	5	4.2
Black/African American	9	7.6
Pacific Islander	1	0.8
White	78	66.1
Other	3	2.5
Missing	1	0.8
Maternal age range, years		
17–20	2	1.7
21–30	55	46.6
31–40	55	46.6
>40	4	3.4
Missing	2	1.7

TABLE 2 DEMOGRAPHIC CHARACTERISTICS OF NURSES

Characteristics	Participants (N = 33)	
	n	%
Years working as a nurse		
<5	5	16
5–10	11	32
11–20	14	42
More than 20	3	10
Years working in labor and delivery		
<5	11	32
5–10	7	23
11–20	12	35
>20	3	10
Nurses' age range, years		
<30	4	12.1
30–40	15	45.5
41–50	9	27.2
51–60	2	6.1
>60	1	3
Missing	2	6.1

significantly predict outcomes. Three items significantly predicted acceptance of the visitor restrictions. These items accounted for approximately 70% of the variance in the outcome (R^2 = 0.691): (a) belief that the patient was less likely to contract COVID (related to how patients value safety), b) preference that family and friends not be present in L&D, and c) ability to breastfeed without distractions. The Cronbach's alpha for the women's survey was .925, which indicates excellent reliability in the study sample.

The open-ended comments provided by individuals who gave birth were fairly evenly split between negative and positive views of visitor restrictions, and many participants conveyed both sentiments. The six themes are listed with representative quotes.

More Intimate and Special. Respondents were very expressive, writing of their pleasure at peaceful and cozy family bonding and recovery without the distraction of visitors: "I liked it! It allowed my partner to focus solely on me (and our baby) without hurting any of our family's feelings as to why they couldn't be there. I think it helped me bond with my baby too because she wasn't passed around. . . ." "I felt I had a more personalized experience. The focus was on baby and me. . . . I'm grateful for this experience . . . by far the best. . . ." Several respondents wrote, "It was perfect."

Pressure Is Off! Participants were grateful at having less pressure to accommodate unwanted family or family wanting to visit. Comments included, "I was happy. I did not have to come up with excuses on why I do not want more family members present . . . it was easy to just refer [to] the restricted policy." One respondent wrote that she had been "stressed at the thought of family and friends playing hot potato with my newborn child while my husband and I were wanting to hold her, get to know her, and just rest."

Missing the Moment of Birth/Missing This Special Time. This theme captures general unhappiness regarding restricted visitors, having to pick who could visit, and being disappointed at not sharing this special time (not seeing a first grandchild be born). Comments included the following: "Was sad my mom couldn't be there with my husband," and

"It made me so sad because I wanted my mother-in-law to be there who flew in from out of state."

Needing More Support. Participants explained how they felt without a mother, friend, or doula to support them: "It was lonely and isolating," and "I was terrified. It was my first birth and didn't know what to expect." There were a few special situations where more support was needed because of complications.

Meeting Siblings for the First Time. There were many comments related to disappointment with sibling restrictions: "My older daughter will now never get the experience of meeting her new baby brother in the hospital. Missed memories."

Kept Me Safe. Comments included, "I felt my baby and I were *safer* from contracting COVID because of the visitor restrictions."

In summary, many respondents were happy with their experience with minimal visitors, allowing the moment to be more intimate and special for the woman and her partner. Other responses suggested loneliness and disappointment. Disappointment with sibling restrictions was the most common negative response.

Nurses' Survey Results

Nurses' demographic results are represented in Table 2. The Cronbach's alpha for the nurses' survey was .705, which indicates acceptable internal consistency reliability. Most nurses believed visitor restrictions led to better patient outcomes (better rest, less stress, more effective breastfeeding, enhanced bonding). Nurses indicated their own preference for limited visitors if they were giving birth under the same circumstances. Nurses reported that having restricted visitation increased job satisfaction, yet they believed that laboring women were better supported with more than one visitor to help them. Nurses in this study preferred only one visitor allowed under the same circumstance if they were giving birth. Nurses' qualitative data showed the following themes about restricted visitation.

> Missing the moment where siblings meet in the hospital was a top disappointment with restricted visitation

More Time for Optimal Care. Nurses expressed that fewer visitors allowed more time for higher-quality nursing care and better patient teaching: "Having only one visitor helped me perform my job more effectively as I was not competing with visitors to perform care and teaching—particularly in the immediate recovery period."

Rest and Relaxation. Nurses' comments were similar to those of the postpartum respondents, reflecting that women had more rest and relaxation without constant interruptions from visitors: "Less stress, more bonding time, and less interruptions."

Pressure to Accommodate Others Over Own Needs. For this theme, comments were similar to those of the participants who gave birth. Nurses recounted how visitor restrictions reduced worry, strain, and pressure on the women giving birth. Women felt less pressure to accommodate unwanted family members and friends, and restricted visitation allowed them to make their own decisions regarding birth support: "Having one visitor is better for the woman and her partner because the woman does not have the stress of 'policing' family members and feeling bad in telling a family member or friend that they can't be in the room."

Safer During Emergencies. Nurses described how fewer visitors reduced distractions in an emergency, leading to better patient safety: "Less visitors are better during an emergency situation because staff are more able to maneuver in the environment instead of jumping over family sleeping on the floor."

Needing More Support. Nurses also wrote that visitor restrictions can lead to less family and social support availability when needed. Their comments advocated for flexibility and individualization of policies, depending on circumstances: "My concerns would be for those teenage mothers-to-be that could really use the support from their own mothers in addition to the father of the baby."

Discussion

The participants who gave birth reported mixed emotions regarding visitor restrictions during the labor, birth, and postpartum hospital experience. They indicated they would "go along" with what family says or wants simply because they do not want to cause a rift in the family dynamics, or they do not have the energy to disagree with family during this special time. With limited visitation, women indicated they could make decisions for themselves without everyone having an opinion and making them feel pressured/coerced. These views are also reflected in the literature. According to Price et al. (2007), women felt that extra visitors contributed to their feelings of disempowerment and often asked them to leave.

The women's comments mirrored nurses' comments regarding how having multiple visitors can interfere with parents' bonding and breastfeeding. Nurses indicated that they know from their experiences observing and promoting optimal bonding that excessive numbers of visitors can diminish and detract from that ideal. Nurses have witnessed repeatedly what women wrote in their comments—that the visitors pass the baby around "like a hot potato, while (we) wanted to hold her," and that having unlimited visitors can make the experience "more rushed and stressful trying to please everyone."

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Women's safety is the priority in the hospital setting. Some nurses expressed that restricting visitation would help in an emergency because there are fewer distractions and individuals to work around. Regardless of visitor policies, extra visitors should be encouraged to go home to sleep or find alternatives that do not obstruct care and allow the environment to be clear of clutter for emergency equipment and staff.

The women's survey results in this study are similar to previous findings related to the need for labor support. According to Bohren et al. (2016), labor companions supported women in four different ways: they (a) educated women on childbirth, helped bridge communication gaps between health care providers and the birthing women, and helped in facilitating nonpharmacologic pain relief; (b) advocated for the laboring women; (c) provided hands-on support, such as encouraging the women to move and change positions, providing massage, or holding a hand; and (d) were present for emotional support, offering praise and reassurance to the laboring women. Women greatly value the emotional support and experiential knowledge gained from female family members and friends, as well as their partners. This support can provide affirmation or support for decision-making during the labor process, which can diminish the loss of control women often experience during childbirth.

Findings from the women's survey indicate that missing the moment when siblings meet in the hospital was a top disappointment with restricted visitation. Visitor restrictions have led to some hospitals providing innovative solutions to connect laboring women with their extended family and friends, such as providing a computer tablet upon admission with video conferencing software. This allows family and friends to feel included in the labor and birth (Burgess et al., 2021). Using virtual platforms could be a solution that allows siblings to meet.

Women prefer support persons with affirmative attributes to achieve positive outcomes (Lunda et al., 2018). Health care administrators, providers, and policy makers should recognize the significance of childbirth support, even during a pandemic. One participant who gave birth wrote, "My doula had to leave the delivery room to switch off with my husband to watch our children in the waiting room. Then she was not allowed back in because the labor was over." A position statement from AWHONN (2018) opposes hospital policies that restrict the presence of a doula in the birth setting during an infectious disease outbreak. Although not all laboring individuals want the assistance of a doula, for those who do, a doula can have an essential role in the birth process, leading to improved birth outcomes. Hospital administrators should consider that general policies may need to be individualized based on unique circumstances. As the pandemic progressed, the hospital in this study changed its policy to allow a doula as well as one support person in the room during labor and birth.

When the pandemic began, COVID transmissibility and outcomes for pregnant individuals with COVID and their newborns were unknown. Hospitals implemented visitor restriction policies and other safeguards to minimize risk to patients and health care workers. Such policies stem from balancing the benefits to the individual patient with the duty to reduce infectious exposure to other patients, visitors, and members of the health care team (Arora et al., 2020). According to Virani et al. (2020), there must be clear and empathetic conversations to help patients understand the reasons for restrictive visitation to promote safety for themselves and the health care staff. As recommended by the Centers for Disease Control and Prevention (CDC, 2021) and American College of Obstetricians and Gynecologists (2014), visitors at our hospital were screened for symptoms and risk factors (e.g., cough, fever, congestion, loss of taste or smell, recent travel) before entry to the L&D unit. Visitors permitted entry were required to wear a standard surgical mask for the duration of their stay.

Health care administrators, providers, and policy makers should recognize the significance of childbirth support, even during a pandemic

According to the (CDC 2022), the number of births to women with COVID-19 during the time of this study (October 2020 to March 2021) was 20,066, and locally, there were 13,274 confirmed cases of COVID-19 between October 2020 and March 2021 (Denton County Public Health, 2021). Earlier in the pandemic, a meta-analysis of 41 pregnant women with COVID-19 indicated that pregnant women may be at increased risk of miscarriage, preterm birth, preeclampsia, and surgical birth, particularly if they were diagnosed with pneumonia (Di Mascio et al., 2020). Researchers also examined outcomes with the delta variant and found that of 1,515 pregnant individuals diagnosed with COVID-19, 5.4% had severe or critical illness (Adhikari et al., 2022). To reduce the risk of maternal and neonatal COVID-19 disease, visitor screening and restrictions were enforced.

Nurses play a key role in educating the public and correcting misinformation. There has been widespread misinformation on how COVID-19 is transmitted, who is at risk of transmitting or contracting the virus, and where outbreaks are occurring (Wen et al., 2020). Nurses must confront misinformation and direct patients and families to reputable public health resources such as the WHO, CDC, and local departments of public health that promote evidence-based infection prevention measures (Centers for Disease Control and Prevention, 2020; WHO, 2020). Front-line nurses must simultaneously protect themselves and other patients from infection while also providing high-quality care (Choi et al., 2020). Nurses must also ensure that women understand the

TABLE 3 WOMEN'S VIEWS OF CHILDBIRTH VISITOR RESTRICTIONS

Survey Items[a]	Mean	*SD*
I felt more supported having only my partner with me during labor and birth.	5.79	3.94
I would have preferred having friends and family with me along with my partner during labor and birth.	5.28	3.85
The restricted visitor policy made me feel less supported during labor and birth.	3.85	3.73
By not having other friends and family with me, I was able to breastfeed my baby without distractions or modesty issues.	6.47	3.73
By not having other friends and family with me, I was able to spend more time with my baby skin to skin without distractions or modesty issues.	6.71	3.58
The restricted visitor policy made me feel more confident that I would not contract COVID-19 while in the hospital.	5.74	3.93
I felt more anxious without more family and/or friends with me during my labor and birth.	4.19	3.87
I felt less supported not having friends and family along with my partner during my labor and birth.	4.45	3.97
I am glad there was a restricted visitor policy in labor and delivery.	5.08	3.92
I considered a home birth or birth center birth because of the visitor restrictions during labor and birth.	2.67	3.76
I would have preferred my children to be present during labor and birth.	6.29	3.70

[a]Response options: *strongly disagree* = 1; *strongly agree* = 10.

reasons for restrictive visitation. A part of a nurse's teaching could encompass an explanation of boundary setting with compassion and consideration of the individual's circumstances. This could mean making space and time for a woman and her partner to express themselves emotionally and being available to help support and transition them through difficult conversations (Virani et al., 2020). Evidence-based policies are essential, but compassion-based exceptions and flexibility are also needed.

Clinical reasoning supports excluding L&D units from visitor prohibition policies (Arora et al., 2020). As noted by the WHO, continuous companionship during labor and birth is recommended for all pregnant individuals to improve labor outcomes. Evidence supports the protective benefits of social connections and support during pregnancy and labor; there are increased maternal, fetal, and pregnancy risks when pregnant and laboring women lack support (Jago et al., 2020).

There are ethical concerns in exempting labor, birth, and postpartum recovery units from visitor restrictions. The increased risk of exposure to other individuals and health care professionals depends on the severity of cases in the hospital and community. In areas of low prevalence, the benefits may outweigh the risks, especially if COVID-19 mitigation strategies are consistently implemented.

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TABLE 4 NURSES' VIEWS OF CHILDBIRTH VISITOR RESTRICTIONS

Survey Items[a]	Mean	*SD*
I prefer having only one designated visitor for women in labor and delivery until transferred to the postpartum unit.	8.42	2.50
I believe the current restricted visitor policy has increased my workload.	2.63	2.65
I have more time to support women in labor with fewer visitor interruptions.	9.21	1.54
I believe that laboring women feel better supported with more than one visitor to help them.	5.12	2.67
I feel safer with the restricted visitor policy because I have less likelihood of contracting COVID-19.	6.72	3.40
Having fewer visitors gives me more time for patient teaching.	9.12	1.93
Having restricted visitors increases my job satisfaction.	8.78	1.93
I believe visitor restrictions lead to better patient outcomes (better rest, less stress, more effective breastfeeding, enhanced bonding).	9.39	1.22
If I were giving birth, I would want only one visitor allowed.	7.96	2.83

[a]Response options: *strongly disagree* = 1; *strongly agree* = 10.

Implications for Practice

Policy changes may be needed to accommodate more than one visitor during a pandemic in labor and birth settings, particularly with special circumstances, such as maternal or infant complications. These changes would acknowledge individual preferences for the presence of extended family and doula support. Policies must balance safety concerns related to infection control and the needs of those who are giving birth. Additionally, policies will most likely change depending on local COVID rates and national guidance.

It has been well documented that human presence and support during labor improve birth experiences and overall outcomes for women and neonates. Focusing only on visitor restrictions does not reflect existing evidence on COVID-19 and mutations. The CDC recommends multiple layered mitigation strategies that hospitals should use for this airborne infection (CDC, 2021c). In addition to high-quality masks (not cloth), vaccinations, and physical distance, the CDC recommends improved ventilation and air filtration to dilute and disperse virus particles. If opening windows or doors is feasible, hospitals should allow and encourage this. All mitigation strategies should be explored and incorporated into existing safety policies. A multipronged approach to safety and infection prevention must involve more than just visitor restrictions.

Limitations, Strengths, and Areas for Further Research

This study had several limitations. It was limited to a community hospital. Over the course of the pandemic, the visitation policy, while still restricted, had changed from only one visitor to allowing two visitors during labor and birth. Approximately half of the respondents were from the one-visitor time frame. Consequently, this may have skewed the results of the study, although many women were still bringing only one support person with them. The self-report survey design and convenience sampling are potential sources of bias. In addition, both survey instruments were designed by the investigators and have no established reliability or validity. Limited demographic information was collected, and a robust description of the samples is not available. Because the study population was limited to English-speaking participants at a single hospital, results cannot be applied beyond this sample.

Although there were limitations, the study also had strengths. Although the surveys were developed by the investigators, they were constructed based on national standards and labor support literature. Cronbach alpha results for this study were acceptable to strong. Using qualitative and quantitative methods allowed for the triangulation of results.

This research could be further evaluated by implementing the study in more diverse hospital systems and including a

larger sample size of nurses and individuals who had given birth. In addition, adding the perceptions of restricted visitation from other health care providers, such as physicians and midwives, will provide additional insights.

Conclusion

The COVID-19 pandemic has severely tested hospitals, clients, and staff. Ensuring adequate safety for staff and clients while encouraging appropriate visitor support in the labor and birth setting has been a challenge. Women in labor have a deep need for companionship, empathy, and support from not only their partner but extended family and friends as well. Nurses need to provide and encourage labor support while also promoting and advocating for intimate private bonding time. Hospital policies must consider the views of nurses, birthing individuals, and families to meet these competing needs.

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