


“I don’t know how we would have coped without it.” Understanding the Importance of a Virtual Hospital Visiting Program During the COVID-19 Pandemic

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Abstract

As the COVID-19 pandemic reached Canada in full strength, the concept of allowing visiting to patients became an impossibility in most healthcare organizations. In March 2020, hospitals across Canada made the decision to close to visitors. This was a complicated decision which left admitted patients with very little option for connecting with family and friends other than through the telephone. In response, North York General Hospital launched a virtual family visiting (VFV) program across all inpatient units. Here we report the findings of a qualitative study of the program informed by an interpretive descriptive approach. Interviews were conducted with families who participated in the VFV program at North York General Hospital in Toronto, Canada during the first wave of the COVID pandemic. A total of 24 family members were interviewed. As anticipated, the family members were all extremely pleased with the opportunity to connect virtually and very satisfied with the VFV program. What was less anticipated was the anxiety and distress that families experienced in being separated from their loved ones. Our data analysis revealed 4 key themes which we have labeled (a) the unforeseen consequences of separation trauma, (b) increased vulnerability of patients and family, (c) a lifeline of human connection, and (d) the role of the facilitator as a connector. This work contributes significantly to a system-level understanding of the impact of imposed separation, increased vulnerability, and the importance of providing an alternative way for families to be present with their loved ones in these unprecedented times.

Keywords

COVID-19, patient- and family-centered care, virtual visit program, qualitative

Introduction

It has been apparent for some time that the idea that patients only need to interact with medical professionals to recover is unfounded (1). There are good reasons to support the notion that friends, and family play a significant role in patients’ emotional wellbeing and therefore in their recovery: hospitals and care facilities are, by their very nature, social institutions. Policies that support open visiting recognize the importance of relationships for patient recovery and are more person-centered (2,3).

As the COVID-19 pandemic reached full strength in Canada, allowing visiting to patients became an impossibility in most healthcare organizations. In March 2020, hospitals across Canada made the decision to limit family presence to decrease the potential spread of the COVID-19 virus. This was a difficult decision that left admitted patients with very little option for connecting with family and friends

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other than through the telephone. During this time, several organizations looked to launch various versions of virtual visiting opportunities for families of admitted patients. The majority of the published literature on such programs to date has been focused on programs implemented in adult and pediatric intensive care units, where virtual visiting has been very successful in connecting patients, families, and health care providers in a timely way (4–9). To our knowledge there is very little, if any, published on virtual family visiting programs in general medical wards or other areas in the hospital.

At North York General Hospital (NYGH) in Toronto, Canada, the Quality and Patient- and Family-Centered Care teams collaborated to create a virtual family visit (VFV) program. The VFV program allows for video calls between patients and families hospital-wide on all inpatient units. The target patient population for this VFV initiative is patients who do not have devices with video technology (like an iPhone or iPad) or need some assistance to use their own devices for a video call (mostly seniors). Ultimately, the program was designed to help bring people closer together and to ensure they felt connected during this time of separation and uncertainty.

As a key COVID-19 response intervention, we felt it was important to understand the experience of patients and families with the VFV program outside the intensive care unit in order to delineate more generalizable benefits and areas for improvement, as well as how such a program may have an impact beyond a pandemic situation.

Methods

Research Question and Design

We employed qualitative methodology informed by an interpretive descriptive approach for this study (10). Qualitative methods are well suited for this study given our interest in developing an in-depth understanding of the lived experiences of family members of patients hospitalized during the COVID-19 pandemic. Interpretive description (ID) is a widely used qualitative research method developed within nursing. It is best known for offering an accessible and theoretically flexible approach to analyzing qualitative data and for generating knowledge relevant to the clinical context (11). Research ethics board (REB) approval was granted by the North York General Hospital REB prior to the start of the study (REB ID #20-033).

Study Setting and Sampling

This study was conducted with people who participated in the VFV program at North York General Hospital in Toronto, Canada during the first wave of the COVID-19 pandemic. In this study, we used the word “family” to refer to 2 or more people who are related in any way—biologically, legally, or emotionally—as defined by the research

participants themselves. We use family, next of kin, close ones, loved ones, and relatives interchangeably in this article. Visitors outside of family members were not involved in the program. We also defined “virtual visits or visiting” to be visiting and social connection between admitted patients and their family members (as defined above) as opposed to the word “visits” used to indicate appointments with health care practitioners for the purposes of care delivery.

Participants were recruited purposely using predetermined quota sampling techniques to ensure that the study sample was representative of patients and families involved with the VFV program in terms of typical socio-demographic factors (age, socio-economic status, marital status, etc). We also used maximum variation sampling to capture the widest possible range of perspectives and to help us understand how virtual visits were experienced by participants in different circumstances (spouses, parents, adult children, etc) (12).

The North York General Hospital VFV program maintains a contact database of all patients and families who have participated in the program. The program is staffed by program facilitators (NYGH staff who had been redeployed) who are in regular contact with program participants. Patients and families who met the sampling criteria were contacted by the VFV program Navigators (senior care specialists employed by NYGH) and asked to provide consent to be contacted by a member of the research team if they were interested in learning more about this study. Once potential participants agreed to be contacted, the research coordinator followed up directly to discuss the study in detail, provide a letter of information and consent form, and arrange a time for the virtual interview. The letter of information and consent form were reviewed again with each participant and informed verbal consent was obtained at the time of the interview.

Data Collection

The method of data collection for this study was in-depth semistructured interviews. Interviews are used extensively in qualitative research as a way of accessing the meaning-making activities, thoughts, perceptions, beliefs, and understandings of people about a topic of interest (13). The semi-structured format allows the interviewee to guide the conversation while at the same time allowing the interviewer to provide direction around certain topics. All interviews were conducted by a PhD trained research coordinator who has extensive experience with qualitative methods (MBS). The interviewer had no prior relationship with any of the participants and was not directly involved in the VFV program in any way. The interviews continued until the research team agreed by consensus with team meetings and transcript review, that thematic saturation had been reached. This is the point at which investigators agree that viewpoints are fully accounted for and that interviewing more participants will provide no new insight into relevant themes (14).

We developed an interview guide informed by the study objectives and input from team members with expertise in qualitative methodology as well as our research collaborators who were working directly in the VFV program (Supplemental Appendix A). The guide was refined throughout the data collection process and additional questions were asked to follow up on or learn more about things that had come up in previous interviews, and to explore ideas and hypotheses. The interviews were also supplemented with field notes to collect data that cannot be captured on the digital recording (eg, interview dynamics, displays of emotion, etc), to clarify certain points or terms used during the interviews, and to document the researcher's impressions of the interview process. All interviews were conducted by Zoom videoconference or by telephone based on the preferences of the participant, and audiotaped and transcribed verbatim for analysis by an external transcription service. The qualitative data was managed using NVivo12 qualitative software (NVivo 12 QSR International).

Data Analysis

In keeping with the iterative process of qualitative methodology, we collected and analyzed the data concurrently to continuously monitor emerging themes and general areas for further exploration. Project team members KND and MBS, who have qualitative methodological expertise, led the data analysis process, using inductive thematic analysis techniques.⁹ In particular, the interview transcripts and field notes were analyzed following the constant comparative method, an inductive approach geared towards identifying patterns, developing conceptualizations about possible relations, and understanding theoretical properties about the data through a systematic process of memoing, theorizing, and writing, as well as by using standard thematic analysis techniques (15).

The interview transcripts and field notes were independently reviewed by KND and MBS to generate a list of descriptive codes about the data. They then attached the codes to segments of the text in each transcript through line-by-line readings and compared the codes in a sample of 5 transcripts to ensure consistent application of the coding framework and discuss any discrepancies. The descriptive codes were grouped into broad topic-oriented categories and all text segments belonging to the same category were compared (16). The topic-oriented categories were further refined and formulated into fewer analytic categories through an inductive, interpretive process that involved going back and forth between the data. Versions of the analysis were reviewed with the research team at regular intervals, and the final analytic framework, representing themes that reflect interpretations of the patterns in the coded transcripts, was discussed among all authors until we reached a consensus on its validity and applicability. We employed several strategies to support the analytic rigor and trustworthiness

of our analysis (17) including a comparison of coding between analysts, seeking alternative explanations for the data during the development of the final analytic framework, and interrogating the coherence of interpretations through discussion with the research team (18).

Results

Between October and November 2020, we interviewed 24 family members of patients who had been hospitalized at North York General Hospital during the period of restricted visiting due to the COVID-19 pandemic. Unfortunately, due to the level of illness and cognitive impairment of most of the patients involved in the virtual visiting program, we were unable to interview any patients themselves as was originally intended. The majority of participants were female (16/24) and were the adult children of admitted patients (20/24) as well as spouses and other relatives (4/24). The research participants spoke on behalf of their loved ones, including other relatives and the admitted patients themselves, who we were not able to access directly due to the fragile state of their health, limited capacity to communicate, or death. Further details on the study sample are provided in Table 1.

Table 1. Study Participant Characteristics.

Participant	Relationship to patient	Participant gender (M/F)	Patient period of hospitalization
P1	Child	M	Spring 2020
P2	Child	F	Winter 2019-Summer 2020
P3	Spouse	F	Spring 2020
P4	Child	F	Spring 2020
P5	Child	M	Spring 2020
P6	Child	F	Spring-Fall 2020
P7	Child	F	Spring 2020
P8	Grandchild	M	Spring 2020
P9	Child	F	Spring 2020
P10	Child	F	Fall 2020
P11	Child	M	Spring 2020
P12	Child	F	Spring 2020
P13	Child	M	Spring 2020
P14	Child-in-law	F	Summer 2020
P15	Spouse	M	Fall 2020
P16	Child	M	Spring-Fall 2020
P17	Child	F	Fall 2020
P18	Child-in-law	F	Spring 2020
P19	Child	F	Spring-Fall 2020
P20	Child	F	Spring 2020
P21	Child	F	Spring 2020
P22	Niece/ Nephew	F	Spring 2020
P23	Child	F	Spring-Summer 2020
P24	Child	M	Spring 2020
P24	Child	M	Spring 2020

As anticipated, the family members were all extremely happy with the opportunity to connect virtually and very satisfied with how the VFV program was conducted. What was less anticipated was the very raw emotion that came with sharing this experience with us and the distress that these families experienced in being separated from their loved ones. Many of the participants broke down in tears while talking to us about not being physically present with their loved ones at their most vulnerable times. Our data analysis revealed 4 key themes which we have labeled (a) the unforeseen consequences of separation trauma, (b) increased vulnerability of patients and family, (c) a lifeline of human connection, and (d) the role of the facilitator as a connector. Supporting quotes from participants are provided in Table 2.

The Unforeseen Consequence of “Separation Trauma”

Healthcare organizations across Canada made the necessary decision to impose highly restrictive blanket “no visitor” policies during the pandemic and NYGH was no exception. However, a key theme in our data was that this did not mean that families were simply inconvenienced by not being able to see their loved ones, but, in fact, experienced tremendous stress and anxiety. Participants expressed deep concern over the trauma of being separated, often with little advance notice, from a loved one in medical distress with limited options for contact. Participants shared stories about the panic they felt watching an ambulance drive away with their critically ill loved one and having no knowledge of when they would be able to see them again or if their relative would survive long enough to do so. They experienced guilt over not being able to comfort and support their loved ones in person, and worried that their relatives would feel lost, abandoned, or confused about why their families were absent.

Increased Vulnerability of Patients and Family

Participants specifically highlighted concerns about the vulnerability of their loved ones as well as the precariousness of the patient’s situation, including being unable to understand what was happening to them clinically and advocate for themselves due to language barriers, sensory impairments, and health conditions. Knowing that their loved one was in such a vulnerable state left many participants feeling powerless, desperate, and full of anxiety.

We learned that this vulnerability extended to the family members themselves as they were now legitimately “on the outside” of the situation. Families struggled to communicate with the clinical team in a meaningful way when they could not physically be present during rounds or attend family meetings. Despite what was perceived to be the best efforts of very busy hospital staff to briefly communicate with them by telephone daily, many participants felt inadequately informed about how their loved one was doing. This was a

significant source of angst and distress for all the family members we interviewed. We were also told that substituting decision-making with inadequate information was an added challenge that left family members feeling powerless and anxious, particularly related to palliative care.

Participants shared trepidation about their loved one’s mental health and physical wellbeing as a result of the visiting restrictions. Many were worried about the impact of social isolation on the patient and how this could contribute to depression, particularly for those with communication challenges or language barriers. Family members felt high levels of guilt that their loved ones would be lonely and disconnected from others and would not necessarily understand why family was not visiting.

A Lifeline of Human Connection

Given the above, the VFV program was not seen as a “nice to have” option during the pandemic, but rather a vital, lifeline of human connection that supported the mental health of both the patients and their family members. Although not the same as in-person visits, many participants shared that the VFVs fostered meaningful connections with their loved ones and allowed them to “lay eyes and ears” on their family members. The virtual visit opportunities were perceived to actively combat social isolation and promote physical health and recovery, particularly in elderly patients. Some participants mentioned directly observing the negative impact of social isolation on the patient’s well-being and recovery during the period of visiting restrictions, saying that they could see their loved one “had no will to live like this.”

The interview participants told us that having visual contact with their loved one provided context and confirmation of reports from the clinical team, supported family decision-making, and promoted better communication with the clinical team: “It is completely an amazing service and it covers many things. First of all, I can physically see her. So, she had some paralysis in the right hand and there was swelling in the right hand, so I was able to see for myself the swelling and then I could talk to the doctors appropriately about it. I was also able to see the room she was in” [P16]. Ultimately, participants felt that the VFV program is a patient and family-centered innovation that can facilitate the regular connection between patients and families, not only during a pandemic situation but at any time when a patient’s care and comfort would benefit from a connection with family.

The Role of the Facilitator as Connector

We also learned from participants that a significant factor for meaningful connection with their loved ones was the involvement of the VFV program facilitators who were dedicated to facilitating contact. We were told that the navigators supported communication during virtual visits in various ways:

Table 2. Exemplar Quotes From the Data.**The Unforeseen Consequence of “Separation Trauma”**

“We just wanted to be there with her, and it was really hard not to.” [P8]

“Hearing that visiting was restricted was horrible. With COVID, this has been a nightmare. We have children and grandchildren and friends—people would come to see him if they could.” [P5]

Increased Vulnerability of Patients and Family

“And for elderly people, family is so critical in their well-being. I mean, it really is. And for my mom just to see us, and know that we were okay, and even it was only a five- or seven-minute little glimpse, she can fall asleep and know, ‘I’ve seen my kids’. You know, you just can’t put a price tag on that. When you’re elderly, and you’re alone, and you’re vulnerable, especially when you’ve had a surgery, and you’re all by yourself. So, to me, just that’s so critical.” [P12]

“It was extremely helpful. it was very difficult for the family not to be able to see her, but especially for my dad, who is older and didn’t understand. And I think the family grew more and more anxious as the time increased. I can’t imagine, if it wasn’t offered, how much even more difficult it would have been in the end, the anxiousness you would have, given your mother, or your loved one, your wife, is in the hospital, and you can’t see her for 12 weeks. It’s like she had fallen and then just disappeared off the face of the earth.” [P1]

A Lifeline of Human Connection

“I can’t emphasize enough how helpful that connection was through the iPad. Without it we would have been lost. The iPad was the only point of human contact that we had with her, which was extremely important in order to have that connection to her in the last weeks of her life. Without this, I can’t imagine how we would have coped.” [P1]

“On days when my mother-in-law couldn’t talk or just wouldn’t talk—where she could talk but she just chose not to talk because maybe she was upset or the dementia kicked in; I don’t know—at least she could see us. She could see us. Then a tear would roll down her face. So, then we would know, “You know what? She still remembers us because even though she can’t talk we know she knows us because she can—we saw her eyes tearing up.” [P14]

“The program should be throughout the hospital at all areas because there’s a lot of people that can’t go to a hospital because of their immune system and they’re afraid of super bugs, and this is a way to avoid all of that—especially for cancer patients and in other areas where the patient is still able to talk and can actually dialogue with whoever is on the thing ... That is so much more important in terms of actual conversation and expressing feelings to the patient.” [P16]

“If I had known that I could’ve done this, I probably would’ve done that as my default option with coming in person being something that I would do less frequently. From the get-go, it was to me the perfect solution for both of us... we could be closer together where I wouldn’t have to try to juggle all of my other life commitments, plus going to visit her. I could easily fit that into my life, in a way that then I didn’t necessarily resent having to spend that time or then also so concerned about the cost of going out there, as I said, and the time of going out there, where going to visit someone for an hour becomes a two or three-hour commitment because of how long it takes to get somewhere and that sort of thing.” [P22]

The Role of the Facilitator as Connector

“XXXX would refresh Mom’s memory and tell her our names and say that we’re on the phone, and just for her to understand the iPad—you know, showing her where to look and little things. All of those little things helped. They’re not big things, but they’re ways to communicate that kept us communicating when she was at her lowest point and totally lost.” [P14] “XXXX, she should be commended, because she was like there in place of us. She really was. And in a very appropriate way, nothing inappropriate, and nothing—there was no overstepping. And it’s just she was very much a comfort to my mother while we couldn’t be ... I guess knowing that she would pass by my mom’s room quite often, and just to poke in and just see how she was doing ... When I was there, I could see that there was a nice connection between my mother and her, and my mom reached out and took XXXX’s hand as I was leaving. And so ... very comforting. Like, no one wants their loved one just lying in a hospital bed, getting nursing care, without that emotional, you know, little bit of emotional care as well.” [P6]

“So, XXXX was our arms and our ears, that’s a good way of saying it, while we couldn’t be in there.” [P12]

“We were having trouble getting a clear understanding of my mother’s condition, because our doctors would just say, ‘Well, I’ve no idea how she’s really doing, and how she’s feeling, because she can’t talk’. Whereas XXXX would say, ‘Well, no, you can get a sense for how she’s feeling’, right. So, she helped us better understand my mom’s situation.” [P6]

providing technical support to initiate and sustain the call, positioning/holding the device during the call, as well as explaining who was on the call/what was happening/relaying what was being said to patients, and repeating patient’s words/explaining gestures/reading messages, etc to family on the other end of the call. This was particularly helpful when the patient had sensory impairments.

The facilitators also functioned in many ways as both a “substitute family member,” developing personal connections that provided comfort and emotional support to patients while their family could not be there, and a helpful connection to the clinical team, by providing additional contextual

information about the patient’s health to their family members.

Discussion

The rapid changes that were made to family visiting policies across the globe in the early days of the COVID-19 pandemic were made with the goal of reducing transmission and protecting vulnerable patients and healthcare workers. As a result, healthcare organizations had to quickly pivot to find ways to connect family members with their loved ones and participate in the care process. Our study of the VFV

program at North York General Hospital uncovered significant unintended consequences of visiting restrictions and how the virtual visiting program became an actual lifeline for patients and families across all inpatient units.

The 4 key themes present in the data from our family participants were (a) the unforeseen consequences of separation, (b) increased vulnerability of patients and family, (c) a lifeline of human connection, and (d) the role of the facilitator as a connector. The patient experience is a very important focus and the subject of discussion in health care; however, we must always be willing to look one step further and be aware of the critical role of family members during hospital admission (19). Assuming that a healthy and stable relationship exists, the family knows the patient better than anyone; they know their common gestures, body language, and most important signs of stress. It is not just about visiting to keep a loved one company; family members are essential to care partners who have a tacit role in the health care system and in the care of their loved ones. Evidence increasingly supports the impact of the presence of family on improved care experiences and patient outcomes and the mental and physical well-being of patients, family, and healthcare providers (20). More than a decade ago, Leape et al wrote that families should be “respected as part of the care team—never visitors—in every area of the hospital, including the emergency department and the intensive care unit.” (20). The findings reported here around separation trauma have been articulated by others who have documented heightened stress and anxiety levels resulting from restrictive visitor policies outside of the pandemic (21). Concerns around psychological and moral distress, patient safety, worsening mental and physical health, communication lapses, and the inability of family/caregivers to offer support and care for their loved ones have also been reported as crucial consequences of the pandemic (21–25).

The results of our study align well with the mental health impact reported in published studies of patient and family experience of visiting restrictions in adult (4,5,26) and pediatric intensive care unit settings (27–29). Rose et al (5) reported a large multicenter cohort representing adult family members experiencing at least one ICU virtual visit in 37 UK hospitals in the second COVID-19 wave and found high levels of psychological distress with over 60% reporting severe distress prior to their first virtual visit with their loved one. Distress levels were subsequently significantly lower in those participants who re-rated their distress on completion of the first virtual visit, supporting the positive impact of virtual visiting programs under restricted conditions and beyond.

The COVID-19 pandemic has had an overwhelming impact on the healthcare system at all levels, not only in hospital emergency departments, and intensive care units. Understanding the increased exposure of patients and families across hospital units in these unpredictable times is more important than ever. The focus must remain on keeping everyone safe from infection, but we need to consider the human side of health care and the effects that something as simple as restricted visiting policies

can have on patients and families. Our results further confirm that being separated from loved ones at their most vulnerable time is more traumatic and anxiety-provoking than might be appreciated (30–33). They also draw attention to the importance of dedicated facilitators for programs like this, to prioritize meaningful relationships and address the needs of patients and families in terms of access, availability, and consistency.

Innovations like virtual family visiting programs provide an opportunity for human connection that can make a significant difference for patients recovering from serious illness or in some cases the opportunity for loved ones to have a final conversation before the end of life. Outside of visiting restrictions imposed in pandemic situations, there may be many advantages of virtual visiting as a standard of care, including enabling access for family members who are not located in the same city or country as their loved ones, who work or have full-time family commitments, and those family members, often spouses, who are frail or have physical disability themselves.

Strengths & Limitations

This is an in-depth qualitative study of an inpatient virtual visiting program that addresses a significant collateral problem created by the restrictions of the pandemic. Capturing the lived experience of such programs using qualitative methods as we have done is important to fully grasp the unintended consequences of the complex policy change and understand the level of impact on the people involved. In particular, a strength of our work is the focus outside the intensive care unit which is a unique contribution to the existing literature. Although this is a single-center study, we feel the learnings from this program implemented at a community hospital are very generalizable across many hospital settings. They also provide useful insight into what impact a more perpetual virtual family visit program could have on patient and family-centered care as a whole.

We also note that it may be a limitation that we only interviewed family members during our data collection. This was not purposeful, but we found that many of the patient participants were elderly and quite frail and were still hospitalized at the time of the study. In addition, due to COVID restrictions, we conducted the interviews via a virtual platform which would have increased the workload for the facilitators or nursing staff and therefore the study team decided that it would be inappropriate to contact patients directly at this time.

Conclusion

We endeavored to study the experience of patients and families of an inpatient virtual visiting program implemented due to the hospital visiting restrictions imposed by the COVID-19 pandemic. The separation trauma and desperation for a lifeline produced by pandemic visiting restrictions as discussed by the participants in this study has only increased as the pandemic continues and indicates a significant need for such innovative

programs to decrease the tremendous unintended consequences. This work contributes to our understanding of the impact of imposed separation, increased vulnerability, and the importance of flexible policies to support virtual family visiting programs in all areas of the hospital in order to maintain a patient and family-centered system of care both within and beyond the pandemic.

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Supplemental Material

Supplemental material for this article is available online.

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