Postnatal quietness - the dilemma of visiting hours

A qualitative interview study with maternity care staff

Backhausen, Mette G.; Broberg, Lotte; Rosted, Elizabeth E.; Råsø, Kamma Z.L.; Thomsen, Thora G.; Beck, Malene

Published in:
Sexual and Reproductive Healthcare

DOI:
10.1016/j.srhc.2023.100860

Publication date:
2023

Document version:
Final published version

Sexual & Reproductive Healthcare 36 (2023) 100860

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.elsevier.com/locate/srhc

Postnatal quietness - the dilemma of visiting hours. A qualitative interview study with maternity care staff

Mette G. Backhausen [a,*], Lotte Broberg [b], Elizabeth E. Rosted [c,e], Kamma Z.L. Råsø [a], Thora G. Thomsen [d,e], Malene Beck [e,f]

[a] Department of Gynecology and Obstetrics, Zealand University Hospital, Roskilde, Denmark
[b] Center for Clinical Research and Prevention, Bispebjerg and Frederiksberg Hospital, Capital Region, Copenhagen Denmark
[c] Department of Oncology and Palliative Care, Zealand University Hospital, Roskilde, Denmark
[d] Department of Otorhinolaryngology and Maxillofacial Surgery, Zealand University Hospital, Køge, Denmark
[e] Department of Regional Health Research, University of Southern Denmark, Denmark
[f] Research Unit PROgrez, Næstved, Slagelse and Ringsted Hospitals, Region Zealand, Denmark

ARTICLE INFO

Keywords:
Postnatal care
Breastfeeding
Quietness
Visitors
Qualitative study

ABSTRACT

Background: As part of the Person and Family Centred Care, involvement of relatives is a key concept. This means that an unrestricted visiting policy in hospitals wards is widely accepted and implemented. In maternity care, benefits and drawbacks of unrestricted visiting is still discussed, while it is acknowledged that a quiet environment is important for both new parents and newborns to enhance breastfeeding. The COVID-19 lockdown provided an opportunity to study how the restrictions for visitors influenced the work of maternity care staff in Denmark.

Objective: This study aimed to explore the experience of maternity care staff on how visitation restrictions for visitors influenced the care of new families in a maternity ward.

Methods: Individual interviews (n = 10) were performed between 20 November 2020 and 25 February 2021. A qualitative descriptive study was performed using thematic analysis.

Results: One overarching theme was identified: "Framing time to the experience of becoming a parent". Further, five sub-themes were identified and illuminated in the analysis: "Increasing confidentiality and presence", "Changing availability and space for guidance", "Welcoming peacefulness", "Being gatekeepers", and "Structuring time is caring".

Conclusion: Restrictions for visitors influenced the care of new families because it encourages the space and place of becoming a parent. The hospital environment was shaped in a calm way, which increased the staffs' bedside time. The experience of an increased confidentiality with new parents led to in-depth conversations, making it easier to identify new parents' needs, focus on the initiation of breastfeeding, and individual guidance.

Introduction

In the last decades, the Person and Family Centred Care has gained attention in the Western health-care systems [1]. This approach encouraged involvement of relatives, which was shown to increase consistency and accuracy of care, as well as patients' emotional well-being [2]. As a result, an unrestricted visiting policy has been implemented at several hospital wards in order to ensure that admitted patients have unlimited support from their relatives [3].

The unrestricted visiting policy has led to discussions on benefits and drawbacks among health professionals in maternity care, especially concerning noise and interruptions that accompany having visitors at all hours [3–8]. Studies show a discrepancy in preferences between health professionals and new parents in relation to visiting policy [4,9]. A questionnaire based study showed that both new parents and health professionals prefer a flexible visiting schedule concerning their partners and restricted visiting hours for other visitors [9]. However, in contrast to new mothers and visitors, hospital staff tend to prefer a more strict visitation policy concerning the number of visitors and visiting times per day, as well as how late visitors should be allowed to stay [4,9]. Interviews with new mothers demonstrated that a quiet time to rest during the day is appreciated [10], and that they enjoy having alone time with

* Corresponding author at: Zealand Universitet Hospital, Sygehusvej 10, 4000 Roskilde, Denmark.
E-mail address: mgb@regionsjaelland.dk (M.G. Backhausen).

https://doi.org/10.1016/j.srhc.2023.100860
Received 5 September 2022; Received in revised form 10 May 2023; Accepted 18 May 2023
Available online 20 May 2023

their babies [11]. Multiple visitors and lack of a scheduled quiet time may cause disruption in patient care [5], but this assumption was far more prevalent among hospital staff than among new mothers [12].

From the point of view of health professionals, it is acknowledged that a quiet environment in a maternity ward is important for both new parents and newborns. This enhances bonding activities, such as skin-to-skin contact, breastfeeding, and recovery from childbirth [5–8]. To develop a visiting policy that takes the need of both new parents and maternity care staff into consideration, we need to gain a deeper understanding of what prevents an unrestricted visiting policy and a quiet environment in maternity care from working together. With the present study we sought to investigate in more details the health professionals' perception of a restricted visiting policy in a maternity setting.

On 11 March 2020, the World Health Organization announced a global pandemic with lockdown in some countries worldwide [13]. To contain the spread of COVID-19 and as a part of the lockdown policy, Danish hospitals imposed visitor restrictions, including to the maternity wards. This shift from full open visiting hours policy to no visitors allowed, provided an opportunity to study how restrictions for visitors influenced the work of maternity care staff.

This study aimed to explore the experience of maternity care staff on how visitation restrictions influenced the care of new families in a maternity ward.

Methods

Study design

A qualitative descriptive study was performed using thematic analysis [14]. Ten individual semi-structured interviews were undertaken to explore the experiences of maternity staff on visitation restrictions influence on the care of new families. Individual interviews were chosen as it was considered suitable for exploring everyday life experiences, and it ensured the informant can speak freely on personal experiences [15]. The Standards for Reporting Qualitative Research (SRQR) [16] was used, as it aims to improve the transparency of all aspects of qualitative research and optimize the reporting quality of the current study.

Study setting

This study was performed at the Zealand University Hospital, which serves as a primary facility with 2500 deliveries annually and covers a large geographic area of both urban and rural settlements. Interviews took place between 20 November 2020 and 25 February 2021 (See Fig. 1 for visiting restrictions during the COVID-19 pandemic). The maternity ward is an 18-bed in-patient ward, consisting of both single and double rooms and one room with three beds. The maternity care includes in-patient care for all new families after uncomplicated births, also including new families after both emergency and elective caesarean section and new mothers with hypertensive disorders and/or gestational diabetes mellitus. The ward provided care for newborns delivered from 35 gestational weeks. The new families had an average stay of two days after delivery. The primary focus was on early parental bonding with newborn, as well as establishment of breastfeeding. The partner or one other support person is admitted with the new mother and newborn. Permanent staff comprised 21 persons, including nurses, midwives and nurse assistants, and a number of substitute staff.

Informants

To ensure rich descriptions, a purposeful sampling strategy with maximum variation was applied [17]. A variation in age, years of experience as a health care professional, years in maternity care, and profession (nurse, midwife, or health assistant) was considered important. All permanent health care staff working either as part time or fulltime at the maternity ward within the period of the COVID-19 restrictions for visitors were considered eligible for participation. All those eligible were informed about the study by e-mail and invited to participate. Participants were selected on the basis of the likelihood that they would contribute information-rich data [18] on their different work life experiences, to allow for a greater range of experiences. All informants were females with an average age of 49 years. Some informants worked half-time, but the majority worked fulltime. Informants' characteristics are shown in Table 1.

Data collection

Data was collected using semi-structured interviews. Before initiating the interviews, an interview-guide was developed and a pilot interview performed, which was inspired by Kvale [19]. The interview-guide consisted of four open-ended questions with supplementary questions. The opening question was intended to gain knowledge about the informants work experiences in general: "what is important to you when you come to work at the hospital?" Followed by aim specific questions concerning the experience of having visitor restrictions imposed from one day to another: "Remember the first shift you had after the lockdown. How did you experience this?" Tell about how/or if the lockdown affected your workflow" and "How would you describe the atmosphere in the maternity ward?".

In all, ten permanent staff wished to participate and were included in the study. Four interviews took place at the hospital, one in the informant's home, and five were conducted by telephone, depending on the preference of the informants. The interviews were conducted either by MGB or MB, which lasted between 15 and 37 min (mean time, 24 min). The interviews were audio recorded and transcribed verbatim by a secretary with no connection to the study. NVivo 12 was used to organize the data.

Data analysis

Data were analysed using inductive thematic analysis, as described by Braun and Clarke [14]. This method of analysis is considered particularly useful for identifying, analysing, and reporting patterns within qualitative data. It is a six-phase non-linear approach that implies moving back and forth between phases when needed. The first two

Table 1
Informants characteristics.

Characteristics	
Age in years (mean/range)	49,4 (35–65)
Profession	
Nurse	6
Midwife	3
Nurse assistant	1
Years in healthcare (mean/range)	18,2 (4–40)
Years in maternity care (mean/range)	8,35 (2–22)

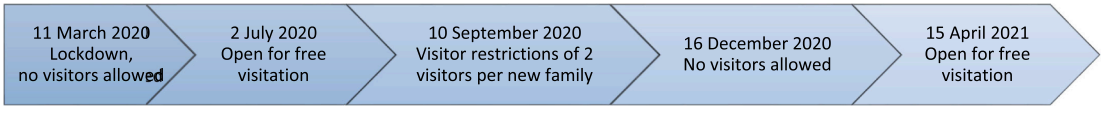

Fig. 1. Timeline for restrictions of visitors in Danish hospitals during the COVID-19 pandemic.

interviews were read through by all authors to familiarize with the content. × then identified initial codes based on meaningful text regarding the study aim. All authors met and discussed potential themes until consensus was reached on the preliminary themes. To secure trustworthiness, the preliminary themes were then reviewed and refined by × and ×, which included going back and forth from the original interview transcripts to the identified codes and themes [20]. Subsequently, one overarching theme and five sub-themes were identified based on multiple meaningful units. All the authors met again to finalize the themes. When no new themes appeared, saturation was considered, as data saturation relates to the emergence of new themes according to Saunders et al [21]. Finally, the results were elaborated using quotes to exemplify how the final themes were identified. No informant checking was performed.

The research group consisted of six female researchers within two professions: midwifery and nursing. Three are midwives with extensive clinical experience. One midwife is employed at the maternity ward of Zealand University Hospital. One nurse have with clinical competences within the Neonatal Intensive Care Unit and is an experienced qualitative researcher. All the authors have a PhD. degree, except one. Additionally, the authors have experience in research, including qualitative methods.

Ethics

Informed written consent was obtained from all the participants prior to the interviews, and data information was managed with confidentiality and anonymity. The participants were further informed of the possibility to withdraw from the study at any time. The study was approved by the Regional Danish Data Protection Agency (REG-121–2020). According to the Danish law, ethical approval is not required for non-invasive studies, including qualitative interview studies.

Results

One overarching theme was generated in the analysis: "Framing time to the experience of becoming a parent". Further, five sub-themes were identified in the analysis: "Increasing confidentiality and presence", "Changing availability and space for guidance", "Welcoming peacefulness", "Being gatekeepers", and "Structuring time is caring", are illuminated in the analyses.

Framing time to the experience of becoming a parent

The analysis identified maternity care staff' experiences on how the concept of time when becoming a parent was shaped in a calm way during the COVID-19 pandemic. Restructuring from a full open visiting policy to no visitors allowed a new frame to be implemented. This change, according to the maternity care staff, meets the parent's need for time to get to know their newborn. This was associated with peace and quietness that, according to the maternity care staff', had been provided based on the visitation restrictions. A staff member said:

> *Time to be with the families I take care of, time to listen to what their needs are, and time to provide them with advice and guidance that I was trained to do as a health care professional (I:3).*

Another explained how she had experienced parents acting more relaxed during the COVID-19 restrictions; hence, walking around the ward in pyjamas without waiting for or expecting to welcome visitors who wanted to see their newborn. The maternity care staff shared how they thought the COVID-19 restrictions in some ways had clarified what is at stake when having a child and being hospitalised after birth, and why peace and quietness, is important during such events.

Changing availability and space for guidance

During the COVID-19 lockdown, the maternity care staff experienced that new families were more available, which gave the staff a better opportunity to be around and spend more time guiding and caring for them. As one explained, *"I have been able to come and go to the hospital rooms and not just jump in and out, checking for visitors and waiting for them to leave (I:2)"*.

When visitors were present, the maternity care staff engaged in other tasks outside the hospital rooms e.g., filling cabinets and cleaning, leaving the families to be with their visitors in peace. Additionally, the maternity care staff shared how they sometimes experienced visitors being a barrier to entering the hospital room and performing relevant observations of families and newborns, or giving guidance. One explained her point of view in relation to barriers when parents had visitors: "*Well, the family is my field of work, when they have visitors, I do not enter my field of work (I:3)"*.

According to the maternity care staff, having visitors by the bedside could be particularly challenging when it came to guidance on breastfeeding. One said "*They [the mothers] feel more of a pressure for the breastfeeding to work when there are visitors present (I:6)"*. Breastfeeding can, in some cases, be based on a time-schedule and implies an agreement of guidance on a specific time, and these agreements tended to be postponed or not completed by both parents and the maternity care staff if visitors were present. One elaborated:

> *It is especially important for the new families, where breastfeeding is on a schedule; if there are lots of visitors present, well the schedule gets messed up and there is a risk of the newborn losing weight (I:7).*

Therefore, having time, particularly for conversations, was considered an important tool in helping them in their family formation, guidance on breastfeeding, and a valued benefit to the professionals because it engaged other sides of their professionality, which they were pleased to have more time for.

Increasing confidentiality and presence

The maternity care staff explained how they experienced a greater depth in the conversations they had with the new parents during the lockdown period. Having more time for the new parents and less interruptions from visitors, made it easier to identify any special needs of the new parents. According to the maternity care staff, this space of confidentiality allows conversations to include more sensitive topics, thereby giving the new parents an opportunity to express their feelings:

> *The connection with the new parents has significantly improved during the corona pandemic… you can talk about more sensitive things than when there are others present (I:2).*

It was mentioned that connection with the father also improved as one explained:

> *I think that you also get closer to the dad. Many fathers want to appear in control, but they are also in a vulnerable phase. However, it rarely shows if relatives are visiting (I:1).*

One reflected the importance of being present, not just in the physical sense but also mentally present, while working as a caregiver by saying: "*It is crucial that we have time to see the other, and not just with a thermometer in your hand (I:3)"*. Thus, a more existential aspect of the maternity care staff was allowed to 'breathe', which the maternity care staff encountered as an encouraging experience in their everyday work life.

Welcoming peacefulness

The maternity care staff shared that peacefulness, to them, was experienced as a welcoming guest because it provided an increased

focus on the parents and their newborns. The peacefulness that came with the initiation of the COVID-19 restrictions for visitors was remarkable and perceived as exceedingly positive by the maternity care staff. This provided them with quietness and time to focus on their tasks without being distracted by visitors:

It was quiet in the hospital rooms, it was quiet around the families, and it also meant that it was quiet around us [the professionals] *(I:7).*

Some even called the absence of visitors: "*a great luxury on our side (I:5)"*. Others commented on the importance of having a peaceful working environment:

I think, it is very important to have some quiet time to do your work without too many interruptions (I:2).

A state of having more inner peace, as a consequence of the restrictions for visitors, was described by the professionals and it gave them a sense of having done the job in a more proper and fulfilling way, thereby completing their tasks before the shift ends and eventually more job satisfaction. One explained:

They [the families] have got all the help they need during their stay. I feel calm in the sense that I have completed my job tasks with the new families in a good way before the end of the shift (I:5).

According to the maternity care staff, the COVID-19 restrictions had paved way for peace and quietness, which to some families, meant an increased focus on both vital (e.g., sleep and breastfeeding) and existential (e.g., reflection on the experience of becoming a parent) needs. One professional explained how in particular the mothers, in her point of view, had better chances of experiencing their bodily and emotional reactions related to giving birth and becoming a mother:

It's a good thing that they have been given the opportunity to be alone and to respond emotionally: To be sad, to be overwhelmed, to be tired (I:2).

Another put it this way:

You walk into the hospital room, it is completely quiet and the new parents are looking at their new baby as two people deeply in love because there are no one to disturb them. We should learn from this, as it is so important for their relation with the baby, for them as a new family and for breastfeeding (I:1).

Being gatekeepers

Thinking back before the introduction of restrictions for visitors, the maternity care staff disclosed that they sometimes felt that they needed to act as gatekeepers in order to provide a peaceful environment in which families, newborns, and staff could together address family relations and do post-birth activities. When visitors are staying at the ward at all hours, the maternity care staff explained how they found it difficult to navigate getting standard tasks done (e.g., measuring vital signs, including heart rate, temp, blood pressure etc.), taking into account the need for a quiet environment for all the new parents and simultaneously creating space for the new parents and their visitors. The maternity care staff therefore reflected on how, when, and whether to encourage visitors to either leave the room or go home, one verbalized that "*it is not a very pleasant situation because you have to act like a police officer and say,* [to visitors]*, 'you have to leave now' (I:9)"*. Another maternity care staff elaborated:

It was difficult for me to say 'no' in a nice way. I do not tend to start discussing with people [visitors], so I thought they can decide for themselves. I cannot do any more. But I clearly explained that I needed to be with the family and talk to both mom and dad, but the visitors were kind of invasive (I:5).

In the maternity care staff's experience, the new parents had difficulties focusing on their own needs and turning down visitors due to tradition: "*In my experience, the new parents cannot say no to visitors, its tradition, when a baby is born, of course it has to be shown to everybody (I:2)"*. The restrictions for visitors exempted the new parents from making the choice of where, when, and whom could visit.

Structuring time is caring

The recent period of variable restrictions for visitors made the maternity care staff reflect on the visiting hours in the ward, having had open visitation for some years, as one said: "*You can eat around the clock and have guests around the clock, that is up to you. I just think that having a structure is important, if not, it creates unrest (I:10)"*. The maternity care staff explained the importance of having fixed visiting hours as an expression of caring for the new parents, which made them able to focus mainly on the parents and the need of the newborn. According to the maternity care staff, it would also contribute to a calm environment, which was considered important in order to be able to provide the care new parents need and leaving the parents with less decisions to make regarding who to invite:

I actually think that it [fixed visiting hours] provides a structure where not everything is just 'fluid', and where there is like a… something that is given in advance. It [fixed visiting hours] is also something that the parents do not have to decide on, because they have enough to decide already. So somehow, I actually think it is caring for them that we provide a fixed structure for visitors (I:4).

The maternity care staff believed that fixed visiting hours would ultimately benefit the families and staff by providing more time, space, and better opportunities to give guidance and support, as one elaborated: "*they are only here for a short period of time; one or two days, why not just soak up all our help, as much as possible (I:7)"*.

Discussion

This study aimed to explore the experience of maternity care staff on how visitation restrictions for visitors influenced the care of new families in a maternity ward. Our findings suggest that the maternity care staff's experience of time when becoming a parent, was shaped in a more calm way, when no visitors where allowed. The maternity care staff experienced new families as more available for guidance, which made it easier to spend more time at the bedside. The experience of an increased confidentiality with the new parents, led to deeper conversations and made it easier to identify the new parents' needs. The peacefulness that followed the restrictions for visitors was described as having a positive effect on the work environment for the maternity care staff with fewer interruptions, but also an increasing focus on the initiation of breastfeeding and needs-based guidance. The maternity care staff considered a fixed visitation policy as caring for the new families, because it meant fewer decisions for the new families to make, and a more clam environment.

In the present study, the importance of having time to support the new parents was the overarching theme, which was considered important. This finding was supported in a qualitative study from England that interviewed twenty new mothers about their experience with postnatal care. The study described the importance of staff having bedside time for guidance and not just *running in and out* [10].

The maternity care staff described an increased availability and an increased confidentiality in the new families during the period of restrictions for visitors, thereby providing the staff with more opportunities to give guidance. A survey among 432 nurses and nurse assistants showed that most nursing staff found it difficult to give nursing care when visitors where present [4]. The challenge of giving guidance with visitor's present was also mentioned by the maternity care staff in the present study, as they sometimes found it being invasive to the patient's privacy and confidentiality. This finding is supported by a Norwegian study where more than half of the staff found visits from family and

friends disturbing from fairly to a very large extent during the day [12]. However, studies have shown that new mothers, to a much larger extent, prefer an open visiting policy or open visiting with a quiet time, while maternity care staff prefer a more restricted policy [4,9]. A recent survey from Ireland investigated women's experience with visitation restrictions imposed in a postnatal ward due to the COVID-19 pandemic; they found that while 90% of the women missed having their partners admitted together with them, only 20% missed having family members visiting [11]. The relatively small proportion of women who missed having family members visiting may be explained by a concern for the spread of COVID-19. However, 7% of the women in the study stated that they enjoyed having time alone with their babies, and they further stated in free text messages that they were able to bond with their new born and get more rest as a result of less visitors [11]. This is in line with our finding, where the maternity care staff stated that having a more restricted visitation policy in general, is caring for the new families in providing them with more time, space, and better opportunities to receive guidance and support from the staff during their short stay. Several of the new mothers in the Irish study were pleased with not having to make excuses for family members to not visit [11], and this was also mentioned by the maternity care staff in the present study as a challenging issue what would possibly reduce if visitation policy included a quiet time. Introducing a quiet time during the day in maternity wards is associated with increased rates of breastfeeding [5,8]. This clearly raises the question on how the stay on a maternity ward should be organized when the needs of new parents, babies, visitors, and maternity care staff are taken into account.

Our study illuminates how maternity care staff experienced that visitation restrictions provided a novel way to further support parents while having a newborn and being in the hospital. This meant that a transition throughout new roles in life for the parents was shaped by the visiting restriction at the hospital. Meleis [22] highlights 'transition' as a core element in healthcare actions and refers to transition as both the process and result of complex interactions between people and the environment. Transition is embedded in situations and involves changes in health status, role relations, expectations, and/or abilities. For Meleis, our study is an example of how restrictions may serve as an explicit professional systematic framework that can be used to develop partnerships around family-centred care. This may strengthen new parents' experience of independence and the ability to act in spaces and places of the hospital with a new born, and unburden the parents' transition to becoming a family [22,23]. Further, strengthening of independence and the ability to act can be considered as useful strategies that can accommodate the transition of the life situation individuals are facing when they have a child [22].

During the period of visitation restrictions, we have gained a greater understanding of the importance of visitation regulations in maternity care. This leaves us with many questions concerning needs, but one overall question is, how do we create the basis for the high-quality visit in a maternity setting, which takes both the new family's wishes and needs into account, and at the same time ensure a professionally rewarding work environment for the health professionals over a very short period of time? To what extent do we assess the value of an expected visit from a close relative over guidance in breastfeeding?

Methodological considerations

The credibility of the study was reflected in the participant sampling diversity with regard to age, profession, and years of experience as a health care professional, thereby allowing various perspectives on the research questions to flourish. It is considered a strength that the interviews were conducted over a three-month period, while the restrictions for visitors still applied. This provided an opportunity to study a highly relevant ongoing problem.

Researcher triangulation was used, represented by two professions and from five different workplaces. This served to secure the trustworthiness of this study. During the process of analysis, three meetings were held to discuss themes until a consensus was reached.

A sample size of ten may be considered small; however, when the study aim is narrow and participant characteristics are highly specific for the study aim, a smaller sample size is considered appropriate [24]. The study was performed in one maternity ward in a Danish hospital setting and the transferability of our results may be limited to maternity wards with a similar organization of care and physical environment, which should be seen in this light.

Conclusion

Restrictions for visitors influenced the care of new families because it encounters a space and place of becoming a parent. The hospital environment was shaped in a calm way, which increased bedside time. The experience of an increased confidentiality with the new parents led to in-depth conversations, which made it easier to identify the new parents' needs and focus on the initiation of breastfeeding and individual guidance. Purposefully, less interruptions and the experience of peacefulness allowed positive experiences by staff members because this was related to having a better work environment when compared to before the COVID-19 pandemic. Parents of newborns, visitors, and maternity care staff may not necessarily agree with what a visitation policy should include; however, based on the results of the present study, it is important for policy makers to consider if staff members have better working conditions with restricted visiting hours, and is able to provide the care they find professionally sound, which provides professional depth, encourages professional integrity, and ultimately benefits the new parents.

Implications for clinical practice

Meleis [22] pointed out that there is an alignment between healthcare, history, missions, goals, and the sustainable development goals of the United Nations. Therefore, we argue that there is a need to inform legislators and policymakers about the content professionals contribute in their work of family transitions in hospitals with newborns. In particular, considering that the length of admissions is becoming shorter. Additionally, there is a global shortage of nurses and midwives, which is also a relevant perspective to highlight. Our study illuminates that supporting transitions during parenting in places designed for this purpose together with predefined visiting hours for the staff allows job satisfaction and compassion. Our study suggests an increased focus on how visits in hospitals may be organized so that these visits can engage both relatives and families (with the support of professionals) in the transition to parenthood. This means that a platform can be created politically to nurture favourable hospital environments that can safeguard and further develop professional offers for parents and newborns at the beginning of life, as a family in the short stay hospitalization represents.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

We would like to thank all maternity staff members that took the time and participated in the interviews for this study.

References

[1] Riddett J. Person-Centred Practice in Nursing and Health Care: Theory and Practice (Second edition) [Internet]. Mental Health Practice; [cited 2022 Feb 3]. Available from: http://journals.rcni.com/mental-health-practice/personcentred-practice-in-nursing-and-health-care-theory-and-practice-second-edition-mhp.20.6.13.s14. DOI: 10.7748/mhp.20.6.13.s14.

[2] Smith L, Medves J, Harrison MB, Tranmer J, Waytuck B. The Impact of Hospital Visiting Hour Policies on Pediatric and Adult Patients and their Visitors. JBI Libr Syst Rev 2009;7(2):38–79. https://doi.org/10.11124/01938924-200907020-00001.

[3] Ellis P. The benefits and drawbacks of open and restricted visiting hours. Nursing Times [online] 2018;114(12):18–20.

[4] Tanner J. Visiting time preferences of patients, visitors and staff. Nurs Times 2005 Jul 5;101(27):38–42.

[5] Grassley JS, Tivis R, Finney J, Chapman S, Bennett S. Evaluation of a Designated Family Bonding Time to Decrease Interruptions and Increase Exclusive Breastfeeding. Nurs Womens Health 2018 Jun;22(3):219–27. https://doi.org/10.1016/j.nwh.2018.03.004.

[6] Adatia S, Law S, Haggerty J. Room for improvement: noise on a maternity ward. BMC Health Serv Res [Internet]. 2014 Nov 29 [cited 2021 Jun 8];14. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4253989/DOI 10.1186/s12913-014-0604-3.

[7] Church L. Quiet Time During Postpartum Hospitalization Can Improve Rest, Bonding, and Breastfeeding. nwhjournal.org. 2020:197–201. DOI 10.1016/j.nwh.2020.03.002.

[8] Lawrie C, Highfield MEF, Mendelson S. Quiet Time to Increase Breastfeeding Rates and Enhance Women's Hospital Experiences in the Postpartum Period. Nurs Womens Health 2021 Jun;25(3):170–8.

[9] Soltani H, Dickinson F, Tanner J. Developing a maternity unit visiting policy. Pract Midwife 2004 Oct;7(9):27–30.

[10] Beake S, Rose V, Bick D, Weavers A, Wray J. A qualitative study of the experiences and expectations of women receiving in-patient postnatal care in one English maternity unit. BMC Pregnancy Childbirth 2010 Oct 27;10(1):70. https://doi.org/10.1186/1471-2393-10-70.

[11] Cullen S, Doherty J, Brosnan M. Women's views on the visiting restrictions during COVID-19 in an Irish maternity hospital. Br J Midwifery 2021 Apr 2;29(4):216–23. https://doi.org/10.12968/bjom.2021.29.4.216.

[12] Valbø A, Iversen HH, Kristoffersen M. Postpartum Care: Evaluation and Experience Among Care Providers and Care Receivers. J Midwifery Womens Health 2011;56(4):332–9. https://doi.org/10.1111/j.1542-2011.2011.00038.x.

[13] Cucinotta D, Vanelli M. WHO Declares COVID-19 a Pandemic. Acta Bio-Medica Atenei Parm 2020 Mar 19;91(1):157–60. https://doi.org/10.23750/abm.v91i1.9397.

[14] Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006 Jan 1;3(2):77–101. https://doi.org/10.1191/1478088706qp063oa.

[15] Brinkmann S, Tanggaard L, Kvalitative metoder.. 2. udgave. Hans Rietzels Forlag; 2015. p. 29–53.

[16] O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med J Assoc Am Med Coll 2014 Sep;89(9):1245–51. https://doi.org/10.1097/ACM.0000000000000388.

[17] Patton M. Designing Qualitative Studies - Purposeful sampling [Internet]. Sage, Beverly Hills, CA; 1990. Available from: https://legacy.oise.utoronto.ca/research/field-centres/ross/ctl1014/Patton1990.pdf.

[18] Malterud K. Qualitative research: standards, challenges, and guidelines. LancetLond Engl 2001 Aug 11;358(9280):483–8. https://doi.org/10.1016/S0140-6736(01)05627-6.

[19] Kvale S. Interview : en introduktion til det kvalitative forskningsinterview. 1. Copenhagen: Hans Reitzel; 1997318 p..

[20] Shenton A. Strategies for ensuring trustworthiness in qualitative research projects. Education for Information IOS Press 2004;22:63–75.

[21] Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant 2018;52(4):1893. https://doi.org/10.1007/s11135-017-0574-8.

[22] Meleis AI. Theoretical Nursing - Development and Progress. 6th edition. Lippincott Williams And Wilki; 2017.

[23] Meleis A. Transitions Theory - Middle-Range and Situation-Specific Theories in Nursing Research and Practice. Springer Publishing Company; 2010.

[24] Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. Qual Health Res 2016 Nov;26(13):1753–60. https://doi.org/10.1177/1049732315617444.