Open visiting: does this benefit adult patients in intensive care units?

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ABSTRACT

As the healthcare system moves toward a consumer-driven paradigm, visiting hours for family and significant others of the intensive care unit patient have become a topic of interest and discussion. Research since the 1970s has generated controversy and speculation over the ideal visiting practices in the adult intensive care unit. Analysis of the growing body of research can now be reviewed to enable existing visiting policies to be revised.

The aim of this dissertation was to examine the benefits for the patient, family members and nurses of appropriate visiting practices within intensive care areas in order to establish if open visiting is the best regime for patients in the adult intensive care unit (ICU). This dissertation explores visiting practices in adult critical care unit settings. Specifically, the benefits of visiting for patients, and the factors that may impede or facilitate visiting practices within the ICU were critically discussed. These factors included the benefits and disadvantages of open visiting, and the nurse as an influential factor in visiting. These areas linked together to form the basis for consideration of visiting in the ICU.

Review of existing literature pertaining to visiting in the ICU indicated that patients wanted open visiting hours yet also indicated that they would like some visiting restrictions. Nurses appeared to value family input into care and were aware of patient and family needs, even though they may restrict visiting to suit their own work practices. Family members can provide the patient with psychological support, provide important historical data, assist the nurse with selected aspects of physical care, and actively encourage the patient's efforts to recover. The outcome of this exploration is the recommendation of an open visiting policy tailored to individual patients, as this would foster nursing practice and ultimately benefit patients and their families.

This finding enhances current understanding of visiting practices within the ICU. The dissemination of research based evidence and the adoption of more progressive and liberal visiting policies would involve and value the family members' contribution to the critically ill patient's care.

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DEFINITION OF TERMS

The terms ‘family’, ‘relative’ and ‘visitor’ in this dissertation refer to immediate family members. They may also extend to a patient’s ‘significant others’ depending on the nature of their relationship with the patient.

Intensive care units (ICU) and critical care areas provide highly specialised care to medical or surgical patients whose conditions are life threatening and require comprehensive care and constant monitoring.

Many hospitals also have designated ICU areas for certain specialties of medicine. The naming is not rigidly standardised. Specialised types of ICUs included in this dissertation are complex care units, which provide greater than ordinary care and observation to people with an unstable condition, and coronary care units (CCU) which are primarily equipped to treat patients with serious heart conditions such as coronary thrombosis.

CHAPTER ONE

INTRODUCTION

Visiting practices in intensive care units (ICU) have been addressed since the 1970s extolling the different visiting practices, nurses' perspectives, physiological responses of the patient, patient preferences and family perspectives of many critical care areas, however, minimal other work done in this field has been found to date over the last 10 years. The majority of the research has come from America and the United Kingdom with few articles being found in New Zealand or Australia.

Interest in this area of nursing has been driven by the need for an ICU visiting policy for the hospital in which I work. Currently, common practice for visiting is "open", and the interpretation of this is left to the professional judgement of the nurses working in this area. This dissertation explores visiting practices in adult critical care settings, specifically, the benefits of visiting for patients, and the factors that may impede or facilitate visiting practices in ICUs. The aim is to establish if open visiting is the best regime for patients in the adult ICU. A secondary aim is to look at barriers to open visiting in intensive care areas. My focus is the ICU but comparisons with coronary care and complex care medical units will also be discussed.

Background

A physical illness or an accident is often the beginning of a series of problems for the individual patient, as well as for their family. In addition to the illness or accident, the patient and family members face another crisis, sudden admission to hospital, and sometimes to an ICU. In this foreign environment, the family's fears, anger, mistrust, helplessness or hopelessness – combined with a lack of knowledge about their family member's illness, hospital routines and worries about the future can precipitate a crisis situation. Even the most organised family unit is thrown into chaos and reorganisation is necessary in order that they might survive this traumatic period. Life revolves around the critically ill patient.

Various authors have described the family as an integrated system (Braulin, 1982, Caine, 1989, Clifford 1986, Daley 1984). This system includes not only biological relatives but also 'significant others', such as friends, whanau, and spiritual advisors. Serious illness of one member of the group may threaten this system (Brown 1987, Hammond 1995). The fear of loss of a family member, changes in family roles, and fears about the financial effects of illness are all potential threats at this time. The result may be severe stress on the family system resulting in fear, anxiety and feelings of helplessness and hopelessness. This stress may also reduce the ability of family members to receive and comprehend much needed information and in the longer term may lead to physical and emotional exhaustion which may be associated with anxiety, loneliness, depression and feelings of uselessness. Any intervention, which reduces the impact of these stresses, will have a direct benefit to the patient (Mendonca & Warren, 1998).

By reducing family stress, it may encourage the family to visit more frequently and to feel more at ease when they do visit. This may help to improve patient care by the family member providing information about the patient, which can be utilised to improve and individualise patient care (Halm & Titler, 1990). Family members may provide emotional support to the patient and by orientating the patient, may reduce the incidence of 'Intensive Care Psychosis' (Lynn-McHale & Bellinger, 1988). Family members often feel caught in a dilemma of wanting to help and lend support to the patient after surgery, yet feeling unsure of what is expected of them and fearful of the unknown (Bourman, 1984). Despite preoperative education and planning for surgery, family members may experience anxiety and feelings of uncertainty during the immediate recovery period. Waiting during and after surgery is a source of stress (Liddle, 1988). Family members may sit restlessly in the waiting room, look frequently at the clock, and find it difficult to concentrate. The waiting room is a place where friendships with other families can be made and support given by others sharing similar concerns.

The life of most people is invariably connected with at least one, and often more, significant others. The nursing literature has for some time acknowledged as one of the fundamental principles upon which the concept of total care is based, the need to incorporate families in the domain of patient care. This concept is especially

important, since the family can provide the patient with a vital support function. In an ICU setting it is even more important as in times of crisis the bond between patient and family becomes closer.

Visiting hours

Visiting is a generic word with a range of meanings in the hospital environment. For the purpose of this study the following definitions are used. “Restricted” visiting practices allow a fixed number of visitors and specific time allowances, usually set by hospital policies. “Open” visiting allows families to visit any time during the 24-hour day, for as long as they wish. These two practices lie at opposite ends of the visiting spectrum. In reality these two extremes have probably never been fully or rigidly implemented in any hospital or ICU. Circumstance and human compassion will always allow for ‘bending the rules’ in a normally restrictive environment to meet an immediate or extreme event. Similarly, there will be times in the most open of visiting regimes when the nursing staff will need to exercise some control. In between these two concepts lies a range of visiting practices which can be defined as “flexible”. Other terms in common usage to describe this middle ground are “contractual”, “structured”, or “unrestricted”. In this dissertation the term “flexible” will be used to discuss the range of visiting practices which fall between the extremes of “open” and “restricted”.

Current visiting policy

Interest in this dissertation has evolved over two decades of nursing practice in a variety of ICU settings in both public and private hospitals. The private sector is more predictable in that patients are booked and expected, whereas in the public sector, ICU patients may arrive at any time due to an accident or as an acute admission. The difference in predictability of admissions has little effect on patient management or visiting practices, however. In my current position as charge nurse in a private hospital ICU, I have observed various restrictive practices when family members are visiting in the ICU. These include family members being made to wait for long periods in the visitors’ room when the patient is first admitted to ICU,

family members sent out of the ICU during minor procedures, and family members denied the opportunity to assist with personal hygiene care. Conversely, there have been other occasions when the presence of family, for instance, a family member crying uncontrollably at the bedside, can upset the patient and disrupt care, or a large number of visitors to the patient, has mitigated against ideal patient care. Nurses make decisions about when to enforce or to be lenient about visiting restrictions, based on individual circumstances of the unit, the nurse, and the patient and nurses' attitudes and beliefs about the consequences of visiting. The seeming arbitrariness of visiting procedures confuses the family and may add to their anxiety.

Currently, the visiting policy for the hospital in which I work is seen by many to be unnecessarily restrictive but it is often not enforced by the nursing staff. Visiting in the surgical wards is permitted only between 11.00 am to 12.00 noon, 2.00 pm to 4.00 pm, and 7.00 pm to 8.00 pm with no restrictions on the number who may visit. There are no specific recommendations for the ICU. A booklet is given to family members providing them with information on the ICU environment, however, this booklet does not provide any guidelines on visiting. In reality, common practice for visiting in the ICU is "open" in that there are no guidelines to restrict visiting at any time or to any number. This raises an issue as day-to-day decisions are left to the professional judgement of the nurses working in this area. Open visiting holds different meanings among nurses and the interpretation and application of open visiting may vary from nurse to nurse and create inconsistencies and frustration for the patient, visitors, and nurses themselves. The nurse-visitor relationship may become adversarial as a result of perceived inconsistencies in visiting hours.

Cultural differences must be considered when visiting policies are developed. While it was challenges from Maori which lead to cultural safety becoming an integral part of nursing practice, its principles are applicable to any culture. The concept is even more important now with increasing cultural diversity in patient and staff populations in New Zealand. Ramsden (as cited in Bunker, 2001, p. 18) suggests that cultural safety occurs when people feel safe to use a health service that is provided by people from a different culture from their own, without risking their own culture. She believes it is about nurses communicating with and listening to their patients, without

making judgements about their cultural and social backgrounds. It is about patients feeling safe no matter what culture they are from.

This chapter has outlined the writer's personal interest in visiting practices, and the need for an ICU visiting policy. In this chapter visiting has been defined and the importance of involving family members in critical care practice. Chapter 2 reviews the literature surrounding visiting hours in critical care areas and is divided into three areas: visiting practices in critical care areas, patient's preferences for visiting in these areas, and physiological effects of visiting on patients in critical care areas. These areas link together to form the basis for consideration of visiting policies to enhance the quality of care of patients within the critical care setting.

Chapter 3 provides critical analysis of the literature reviewed in Chapter 2 to demonstrate which visiting regime is most beneficial to patients in the ICU, and the factors that may impede or facilitate visiting practices in the ICU. This analysis includes the benefits and disadvantages of open visiting, the nurse as an influential factor in visiting and implications for nursing practice. Chapter 4 concludes this dissertation with recommendations for practice and implications for further research. This dissertation will contribute to the existing body of knowledge surrounding visiting in critical care areas in the development of health care delivery in New Zealand. This is outlined in chapter 4 and this information may augment what nursing needs to know about support strategies for nursing policy and nursing education.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Research over the last three decades has generated controversy and debate over ideal visiting practices in adult critical care settings. Analysis of the research findings aids the review and revision of existing visiting policies. This dissertation examines literature surrounding visiting hours in critical care areas to consider whether open visiting is the best regime for patients in the adult ICU, and the factors that may impede or facilitate visiting practice for the intensive care unit patient. Literature used to answer these questions includes a review of restricted and open visiting practices, patient and family preferences, and the physiological effects of visiting on patients in critical care areas. A clearer understanding of these factors will enable nurses to implement a visiting policy best suited for their area of practice based on evidence-based research.

Criteria for literature inclusion

Literature was included if it was published in English dated from 1975 onward and related to:

- Critical care patients
- Family members of adult critical care patients
- Critical care nurses
- Interaction between patients, families and nurses in critical care areas
- Patients' preferences for visiting in critical care areas

Search strategy and outcomes

ProQuest, CINAHL, InfoTrac, OneFile and Medline databases were searched to retrieve articles relating to critical care visiting in order to establish whether open visiting was beneficial to patients in critical care settings, and the factors that may impede or facilitate visiting practices within ICUs. Search terms used were: critical,

care, family, life, needs, intensive, physiological, open, restriction and visit. Search terms were used individually and linked in various combinations with Boolean operators. Information was sought specific to Australia and New Zealand to explore visiting in ICU, as I believed the Australian context may be more relevant to New Zealand than literature from the United Kingdom or the United States of America. The results of the literature search was disappointing, with few articles being found in New Zealand or Australia.

In total, 36 English language publications predominantly from the United Kingdom and United States of America were retrieved and studied. Of these, 26 described research studies in the field of visiting in critical care areas and explored visiting practices, patient, nurse, family perceptions of visiting, physiologic responses of the patient to visiting, patient preferences on visiting, child visiting and open visiting. There is little discussion on matters of cultural issues in these studies.

Visiting practices

Restrictive visiting

Historically, the nature of the critical care environment has influenced regulations relating to visiting in these areas. Hamner (1990) reports that in 1962 the United States Public Health Service published recommendations that family visiting be restricted to immediate family members for short periods and that a waiting room be made available. In 1965 these recommendations were that the number and length of visits should be adjusted to the condition of the patient and the ability of the physical characteristics of the unit to accommodate visitors (Hopping, Sickbert & Ruth, 1992). This was typical of many critical care areas during this time. Traditionally, visiting practices were more often introduced to enable hospitals to control and cope with patients' relatives, than to benefit patients in terms of quiet and rest (Milne, 1998). Despite these practices being introduced in the 1960s, recent research suggests restrictive visiting practices still continue in many critical care areas today (Hopping et al., 1992; Simpson & Shaver 1990).

Various writers demonstrate that restrictive visiting is related to traditional beliefs rather than evidence-based research. Hopping et al. (1992) surveyed 50 coronary care units (CCU), and compared factors related to the setting and control of visiting policies in CCUs. They found that there are more liberal visiting policies in teaching hospitals than in community hospitals, and the rationale for restrictive visiting policies included increased sleep or rest for the patients, more control for nurses, undisturbed change of shift report and decreased crowding in the unit. Although the setting in this research was CCUs which may limit the extent to which the findings can be generalised to the whole population of critical care areas, a strength of the study is its large size and that it confirms findings of earlier studies that restrictive visiting policies are related to traditional beliefs rather than evidence based research (Milne, 1998; Simpson & Shaver 1990).

Some studies suggest institutional and unit needs drive visiting policies more than patients' medical or emotional needs. Biley, Millar, and Wilson (1993) surveyed visiting practices in 66 ICUs in the UK, and found no consensus concerning ideal visiting policy. This again highlights that the majority of ICUs practised some form of restrictive visiting. Typical examples of restrictive practices included visiting only between certain times, children not able to visit, restrictions of whom and how many people could visit, and length of visit. This study has been replicated by Plowright (1996) to ascertain whether two years after the publication of the results of Biley et al. (1993) visiting within the ICU setting remained restricted. Although more favourable results were found regarding some aspects of visiting practices, only nine of the 41 ICUs in the study that claimed to have open visiting actually had this. Children remained restricted visitors in the majority of the ICUs that took part.

While the literature does not support restrictive visiting practices, implementing a new visiting policy without taking into account nurses' attitudes and beliefs could hinder a successful transition to a more open policy. The study by Simon, Phillips and Baladamenti, (1997) surveyed 201 critical care nurses in five metropolitan hospitals in the USA regarding their perceptions about open versus restricted visiting hours. The results indicated that most nurses did not restrict visiting consistently, which suggests that nurses override visiting policies even when restrictive policies

are in place. Variables affecting visiting practices were the patient's need for rest, the nurses' workload, and the positive effects of visiting on the patients, indicating that common practice was often more liberal than hospital policy. Despite indicating that they have implemented more flexible visiting policies, individual nurses can and do exercise individual restrictions by limiting the age and number of visitors allowed at the bedside, and asking them to leave during procedures, doctors' rounds and patient handover (Biley et al., 1993). Again, the variables affecting visiting practices were similar: the patient's need for rest, the nurses' workload, and the perceived positive effects of visiting on the patients. Nurses' perceptions of an ideal visiting policy included restrictions on the number of visitors (75%), the hours of visiting (57%), visiting by children (55%), and duration of visit (54%). Patients' or family members' requests were ranked as least important, although no rationale was provided for this (Simon et al.1997).

Open visiting

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Open visiting raises the possibility that a patient could have visitors any time during the 24 hour day, as often as they desire, and for as long as they wish, and could include family members and children (Kirchoff, Pugh, Calame & Reynolds, 1993). Ideally, all of those affected by the visiting policy, patient, family member and nurse should have input into the decision-making. Plowright (1998) reports that in 1992 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting Code of Professional Conduct required that the registered nurse must "act to promote and safeguard the interests of the patients", and work in an "open and co-operative manner with patients and their families, fostering their independence and recognising and respecting their involvement in the planning and delivery of care" (p. 269).

Despite evidence that the involvement of family in a critically ill patient's care is beneficial and respects the rights of patients and their families to be together and support each other during a period of stress and crisis, (Dracup, 1988; Hammond, 1995), nurses still appear to exert considerable power and control by restricting visitors (Biley et al., 1993; Henneman & Cardin, 2002; Kirchoff et al., 1993; Livesay, Gilliam, Mokracek, Sebastian & Hickey 2004). Such limitations reduce interaction among patient, family and nurse and decrease the opportunity to provide an optimally

therapeutic environment for critically ill patients, which may suggest that nurses' practice in managing visiting is not necessarily always patient centred (Hammond 1995, Kirchoff et al., 1993).

Marsden (1992) argues that patients do not abandon their family ties when they become ill and that family members are an important part of the care process. She believes that nurses are obliged to work towards establishing an effective relationship with families because intensive care practice is not confined to dealing with the patient's physiological and technical needs – it also involves learning about the patient in the context of his/her family. Marsden (1992) states that nurses are required to utilise the abundance of nursing research which promotes visiting as being beneficial to themselves, the patients and the family members in ICU, that visitors should never be excluded during 'routine' care in the ICU, and that spontaneous banishment during emergencies needs to be re-examined on a case by case basis.

In practice, nurses working in some critical care areas continue to place restrictions on visiting despite open visiting policies. More specifically, reasons given for restrictions were that patients' conditions were too critical or that they needed rest, doctors' rounds were in progress, or simply that nurses found visitors rude or irritating (Plowright, 1998). Nurses also stated that the increased time spent with families took time away from patient care (Henneman & Cardin, 2002). Often, nurses required visitors to leave if there was an emergency on the unit or if their presence, in the opinion of the nurse, was detrimental to the patient, or if physician rounds were being conducted (Henneman & Cardin, 2002; Kirchoff et al., 1993).

Patients, families and nurses may choose to adopt open visiting procedures, allowing effective patient care from the nurses and optimal timing of the visits for the family. Patient input into the timing and number of visitors shows respect for the patient's wishes (Fontaine, Briggs & Pope-Smith, 2001). Even with more liberal visiting policies, limits may need to be established for individual patients in the best interest of the patient's recovery.

Surveys examining the visiting policies of various ICUs and CCUs reveal a diverse mix of practices. Restrictions on frequency of visits, length of time per visit, number

of visitors, and minimum age requirement were common. No consensus of an ideal visiting policy was evident in the studies, and visiting practices varied depending on factors such as size of hospital, type of hospital, and the level of education of the nurses (Biley et al., 1993; Henneman, 1989; Hopping et al., 1992; Kirchoff et al., 1993; Plowright, 1996; Simon et al., 1997). This may be due to some nurses' beliefs that visitors are physiologically stressful to patients, and decrease patients' rest requirements (Hopping et al., 1992; Simpson & Shaver 1990). Nursing literature clearly indicates that family visiting practices still vary widely and that controversy and speculation continue over ideal visiting practices in adult critical care areas. This is despite the publication of literature advocating changes in restrictive visiting policies (Biley et al., 1993; Kirchhoff et al., 1993; Plowright, 1996; Roland, Russell, Richards & Sullivan, 2001; Simon et al., 1997). It is interesting to note that open visiting has been utilized in paediatric populations for some time.

Patient preferences

Several studies have demonstrated that patients desire flexible visiting practices and there is much evidence to suggest this is beneficial (Gonzalez, Carroll, Elliott, Fitzgerald & Vallent 2004; Henneman & Cardin 2002; Roland et al., 2001; Simpson, 1991; Titler & Walsh, 1992). Simpson (1991) compared patients' preferences for visits between CCU patients and ICU patients. She found individual characteristics influenced how patients viewed an ideal visiting policy including age, illness related characteristics, personality and types of units. Differences between CCU patients and ICU patients suggested CCU patients prefer afternoon and evening visits while ICU patients have no preference. CCU patients preferred longer visits than ICU patients and there was evidence to suggest patients may prefer less frequent visiting intervals. The setting in this research was CCUs and ICUs, which may limit the extent to which findings can be generalised to the whole population of critical care areas. Illness-related characteristics determine the critical care setting. For example, if patients require ventilation they will be in ICU, not CCU. Although this study was conducted in 1991, the findings are consistent with other results in the literature (Gonzalez et al., 2004; Roland et al., 2001).

Roland et al. (2001) surveyed 20 critically ill patients in a 15 bed combined medical ICU and CCU in a 350-bed Veterans Affairs Hospital regarding their satisfaction with the current visiting policy. Questionnaires were based on criteria identified from a literature review on visiting in critical care. In addition, patients completed items on how visitors affected their health, and any allowable tasks (such as assisting with personal care). A Likert-type scale of 1 to 5 was used to rank the participants' satisfaction with the visiting policy. From analysis of this survey, changes were implemented and secondary study results showed "open visiting hours have been shown here to help meet the family's needs and have positive effects on the patient" (p. 9) and "changing to a more liberalized visiting policy not only improves customer relations and satisfaction, but also may decrease the length of the patient's hospital stay" (Roland et al., p. 10). Although the sample population in this study was small, it is a relevant study for this dissertation as the sample population is comparable to my practice area.

Gonzalez et al. (2004), examined patients' preferences for family visiting in an ICU and a complex care medical unit. Sixty-two patients participated in a structured interview that assessed patients' preferences for visiting, stressors and benefits of visiting, and patients' perceived satisfaction with hospital guidelines for visiting. Gonzalez et al. (2004) clearly demonstrate in this paper that patients in both units rated visiting as a non-stressful experience because visitors offered reassurance, comfort and calming. Patients in the ICU valued the fact that visitors could assist them in interpreting the information provided by healthcare providers and that visitors could provide information to help nurses understand a patient's personality and coping style. Patients in the ICU were more satisfied with visiting practices than were patients in the complex care medical unit, although both groups preferred visits of 35 to 55 minutes, three to four times a day, and with usually no more than three visitors.

Differences between the ICU and complex care medical unit may have been influenced by age, illness-related characteristics, personality, types of unit and gender. The ICU patients in Gonzalez et al. (2004) study had to be in a stable haemodynamic condition and not intubated, a situation that may not reflect typical ICU patients, and some may argue that needs differ between male and female patients

because they may respond differently to an illness and admission to a critical care area, and have a larger number of social support needs. This study showed that patients clearly see the value in having visitors and are very satisfied with a visiting guideline that is flexible enough to meet the patient's needs and the needs of the visitors. The researchers state 'patients in the ICU and the CCMU thought that having visitors demonstrated that the patients were loved and cared for by others' (p. 196). One ICU patient described how 'the knowledge that people are coming makes you feel like they love you' (p. 197), and a patient from the CCMU described how 'not being alone makes you feel happy and loved' (p. 197).

This research demonstrated that patients want open visiting hours but also indicated they would like some visiting restrictions. These restricted times included times when patients are not feeling well, and when family or visitor dynamics are not optimal. This provides an opportunity for patients and nurses to communicate openly and to collaboratively devise a dynamic rather than generic plan for visiting to best meet the needs of the patient. If patients want personalised restrictions, however, this raises two issues, firstly, how does the nurse know what restrictions each patient wants, and how would it be prearranged with the patient before visitors arrive, and secondly, how would this be implemented? The literature offers no clear guidance on the best way to address these concerns.

These studies provide the input of patients in the ongoing discussion of visiting practices. Patients clearly see the value in having visitors and are very satisfied with a visiting guideline that is flexible enough to meet their needs and the needs of family members. While patients prefer a flexible visiting regime, this does not take into consideration and may not necessarily be good for other patients in the ICU. It also illuminates the unique needs and diversity among patient populations.

Physiological effects

Traditionally, some nurses may have feared open visiting as potentially harmful to critically ill patients. They believed that open visiting increased intracranial pressure, blood pressure, heart rate, and the frequency of premature atrial and ventricular beats

(Kirchoff et al., 1993; Messner, 1996). It is interesting to note that no research supports the belief that visits and family involvement can have a negative physiologic effect on the patient. Conversely, other opinions reveal that open visiting promotes stress reduction and a sense of calm, thus promoting patient rest (Guiliano & Guiliano, 1992; Kirchoff et al., 1993; Simpson, 1996).

Four studies compared the physiological response of patients to visitors, nurse-patient interactions, and other social interactions. Simpson and Shaver (1990) undertook an observational study of 24 CCU patients by using four cardiovascular indicators, systolic blood pressure, diastolic blood pressure, heart rate and premature ventricular contractions to compare the patients' response to family visits and interviews with a nurse. The study took into account the influence of medication given within one hour of the visit, as medications may affect cardiovascular responses even if given hours before the visit. One finding of this study was that systolic and diastolic blood pressure was significantly lower during the visit than during the interview, which may suggest a calming effect of visitors. Another finding was that the physiological effects of medications may be more important than the timing of administration in relation to the visit.

In a later study, Simpson and Shaver (1991) compared cardiovascular responses in 24 hypertensive and normotensive CCU patients to visitors and interviews with the investigator. One of the findings of the study was that family visits were no more physiologically stressful than interviews with the investigator for both the hypertensive and normotensive patients. Though no exclusion criteria were stated it is interesting to note that patients were not included in the study if their nurses thought they should not be approached for medical or psychological reasons. This may have introduced bias. Also 17 of the participants were male and only seven participants were female. It may be useful to explore the differences in gender as it may provide insightful evidence. It is therefore not easy to assess the generalisability of the study findings to a target group or whether the study participants are a typical subset of the source population.

Giuliano and Giuliano (1992) measured heart rate, blood pressure and cardiac rhythm in response to family visiting and nurse-physician rounds in 50 ICU patients and

found no significant differences in cardiovascular responses between the family visiting group and nurse-physician rounds. Their findings suggest that family visiting was no more stressful than nurse-physician rounds across a variety of patient illness acuity levels. The researchers suggest challenging validity of restricting family visits on the premise of reducing stress.

Schulte, Burrell, Gueldner, Bramlett, Fuszard, et al. (1993) compared cardiac performance in restricted versus open visiting hours in 25 CCU patients and found no significant difference between the rates of premature ventricular contractions and premature atrial contractions for the restricted versus open group. An interesting finding in this study was a decrease in heart rate in the patients exposed to open visiting, which may suggest that family visits had a calming effect on physiological responses in patients with cardiovascular illness.

In contrast, studies carried out by Simpson and Shaver 1990, Simpson 1991, Giuliano and Giuliano 1992, contradict an earlier study by Brown (1976). Brown's descriptive study of 50 CCU patients compared the effect of family visits on heart rate, rhythm and blood pressure. Brown found that family visits of 10 minutes every hour created an increase in systolic blood pressure and heart rate on CCU patients. The designated visiting time in the sample CCU was the 10 minutes before each hour between 10 a.m. and 9 p.m. In Brown's study, however, it appears that the visiting schedule, rather than the actual visit, may have been the greatest source of patients' stress. Interestingly, this study noted that symptoms occurred either during the onset of the interaction or during the first ten minutes. Early fears relating to the negative physiological effects of visiting patients in critical care areas have not been substantiated in later literature, however, these concerns are still cited as reasons for limiting family visitors (Giuliano & Giuliano, 1992; Schulte et al., 1993; Simpson & Shaver, 1990).

Although there is a paucity of recent research on physiological responses of the patient to visiting in critical care areas, the above studies showed no deleterious physiologic effects of family visiting on critical care patients (Giuliano & Giuliano, 1992; Schulte et al., 1993; Simpson & Shaver, 1990; Simpson & Shaver, 1991). When attempting to justify limited visiting for critical care patients, anecdotally

nurses have cited physiological changes and need for rest. To date studies have not conclusively demonstrated a relationship between the presence of the family and changes in physiological measures. Additional research exploring physiologic parameters of the patient may clarify and strengthen the existing knowledge base.

Summary

Review of existing literature pertaining to visiting in the ICU demonstrates that visiting practices still vary widely and controversy and speculation continue over the ideal visiting practices in the adult ICU (Biley et al., 1993; Kirchoff et al., 1993; Plowright, 1996; Roland et al., 2001). Patients appear to want open visiting hours yet also indicated that they would like some visiting restrictions. Again, this raises the issues of how nurses interpret this, and how they would implement a visiting regime to suit individual patients (Gonzalez et al., 2004; Roland et al., 2001; Simpson, 1991; Titler & Walsh, 1992). Nurses appear to value family input into care and are aware of patient and family needs, even though they may restrict visiting to suit their own work practices (Henneman, 1989; Plowright, 1998). There is no conclusive evidence to support the belief by some nurses that there is a deleterious physiological effect of family visiting (Giuliano & Giuliano, 1992; Kirchoff et al., 1993; Messner, 1996; Simpson & Shaver 1991). The results of these studies illustrate the unique needs and diversity among patient populations, and disparity amongst nurses concerning perceptions, education, experience, or ability to integrate knowledge into practice.

CHAPTER THREE

DISCUSSION

Introduction

The previous chapter explored the concept of visiting in critical care areas, with particular emphasis on the factors influencing visiting with respect to adult patients. The purpose of this chapter is to critically discuss the findings of the literature review pertaining to visiting in critical care areas, in the context of its broader contributions. This includes the benefits and disadvantages of open visiting to patients, family members and staff in the ICU, and the nurse as an influential factor in visiting. How the proposed strategies for an individualised open visiting policy will affect nursing practice will also be explored. Also areas warranting further development will be identified, including implications for nursing practice.

Many studies in adult critical care units have demonstrated the benefit of open visiting for nursing staff, the patients and their families, however, open visiting also has adverse as well as beneficial effects (Biley et al., 1993; Kirchoff et al., 1993; Plowright, 1996; Roland et al., 2001; Simon et al., 1997). It is clear that nurses play a pivotal role in governing visiting hours, therefore an essential component in whether open visiting practices are successful will depend on the attitudes and beliefs of the nurses (Kirchoff et al., 1993). Traditionally nurses have favoured more restrictive visiting practices for a variety of reasons based on institutional needs or traditional beliefs rather than the findings of scientific research. These traditions need to be challenged in view of the additional knowledge that now exists on this subject. Critical care nurses need to further refine their visiting policies to better meet patient and family needs.

The benefits of open visiting

The cornerstone of care is the patient's needs and desires. Patients clearly see the value in having visitors and are very satisfied with a visiting guideline that is flexible

enough to meet their needs and the needs of family members. Studies in adult critical care areas have demonstrated that no adverse physiological effects from visiting exist, indeed, visitors may provide reassurance, comfort and calming to the patient, and may decrease length of stay and improve customer relations and satisfaction (Gonzalez et al., 2004; Roland et al., 2001; Simon et al., 1997).

Involving family members in the overall care of critical care patients will benefit patients, families, and nursing staff alike. Family members can provide the patient with much needed psychological support, provide important historical data, assist the nurse with selected aspects of physical care, and actively encourage the patient's efforts to recover. Open visiting allows the family member an opportunity to provide input into the patient's care, be involved with the patient's healing and to build a trust with the staff caring for the patient. Patients in the ICU are often critically ill or at the end stages of their lives. Open visiting respects the rights of patients and families to be together and support each other during a period of stress and crisis. Families need to be together at such a time without restrictions. Positive reinforcement for critically ill patients is vital, so it is best for family members to be present when they are needed (Biley et al., 1993; Kirchoff et al., 1993; Plowright, 1996; Roland et al., 2001; Simon et al., 1997).

From a practical viewpoint, open visiting allows the family member to visit at their convenience. It allows family members to continue their employment, meet the needs of other family members, and stay involved in other activities in their life on their own time schedule. Open visiting hours allow family members to visit according to the patient's needs and wishes instead of by the clock. Although the patient's needs and desires are first priority, those of the family are also significant in the critical care environment where they also 'find' themselves. Requirements here include the need for assurance, proximity, information, comfort and support (Molter, 1979). Being able to visit their 'loved one' is a critical element of their 'care' and open visiting policies go a significant way towards meeting such needs. The very lack of guidelines in an open visiting regime can lead to confusion and anxiety when a nurse appears to make an arbitrary decision restricting visiting without consulting the patient or family. This can result in inconsistent visiting regimes being imposed on

visitors at different times and by different nurses, all of which adds to the already stressful situation for the patients and family members.

Although open visiting has been widely implemented in neonatal and paediatric critical care units in recent decades, many adult units have yet to make this move. This raises the issue of why adult critical care units do not implement open visiting when neonatal and paediatric units already do so. To suggest that family members need our permission to be with their loved one when they are critically ill is somewhat contradictory, especially in a healthcare system that is to be driven by the needs of the patient. In order to provide holistic care the patient must be considered as a member of a family unit and their needs assessed within a framework of total patient care despite their age. While open visiting is promoted for patients in ICU, limits may need to be established for individual patients in the best interest of their recovery. No literature is available that explores the effect of open visiting on other patients in the ICU.

Disadvantages of open visiting

Even among nurses who recognise the importance of a family's presence in the ICU for both the patient's and family's psychosocial needs, there are significant impediments to the implementation of open visiting policies in many adult critical care areas. Some of these issues also occur in paediatric and neonatal settings and are just as significant.

The care of critically ill patients today places increasing demands on the critical care nurse. Patient acuity, ever expanding technology, and nursing shortage create many issues related to staffing ratios, care responsibilities, and skill mix. Family members who constantly stay at the bedside and do not attend to their own health may also make more demands on nurses thereby outweighing the positive effects of their visits on the recovery of the patient (Kirchoff et al., 1993). These family members may be threatening or unnerving to nurses because of their behaviour, such as continually monitoring and attempting to control nurses, demanding to examine records and taking notes, wanting to select the nurses who care for their relative, insisting on

detailed information before agreeing to even minor changes in treatment, and delaying or denying medications. Some nurse's behaviour may actually contribute to this, however. For example, withholding information, excluding the family members from decision making and participation, acting defensively when questioned, and ignoring their input in care planning may provoke such responses (Henneman & Cardin, 2002). Including family members in care planning and providing consistent and frequent information may help decrease hyper-vigilance.

Henneman and Cardin (2002) raise a number of issues regarding open visiting. For example, the ability to safely and confidentially manage critical care operations may be jeopardised by open visiting. It may become exceedingly difficult to balance visitor traffic flow and monitoring, patient confidentiality issues, day-to-day unit operation, and open communication between staff with an open visiting policy. The combination of unit and patient demands along with the increased flow of visitors may lead to a hectic and stressful environment. Families may misinterpret overheard comments, invade other patients' privacy, and may incorrectly perceive nursing time spent with other patients. Open visiting does not take into consideration and may not necessarily be good for other patients in the ICU. Patients should not lose their right to privacy and confidentiality with open visiting, and in fact, they may not want their family to know all of their medical information.

Patients prefer a visiting guideline that is flexible enough to meet their needs and the needs of their family members. Family members can provide the patient with psychologic support, provide important historical data, assist the nurse with selected aspects of physical care, and actively encourage the patient's efforts to recover. Conversely, patients want open visiting hours but have also indicated they would like some visiting restrictions (Gonzalez et al., 2004; Simpson, 1991). Managing visitors could be a burden for nurses during times of low staffing and high patient acuity. Increased time spent with families reduces patient care time. Open visiting goes a lot further in meeting the needs of all parties than restrictive visiting, however, there are significant impediments to the implementation of open visiting policies in many adult critical care facilities and needs of other patients must be taken into consideration (Henneman & Cardin, 2002; Hickey & Leske, 1992).

The Nurse as an influential factor in visiting

The nurse plays a pivotal role in the visiting strategy and the exposition of it. Despite evidence that the involvement of family members in a patient's care is beneficial, some nurses still appear to exert considerable power and control by restricting visitors. Some research indicates that nurses have identified the importance of visitors to the patient's recovery and will to live, and often override visiting policies even when restrictive policies are in place indicating that common practice is often more liberal than hospital policy (Simon et al., 1997). Conversely, other research on visiting practices in critical care areas has demonstrated that many nurses still view visiting in a negative fashion and promulgate attitudes accordingly (Biley, 1993; Kirchoff et al., 1993).

The rationale for this action is often based on their own experience and judgement rather than research-based evidence, apparently in the belief that visits can cause stress, exhaustion and adverse physiological effects on the patient. Although some of these concerns have merit, these assumptions are fears rather than actual problems and are without research foundation. Indeed, there are some positive effects from open visiting, which suggest that family visits have a calming effect on physiological responses in patients (Kirchoff et al., 1993; Milne, 1998; Schulte et al., 1993).

Nurses' experience may further influence attitudes and beliefs about visiting in critical care areas. According to Benner (1984), the 'expert' nurse will have developed a wealth of knowledge about visiting and its effects on the patients, and may be more perceptive of both the positive and negative effects that visitors can have on the critical care patient and some of the reasons for this. Plowright (1998) identified that nurses with more intensive care experience perceived the physiological and psychological effects of visiting to be more important, possibly because they had been exposed to situations where visiting had been both beneficial and detrimental to patients. Plowright's (1998) study also showed junior nurses believed that the senior nurses should have the most control over visiting and visitors. Previously, inexperienced nurses have readily admitted that they often feel incompetent at meeting the psychosocial needs of both patients and their visitors, especially in

difficult circumstances where they are bewildered by the physical and physiological needs of patients (Benner, Tanner, & Chelsa, 1996; Kosco & Warren, 2000). Overall, however, studies indicate that for a variety of reasons, it is natural instinct for many nurses to adopt more restrictive visiting practices in the belief they are acting in the best interests of the patient, whilst at the same time making their own work environment more manageable and less stressful for themselves. The beliefs and attitudes of critical care nurses regarding visiting of critically ill patients are influenced by many factors. Most of these factors appear to be in relation to what is perceived as in the patients' best interests. Because of their constant interaction with both patient and family critical care nurses are in a unique position to meet families' needs.

In summary, the opinions of the nursing staff are central to the implementation of visiting policies. Any attempt by administrators to alter visiting policies without acknowledging and/or altering nurses' attitudes and beliefs toward visiting is unlikely to be successful. Many of the traditional reasons given to support restrictive visiting practices are not supported by research evidence. In a changing world where 'consumers' are accorded more rights, nurses must acknowledge the need for change. Active participation in the family members' decision-making and care when faced with a life-threatening illness or injury is expected by today's educated consumer.

Implications for nursing practice

The need to utilize research findings and integrate theory into practice and evaluate the effect is of fundamental importance to the quality of care delivered to the critically ill patient and their family. Before attempting to change visiting policies and practice, it would be necessary to explore and challenge the previously held beliefs and attitudes of nursing staff concerning family-centred care and visiting within critical care areas. This would involve allowing the nursing staff time to reflect on their current practice and involve discussion and the dissemination of the research findings to allow them to make reasonable decisions about visiting that are in the best interest of the patient. This would also dispel many of the myths and outdated attitudes of some critical care nurses. For example, it may not be widely

known that there is no conclusive evidence to support the belief by some nurses that there is a deleterious physiological effect of family visiting (Giuliano & Giuliano, 1992; Kirchoff et al., 1993; Messner, 1996; Simpson & Shaver 1991).

Nurses are ideally placed to manage the visiting strategy for each ICU and patient, as they are constantly present at the patients' bedside. This decision-making authority cannot reside with any other group or individual in the ICU setting. Patients and families will have opinions and needs, but may have no overall knowledge of the requirements of the ICU environment. Hospital administrators normally have only an overview of the ICU environment but nurses are present in the ICU all the time and do have an intimate knowledge of their work environment and their patients. Therefore nurses play a central role determining visiting policies and practice within the hospital environment

Even with more liberal visiting policies, limits will need to be established for individual patients in the best interest of their recovery. Four key concepts may be used to assist nurses in adopting strategies for a more individualised visiting policy. They are consistency, communication, and continuing education and evaluation. Consistency is achieved by obtaining nurse input and consensus for situations when visiting is not appropriate and other exceptions to the policy. The survey by Simon et al. (1997), found that most nurses did not restrict visiting consistently even when a restrictive policy was in place. All staff must be required to enforce the agreed on policy so that families understand the policy or the reasons for exceptions.

Communication is improved by the use of staff and customer satisfaction tools. A continuing process of evaluation is used to address staff concerns or problem areas for educational needs. Education assists the staff in the communication process, listening skills, cultural sensitivity and patient satisfaction. In addition, other resources that can be utilised to support both staff and patients/families may include pastoral care, whanau support, social services, physicians, local support groups, and hospital administrators.

Cultural issues surrounding visiting are important to consider in New Zealand's multi-cultural society. There is a paucity of literature on this aspect of visiting in the

ICU, however, as previously stated, Ramsden (2001) indicated it is about nurses communicating with and listening to their patients, without making judgements about their cultural and social backgrounds. It is about patients feeling safe no matter what culture they or the staff are from.

In summary, this chapter has discussed the benefits of open visiting and how patients value a flexible visiting guideline to meet their needs and the needs of family members. Within this chapter, disadvantages of open visiting and the impediments to the implementation of open visiting policies have been explored and identified, including the nurse as an influential factor, how the nurse plays a pivotal role in the visiting strategy, and implications for nursing practice. The next chapter concludes this dissertation with recommendations for practice and implications for further research.

CHAPTER FOUR

CONCLUSION

This dissertation has explored visiting practices in adult critical care unit settings, and examined the benefits for the patient, family members and nurses of appropriate visiting practices within intensive care areas in order to establish if open visiting is the best regime for patients in the adult ICU. Specifically, the benefits of visiting for patients, and the factors that may impede or facilitate visiting practices within the ICU were critically discussed. These factors included the benefits and disadvantages of open visiting, and the nurse as an influential factor in visiting. These areas linked together to form the basis for consideration of visiting in the ICU.

Exploration of existing literature pertaining to visiting in the ICU indicated that patients wanted open visiting hours yet also indicated that they would like some visiting restrictions. Nurses appeared to value family input into care and were aware of patient and family needs, even though they may restrict visiting to suit their own work practices, and there was no evidence to support the belief by some nurses that there was a deleterious physiological effect of family visiting. Family members can provide the patient with psychological support, provide important historical data, assist the nurse with selected aspects of physical care, and actively encourage the patient's efforts to recover. The outcome of this dissertation is the recommendation of an open visiting policy tailored to individual patients, as this would foster nursing practice and ultimately benefit patients and their families.

This finding enhances current understanding of visiting practices within the ICU. The dissemination of research based evidence and the adoption of more progressive and liberal visiting policies would involve and value the family members contribution to the critically ill patients care.

Recommendations for ICU

I believe the application of an individualised open visiting regime should be recommended for patients, family members and staff in this practice area. Some structure combined with support will help families to adapt and cope with the crisis of their family member being admitted to an ICU. Nurses must have the knowledge to make reasonable decisions surrounding visiting that are in the best interests of the patient and family. Conversely, visitors must be aware of patient privacy, the geographical space available to provide care, and their ability to assist in care. Developing an individualised open visiting policy provides for patients' individual differences and family needs whilst allowing the nurse to maintain control and organisation of the unit (Henneman, 1989; Kirchoff et al., 1993). Thus, a single individualised open visiting strategy for any one particular patient may offer a suitable compromise on visiting concerns for any patients, their families and nursing staff.

Numerous authors have emphasized the importance of individualising visiting practices for example, Halm and Titler 1990, Simpson 1991, and Simpson 1993. The literature strongly leans towards a patient's desire for open visiting practice, emphasized by findings of desire for visits of longer duration but reduced visiting frequency (Gonzalez et al., 2004; Roland et al., 2001; Simpson, 1991). Clearly, formulating a strategy for any one individual is going to be a multifactorial exercise, including age, illness related characteristics, culture, personality and type of critical care area. These studies provide the input of patients in the ongoing discussion of visiting practices. Patients clearly see the value in having visitors and are very satisfied with the visiting guidelines that are flexible enough to meet their needs and the needs of family members.

Having explored the benefits of visiting to patients in the ICU and the factors that may impede or facilitate visiting practices for the ICU patient, I feel confident that an open individualised visiting policy is ideal for my area of practice as this addresses the needs of patient, family and nurse. The conclusion is that it is apparent that the visiting needs will vary according to different patients, visitors and critical care

nurses. The solution may be that the visiting should be open and negotiated between all the parties, rather than having a blanket policy for all patients

Today's educated consumers expect to actively participate in decision-making and care when faced with a life-threatening illness or injury of a family member. Critical care nurses who are knowledgeable about family needs and the role of the family in patient recovery provide valuable support to families (Hickey & Leske, 1992). Implementation of strategies in the intensive care setting can optimise the strengths to be gained from a concerned family's interest and participation in their family member's critical admission to ICU. In any setting, an infrastructure that supports both the patient and the staff is essential. Less experienced staff members will always need support in performing care and procedures in front of vigilant family members. Components of any programme must include communication of guidelines, clearly and succinctly, to all family members, consistency in interactions with different families and in dealing with issues, and continuing education, evaluation, and modification of guidelines to promote staff and customer satisfaction.

The best visiting strategy will vary according to the circumstances. Individualised open visiting is a strategy to bridge the gap between the needs of the patient and family with those of the nurse and unit. Developing an individual open visiting policy provides for patients' individual differences while allowing nurses to maintain control and organisation of the unit. While not a panacea, individualised open visiting may offer a suitable compromise for addressing the concerns of both nurses and patients/families.

The successful transition to more individualised open visiting practices depends on the positive attitudes and beliefs of the nursing staff. Since nurses play a large role in the regulation and enforcement of the visiting practices, their willingness to support less restrictive practices is an essential component of its success (Kirchoff et al., 1993). The real incentive to change nurses' attitudes and beliefs towards visiting comes from the collective studies that show how important open visiting is to patients and families. The body of research does not support the assumptions that open visiting is detrimental to the patient's condition or the extent of rest.

Research has confirmed the patients' and families' desire for open visiting practice. It has not yet provided us with the evidence to predict an ideal number of visits per day, but it has suggested how individual characteristics may influence a patient's visiting preferences. Frequency of visiting may need to be tailored to individual characteristics such as age, illness related characteristics, and type of unit (Gonzalez et al., 2004; Roland et al., 2001; Simpson, 1991). More qualitative studies are required. This would facilitate clarification of visiting preferences based on gender, clinical sub-populations, cultural characteristics and types of critical care units. Then further refinement of visiting policies would be made accommodating patient, family, and organisational needs.

With the increased emphasis on customer needs, hospitals are searching for better ways to increase satisfaction and decrease costs. Changing to a more liberalised visiting policy not only improves customer relations and satisfaction, but may also decrease the length of a patient's stay in critical care (Roland et al., 2001). Therefore, an open visiting policy tailored to individual patients will foster nursing practice and ultimately benefit patients and their families. Family members can provide the patient with much needed psychological support, provide important historical data, assist the nurse with selected aspects of physical care, and actively encourage the patient's efforts to recover. We need to educate and utilise our senior nurses to facilitate this, as they are more perceptive of the positive and negative effects that visitors can have on the critical care patient (Plowright, 1998).

Implications for further research

There is a need to generate further research on this topic within this country and health care system. The concept of family-centred and holistic care in New Zealand needs to be defined and developed within the adult critical care environment. More investigation into the particular needs of the different cultural groups is also essential.

Research priorities for future investigation of visiting hours include further investigation to clarify visiting preferences based on gender, clinical sub-populations,

cultural characteristics and types of unit, examination of patients' sleep and rest cycles, anxiety, pain level and amount of confusion in relation to visiting practices. Visiting practices in relation to patient outcomes such as length of stay, complications and total days on the ventilator also need investigation. Identification of ways to increase the quality of family visits based on patient and family satisfaction and physiological changes would also be beneficial. A comparative study of the nurses' and family's perceptions and experiences towards visiting within the critical care setting using a qualitative research approach would help to develop greater insight and understanding and identify any disparity between them.

Additional knowledge in these areas could assist critical care nurses to further refine their visiting policies to meet individual patient and family needs. The dissemination of research-based evidence and the adoption of more progressive and liberal visiting policies would involve and value the family members contribution to the critically ill patient's care. In our increasingly economically driven society, it is imperative that nurses evaluate their practice and embark on research to investigate clinical outcomes, cost effectiveness and the impact of practice on patients and staff. Visiting practices will have to be 're-visited' in order to ensure that they are acceptable to all the major stakeholders involved, and they should be reviewed regularly through audit and adjusted according to the needs of those concerned.

As a charge nurse in a newly established private hospital ICU, I am interested in developing an appropriate research-based visiting policy for my unit. Currently, common practice for visiting is "open", and the interpretation of this is left to the professional judgement of the nurses working in this area. A frequent concern voiced by patients and their families is the inconsistency related to visiting hours. Some nurses let patients' family members visit quite liberally, whereas others will be quite restrictive. This inconsistency causes anxiety with patients and families who are struggling to maintain some control over an already stressful situation.

This inquiry into visiting in critical care areas has stimulated a lot of thought about the reasons visiting practices continue to vary widely and how controversy and speculation continue over ideal visiting practices. This dissertation has provided information with which to challenge critical care nurses to encourage practice

development. The adoption of research-based policies fosters nursing practice and ultimately benefits patients and their families. Having explored the broader contributions of visiting to patients in the ICU, I feel confident in recommending an open individualised visiting policy for my area of practice.

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