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Dominant Strategies of Patient Visiting in Selected Intensive Care Units in Iran

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Abstract

Background: Positive outcomes of visiting have been supported in many studies. In Iran, the results of studies showed the implementation of restricted visiting policies in most intensive care units (ICUs). However, medical staff of ICUs, especially nurses claimed to address the needs of patients and their families.
Objectives: This study aimed to explain the strategies employed in the context of restricted policies to address the needs of patients and their relatives.
Methods: A descriptive qualitative study with an approach of thematic analysis was used. Ten nurses, six head nurses, and two physicians participated in the research through purposeful sampling. Most of the data were collected using individual semi-structured interviews, but observation and related document revision were also used. The method introduced by Braun and Clarke (2006) was used to analyze the data.
Results: Three categories emerged, including "visual visiting", "mini visiting" and "individualized visiting", which are employed with respect to the conditions of the ward and patients, staff approaches and policies adopted at the hospital level.
Conclusions: The dominant strategies of visiting in selected ICUs in Iran were explained. It seems that given all the situations including special cultural traits of Iranian people, individualized visiting is the most suitable strategy to bring about positive impacts of visiting on the process of physical and mental recovery of ICU patients while it is necessary that decisions be made separately in each ward and for each patient.

Keywords: Intensive Care Unit, Iran, Nursing, Visiting, Patient Visitors

1. Background

Being hospitalized in an intensive care unit (ICU) is a potentially worrying event (1). Studies suggested that separation of patients from the family members during the stay at ICUs deteriorates their condition (2). Researchers believe that in addition to receiving care from medical staff, patients need reassurance, calmness and support that can only be provided by their family and relatives (3).

Positive outcomes of visiting have been supported in many studies. Smith et al. studied the impact of visiting on patients and their families through a systematic review. Their findings indicated the positive effects of visiting on patients and their families, including satisfaction improvement and also anxiety reduction (4). Furthermore, it has been proved that the presence of family members in ICU can positively influence the recovery process, feeling good, and outcomes of disease (5).

On the other hand, ICU patients' families are suffering from spiritual distress during the period in which their patient stays there. Some researches confirm the incidence of the symptoms of depression and stress in families in the first days after the patient admission until first 3 months after discharge. Different approaches have been suggested to manage such negative outcomes in the families including family-based care aiming to revise visiting polices and methods of informing families (6).

In a study performed by Jacob et al. in a neurosurgery ICU, needs of patients' families have been investigated in a qualitative study after the change of restricting visiting policy and execution of continuous visiting and designating a specific space to a family member close to the patient. The results indicated that the patient's needs at a very high level were met compared to previous studies with restricted visiting (7). In another research conducted at an ICU in Australia, the effect of the flexible visiting (21 hours during a daynight) on the rate of satisfaction of the patients, families and staff has been studied. Families were so appreciative of having more time to visit their parents. Results proved that patients, families and staff had a positive evaluation of performing flexible visiting (8). However, some limited studies showed that patient visiting can be stressful for families (9) and restricted visiting can be

considered as a chance for family members which results in rest, self-care and prevention from tiredness (10).

The importance of visiting is to the extent that health care authorities and even political leaders in some cases recommend flexible visiting to medical systems (11).

Although various reasons have been proposed for adopting a restricted visiting policy, none draw on reliable evidence. Hence, visiting routines in some ICUs have faced fewer restrictions in Europe and America (6, 12). However, different policies and rules for visiting have been reported in various parts of the world (4). In Iran, the results of the study conducted by Haghbin et al. showed the implementation of restricted visiting policies in most ICUs in southern Iran (13). Results of the KhaleghParast et al. study, which was conducted at cardiac surgery ICUs of one of Tehran heart centers during 2014 - 2015, showed more than half of the patients' families were not pleased with the restricting visiting policies (55.1%). In these ICUs, one hour is allocated to the families every day, from 15 to 16 (9).

The reasons for this restriction were investigated in two studies in Iran. Maintaining patient privacy, increasing patient safety, and protecting the physical health of patients have been reported as the main reasons for visiting limitations by Tayebi et al. (14). Khaleghpararst et al. also reported the obstacles of open visiting through qualitative research in a cardiac surgery ICU in Tehran, Iran. Staff shortage and negative attitude of staff were two main barriers in their study (15).

Despite numerous evidences about flexible visiting, results of the mentioned studies showed that healthcare professionals justify restricted visiting and show no tendency to the change of approaches and believe that their current strategies satisfy parent and family needs.

2. Objectives

This study aimed to explain the strategies employed in the context of restricted policies to address the needs of patients and their relatives.

3. Methods

This study is a descriptive qualitative study with an approach of thematic analysis. As an independent descriptive qualitative study, thematic analysis is described as a method for determining, analyzing and reporting patterns or themes (16). Moreover, it is introduced as a method that provides the researchers with major skills to guide other qualitative methods. It has been indicated that thematic analysis as a flexible and useful research tool provides pure, detailed, and complex data. Thematic analysis exists to answer some questions including "what are the concerns of people about a special phenomenon?" and "what are the reasons for using or not using a service or procedure?" Noticeably, thematic analysis makes an attempt to search and determine the distinguished patterns developed in the interviews (17). Given the aim of this study and its main question, the researchers selected the thematic analysis to guide the analysis process.

3.1. Participants

Sampling was conducted in 2012. Ten nurses, 6 head nurses, and 2 physicians participated in the study through purposeful sampling and the process of constant comparative analysis. Participants were selected from different ICU wards and hospitals to achieve maximum variation.

3.2. Data Collection

Most of the data were collected using individual semi-structured interviews. Interviews were started with one open question: "what is your approach to meeting the visiting needs of patients and their families?" The follow-up questions were formed based on the first answer but some questions were already prepared as an interview guide by researchers. For example "Is the same strategy employed for all patients?" and "What factors have made you choose this strategy?" On average, each interview took 30 minutes. In addition to interviews, nonparticipatory observations were used to collect data. The researchers took field notes of incidents occurring inside and outside of the wards during visiting hours. What mattered most in observations was the way visitors and nurses interacted with one another and how patients and visitors interacted in different visiting strategies. Some documents were reviewed, in some cases, in order to study written instructions and policies related to visiting.

3.3. Data Analysis

The method introduced by Braun and Clarke (2006) was used to analyze the data. In the familiarizing phase, the interviews were transcribed and the transcriptions were read several times and primary ideas were written down. In generating the phase of the initial codes, primary codes were created. These codes were then integrated into potential themes and a search was conducted to arrange related data with the themes created. Then the themes were reviewed in two levels. In the level one, proportion and relation of the themes were measured against the extracted codes. In the other level, all data were reviewed again. In the phase of defining and naming themes, the themes were named with respect to the concept conveyed by subcategory codes. In the final phase, the relevance of extracted themes and the research question was studied

and prepared for the final report. Regular study of created codes and transcriptions of interviews, questioning the data, simultaneous gathering and analyzing data, constant comparison, and finding samples based on previous interviews helped the researchers to produce the themes. The MAX qualitative data analysis (MAXQDA) 10 software was used to retrieve and manage the data during the analysis process. The MAXQDA is a software program designed for computer-assisted qualitative and mixed methods data, text and multimedia analysis in academic, scientific, and business institutions.

3.4. Rigor

What reflects the quality of a thematic analysis is the clear explanation of what has been done (16). An attempt has been made in this paper to fully explain the details of the analysis procedure to provide the readers with a sound judgment concerning the quality of the findings and the extent to which they reflect the subject of the study. As a practical solution to provide rigor in the qualitative descriptive studies including thematic analysis, it is suggested that the researchers keep their personal notes taken during the research and name and code them simultaneously. The theoretical memos that researchers wrote during the research were inserted into the analysis process and helped extract the themes. One of the best methods to judge the quality of qualitative study findings is whether it has gained a new insight into the phenomenon under study? (17). Given the restricted studies on patient visiting in Iran, the findings of the study reflected this new insight into the visiting process in Iran's ICUs. Moreover, strategies commonly used in qualitative studies were employed to validate the study. During the process of respondent validation, the participants were asked to review the primary codes and express their opinions. Primary open codes were confirmed by the participants in most cases. In addition, some colleagues were called upon to review and confirm the analysis process. To provide maximum variation, variables including the kind of hospital and ICU specialty were considered in sampling.

3.5. Ethical Considerations

This paper was extracted from a doctoral dissertation of nursing adopted by the ethic committee of our university and funded by them. All participants filled informed consent prior to the interviews and each was given a code to keep their names secret.

4. Results

Participants had 1 to 26 years of experience in ICU and they were selected from different ICUs including internal, surgery, mixed as well as specialized ICUs like organ transplantation, gynecology and neurosurgery.

Results showed that health care professionals employed different strategies for patient visiting and claimed that satisfy the visiting needs of patients and their families as much as possible. Three themes emerged including "visual visiting", "mini visiting" and "individualized visiting" which are used with respect to the conditions of the ward and patients, staff approaches and policies adopted at the hospital level.

1. Visual visiting: staff prefers situations in which direct entering of visitors into the ward is kept to a minimum. Visiting through windows is the most noticeable example of this kind of visiting. Into the design of ICUs built in recent years a corridor has been designed as an observation corridor, which makes it possible to visit patients behind the big windows of the ward. Experience of nurses indicated that this strategy meets the need of visitors with least trouble and challenge. Nurses control the visiting time in this method and whenever they decide they can block visiting by closing curtains. In fact, staff can control the visiting process easily in this method. While this method is greatly favored, it is open to serious criticisms because visiting does not occur in a real sense and visitors and patients do not have direct contacts. However, most ICUs have considerably welcomed this policy.

Visiting through windows prevents the ward from being overcrowded. We set a time and open the curtains so that families can observe their patients and visiting becomes possible without disturbance to the ward (a trauma ICU head nurse).

My experience shows that visiting through window does not work for patients, but it might be good for visitors. It may lead to misunderstanding because visitors see their patients from far and they cannot call their names, talk to them or express their emotions. Patients may be asleep, but visitors might think that they are unconscious (an anesthesia physician).

The researcher's observation goes as follow:

The ward was L-shaped where visitors could see their family members through windows and the important point was that due to the special arrangement of the ICU not all beds could be properly seen and visitors had to stand on the edge of the windows to see their patients and sometimes some groups gathered behind one window. So, they made great efforts to see their patients.

2. Mini visiting: there are few ICUs that completely forbid visiting. Even those which do not have daily fixed visiting, allow short visits subject to the permission of the head nurse or the charge nurse. In recent years, many wards especially those which do not provide window visiting have allocated some time to visiting in person. In most cases,

this visiting is restricted to immediate family members and limited hours in a day or some days of the week and usually under the supervision of the head nurse or the person in charge of the shift.

Our head nurse has set a timetable and announced that visitors can come between 10 and 12 a.m. when staff have already done their duties and can personally control the visits. For those patients who need visiting for a variety of reasons we can ask families to come in the morning to see their patients for 5 to 10 minutes (a neurosurgery ward nurse).

3. Individualized visiting: in most interviews, ICU staff mentioned some cases in which they acted differently and issued visiting permission or conversely prohibited visiting due to special conditions of patients or visitors. In this kind of visiting, the condition of the patient as a unique person is considered and accordingly his need for visiting is determined. It is in this strategy that a patient may need regular visiting by immediate family members or at the discretion of the nurse in charge he may need restricted visiting for a variety of reasons. Either way, it is the condition of the patient and his family that determines the approach to visiting and decisions are not made based on the routines and preferences of the ward. Age (children), level of consciousness (conscious patients), patient's mental status (restless patients), and the severity of illness (end stage patients) are examples of these unique situation related to ICU patients that redound to the individualized visiting strategy. It is very unfortunate, however, that this is the most dominant strategy carried out in a few cases by some nurses.

We are so flexible toward a patient who is a kid and allow his mother to come more frequently because a kid may shout time after time and his brain pressure may increase, so if someone stays by his side it will be better for him (an ICU head nurse in neurosurgery).

Those patients who are conscious and we understand that they are facing psychological problems, going through depression or being delirious or a patient who can be released from ICU but there is a problem that makes it impossible for him to leave the ward, for example, there is no vacant bed in ward need more visiting and we allow that (an anesthesia attending physician).

There are times when the visitor has a special condition, for instance, our patient's wife is pregnant or they are newlywed couples, so we are not that tough on them (a mixed ICU head nurse).

5. Discussion

Visiting policies are different from one country to another according to the culture, the atmosphere of a hospital, geographic area, hospital facilities and personnel readiness to accept change (9). Visiting strategies in Iran often derive from policies and routines practiced for years. The easiest way to control the ward is to put some distance between families on the one hand and the patients on the other, using the visual visiting strategy. The major example of this strategy is visiting through windows. Indeed, this strategy cannot be assumed visiting because there is no interaction in this situation. The important thing to remember here is that the structure of the ward and corridors of observation built in a way that even seeing the patients is not possible. Although to some extent this pattern is acceptable, common and forms an integral part of the physical structure of ICUs in Iran and it is taken into account while designing ICU wards, many challenges still persist in this regard. No studies have been pointed this visiting strategy and it seems that it is not a common practice in other parts of the world. However, Haghbin et al. showed that in some ICUs in southern Iran, visitors were only allowed to see the patients through glass windows (13).

Although visiting through windows is highly favored by wards and staff members, some inherent challenges lead ICUs to conduct short-term visiting in person in most wards. It is more obvious for wards that cannot provide visiting through windows due to structural restrictions. Restricted and short-term visiting, visiting in allocated times for family members are particularly considered. Visiting in person even short-term visiting provides patients and their families with face to face encounters. The nurses participating in this study believed that they could not completely prohibit visiting and avoid informing families of their patients' conditions, but they believed that restricted and short-term visiting would suffice for patients' families. Cook confirms the same fact and believes although nurses are aware of families' and patients' needs, they restrict visiting (18).

Results of some studies in America and Europe demonstrate that nurses prefer policies of restricted visiting in most wards and they usually specify two or three times a day for visiting and devote 30 to 60 minutes for each visit (19). Results of the study conducted by Haghbin et al. confirm these findings (The visiting time in 15.5% and 23.9% of the ICUs were 1.5 - 2 hours and 1 hour per day, respectively) and report the restricted policies as the most dominant strategy in Iran (13).

Criticizing restricted visiting, Clarke and Harrison state that nurses exercise a considerable deal of power and control by restricting visiting while skilled care should not be merely aimed at controlling and dominating the ward but at improving the conditions of patients and families (20).

Another pattern that most nurses and physicians par-

ticipating in the study took into consideration for addressing families' and patients' needs was individualized visiting. Participants repeatedly mentioned that although ICUs restrict or prohibit visiting, decisions are often made with respect to patients' conditions and the same procedure cannot always be followed for all patients. With more flexibility, this pattern is approximately like the strategy being supported by respective studies, and it is regarded as the best decision for visiting and control over ICU settings.

Results of the study conducted by Vandijck et al. in Belgium showed that despite the restricted visiting policies, three forth of wards announced that they adapt visiting hours to individual cases (21). Results of the study about visiting management conducted by Farrell et al. in England on 8 skilled nurses indicated that they use a variety of strategies when approaching visitors. They believed that each situation is unique and requires individual consideration and management. Visiting may have positive and negative impacts on the condition of patients. On the one hand, presence of some visitors makes patients worried and on the other hand presence of some other visitors makes them calm. Thus, each patient and each family should be studied separately and individualized care should be exercised (22). Cook believes that the development of individualized open visiting both meets individual needs of patients and their families and provides nurses with the opportunity to have control over their ward and organization (18). Sims and Miracle favor the individualized visiting strategy and believe that the benefits of visiting should be measured against its costs and ideally visiting should be done at the discretion of nurses and conditions of patients (23).

Finally, we have to mention the key element for visiting management. Our participants stipulated that effective communication between parties to visiting plays an important role in the formation of a favorable visiting process. This can be observed, explicitly or implicitly, in most related studies with more emphasis on satisfying the needs of patients and their families and reducing the stress and anxiety experienced by families and making them aware of patients' conditions through effective communication rather than mere justification of visiting restrictions. Olsen et al. believed that nurses should strike a balance between the support created and stress resulting from visiting and explain when it is best for families to visit patients (12). Results of the grounded theory study conducted by Hupcey indicated that when ICU nurses and patients' families interact on the basis of trust, a great deal of nurses' time will be devoted to families. Furthermore, families become less sensitive and allow nurses to fulfill their duties toward the patients without having to deal with families and their persistent questions. A communication based on trust between ICU nurses and patients' family leads to a sense of security in patients as well (24). However some studies had different results. For example in a study conducted by Pagnamenta et al., the effect of a communication strategy (VALUE) was evaluated on improving family satisfaction. This strategy aims to improve the interaction between medical staff and a close family member. They did not find any significant correlation and concluded that implementing this strategy does not work as assumed before (25).

5.1. Conclusion

The dominant strategies of visiting in selected ICUs were explained. "Visual visiting" (visiting through window) was introduced as one of the strategies used by health care institutes. "Mini visiting" are limited to short-term visiting in person, and "individualized visiting" was specified as an acceptable policy consistent with patient needs. Establishing an effective relationship and convincing patients and their families of restricted visiting were introduced as an approach to solving challenges although the needs of visiting patients are not often met. It seems that given all the situations including special cultural traits of Iranian people, individualized visiting is the most suitable strategy to bring about positive impacts of visiting on the process of physical and mental recovery of ICU patients while it is necessary that decisions be made separately in each ward and for each patient.

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