FAMILY VISITATION IN THE ADULT ICU

By

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DEDICATION

This Master’s Project is dedicated to the families of the critically ill and injured who wait, hour after hour, minute after agonizing minute, and to the dedicated ICU nurses who strive to provide the best possible care to those patients and families.
Abstract

ICU admission has potentially devastating implications for patients and their family members. Although the ability to be near the patient is consistently ranked as being highly important by family members, visitation of patients in the ICU has traditionally been restricted. Research supporting open, flexible ICU visitation policies has resulted in more hospitals adopting these policies. However, ICU nurses’ beliefs and attitudes about open visitation vary widely and open visitation policies are not always implemented by the nurses who control access to the patient. Researchers have described ICU visitation policies, nurses’ attitudes and beliefs regarding open visitation policies, and to a lesser extent, nurses’ practice in relation to policy. However, no research was found that has looked at the relationship between nurses’ attitudes and beliefs and nurses’ practice to determine the relationship between the two. This paper looks at the research surrounding open visitation policy, nurses’ attitudes and beliefs, and nurses’ practices surrounding open visitation of the adult ICU patient and introduces a future research project.
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CHAPTER ONE

Introduction

There are over five million admissions to intensive care units (ICU) each year in the United States with an average patient mortality rate of 10 to 20 percent (Society of Critical Care Medicine, 2006). Up to 75 percent of patients are unable to participate when difficult decisions about treatment goals must be made (Curtis & Rubenfeld, 2001). Family members frequently make important treatment decisions on behalf of critically ill or injured patients who cannot speak for themselves. As a result, family members may suffer from significant depression and anxiety (Pochard et al., 2001) or from symptoms of post traumatic stress disorder (Pittman & Fowler, 1998) and these symptoms may adversely affect their decision making ability. Research shows that family members of patients in the adult ICU have an almost universal need to be near their loved ones (Sims & Miracle, 2006; Roland, Russell, Richards, & Sullivan, 2001; Kleinpell & Powers, 1992; Leske, 1986; Warren, M., 1982; Warren, N., 1993). Several studies have demonstrated that family members are more satisfied, less anxious and less depressed with open, flexible ICU visitation policies (See Definitions, Appendix A), therefore, open visitation may improve family members’ decision making ability (Peterson, 2005; Cullen, Titler, & Drahoza, 2003; Roland et al.; Berwick & Kotagal, 2004).

Background

Visitation of the adult ICU patient has traditionally been restricted (Titler & Walsh, 1992). In the past two decades, a push to liberalize ICU visitation has emerged in response to publicized studies in which visitation is demonstrated to be beneficial to patients, family
members and nurses (Magarey & McCutcheon, 2005; Sims & Miracle, 2006). Recent publications calling for flexible, open visitation have come from The American College of Chest Physicians (Sessler, 2005), The Society of Critical Care Medicine (Kleinpell, 2008), The American Association of Critical Care Nurses (Duran, Oman, Abel, Koziel, & Szymanski, 2007) and the Institute of Medicine (IOM) (IOM, 2001).

The needs of family members of ICU patients have been well-established using the Critical Care Family Needs Inventory (CCFNI) (Molter & Leske, 1983). The need to be near the patient has consistently been ranked by family members as being among their most important needs (Maxwell, Stuenkel, & Saylor, 2007; Farrell et al., 2005). Nurses do not always accurately assess the needs of family members of critically ill patients and tend to underestimate the importance of needs family members consider significant (Maxwell et al.). Furthermore, nurses’ practice in relation to visitation reportedly varies widely and independent of policy (Livesay, Mokracek, Sebastian, & Hickey, 2004; Henneman & Cardin, 2002; Davidson et al., 2007). This variation in nurses’ practice creates tension among nurses due to perceptions by family members that nurses who allow them more time with their loved one are “better” than nurses who strictly enforce the visiting hours (Simpson et al., 1996).

The American Nurses Association Code of Ethics for Nurses (2000) asserts that addressing patient needs requires nurses to recognize “the patient’s place in the family or other networks of relationship” and that when the patient’s wishes conflict with the wishes of others, the nurses must seek to resolve the conflict. In cases where conflict persists, “the nurse’s commitment remains to the identified patient”. In the case of visitation in the ICU, it sometimes
appears that the conflict is between the patient, or the patient by proxy, and the bedside nurse (Berwick & Kotagal, 2004), in which case the nurse has a clear duty to understand and protect the best interest of the patient.

Nurses frequently report concerns that visitation may be physiologically harmful for patients, tiring for visitors or interrupt delivery of nursing care (Roland, et al., 2001). These perceived barriers to visitation have been studied and reviewed extensively (Sims & Miracle, 2006; Fumagalli et al., 2006; Hepworth, Hendrickson, & Lopez, 1994; Kirchhoff, Pugh, Calame, & Reynolds, 1993) and do not support restricting visitation. There are no clear indications that visitation must be limited for all ICU patients. A majority of the literature supports open, flexible visitation policies granting increased access to patients in the adult ICU to meet the needs of family members, decrease family members’ stress and improve coping and decision making abilities (Davidson et al., 2007; Sims & Miracle).

Early research regarding the Theory of Reasoned Action (TRA), as described by Ajzen and Fishbein (1977), postulated a strong predictive relationship between global attitudes and beliefs, and behavior. Therefore, a significant portion of the research surrounding open visitation has relied upon measuring nurses’ global attitudes and beliefs, or perceptions regarding open visitation policies to guide policy development and implementation (Kirchhoff et al., 1993; Berti, Ferdinande, & Moons, 2007; Duran et al., 2007; Garrouste-Orgeas, et al., 2008; Livesay, Mokracek, Sebastian & Hickey, 2004; Marco, Garayalde, Margall & Asiain, 2006; Ramsey, Cathelyn, Gugliotta & Glenn, 1999). Later evidence demonstrated that the ability to predict individual behaviors from global attitudes was less reliable than early findings suggested (Ajzen
& Fishbein, 2005). However, specific behaviors can be predicted more reliably by using compatibility measures of attitudes toward the behaviors (Ajzen & Fishbein, 2005). For example, rather than assessing nurses’ global attitudes and beliefs toward open visitation or regarding the perceived affect of visitation on family members, a researcher would assess nurses’ attitudes toward individual behaviors, such as allowing a family member to perform oral care for the patient or to stay overnight if the patient were dying, to more accurately predict behavior.

**Statement of the Problem**

Although the ability to be near the patient is consistently ranked as being highly important by family members, visitation of patients in the ICU has traditionally been restricted. A movement to liberalize visitation policies has resulted in research that supports open, flexible visitation policies in the adult ICU setting, which has resulted in more hospitals adopting open visitation policies. In cases where hospital policies support open visitation, nurses’ practice in relation to family visitation varies widely and is not always consistent with policy. Researchers have frequently used measurement of nurses’ attitudes and beliefs regarding visitation (Berti, Ferdinande, & Moons, 2007; Duran et al., 2007; Livesay et al., 2004) to guide policy development and to evaluate implementation of open visitation. Open ICU visitation policies, however, may not result in nurses changing their family visitation practices.

**Purpose**

The purpose of this review of the literature was to determine the trend of ICU visitation policies, and to evaluate nurses’ perceptions of open visitation policies as well as their practices
to determine if nurses’ practice reflects policy. The literature regarding nurses’ perceptions, attitudes, and beliefs surrounding family visitation was also reviewed.

**Search Methods**

An initial search using the keywords *visitation; family; ICU; critical care; adult; policy; attitudes and beliefs* was conducted limiting results to those published in English, years 1998-2008, and search criterion for “ages” was limited to 18 years and older. The search was expanded to include the dates 1988-2008 and the keywords *open visitation; flexible visitation; restricted; relatives; opinion; satisfaction; nursing behavior; and nursing practices*. Much of the relevant research was based upon earlier works published in the 1970s, therefore, the search was broadened to include the years 1970-2008 to capture articles sentinel to the topic. A total of 79 articles were reviewed.

Databases searched include: The Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO Medline, and Evidence Based Medicine review (Cochrane). In addition, a general search using Google, Google Scholar and Dogpile was also performed resulting in three additional articles. Studies included in this review include those pertaining to nurses’ perceptions, attitudes and beliefs regarding family visitation in the adult ICU and studies containing data regarding nurses’ practice in relation to stated policy were included. No studies were found that measured the relationship between nurses’ perceptions and nurses’ practice, although theory postulates that they correlate.
Significance to Nursing and Healthcare

The ICU is a frightening place, for patients and their family members. Illness or injury requiring ICU admission is often life threatening and can produce severe anxiety within the family system (Curtis & Rubenfeld, 2001). These events are often sudden, making preparation for, or prevention of, the adverse effects on the family impossible (Van Horn & Dautz, 2007). Families describe the need to be near their loved one as being of high importance, yet they are often excluded from the bedside, except for brief interludes, without explanation (Berwick & Kotagal, 2008; Simpson et al., 1996), despite evidence that visitation is generally not harmful to patients and is beneficial to families (Davidson et al., 2007; Sims & Miracle, 2006).

Critical care nurses are in the best position to identify the needs of patients and families because they are responsible for the constant and holistic care of the patient (Roland et al., 2001; Curry, 1995), however they do not always accurately assess the needs of family members (Maxwell et al., 2007). Nurses are the gatekeepers to the ICU and control access to the patient, making family members dependent upon nurses to grant them access to their loved ones (Farrell et al., 2005). Variation in the implementation of visiting policy by critical care nurses creates added stress for family members and fosters an atmosphere of distrust between families and nurses (Henneman & Cardin, 2002). The purpose of this review is to provide support for the implementation of evidence-based policies and practices surrounding visitation in the adult ICU setting and to inform future research in this area.
Summary

ICU admission has potentially devastating implications for patients and their family members. The stress and anxiety experienced by family members can impair short and long-term functioning as well as the ability to make critical medical decisions on behalf of the patient. Allowing family members’ access to the patient has been shown to alleviate much of this distress (Cullen et al., 2003; Peterson, 2005). Restrictive visitation policies that limit who may visit, including when and for how long, have traditionally been the norm despite a growing body of research suggesting that less restrictive visitation policies are not harmful. Open visitation is gaining acceptance, however, independent of policy; nursing practices vary with regard to allowing access to patients in the ICU. Variations in practice result in uncertainty and added stress for family members. Families view nurses who grant them increased access as being “better” than nurses who are restrictive, which creates tension among staff. There is little research to explain the reason for these variations, although nurses’ attitudes and beliefs regarding possible negative effects of visitation have been implicated.

Prior literature reviews have focused on the needs of family members and perceived barriers to visitation, but none have examined the body of literature pertaining to visitation policies and practices, nurses’ perceptions, attitudes and beliefs in regards to visitation policies, or the relationship between policy and practice in the adult ICU.
CHAPTER TWO: REVIEW OF THE LITERATURE

ICU Visitation Policies

The purpose of this review of the literature was to determine the trend of ICU visitation policies, and to evaluate nurses’ perceptions of open visitation policies as well as their practices to determine if nurses’ practice reflects policy.

Historical Perspectives

Prior to the advent of modern hospitals, most births, deaths, and care during illness occurred at home. One of the earliest hospitals was started by William Penn in Philadelphia in 1713. Family members frequently accompanied the patient and tended to their basic needs in the hospital (McGrew, 1985). The first visiting restrictions were imposed in the 1800s when visiting hours were limited to non-paying patients in an attempt to keep order in the wards (Rosenberg, 1987). For many decades afterward, paying patients enjoyed the privilege of nearly unlimited visitation in their private and semi-private rooms (Rosenberg).

The critical care unit was developed primarily in response to technological advances that allowed patients to be mechanically ventilated. The first ICU is credited to Bjorn Ibsen in 1952 (Richmond, 2007). In 1962, the United States Public Health Service (USPHS) recommended that visitation in the ICU be limited to five minutes every hour and to no more than two visitors at a time; no rationale was found for this recommendation (Hopping, Sickbert, & Ruth, 1992). Three years later, the USPHS rescinded its prior recommendation of restricting visitation and recommended that visitation of the ICU patient be based upon the patient’s condition and the
staff’s “ability to entertain visitors in the setting” (United States Public Health Service, 1965; Titler & Walsh, 1992; Hopping et al).

Current Visitation Policies

The literature pertaining to visitation policies in adult ICUs was reviewed to review the trend of open visitation. The historical progression of open visitation demonstrated by key studies conducted in the past two decades is discussed below.

In 1988, a landmark survey distributed by Stockdale and Hughes at the American Association of Critical Care Nurses (AACN) National Teaching Institute (NTI), gathered visitation policy data from 240 nurses representing 197 ICUs. The majority of the ICUs (73.1%) had policies that limited visitation with regard to the number of visits allowed each day, the number and type of visitors (94.4%) with most (87.3%) allowing two visitors at a time. Restrictions on the length of time per visit (84.8%) and minimum age of visitors (89.3%) were also reported. At the same time, 38% or respondents to Stockdale and Hughes stated that the ideal number of visits allowed per day was an unlimited number, and nearly 27% stated the ideal visit length was unlimited.

A later nationwide survey of nurses caring for Acute Myocardial Infarction (AMI) patients obtained information related to visitation policy (Carlson, Riegel, & Thomason, 1998). More than 2,500 surveys were mailed to RNs who routinely cared for AMI patients in the first few days of hospitalization and 882 (34.8%) were returned. The ICU visitation policy most commonly described (53.5%, n=470) was a structured one in which 10 minute visits were allowed every two hours. The next most commonly described policy was open visiting with
some limitations by nurses (39.2%, n=344), although the exact nature of those limitations was not described. Less than four percent of nurses (n=33) reported completely open visiting. The differences in unit policies were found to be independent of hospital size or teaching status. The results demonstrated that ICU visitation policies had moved only slightly toward becoming more liberalized in the preceding decade.

More recently, Kirchhoff and Dahl (2006) reported findings from a national critical care survey developed by the AACN to gather necessary data to describe issues of workforce, compensation, and care specific to critical care units and nurses who work in them. One issue surveyed was ICU visitation policy. Of the 658 facilities eligible for the survey, 118 (18%) participated, representing 576 critical care units. Fourteen percent (n=16) reported a policy of open visitation at all times; 44 percent (n=52) reported open visitation on a scheduled basis and 31 percent (n=36) reported open except for rounds or shift changes. There were ten units (9%) that described their visitation policy as “other.” Larger units (≥30 beds) were more likely to be open at all times. This study revealed that open visitation policies were gaining acceptance, at least in larger ICUs.

Most recently, Lee et al. (2007) conducted a survey of ICUs’ visitation policies in New England. Of the 177 hospitals contacted, 96 percent (n=171) responded, representing a total of 195 ICUs. The survey revealed that 32 percent (n=62) had unrestricted, open visiting hours. However, the majority of ICUs reported restrictions on one or more of the following: number and duration of visits, number and age of visitors, and hours of visitation. In addition, there was considerable variation among ICUs having restricted visiting policies. For instance, the number
of visits allowed per day ranged from 2 to 24. The minimum age of visitors reported was between 12 and 14 years, and the most frequently reported lengths of time allowed for visits were between 10 and 15 minutes. The visiting policy that had the greatest degree of consensus was limiting the number of visitors allowed at the bedside to two per visit. The wide variation in visitation policies among ICUs suggests that there is little consensus regarding best practice for visitation policy.

To summarize, ICU visitation policies have slowly become more open and flexible over the past two decades. In 1988, ICU policies governing visitation were universally restrictive. Currently, nearly a third of ICUs have open, unrestricted visitation policies. The majority of adult ICUs continue to restrict visitation despite a growing body of evidence to support open visitation (Sims & Miracle, 2006; Davidson et al., 2007; Fumagalli et al., 2006; Gonzalez, Carrol, Elliott, Fitzgerald, & Vallent, 2004).

**ICU Visitation: Nurses’ Attitudes and Beliefs, and Practices**

Family members of critically ill patients consistently rank the ability to be near the patient as being highly important (Maxwell, et al., 2007; Kleinpell & Powers, 1992); however, the majority of ICUs have visitation policies that restrict family members’ access to the patient. ICU nurses have the power to regulate patient visitation, however, nurses’ beliefs and attitudes toward visitation are variable and incongruent with those of patients and their family members (Maxwell et al.). It has further been demonstrated that nurses vary in their visitation practices, irrespective of policy (Lee et al. 2007; Farrell et al., 2005; Henneman & Cardin, 2002; Halm & Titler, 1990; Maxwell et al.).
Discussions regarding attitudes and beliefs can be framed in reference to the Theory of Planned Behavior (Ajzen & Fishbein, 2005). The Theory of Planned Behavior was developed from the Theory of Reasoned Action proposed by Fishbein and Ajzen (1975). According to the Theory of Planned Behavior (See Theory of Planned Behavior, Appendix B) (Francis et al., 2004), the intention to perform an action depends upon several factors: (1) Behavioral beliefs about the likely outcomes of the behavior and the evaluation of these outcomes, (2) Normative beliefs about the normative expectations of others and motivation to comply with those expectations, and (3) Control beliefs about the presence of factors that may facilitate or impede performance of the behavior and the perceived power of these factors. The more favorable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person’s intention to perform the behavior in question. The theory was renamed after the concept of control beliefs was introduced (Ajzen, 1985). A few researchers have measured ICU nurses’ global attitudes and beliefs toward visiting in adult critical care units using this framework (Kirchhoff et al., 1993; Marco et al. 2006; Berti, Ferdinande, & Moons, 2007). However, because not all researchers reporting nurses’ perceptions of visitation in the adult ICU have used this framework, the term “perception” is used interchangeably with attitudes and beliefs to capture the nurses’ surveyed thoughts or reported feelings about the subject.

Nurses’ Attitudes and Beliefs

Most studies measuring nurses’ perceptions, beliefs, or attitudes regarding ICU visitation did not provide specific information regarding nurses’ actual practice in relation to unit policy, that is, they did not measure whether or not nurses implemented the policy as written.
One of the first studies to look at nurses’ beliefs and attitudes toward visiting in the adult ICU was conducted by Kirchhoff et al. (1993). The study used a combination of interviews and questionnaires to gather data on nurses’ attitudes and beliefs using the Theory of Reasoned Action. Interviews were used to elicit nurses’ beliefs about the effect of visiting on patient, families, nurses and nursing care delivery. Data on nurses’ beliefs about the best visiting policy for patients, families and nurses as well as factors affecting enforcement of visitation policy were also obtained. A questionnaire was used to assess nurses’ attitudes toward visiting. Descriptions of nurses’ beliefs toward the consequences of visiting on patients, families, staff, and the unit, were derived from a content analysis of the interviews. ICU nurses from two states, Utah (n=29) and Ohio (n=41), were surveyed. Results showed that most nurses believed visitation to be more positive from a psychological perspective than from a physiologic perspective, and that the effects could differ depending upon patient and family member characteristics. Approximately one third of the nurses believed that visitation should be limited to prevent family members from becoming exhausted or from feeling obligated to stay. Beliefs about the effects of family visitation on the unit and nursing staff were mostly negative. The nurses believed that family visitation made it more difficult for nurses to concentrate and feel in control, and that it resulted in nursing care delays. Conversely, family visitation was believed to enhance nursing care by providing added patient information. Attitudes regarding the effects of visitors on the patient and family were more positive than were attitudes about the effects of visiting on the nursing staff.

Simpson et al. (1996) surveyed nurses’ attitudes and beliefs before (n=36) and after (n=32) implementation of a 3-month trial visitation policy described as open at the nurses’
discretion. The majority of nurses (58%, n=21) favored the trial. After implementation, the majority of nurses (90%, n=29) reported being at least somewhat satisfied with open visitation and 78 percent (n=25) preferred the new policy. Nurses’ beliefs about the effects of open visitation were consistent with other studies in that most agreed patients and families benefitted more than staff and that psychological benefit were greater than physiological benefits. Nurses further believed that the effects were dependent upon patient, family member and unit characteristics. Nurses attitudes about the benefits of open visitation on families (scored from 1=positive to 7=negative) was 2.1 compared to 4.8 for restricted visitation. The nurses’ attitudes regarding the effects of open visitation on patients or staff did not change after the implementation of the trial.

ICU nurses (n=201) at five greater Milwaukee area hospitals were surveyed to determine their perceptions of open visiting hours (Simon, Phillips, Badalamenti, Ohlert, & Krumberger, 1997). Open visitation was perceived by nurses to benefit patients (68%) and family members (88%). Nurses perceived that restricted visitation policies decrease environmental noise (83%), promote patient rest (83%), increase nurses’ satisfaction (57%), and decrease family members’ satisfaction (70%). Nurses reported that the ideal visiting policy is one in which restrictions are placed on the number of visitors (75%), the hours of visitation (57%), visitation by children (55%), and duration of visits (54%) without limitation to immediate family (60%). The primary rationale nurses gave for following or not following the official visitation policy were nursing judgment based on individual situations and assessment of patient, visitor, staff and unit characteristics. That is to say, the nurses’ visitation practices were based upon their ongoing
assessments of patient condition, the effect of visits on the patient and family members, and the level of activity in the unit.

Livesay et al. (2004) surveyed Neuroscience ICU nurses (n=22) and patient care assistants (PCAs) (n=4) to determine perceptions of (1) the current unit visitation policy, (2) the need for changes in unit policy and practices, and (3) the impact of the current visitation policy on patient outcomes. The unit had an open visitation policy described as ongoing except from 6 to 8 am and pm. The policy allowed for one visitor at a time to stay overnight with a patient if the patient was in a private room, and children under 10 years of age were not allowed to visit at any time. Not all participants answered all questions, resulting in variations in responses reported per question. Answers from nurses were not presented separately from those of the PCAs. Among 25 respondents, 18 (72%) believed visits to have both positive and negative effects on patients. Specifically five (20%) nurses indicated that family visitation had a positive effect on the patient and only two nurses perceived family visits might be negative for both family members and patients. The majority of staff (68%) stated they would modify the current visitation policy by limiting visit length to between 20 and 30 minutes, closing the unit for longer periods at changes of shift and for assessments, and closing the unit at night. It is unclear if nurses adhered to or deviated from the current open visitation policy.

Berti et al. (2007) used a descriptive, cross-sectional, multicenter survey to describe the beliefs and attitudes of ICU nurses (n=531) toward visiting, visiting hours, and open visiting policies within the adult ICU. Most of the nurses (75.1%) reported that they believed visitation was beneficial to patients. Sixty percent of nurses believed that family members helped the
patient to understand information. Conversely, 55.9 percent did not believe that an open visitation policy was important for patient recovery and 57.8 percent of nurses believed that an open visitation policy did not offer more comfort to the patient. The majority of nurses (73.8%) believed that open visiting impeded nursing care and that it caused nurses to use more time providing information to family members (82.3%). However, nurses overwhelmingly favored making exceptions to restricted visitation policy (98.7%) in circumstances when a patient was dying. In cases where family members had practical problems complying with visitation policy, nurses (83.8%) favored making exceptions, as well as when warranted by the patient’s emotional needs (70.2%). A slight majority of nurses (57.2%) favored flexibility during the first 24 hours of hospitalization. Nurses were opposed (70.4%) to giving patients control over the time, duration, or number of visitors. The majority of nurses surveyed (75.3%) did not want an open visitation policy. The overall score was 1.87 on a 4 point scale, indicating that nurses’ beliefs regarding open visitation were generally negative across 20 surveyed items.

Several studies conducted outside of the United States illustrate that variability in nurses’ attitudes and beliefs is not unique (Garrouste-Orgeas et al., 2008; Marco et al. 2006; Plowright, 1998). Plowright (1998) found that English nurses’ (n=68) overall perception of the importance of visiting measured 8.7 on a 10-point scale (where 1=not important and 10=very important), however, the beliefs about the effects of visiting on the unit were predominantly negative due to increased numbers of people, increased noise level, and frequent interruptions in care delivery. Nurses perceived visitation to have a positive effect on patients’ psychological and physiological well being and a generally positive effect on nursing care. Garrouste-Orgeas et al. examined ICU
nurses’ (n= 30) perceptions of an unrestricted visitation policy in Paris, France. Results showed that nurses’ perceptions regarding unrestricted family visitation were favorable except for occasionally delaying the organization of care and the need to alter behavior due to the presence of family. In another study, ICU nurses’ (n=46) beliefs and attitudes were surveyed by Marco et al. (2006) in Spain, and both were found to be positive after implementation of an open visitation. Furthermore, there was a significant, positive correlation between the nurses’ beliefs and their attitudes. On the beliefs scale, the nurses’ average response was 3 on a scale of 1 to 4 where 4 represented the most possible positive response. The mean value of nurses’ attitudes toward open visiting was 6 on a scale of 1 to 7 where 7 was the most favorable attitude. Nurses were asked about their satisfaction with the current, open visitation policy, and given the chance to answer either affirmatively or negatively, 93.3 percent (n=42) reported being satisfied while 6.7 percent (n=3) reported they were not satisfied with the current open visitation policy.

In conclusion, the literature surrounding nurses’ perceptions, attitudes and beliefs regarding visitation reveals they vary widely in some areas and are consistent in others. Nurses generally believe open visitation to be more beneficial to patients and families than to nursing staff. There is consensus that visitation policies should be individualized based upon patient, family member and unit characteristics with the nurse maintaining ultimate authority. The majority of nurses expressed consensus that visiting restrictions should be liberalized for patients near death, or for whom family presence was calming. ICU nurses further agree that information provided by family members is beneficial to nursing and can improve patient outcomes. Nurses’ attitudes and beliefs in relation to open visitation policy range from overwhelmingly positive to
negative. There is no clear consensus as to what constitutes best ICU visitation policy. It is not known if these variations in attitudes and beliefs resulted in variations in nurses’ practices.

Nurses’ Visitation Practices

Researchers have demonstrated that nurses’ attitudes and beliefs vary widely with respect to visitation policy. In this section, literature regarding nurses’ practice in relation to policy will be reviewed in an attempt to determine if similar variation exists.

In a nationwide survey of nurses (n=882) regarding their practice in patients with AMI, Carlson et al. (1998) showed that a majority of nurses sometimes (65%, n=570) or always (14.5%, n=127) deviated from the unit policy in relation to visitation. There were no significant differences between these nurses and their colleagues based upon age, level of education, AACN membership, assigned primary unit, or hospital size. Nurses provided 701 written explanations for deviating from visitation policy and most were patient-related (n=498). Physiologic status (n=253), patient desires or needs (n=119), patient situation or circumstances (n=70), and patient response to visitors (n=56) were identified as major themes. Unit factors accounted for 22 (3.1%) of the reasons for deviating from visitation policy. A significant number of responses (n=105) described their actual deviations in behavior rather than offering a reason for deviating from the policy. The majority of the deviations from policy resulted in liberalization of the visitation policy (74.3%, n=78) such as liberalization of the length of the visit (22%, n=23), visitor age limitation (20%, n=21), number of visitors (10.5%, n=11), or relationship requirement (6%, n=6). In addition, two of the 105 nurses allowed pet visitation. Among those reporting deviations in behavior, (15%, n=16) merely stated that they individualized visitation. Five nurses
described increasing restrictions on visiting. These data clearly illustrated that the nurses’ practice in relation to visitation policy was variable and favored liberalization of restrictions except in a few instances.

In contrast, Livesay et al. (2004) surveyed nurses (n=22) and PCAs (n=4) regarding their perceptions of open visiting. Practice was not specifically measured. However, when asked to describe their responses to family members inquiring about visiting hours, 85 percent (n=22) stated they told family members the unit was closed after 10:30 PM, while the visitation policy was open except for shift change. Interestingly, only 7 of the 28 responses (25%) identified the visitation as open. Reasons for amending the visiting policy included nurse discretion, patient condition, procedures, and self-care of family members. Despite the open visitation policy, approximately 20 per cent of the nurses responded that they supported amending visiting hours to let a family member be present at night if the patient’s condition warranted it. This suggests that the nurses were not familiar with the policy and a pattern of practice had developed within the unit that discouraged visitation at night.

Simpson et al., 1996 described the process by which nurses (n=36) in one critical care unit modified visiting from a restricted to a modified open policy. The impetus for the policy change reportedly stemmed from conflicts surrounding nurses’ inconsistencies in visitation practice. Nurses’ practices reportedly ranged from more liberal to more restrictive than the policy. Complaints were voiced by patients, family members and nurses regarding these inconsistencies. One reason provided for implementation of an open policy, rather than creating a new policy with a new set of rules, was that the existing policy was being applied
inconsistently. Adherence to the new policy was not measured directly; however, more nurses (n=29 of 32) were able to accurately describe the new open visitation policy compared to the old restrictive policy in which only 10 of 36 nurses were able to accurately describe the policy.

In Kirchhoff et al. (1993) nurses cited several conditions under which visitation might be restricted or limited including, patient fatigue, critical condition, interference with patient care, large family size, and difficult visitors. Conditions leading to flexibility included helpfulness of family member(s), patient age, either very young or very old, and patient instability or dying. Patient instability was viewed both as a reason to restrict and to liberalize visitation, depending upon if the instability was perceived to be associated with imminent death.

Simon et al. (1997) surveyed 201 critical care nurses at five metropolitan hospitals and found that, although 70 percent of the visitation policies were considered restrictive, 78 percent of the nurses said they were flexible in their visitation practices. Similar findings were reported in two older studies. Youngner, Coulton, Welton, Juknialis, and Jackson (1984) demonstrated that 90-95% of the nurses surveyed (n=78) made exceptions to their official policies based on the needs of the patients, family, or staff. In a survey of 226 ICU nurses by Hickey and Lewandowski (1988), only 39 percent reported that the unit visitation policy was followed consistently.

Nurses’ practices regarding family visitation in the ICU are variable. Some nurses are more liberal than the stated unit policies while others practice in accordance with the policies or are stricter. Many base their application of policy on the perceived needs of the patient and family members. Others structure visitation around nursing tasks and nursing schedules.
Essentially, visitation policy does not dictate the frequency and duration of family visits. Policy does not predict nor change nurses’ attitudes and behaviors about allowing visitors (Sims & Miracle, 2006; Livesay et al., 2004; Simon et al., 1997).

**Summary**

Visitation in the adult ICU has historically been restrictive. The patient and family-centered care movements have resulted in a push toward open visitation policies (Azoulay et al., 2001). Despite a growing body of evidence that visitation is not harmful to patients, family members or staff, restricted visitation persists in the majority of ICU settings, although open visitation appears to be more prevalent and accepted in larger ICUs and in those associated with teaching centers. Wide variations in policy suggest that no single policy has emerged that is considered best-practice.

Nurses’ perceptions of open visitation in the adult intensive care unit range from favorable to skeptical. Nurses’ perceptions regarding visitation have been measured before and after implementation of liberalized visitation policies, however, no clear relationship between these perceptions and actual practice has been established.

Nurses’ practices range from liberal to restrictive, and it has been demonstrated that, among nurses, practices regarding visitation vary independently from unit visiting policy (Halm & Titler, 1990; Simpson et al., 1996; Henneman & Cardin, 2002). These variations in practice have been described as a source of conflict between family members and nurses as well as among nurses working in the same ICU. The conflicts caused by variations in practice have
prompted several units to adopt open visitation policies; however, as noted previously, there is evidence that policy does not influence practice.
CHAPTER THREE: ADDRESSING THE PRACTICE PROBLEM

The preceding review of the literature shows that visitation policies for adult intensive care patients vary widely, ranging from open in about one third of ICUs to restrictive in the remaining units. Similarly, nursing practice has been demonstrated to vary with respect to visitation, independent of unit policy. Nurses’ attitudes and beliefs also vary from highly supportive or positive to highly negative with respect to open ICU visitation policies. It appears from the literature that most nurses believe they are in the best position to determine the appropriateness of visitation based upon individual patient, family and staff characteristics and needs. Nurses consistently cite several examples where they feel visitation should be individualized to suit patient, family member, or staff and unit circumstances.

Implications for Nursing and Healthcare

Open visitation in the adult ICU has been shown to improve patient and family satisfaction, coping, decision making abilities and decrease adverse consequences associated with ICU admission (Peterson, 2005; Cullen, Titler, & Drahoza, 2003). Conversely, restrictive visitation has been associated with negative consequences for patients, family members, and staff. Nurses tend to underestimate the importance of family visitation (Kosco & Warren, 2000) and frequently express concerns regarding possible negative effects of visitation that are largely unsupported by research. In addition, nurses’ practice regarding visitation varies widely and is independent of policy. Currently, about a third of adult ICUs have open visitation policies, and the trend is likely to continue due to ongoing recommendations from many sources. Wide variations in policies, perceptions and practice suggest that there is currently no generally
accepted best practice regarding visitation of the adult ICU patient and that policy changes alone are unlikely to result in changes in nurses’ practice.

**Implications for Future Research**

Researchers have described ICU visitation policies, nurses’ attitudes, beliefs and perceptions of ICU visitation policies, and to a lesser extent, nurses’ practice in relation to policy. However, no study was found that has looked at the relationship between nurses’ attitudes and beliefs about open ICU visitation, and nurses’ practice regarding implementation of open ICU visitation. The implication of this gap in the literature is that the method of measuring nurses’ global attitudes and beliefs as a proxy for nurses’ practice may not be useful in the development of open visitation policy evaluation of its implementation. Future studies to measure the relationship between these variables are needed.

**Summary and Conclusions**

The debate surrounding open visitation in the adult ICU has persisted for decades (Kirchhoff, Hansen, & Fullmer, 1985; Hamner, 1990; Kleinpell, 2008). It has been well-established that families and patients desire open visitation, that open visitation is beneficial and generally not harmful. Despite a growing body of evidence in support of open visitation, only about a third of ICUs currently have open visitation policies. Despite evidence to the contrary, nurses frequently voice concerns that visitation is harmful to patients and family members and interrupts the delivery of nursing care. Nurses also underestimate the importance of visitation. It has been shown that nurses’ practice varies irrespective of policy, therefore, even if open visitation policies become the norm, it is unclear if open visitation will be realized in practice.
Many researchers have utilized nurses’ measured attitudes and beliefs to guide policy development and implementation. This was based upon early research using the Theory of Reasoned Action which showed that global attitudes correlated well with behavior. Later analysis revealed that only when specific behavioral beliefs and attitudes are measured do they correlate significantly with specific behaviors. Future research should be conducted to establish the relationship between nurses’ attitudes and beliefs toward specific behaviors associated with open visitation to determine if they correlated with their overall stated practice.
Appendix A

Definitions

_Critically Ill Patient_

A critically ill patient is a person admitted to the ICU as the result of life-threatening or potentially life-threatening alterations of physiology (American Association of Critical Care Nurses, 2008). Persons able to self-direct their care or visitation preferences are not the focus of this project and will only be discussed in relation to background patient preference data.

_Family Member_

A family member, for the purpose of this project, is anyone identified as a family member by the patient or the patient’s legal surrogate or to be of significance to the patient. The term family member need not be restricted to persons related by blood or marriage (Farrell et al., 2005; Damboise & Cardin, 2003).

_Legal Surrogate_

When a durable power of attorney for health care is in place, the agent appointed by that document is authorized to make health care decisions within the scope of authority specifically granted by the document. In some instances, surrogates are court-appointed guardians with authority to make health care decisions. If there is no appointed surrogate, the law in most states allows the next of kin to act as surrogate decision-makers. States providing this option by statute usually stipulate a hierarchy of surrogates, starting with the person’s spouse (or domestic partner where recognized), then an adult child, a parent, a sibling, and then possibly other relatives. A growing number of states also authorize a close friend to act as the surrogate. If it is not clear who
should make decisions, doctors may be required to consult with the hospital ethics board or lawyers (Sabatino, 2007).

All surrogates have an obligation to follow the expressed wishes of the adult person and to act in the person’s best interest, taking into account the person’s values if known. Health care practitioners have an ethical responsibility to honor these wishes as well (Sabatino, 2007).

*Visitation*

Visitation refers to the interaction between critically ill patients and family members within the critical care environment (Moseley & Jones, 1991).

*Cohabitation*

Cohabitation generally defined as living with someone or occupying the same space over an extended period of time (Slota, Shearn, Potersnak, & Haas, 2003).

*Restrictive Visitation*

Sets rigid limits on who may have access to the patient, when visitation can occur, the length of the visit and the number of visitors (Stockdale & Hughes, 1988).

*Open on a Scheduled Basis*

A visitation policy in which visitation is open during a set, limited number of hours and restricted during set hours, such as at night and during shift change (Sims & Miracle, 2006).

*Open Visitation and Flexible Visitation*

For the purpose of this project, the terms flexible and open visitation are used interchangeably (Sims & Miracle, 2006) along with liberalized or liberal visitation (Ramsey et al., 1999). Open or flexible visitation is defined as visitation at the discretion of the nurse
(Simpson et al., 1996; Sims & Miracle) as guided by a unit philosophy of patient and family centered care, where the application of nursing discretion is within a framework that supports the nurse in providing for the needs of patients and their family members in an individualized manner. Open/flexible visitation is guided by the changing needs and interests of the patient, family members and primary care nurse as assessed by the patient, if able, the bedside nurse and family members in an effort maximize outcomes (Henneman & Cardin, 2002).

**ICU Visitation Policy**

The terms ICU visitation policy, visitation policy, or policy are used interchangeably to describe an institution’s written rules governing visitation of ICU patients (Livesay et al., 2004; Kirchhoff et al., 1993).

**Practice**

Practice describes the nurses’ behaviors in the application of the visitation policy (Farrell et al., 2005; Kirchhoff et al., 1993).
Appendix B

The Theory of Planned Behavior

This diagram of the Theory of Planned Behavior demonstrates the three levels of behavioral control that influence behavior. Please note that the earlier version of the theory, called the Theory of Reasoned Action, did not contain the third level pertaining to Control Beliefs (Ajzen & Fishbein, 2005).
REFERENCES


