ICU Visitors - Is it Time for a Change in Visitation Policy?

Dear Editor,

Intensive care units (ICUs) are unique and dynamic areas in hospitals. Visitors have been traditionally discouraged there. The severe illness and injuries of the patients admitted there necessitate many procedures and devices with more opportunities to transmit pathogens person-to-person. Doctors would control visits by visitors to protect the perceived best interests of the patients since they were considered the main carriers of nosocomial infections.

There is a gradual shift in the paradigm. A quote from a JAMA article is particularly thought-provoking- "In an effort to stabilize the details of ICU operations, health care institutions and professionals neglect the plausible assertion that the visitors are patients' lives, not the other way around" [1]. Controlled visiting hours is now considered nothing more than an extension of the patriarchal history of hospitals. ICUs around the world are becoming more liberal in the visitation policy regardless of the hour aiming for a holistic and healing approach to the health of the patients. The visitors must, however, be gowned and frequent hand washing is encouraged [2,3]. In the Armed Forces, it is possible to enforce this in smaller hospitals. The usual problems with families not following the "rules" are few, mostly more than two in the room, bringing sick people or children to visit and FOOD (personal pet peeve) into the room.

Times of visitation should focus on patient's wishes weighed along with family-patient dynamics apart from the disease condition for which he has been admitted in the ICU [4]. Only when the patient's condition doesn't allow for visitors should visitors be restricted. Most patients themselves discourage visitors in the early mornings or late evenings when they were attempting to rest or when they can have the opportunity to speak with their physicians on the rounds [5].

The haphazard routine of most doctors leave no fixed time for procedures. Should limited visiting be enforced when procedures are scheduled? One school of thought feels that family members may not like to see a CVP catheter being inserted or watch debridement of a bedsore performed on their loved one. What if a family member passes out during the dramatic procedure? When I do bedside procedures that frankly most families don't want to witness, or that would require a sterile field, I always ask the families to step outside for awhile... and explain why. No one has ever refused. Most take the opportunity to get a bite to eat or make phone calls.

A different school of thought is that what's wrong with visitors seeing everything we do for the patient, as long as the patient or his surrogate decision-maker consent to that? Shielding loved ones from the realities of the patient's illness lead to unrealistic expectations and delayed decision making abilities. Their presence can be seen as an opportunity for communication, teaching, establishing relationships, etc [6]. In our setup as critical care providers, we can explore the possibility of trying to incorporate the family into some of the daily tasks such as sponging. Not only will this make them feel included and reduce their sense of helplessness but as per Dr. Dorothea Orem, nurse theorist and creator of Self Care Deficit Nursing Theory, it is unrealistic to expect the nursing staff to do it all [7].

Relatives of patients in ICUs have repeatedly highlighted the

need for frequent reassurance and the provision of sufficient information on a regular basis. A board outside the ICU listing the condition as 'critical' / 'stable' is not sufficient. Families want to receive appropriate and clear information devoid of inconsistencies, preferably from a single source. Delivering information about the patient in easily understandable words and in an empathic manner is an integral part of high quality care in ICU [8].

However, a lower ratio of the time family members receive information to the time actually allowed to see the patients is a caregiver-related predictor of satisfaction [2]. Families feel comforted to see their patient for themselves and to speak to them if possible. It works both ways. A patient from the ICU described how "not being alone makes you feel happy, cared for and loved" [9]. My own worry about how my son would react to the news of my sudden admission in the ICU where I was recently admitted was over when I saw him there. And I saw his worry disappear - his mother may have required admission but things are not that bad.

The extent to which relatives of ICU patients are satisfied is dependent mainly on multiple caregiver-related factors. Our obligations include meeting the informational needs of patients and their families by disclosing all available information in a frank, direct and compassionate way. Moreover, satisfaction of visitors is considered a major criterion in the assessment of quality of care and of compliance with accreditation requirements. Visitors are our best allies. They will feel we have given our best care and done all we can... even if the patient has a poor outcome.

References

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