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Visiting Hour Policies in Intensive Care Units, Southern Iran

[1]S. Haghbine, [2]Z. Tayebi, [2]A. Abasiyan, [3]T. Farkhondeh and [4]V. Kazemi

[1]Peadiatric Intensive Care Unit, Paediatric Department,
Namazi Hospital, Shiraz University of Medical Sciences, Shiraz, Iran
[2]Nursing Department, Namazi Hospital, Shiraz University of Medical Sciences, Shiraz, Iran
[3]Department of toxicology, Faculty of Veterinary Medicine, University of Tehran, Tehran, Iran
[4]Food and Drug Organization, Ministry of Health and Medical Education, Tehran, Iran

Abstract: Admission to intensive care unit is potentially a stressful experience for both the patients and their families. Visiting policies can affect the patients' conditions and consequently their families. The present study aims to investigate the current status of the visiting hours and policies in intensive care units, Fars, southern Iran.This descriptive cross sectional study was carried out in summer 2009 and was prepared and filled for each unit. The data were collected through face-to-face and telephone talks with the head nurses of the units.In the present survey, 71 intensive care units were studied, consisting of general (20%), specialist (17%), neonatal/pediatric (18%) and cardiac (38%) units in private centers, university teaching and governmental non-teaching hospitals. As the data showed, restrictions were on the numbers of visitors, age and hours of visitation in all units. The study were reviewed and approved by the ethics committee of Shiraz university of Medical Sciences, Iran. Considering the benefit of the open visiting policies, revision of the existing ones is adopted.

Key words: Visiting Policy Family Intensive Care Unit Visiting Hours

INTRODUCTION

Admission to intensive care unit (ICU) is potentially a stressful experience for both the patients and their families. Besides, pain and severity of the critical diseases and sometimes life threatening conditions, anxiety due to the prospective diagnostic and therapeutic procedures, sleeplessness, immobility and overwhelming noises from ICU equipment such as ventilators and monitors cause the patients to feel helpless and worried. In addition, overhearing the stranger and unfamiliar conversations of the staff and visitors about the patients' conditions, psychologically affect the ICU patients who are alone and separated from their caring families [1-3].

Reported studies indicated that the isolated patients feel more feared and pain [4] that is why the authorities in the field believe that besides medical cares, reassurance and emotional support on the part of families and friends could be helpful [5].

The critical condition of the patients could be a source of stress and suffering for the respective families as well, so that sometimes it was referred to as in-family crisis [6- 8].Therefore, it has long been suggested that open and flexible visiting policies can positively affect the patients' conditions and consequently their families and can help them cope with the crisis and promote their satisfaction [9].

Restricted visiting hours are due to variety of reasons; including creating more discipline in the wards, avoiding the transmission of infection, Ismail and Mulley and Smith *et al.* [10,11] providing more time to spare for the patient's rest, avoiding crowded visitors and interruption of nursing care and reducing the tension between the health staff and the patient's visiting families [12, 13].

Clearly, visiting policies and rules vary from country to country depending on culture and hospital space, the geographical location, availability of facilities and

Corresponding Author: Vida Kazemi, Food and Drug Organization,
Ministry of Health and Medical Education, Tehran, Iran.

technologies, readiness of the staff for the prospective changes, developments and the existing routines [11].

Restricted visiting policies are more emphasized in ICUs, because of its structure, philosophy and its specialty features [12]. Currently, such policies are practiced in the majority of countries [13]. Nowadays, the role of families in the critical patients' recovery is considered very important and professionals focus on family and patient- centered systems. Accordingly, open visiting policies in which the patients could have control over their own circumstances, is advisable because it promotes the visiting opportunities for the families and therefore, their contribution to proper decision making about the patients' more secured environment. Unfortunately, such provisions may be impeded by the chaotic and highly technological environment of ICUs [14].

The bulk of related literature has identified open visiting policy as an unsatisfied need for both the patients and their families. Now, the question is why the ICUs do not support the open policy [4, 14].There have been very few studies conducted in Iran on the existing visiting policies, the strategies and the potential challenges facing the authorities. The present study seeks to investigate the current status of the visiting hour and policies in ICUs, Fars and southern Iran.

MATERIALSAND METHODS

This descriptive cross sectional study, conducted in winter 2009 and summer 2010, aimed to investigate the present visiting policies and rules, as practiced in ICUs of Fars, southern Iran. All the ICUs were identified by Shiraz University of Medical Sciences, Shiraz, Iran. To obtain the relevant data, a questionnaire was developed and filled for each unit, according to the study done by Anzoletti *et al.* [3] and then reviewed by an expert for its validity. The data were collected through face-to-face and telephone talks with the head nurses of the ICUs, by a single researcher. The questionnaire consisted of 22 closed and semi closed items dealing with personnel and their respective data, the ICU structures and the visiting policies. To finalize the procedures, a pilot study was carried out on three ICUs and the questionnaire was evaluated and revised based on the collected data. The study design and procedures were reviewed and approved by the ethics committee of Shiraz university of Medical Sciences, Iran.

RESULTS

In the present survey, 71 ICU were studied, of which 14(20%) were general ICU dealing with various types of patients, including surgical and medical ones. There were 17(24%) specialist ICUs; cardiac surgery, neurosurgery and transplantation. The remaining 40 (56%) ICUs consisted of pediatric/neonatal and cardiac ICU with 13(18%) and 27(38%) respectively. Forty three percent of the ICUs were in private hospitals and 28% were in university hospitals. The rest were located in governmental non-teaching hospitals (29%).

Descriptive analysis of the geographical and organizational characteristics is presented in Tables 1. As shown, there were 5-8 beds in 50% of the investigated ICUs and only 8% of them had 13 beds; bed arrangement survey also, revealed that in 49.3% of the units, the beds were in the open space. In 45% of the ICUs, there were separated, partitioned rooms and in some limited cases, the units possessed both open and separated spaces. The average monthly admission rate in 21% of the ICUs was 12-25patients and in 18% was 26-41patients. It is worth mentioning that in 28% of the units the in charge nurses were not cooperative or know enough and did not provide us with the required details. There were no waiting rooms or space in 59% of the ICUs.

Table 1: Characteristics of the surveyed intensive care units, Fars, sothern Iran, 2010.

Hospital location		Number	%
	City	52	73
	Town	19	27
Type of hospital	Private	30	42
	Government, teaching	20	28
	Governmental, non-teaching	21	30
Type of ICU	General	14	20
	Specialist	17	24
	Cardiac	27	38
	Pediatric	2	3
	Neonatal	11	15
Number of beds	1-4	20	28
	5-8	35	50
	9-12	9	14
	≥13	6	8
Bed arrangement in the unit	Open space	35	49.3
	Partitioned	32	45
	Open and partitioned	4	5.7
Monthly admission (mean)	<25	24	34
	26-41	13	18
	42-62	7	10
	>63	7	10
	No information	20	28
Waiting room	yes	30	41
	No	41	59

Table 2: Personnel's characteristics in the surveyed intensive care units, Fars, sothern Iran, 2010.

Number	Graduate Nurses	Undergraduate Nurses	Nurse/Bed
Pediatric/Neonatal	17.1	7	1.55
General	15.2	6.1	2.5
Specialist	22	6	3.6
Cardiac	10.4	33	1.5

Table 3: Visiting policies in the surveyed intensive care units, Fars, Sothern Iran, 2010.

Open policy		Number	%
	Yes	8	11.3
	No	63	88.7
Daily visiting time	No visitation	28	39.4
	Up to 1 hour	17	23.9
	1.5-2 hour	11	15.5
	>2 hours	15	21.2
Frequency of visit per week	0 days	28	39.4
	2 days	2	2.8
	3 days	1	1.4
	Every day	40	56.4
Number of visitors at a time	0 person	28	39.4
	One person	21	29.6
	2 persons	22	31
Visit by children permitted	Yes	0	0
	No	66	93
	sometimes	5	7
In-charge of visiting hours	Nurse in-charge	16	22.5
	Physician	7	9.9
	Hospital authorities	40	56.3
	Group decision	3	4.2
	Unknown	5	7.1
Decision on exceptional events	Nurse in-charge	48	67.6
	Physician	10	14.1
	both	13	18.3
Telephone Information provision	Yes	65	91.6
	No	6	8.4
The person receiving telephone information	No one	6	8.4
	Immediate family	19	26.8
	Relatives	46	64.8

Table 4: Entry precaution to the surveyed intensive care units, Fars, 2010

	Yes (%)	No (%)
Gown	40 (56)	31 (44)
Mask	14 (20)	57 (80)
Shoes change (cover)	22 (31)	49 (69)
Hand washing	13 (18)	58 (82)

Table 2 showed that on average, the units had 16.1 graduate nurses and 0.8 undergraduate nurses and the ratio of nurse to bed was 2.2 (i.e. the proportion of nurses relative to the beds in 24 hour shift). The highest ratio was found to be 3.6, belonging to the specialist units which is reasonable. However, this ratio was rather low (1.55) in pediatric and neonatal ICUs.

Table 3 demonstrated the visiting policies in the surveyed ICUs. The data showed relatively similar pattern of restriction in the majority of ICUs. The policy was restricted in terms of day, number of visitors, their age and visiting hours. Only in 11.3% of them, consisting of NICU and a single adult cardiac ICU, open visiting hours were practiced. In 21% of the units the visiting hours exceeded 2 hours, in 15.5% it was 1.5-2 hours and in 23.9% it was just one hour a day. In 39.4% (28 units) of the units no visitation were allowed. In some ICUs, due to the limitation of space and facilities, the visitors were allowed to see their patients just through the glass windows, which make the visiting more restricted. In 56.4% of the ICUs, the visitors were allowed to visit the patients on any day of the week. The number of visitors allowed in for each patient was one person in 29.6% of the cases and for the rest of the ICUs that allowed visiting (43 units), it was two persons. In 90% of the ICUs children were not allowed to enter to visit. It was found out that in 56.3%, the visiting rules were developed and publicized by the hospital authorities. The nurses and clinicians were responsible for the task in 23% and 10% of the ICUS, respectively. In 7% the routine traditional policies were followed and in the remaining units, the decisions were made on team basis. It was also revealed that in the case of unexpected events, the decision making was mostly done by the in-charge nurses (67.6%), followed by the doctors (14.1%) and finally by both together (18.3%). In 91.6% of the units, the relatives were informed of their patients' conditions on the telephone, of which in 26.8% only the immediate family members were given the respective information.

Table 4 provides some details about the access procedures to the ICUs. The data show that gown was the mostly used protection in the ICUs (40 units), while hand washing was required only in 13 units (18%).

DISCUSSION

To the best of our knowledge, this study was the first of its kind, conducted on the visiting hour's policies in the intensive care units of Fars province, south of Iran. Most of the data were collected through face to face conversation. Therefore, it could serve as a sufficiently reliable representative picture of current units across the nation. The survey is descriptive rather than analytical, which can provide the relevant data about the existing visiting policies.

The main finding of this survey was the tendency of intensive care units toward the uniform practicing restriction on the visiting hours. In cases the patient was dying or was a child, the policies were opener and more flexible. The present findings are in agreement with those reported from some other countries. Quinioand co-workers reported that 97% of the ICUs in France were following the restrictive policy. Their mean daily visiting time was 168 minutes. In 90% of their ICUs; the number of visiting persons was limited and in 60% of them, it was only the immediate family members allowed to visit [15].

Gianini*et al.* and Berti *et al.* [4, 13] similarly conducted a study in Italy and found almost the same results. Compared to most European and American countries, Italian counterparts were practicing more restrictive visiting policies. In Finland and Belgium this number was reported to be only 3.3%.

Berti *et al.* [13] revealed that the influential environmental and organization factors in restricting policies as practiced in Belgium, include the limitation of ICU space, Patient's privacy, avoiding crowds and noises, insufficient nurse to bed ratio and so on. It seems that the same factors are present in Iranian ICUs as well. For example, half of the surveyed ICUs are organized as open spaces and the visiting persons may disrupt the patient's privacy [3]. demonstrated that Italian ICU authorities are not inclined to practice flexible and open policy and they follow restrictive rules with no scientific grounds. On the contrary, the findings in Swedish ICUs showed that there is no restriction in 70% of the ICUs even during night hours [16]. This might be due to different cultural and attitudinal factors in different communities.

The situation in most NICUs was much more favorable in terms of parents and particularly breast feeding mothers unrestricted visiting opportunities (90%). The corresponding range in European NICUs was from 11% in Spain to 100% in United Kingdom, with 29% in Italy [11].

Gowning procedures persisted in 56% of the ICUs in the present study, while hand washing was urged in just 13% of them. These findings are relatively in agreement with the two studies done by Anzoletti *et al.* and Gianini *et al.* however, hand washing was more emphasized in them (59 % and 65%, respectively), compared to the present study [3, 4].Nevertheless, protective clothing is an archaic ritual and certainly the significance of hand washing as a measure to control infection is beyond dispute. In support of such measures, Burchardi *et al.* found that the risk of infection is not actually due to visitors from outside the hospitals and protective clothing is not therefore recommended [3]. Unfortunately, contrary to the evidence supporting hand washing precaution for both staff and relatives, in the existing ICUs it is not adequately followed and implemented.

The present survey revealed that waiting rooms were not present in 59% of ICUs. In some of them, to make up for this deficiency, there were some furniture and facilities for visitors in the corridors next to the wards. This may be attributable to the limitation of space and limited attention to the comfort of families and the Importance of the issue. To promote the families' satisfaction and comfort, the health authorities should be more attentive to the provision of more facilities and space.

The stated data revealed that the hospital authorities play a critical role in making visiting policies in the majorities of ICUs. However, the in-charge nurses and rarely the physicians make practical decisions in the units. The nurses are aware that with open policies, the patient and families anxiety is reduced. But due to several factors including staff and patient's safety, high workload and infection control, they may emphasize restriction on visitatio [14, 17]. Reported studies have demonstrated that there is a relationship between the nurses' educational status and experience and their attitude to the visitors [13]. Researchers in the field unanimously agree that the attitudes of the ICU's staff is the most important factor that can facilitate the path towards unrestricted visiting hours policy and a commitment to removing all barriers [3].

Therefore, it seems that the need for open policies in the ICUs should be satisfied in order to give more reassurance and relaxation to the suffering patients and accordingly, make their families more informed of their love ones' conditions and feelings [9, 18].

Considering the benefit of open visiting hours, we believe that a revision of current policies is required in the units and a change should be made to create more positive and satisfactory effects on the patients and their families. There are many surveys which lend support to the liberalization of visiting hours [11, 16, 19].

Despite lots of evidence supporting open policy, the ICU staff and particularly the nurses do not favor liberalization of the visiting hours. They believe that such a policy may cause interference with the nursing care of the critically ill patients and that emotional involvement may produce stress and strains [7]. Confidentiality of the

patients' information, their privacy, repeated explanation of the patients' conditions to their visitors and tiring workloads are among other factors why they do not appreciate open policies [13, 14, 19] Nurses are in fact, well aware of the positive feature of the open visiting hours, but they prefer the liberalization based on the individual patient's condition [13].We do not recommend universal implementation of unrestricted ICU visiting policies, but rather revising the current policies is suggested so that a balance is made between the family's needs to obtain information, patient's safety and the nurses' management of the patients in ICUs.

CONCLUSION

The present findings deal with the ICUs in Fars province, Iran have demonstrated that a similar pattern of visiting restriction is followed in the ICUs. Revision of the existing policies is a serious need which can be satisfied through appropriate decisions made by the corresponding authorities and health staff, who should also take into account the cultural aspects and patients' rights.

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