Evidence-based best practice regarding visiting policies at hospital intensive care units: A rapid review

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ABSTRACT

Background

The Centre for Clinical Effectiveness received a request to identify literature about hospital intensive care unit visiting policy.

Objective

This rapid review of the literature aims to inform the development of a Monash Health hospital intensive care unit visiting policy at Monash Health.

Methods

A systematic search of publications from 2010 – 2015 was conducted in diverse literature databases and the internet. The search identified policy statements, practice recommendations, systematic reviews, literature reviews, and hospital evaluation reports. A narrative synthesis of the results of ten publications was conducted.

Results

The quality of evidence is diverse and limited in terms of providing unbiased evaluations of the effect of specific visiting policies on healthcare outcomes and patient, family and/or clinical staff satisfaction. Evidence was synthesised from descriptive quantitative and qualitative studies which captured patient, family and clinical staffs' perspectives or responses.

Despite the evidence that open visiting policies have been shown to: increase patient, family and clinical staff satisfaction; reduce patient and family anxiety; improve communication between nurses and patients; and reduce patient length of stay, [1-4] restricted visiting hours are still imposed in many intensive care units. [5, 6] ICU clinical staff members have agreed that open visitation policies are a positive aspect of patients' care. [4, 7-9]

The American Association of Critical Care Nurses, and Best Practice guidance from the Joanna Briggs Institution have recommended that open and more flexible visiting policy should be facilitated, [2, 4, 7] while preserving the patients' rights on confidentiality. [1, 3]

Most Melbourne hospitals facilitate open intensive care unit policies on visiting hours, where visitors are allowed anytime. The policies, however, do impose certain restrictions on non-immediate family members, visitation during designated patient rest periods or during ward rounds. Nevertheless, in most hospitals, flexibility is exercised at the discretion of the intensive care unit Nurse Unit Manager.

Conclusion

The literature recommended that best practice should be formulated based on patient outcomes where visiting hours should be used as guidelines, not rules that allow flexibility dependent upon individual patient/family situation. [1] Patients should be able to exercise their rights where they may refuse visitors due to personal well-being or concerns over confidentiality. [1, 3] Any policies and guidelines established should be clear and consistent to circumvent confusion between intensive care unit staff, the patients and their families. [3, 8] The intensive care unit team should aim on provide family-centered care with open visiting hours to allow full access to patients where possible.

DETAILED REPORT

Review question

What is the best available evidence regarding hospital ICU visiting policies for patients and their visitors?

Background

The Centre for Clinical Effectiveness (CCE) received a request to find the evidence for best recommended practices associated with hospital intensive care unit (ICU) visiting policies.

Objective

This rapid review aimed to determine the evidence for best recommended practices associated with hospital ICU visiting policies.

Methods

Inclusion criteria

Population	**Inclusion:**	Visiting policies in hospital ICUs.
	Exclusion:	Visiting policies in neonatal ICUs and other wards.
Outcomes	**Inclusion:**	Visiting policies and its impact on patients and their families, and clinical staff (e.g. satisfaction, patient confidentiality, patient care)
	Exclusion:	Others.
Setting	**Inclusion:**	Hospitals in international and national regions.
	Exclusion:	General practices, community-based pharmacies and residential settings.
Publication Details	**Inclusion:**	Systematic reviews, literature reviews, and hospital evaluation reports were included.
	Exclusion:	Other study designs, non-English publications and animal studies.
Publication Date		2010 – Present (March 2015).
Databases searched	Peer reviewed literature database: Ovid MEDLINE, ALL EBM and the Joanna Briggs Institute EBP Database. Grey literature source: Google.	

Search strategy

A comprehensive search strategy was used for the literature review, as detailed in Appendix I. Published records in English that fulfilled the inclusion criteria were systematically searched in Ovid MEDLINE, ALL EBM, the Joanna Briggs Institute EBP Database and Google, while employing the date limits from 2010 - current (March 2015). Modified block building was used to accommodate differences in search terms, indexes and thesaurus across the electronic databases. Thirdly, the reference lists of all included peer-reviewed articles were searched for additional studies. Searches of medical databases were screened by one reviewer in consultation with colleagues.

Risk of bias

The methodological quality of included studies was not assessed.

Results

The literature search identified policy statements, practice recommendations, systematic reviews, literature reviews, and hospital evaluation reports.

A narrative synthesis of ten publications (including two systematic reviews) was conducted. The quality of the included studies in the systematic reviews was diverse. It included quantitative and qualitative studies related to visitation models in adult ICUs in acute care hospitals within the context of Patient and Family Centered Care (PFCC). Quantitative studies included descriptive observational studies and pre–post intervention survey design studies that examined outcomes associated with the visiting policies. Qualitative studies examined the beliefs, meaning and perceptions of restrictive, open and flexible visiting hours within the context of PFCC.

The impact of open or flexible ICU visiting policies indicated: overall benefit to patients [1-4, 7-9]; interference with clinical staff workflow [1-3, 8]; patient family satisfaction [2, 4, 7-9]; and impact on patient confidentiality [1, 3].

Table 1 provides an overview of where literature exists on particular outcomes that are impacted by visiting polices with further detail described in Table 3.

Visiting policies were described in 7 publications [2-7, 10], and recommendations for practice were described in 7 publications [1-4, 7, 8, 10]. The source of these publications is listed in Table 2 with further description in Table 3.

The ICU visiting hours across 8 Australian hospitals is described in Table 4.

Table 1. Overview of the impact of open visiting policies

	Impact of open ICU visiting policies			
Sources	**Overall benefit to patient**	**Interference with clinical staff workflow**	**High patients' family satisfaction**	**Patient confidentiality discussed**
American Association of Critical Care Nurses (2011) [2]	✓	✓	✓	-
British Association of Critical Care Nurses (2012) [3]	✓	✓	-	✓
Ciufo (2011) [1]	✓	✓	-	✓
Joanna Briggs Institute (2010) [7]	✓	-	✓	-
Joanna Briggs Institute (2012) [4]	✓	-	✓	-
Kynoch (2011) [9]	✓	-	✓	-
Whitton (2011) [8]	✓	✓	✓	-

Key: "–" Conclusions on the impact of open visiting policies with regards to that particular aspect not reported

Table 2. Overview of the sources of literature describing visiting policies and practice recommendations

Sources	Policy described	Practice recommendations
American Association of Critical Care Nurses (2011) [2]	✓	✓
British Association of Critical Care Nurses (2012) [3]	✓	✓
Cannon (2011) [10]	✓	✓
Ciufo (2011) [1]	Not detailed	✓
Joanna Briggs Institute (2010) [7]	✓	✓
Joanna Briggs Institute (2012) [4]	✓	✓
Liu (2012) [5]	✓	Not detailed
Spreen (2011) [6]	✓	Not detailed
Whitton (2011) [8]	Not detailed	✓

Table 3. Narrative synthesis of results

1. Assessing the impact of ICU visiting policies on patients, families and clinical staff

1.1 Overall benefit to patient and other impacts on patient care

A large body of evidence suggests that unrestricted visiting hours is beneficial to patients [1-4] despite some evidence that open visitation interfered moderately with patient care. [8]

Evidence suggests that flexible (or unrestricted) visitation increases the quality and safety of patient care by:

1) Decreasing patient anxiety, confusion and agitation due to the "positive energy" from their visitors. [2, 7, 8]
2) Increasing patients' feeling of protection and security. [2, 3]
3) Improving communication between staff and patients, where relatives interpret better for their loved ones. Visitors offer information to enable nurses to better understand the patients, and play a role in both communication and decision-making in very ill patients. [3, 4]
4) Having a beneficial effect on cardiovascular complications. [2, 3]
5) Decreasing length of ICU stay. [2]

Open visitation may have the following impact on patient care:

1) Significantly greater environmental microbial contamination during the unrestrictive times, [3] however this did not result in any increase in septic complications in patients. [3, 7]
2) Having a perceived increase in noise levels in the busy unit. [3]
3) Patient safety could be compromised due to lack of space in most critical care areas, where there is reduced access in an emergency. [3]
4) Physiologically stressful and mentally exhausting to patients, however there was no evidence to support this. [2]

A review of some studies show that although ICU nurses agree that open family visitation may interfere with some aspects of patient care, the benefits to the patient overwhelmingly outweigh the risks and both family members and ICU workers agree the open visitation policy is a positive aspect of the patients' care. [8] The author concludes that there is no conclusive evidence that increased family visitation has a direct positive or negative impact on the patient's overall clinical performance. [8]

1.2 High patients' family satisfaction

Findings demonstrate that an unrestricted ICU visitation is associated with high family/visitor satisfaction, moderate symptoms of anxiety and depression in family members, [7-9] and even reduced family member anxiety. [2] Conversely, restricted ICU visiting hours is mentioned to be "negative and burdensome" by patients' families. [9]

1.3	Interference with clinical staff workflow and delivery of care

Although lacking evidence to support this belief, some ICU workers still feel that family visitation interferes with the provision of care. [2, 8] Another report mentions three separate publications describing that nurses feel that visitors hinder their work due to the time they spend entertaining visitors' questions, providing information, and educating them, [3] therefore becoming an impediment to practice and causing an increase in nurses' workload. [1]

Conversely, other findings outlined in another review demonstrate that visiting is beneficial to patients and an unrestricted ICU visitation, as perceived by ICU workers, has no substantial interference with the delivery of care. [8] Furthermore, ICU workers generally agree that the open visitation policy is a positive aspect of the patients' care. [4, 7-9] In practice, 78% of ICU nurses in adult critical care units prefer unrestricted policies. [2]

Spain nurses feel a greater professional satisfaction – whilst at the time interacting with visitors can be burdensome, the benefits to the patient are seen as reward. [3]

1.4	Patient confidentiality upheld

The right not to have visitors should also be upheld. [1, 3] Patients will not want visitors if they are unsure of the daily routine of the critical care area, feeling unwell, or if the patient is talking to doctors. It is necessary for patients not to lose the right to have confidentiality. [3] Evidence also shows that the idea of a lack of space led to concerns that the confidentiality of other patients might also be broken. [3]

The ICU staff are required to provide information to the patient only, unless that patient has given consent for another person to receive information. It is helpful to clinical staff if one person (usually next of kin) is identified as the main contact, this helps to protect a patients' confidentiality. [3]

2. Policies described

2.1	American Association of Critical Care Nurses (AACN), 2012

The AACN outlines the following statements of expected practice, based on peer-reviewed professional and organisational standards with the support of clinical study recommendations: [2]

1) Facilitate unrestricted access of hospitalized patients to a chosen support person (eg, family member, friend, or trusted individual) who is integral to the provision of emotional and social support 24 hours a day, according to patient preference, unless the support person infringes on the rights of others and their safety, or it is medically or therapeutically contraindicated.
2) Ensure that the facility/unit has an approved written practice document (ie, policy, procedure, or standard of care) for allowing the patient's designated support person—who may or may not be the patient's surrogate decision maker or legally authorized representative—to be at the bedside during the course of the patient's stay, according to the patient's wishes.
3) Evaluate policies to ensure that they prohibit discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and/or gender identity or expression.
4) Ensure that there is an approved written practice document (ie, policy, procedure, or standard of care) for limiting visitors whose presence infringes on the rights of others and their safety or are medically or therapeutically contraindicated to support clinical staff in negotiating visiting privileges.

2.2	Joanna Briggs Institution (JBI) Best Practice, 2010

To address the impact of hospital visiting hour policies on paediatric and adult patients and their visitors, JBI recommends the following based on a systematic review of research with moderate support that warrants consideration of application: [7]

1) More open visitation in adult ICU environments should be considered.
2) Patient control of ICU visiting should be considered, such as individualised contracts or patient control devices.
3) Visitation to neonatal ICU should be open to parents and guardians 24 hours per day, with sibling visitation to be allowed with parental approval.
4) Both siblings and parents of NICU patients would benefit from participation in a pre-visit education process.
5) A 'combination' visiting policy should be considered for maternity settings, where the women's partner or another identified individual would have open visiting, with restricted visiting for other visitors.
6) A separate lounge/family room should be considered for maternity ward visits, away from bed areas to reduce sleep disturbances during the day.
7) Open visiting be considered for general wards, with a "quiet hour" for patient rest.

2.3	Joanna Briggs Institution(JBI) Best practice, 2012

To assess interventions to meet family needs of critically ill patients in an adult intensive care unit, JBI recommends the following based on a systematic review of research with moderate support that warrants consideration of application: [4]

1) Nurse coached volunteer programs can provide support for families of ICU patients and improve comfort.
2) A structured communication program for family members of ICU patients can decrease the number of incoming telephone calls from family members without compromising satisfaction with care or the family's need for information.
3) Open or more flexible visiting hours for families of ICU patients may help improve family satisfaction.
4) Information provided to families via an information leaflet or specifically developed education program may help alleviate anxiety and improve comprehension.

2.4 Hospitals with restricted ICU visiting hours

The majority of hospitals surveyed in one study have restrictive hospital and ICU visitation policies. [5] The most common restrictions are related to visiting hours, followed by visitor number and age. Importantly, exceptions to the visitation policies are permitted in 94.8% of the ICUs.

None of the 105 ICUs surveyed has an open visiting policy, as reported in a study by Spreen et al, 2011. [6] Majority of ICUs impose restrictions on the duration visits ranging from 30 up to 240 minutes per visit. The survey also reveal that 90% of ICUs have family sleeping rooms when the patient is very ill and 99% of hospitals restrict the number of visitors at any one time. In addition, a large proportion of ICUs in hospitals have waiting rooms and catering facilities available. [6]

3. Practice recommendations

3.1 Respecting patients' rights

Patients should be able to turn away visitors if they are unwell or in conversation with doctors. [3]

3.2 Imposing restrictions

According to the AACN, restriction of adult (and child) visitors in the ICU may be justified under the following conditions: [2]

1) When there is a legal reason documented in the chart.
2) Their behaviour creates a direct risk to the patient, family, staff, or others in the environment.
3) Their behaviour disrupts the functioning of the patient care unit.
4) They have a contagious illness or have a known exposure to a communicable disease that would jeopardize the patient's health.
5) An infectious disease outbreak in the community requires severe access restrictions.
6) A patient in a shared room requires immediate lifesaving measures (eg, resuscitation) or a sensitive private discussion needs to occur.
7) In these instances, those present with the other patient may be asked to temporarily step out of the room.
8) To adhere to a patient's request for reduced number of visitors.
9) To protect the privacy of other patients.

3.3 Appointing a family care specialist (FCS)

Evaluation of the benefit of having a family care specialist (FCS) in the ICU – "identifiable and recognisable" face for the family whose role is to meet the evolving needs of the families of the critical care patient. After the implementation of the FCS, the ICU staff nurses' satisfaction is improved, and they view the role of the FCS as a vital part of their team. Family satisfaction is increased, and patients benefit by the FCS's role in implementing a palliative care program. [10]

3.4 Establish clear, concise guidelines

Inconsistencies among ICU staff regarding visiting policies might confuse family members about standard routines and patient care expectations. Evidence recommends that a clear policy be established on visitation where "clear and consistent guidelines" must be put in place. [3, 8]

Table 4. ICU visiting hours at Australian hospitals

Hospitals	Timing	Guidance
Austin Health Melbourne (Public)	Any time except: 7.00 am to 8.00 am, 1.00 pm to 2.00 pm, 9.00 pm to 10.00 pm	Restrictions apply during 7.00 am to 8.00 am, 1.00 pm to 2.00 pm, and 9.00 pm to 10.00 pm to allow for nursing handover and patient assessment, and 3.30 pm to 4.30 pm to promote a patient rest period. A maximum of two visitors per patient by the bedside at all times.
The Royal Melbourne Hospital (Public)	9.30 am to 3.00 pm (9.30 to 2.00 pm on Fridays) 5.00 pm to 8.00 pm	Ward rounds are conducted twice daily. We need to consider patient privacy and confidentiality and therefore ask visitors to leave the unit between 8.00 am to 10.00 am and 2.00 pm to 5.00 pm. Every effort is made for the ward rounds to finish on time, but they may be extended if patients' conditions require it. Your patience while waiting is appreciated.
The Alfred Hospital Melbourne (Public)	Anytime	No enforced visiting hours for patients in the ICU.
Box Hill Hospital (Public)	Anytime	Some restrictions may apply, please speak to the Nurse Unit Manager for more information.
St Vincent's Hospital Melbourne (Public and private)	Anytime except: ward rounds in the morning and afternoon	To ensure privacy for all patients, visitors are not admitted during ward rounds (morning and afternoon), but are welcome at all other times. Visitors are limited to next-of-kin with only two visitors able to visit a patient at the same time.
Liverpool Hospital New South Wales (Public)	Anytime	-
North Shore Private Hospital New South Wales (Private)	10.00 am to 1.00 pm and 3.00 pm to 8.00 pm	Rest period for patients is between 1.00 pm and 3.00 pm. No visitors are permitted. Due to the unpredictable nature of the ICU a registered nurse or team leader must authorise visitor access to the unit. You may be asked to wait in the waiting room during procedures & medical rounds.
Mater Hospital Brisbane (Public)	10.00 am to 1.00 pm and 2.00 pm to 8.00 pm	The period between 1.00 pm and 2.00 pm is a rest period.
Monash Health (Public)	Anytime for immediate family members (Dandenong); 11.00 am to 8.00 pm (Clayton) 8.00 am to 8.00 pm for all other visitors (Dandenong)	Dandenong: There are no restrictions imposed on immediate family members; other visitors are restricted between 8.00 am to 8.00 pm. A rest period is observed between 1:30 pm to 3:30 pm, where visitors may be restricted upon discretion of the Nurse Unit Manager. Clayton: Visiting hours are between 11.00 am to 8.00 pm for immediate family members. A rest period is observed between 4.00 pm to 6.00 pm. Flexibility is exercised upon discretion of the Nurse Unit Manager.

Discussion

Overall, findings support more liberal visiting policies that can improve patient care outcomes, reduce anxiety, improve the quality of care for both patients and families, and improve communication between patients, families and nurses. [1-4, 7] The belief of some ICU nurses that family visitation increases physiologic stress in the patient and interferes with the provision of care, is mentally exhausting to patients, and contributes to increased infection is not supported by evidence. [3] However, despite the benefits that unrestricted visiting hours have on patients and their families, a survey done by Liu (2012) revealed that majority of hospitals have restrictive hospital and ICU visitation policies related to visiting hours, visitor number and age of visitors. Nevertheless, 94.8% of the ICUs permit exceptions to the visitation policies. [5] Policies should be established taking into consideration, cultural differences

and principles, the size of the hospital, the hospital's geographic location, the daily admittance of patients, the distance to the hospital for visitors, the hospital's access to and implementation of current technology and the clinical staff's ability and willingness to adopt new knowledge and routines. [7]

Limitations

The hospitals that were surveyed varied in size, admissions and patients access of which are taken into account for the development of policies. Many of these strategies were not evaluated quantitatively on their effects; therefore, this limitation needs to be considered when considering these strategies.

Policies were mixed strategies in terms of restrictions to the number of visitors and visiting hours; some of the evidence did not explicitly define policies but only described policies as being open or flexible.

Conclusions

Recommendations for best practice should be formulated based on patient outcomes where visiting hours should be used as guidelines, not rules, that allow flexibility dependent upon individual patient/family situation. [1] Patients should be able to exercise their rights where they may refuse visitors due to personal well-being or concerns over confidentiality. [1, 3] Any policies and guidelines established should be clear and consistent to circumvent confusion between ICU staff, the patients and their families. [3, 8] The ICU team should aim to provide family-centred care with open visiting hours to allow full access to patients where possible.

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Appendix I: Search strategies

Databases (search conducted on 19 March 2015)	Records
MEDLINE (Ovid) Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) 1950 to Present	7
The Joanna Briggs Institute EBP Database - Current to March 11, 2015	6
EBM Reviews • **Cochrane Database of Systematic reviews** 2005 to February 2015 • **ACP Journal Club** 1991 to February 2015 • **Database of Abstracts of Reviews of Effects** 1st Quarter 2015 • **Cochrane Central Register of Controlled Trials** February 2015 • **Cochrane Methodology Register** 3rd Quarter 2012 • **Health Technology Assessment** 1st Quarter 2015 • **NHS Economic Evaluation Database** 1st Quarter 2015	1
Google (critical care OR intensive care) AND (visiting hour) AND (best practice)	427
Total records	**441**

Search terms in Ovid MEDLINE:		
#	**Terms**	**Records**
1	*critical care/ or *intensive care/	24786
2	critical care.mp.	35637
3	intensive care.mp.	122102
4	visiting hour.mp.	10
5	1 or 2 or 3	145078
6	4 and 5	7

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