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# ICU Nurses' Perception of Visits to Patients

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**Article received:** 01.11.2019.

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**Article accepted:** 11.02.2020.

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**DOI:** 10.24141/2/4/1/8

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**Keywords:** children's visits, open ICU concept, visiting policy, visit limitation, visit-related infections

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## Abstract

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**Introduction.** Visits to patients are part of a positive and effective strategy of helping patients and their families to better adapt to the stress caused by a patient's admission to an intensive care unit (ICU).

**Aim.** To determine the ICU nurses' perception of visits to patients.

**Methods.** The study was conducted at the University Hospital Centre Zagreb (UHC). The cross-sectional study included nurses who work in ICUs. An anonymous, self-designed questionnaire was used and filled in by 44 respondents. The questionnaire consisted of 17 closed-ended questions pertaining to demographic data, questions related to information on visits and questions about the concept of open visits.

**Results.** Out of the total number of 44 respondents, 25 respondents stated that their ICU has booklets about the manner of visits and visiting hours, and that they hand them out to families, while 19 respondents stated that they do not have such booklets. 61% of the respondents feel they have sufficient training to communicate with the patient's family. 41% of the respondents said that the visits had a positive effect on the patient's condition and only 2% stated that the visits had no positive effect. 57% of the respondents think that visits sometimes have a positive effect on the patient's condition. Of the total number of respondents, 84% feel that visiting hours should be limited. Respondents feel that visits sometimes impede them in their work (66%), while 59% of the respondents feel that visits help spread infections. Out of the total number of respondents, only 32% of them stated that they were familiar with the open ICU concept.

**Conclusion.** More than half of the respondents stated that they have a written visiting policy on ICU wards, and that they are trained to communicate with the family members of patients. Most respondents feel that visits contribute to the spread of infections and that they would limit children's visits to the ICU. The respondents' poor knowledge of the open ICU concept creates one of the barriers to introducing it in their wards.

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## Introduction

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According to the Law on the Protection of Patients' Rights, the Official Gazette of the Republic of Croatia Narodne Novine, 169/2004, 37/08, Article 2, every patient is guaranteed a general and equal right to quality and continuous health care, appropriate to their state of health, in accordance with generally accepted professional standards and ethical principles, in the best interest of the patient, and respecting their personal views (1). The protection of patients' rights is implemented according to the principles of humanity and accessibility.

The principle of humanity in the protection of patients' rights is achieved by ensuring that the patient is respected as a human being, by securing the patient's right to physical and mental integrity, by protecting the patient's personality, including respecting their privacy and worldview, as well as moral and religious beliefs. The principle of availability in the protection of patients' rights implies an equal opportunity to protect the rights of all patients (1).

Patients' rights are:

- the right to co-determination,
- the right to information,
- the right to refuse information,
- the right to accept or reject an individual diagnostic or therapeutic procedure,
- the right to access medical records,
- the right to confidentiality,
- the right to maintain personal contacts,
- the right to arbitrarily leave the health care facility,
- the right to privacy,
- the right to compensation for damages.

During their hospital stay, patients have the right to receive visitors in accordance with the rules of the medical institution, as well as the right to prohibit visits to a specific person or persons (2).

## Visiting policy

Visiting policy is a hotly disputed topic among medical professionals with regard to the best way to manage visits to intensive care units. The debate

is centred on whether or not visiting hours should be open (unlimited) or closed (limited). It is difficult to define these terms because some ICUs claim to practice open visiting hours, i.e. they allow visitors to visit at any time, but still limit the number of visitors due to limited space (3). A flexible and open visiting policy can have a positive effect on the condition of patients and family members and can help them be more satisfied and cope with crises more easily. Some studies indicate that visits should be possible at all times (and that this is necessary), while other studies indicate that it is necessary to preserve the patients' privacy and the dignity of their visitors (4).

In the last ten years, ICUs around the world have been developing increasingly, but there are still no specific rules or a consensus on visiting policies (5). Visiting rules and policies vary from country to country and depend on culture, hospital and ICU facilities, geographical location, availability of content and technology, staff willingness to accept future changes and various routines (5).

Visiting rules are set by the staff in intensive care units, and they have to balance the needs of the family, the need for patients to rest and the nurse's obligation to provide quality health care. In addition, there are differences among healthcare providers about their comfort levels in communicating with families. For example, those who feel more comfortable working with families may favour open visits, while those who do not feel comfortable want a stricter visiting policy. To create the best visiting policy, implementing a multidisciplinary strategy can help improve the quality of health care and patient satisfaction through collaboration between teams and, most importantly, involvement of the patient and his or her family in the implementation and planning of a new visiting policy.

Patient priorities for visits vary depending on age, disease-related characteristics, type of ICU, sustainable or unsustainable hemodynamic condition, whether the patient is intubated and differences between the needs of men and women. Although patients prefer the open concept of visits, they sometimes want limited visits, especially when family dynamics are not welcome. In this case, instead of applying a general visit scheme and strategy, certain personal restrictions can be put into place prior to the visitor's arrival (4).

## Benefits for patients

Some nurses believe that visits increase the psychological stress for the patient, interfere with the provision of adequate care, mentally exhaust the patient and their family members and contribute to the spread of infections. Studies have proven that the open ICU concept reduces anxiety and depression in patients, reduces the length of stay in the ICU (6) and improves hormone blood levels (5). Several studies have shown that visits provide comfort and support, reduce cardiovascular complications and create a sense of safety and satisfaction (4). Some patients state that they can feel "positive energy" from their visitors, which gives them a stronger will to survive (3) and they are more satisfied because they recognize the needs of their family members as well as their own (4). The presence of family members during procedures also provides them with a sense of protection and safety. They feel that their rights are protected (3). Advantages related to a reduced risk of post-intensive care syndrome (PICS) in patients (PICS-P) and their families (PICS-F) have also been identified (7).

The role of the family in improving the health status of patients is very important. Many studies show that the open concept of visits is recommended in many countries. Medical staff believe that unlimited visiting hours improve the mental and physical condition of the patient. This also improves the interaction of patients and their families with the medical staff (4). However, patients prefer shorter visits, a limitation of the number of visitors and privacy during care. In other words, flexible visiting hours are more important to them than the duration of the visit (5). The right of the patient to have no visits should also be upheld. Some patients do not want visits if they are not sufficiently familiar with the daily routine of the ICU or if they feel unwell. It is important that the patient does not lose the right to confidentiality (3).

## Children's visits to the ICU

Children's visits to the ICU are often intuitively restricted, with the rationale that they might be harmed by what they see or that they would misbehave (8), which in turn would stress and exhaust the patient. These prejudices are neither based on evidence nor on genuine needs of the patient or the children. Medical staff is afraid that it will not be able to provide support for the child and the family during their visit

because of a lack of knowledge and understanding of how to approach the child; there is also a lack of education and resources to support staff to facilitate children's visits (8).

A child's visit can provide distraction, hope and a sense of normality and help patients feel safe. Children can help reduce factors that contribute to the onset of delirium tremens and post-intensive care syndrome. It is important that parents and medical staff prepare the child prior to the visit to the ICU (3). Prepared children do not exhibit negative behaviour and show fewer signs of emotional change than children who have never visited the ICU before. It is recommended that children's visits be allowed, provided the children are not the carriers of an infectious disease (8).

Understanding a child's psychological needs is an important element in the development of visiting policies. Allowing children to visit reduces perceived fears and helps develop better understanding; children are thus not frightened but relieved and joyful when meeting a loved one. The sense of separation and abandonment is reduced, and, depending on the child's cognitive development, the child can understand what is happening. Children's visits are necessary as they facilitate the relationship among family members and help cope with the complications caused by the nature and impact of the critical illness (3).

## Limitation of visits

Nurses and physicians feel that limiting visiting hours has advantages and disadvantages. The advantages include compliance with the law and prevention of chaos, respect for the patient's wish not to receive visits, better control of infection transmission, consistency and continuity in the work of nurses. The disadvantages of visit limitation include failure to meet the emotional and spiritual needs of the patient and their family, lack of information about the patient's condition and a high number of visitors in a short time. Restricting visits is associated with traditional beliefs that it is important for patients to rest as much as possible, but this also gives medical staff greater control, preventing crowded patient rooms and avoiding rude or provocative visitors.

Lack of resources, rapid spread of technology and the severity of a patient's condition are all reasons why nurses may feel threatened or disappointed by the presence of the patient's family (4).

Limitation of visits by adults and children to the ICU is justified if:

- there is a legal reason that has to be documented in the medical records
- a visitor's behaviour is a risk to the patient, the family, the medical staff and other persons present
- a visitor's behaviour is obstructing patient care
- the visitor has an infectious disease or is the carrier of an infectious disease that could endanger the patient's recovery
- there is an epidemic of an infectious disease in the area that requires visiting hours to be restricted
- an emergency procedure (e.g. resuscitation) is being performed in a shared room, or when intimacy is needed for a private conversation
- visitors visit patients who share a room (visitors can be asked to temporarily leave the room)
- a patient demands that the number of visits be limited.
- there is a need for the protection of patient privacy (8).

### **Risk of infection transmission during a visit**

Medical professionals are concerned that visitors could expose vulnerable patients to an increased risk of infection (3). Direct and indirect contact with medical professionals may be an important means of exposure to pathogens causing hospital infections, but little is known about the patterns of contact with staff and visitors in hospitals. Understanding patient contact patterns has important implications, not only for the prevention of infections, but also for other quality and safety measures, such as patient falls (9). It is well known that most infections are transmitted by medical professionals who switch between patients without proper hand decontamination. Therefore, evidence indicates that proper washing of hands before the visit should prevent an increase of infections within the ICU (3). Given the importance of frequent interaction of medical staff with the patient in order to ensure safe and quality care, limiting contacts is certainly not in the best interest of the patient or the care team. However, studying contact patterns could potentially improve the understanding of ways of transmission, thus playing an impor-

tant role in the efforts to reduce the risk of infection by changing workflow patterns in order to reduce transmission possibilities, emphasizing the importance of compliance with standard precautionary measures, as well as precautionary measures during isolation (9).

Studies conducted with the aim of monitoring the safety and health of patients with limited and unlimited visits show that during unlimited visits, the patient's environment is significantly more micro-biologically contaminated, which is not surprising. However, sepsis complications in patients were similar with limited and unlimited visits. This contradicts some nurses' general belief that visitors are the cause of increased infection rates and that they directly infect patients (3).

An observational study on infection prevention was conducted in New York from June to August 2010 at 3 hospitals. The aim of this research was to determine the frequency, type and duration of contacts between various medical professionals, other hospital staff and visitors to patients in acute care settings through direct observation and a survey among medical professionals (9). Nurses were the most frequent visitors (45%), followed by family members (23%), doctors (17%), non-medical staff (7%) and other medical staff (4%). The visits lasted from 1 to 124 minutes (M=3 minutes for each group) (9). 22% of the time, those entering the room did not touch anything in the room, 33% of the time they touched only the patient's environment, 27% of the time they touched the patient and 18% of the time they were in contact with the patient's blood/other secretions. Other medical staff (this group includes physiotherapists, respiratory therapists, radiology technicians and laboratory technicians) visit approximately 2.8 patients per hour, while nurses visit 4.5 patients per hour (9).

### **The needs of families of patients treated in the ICU**

Family members often act as spokespersons and protectors of psychologically or physically compromised patients. Critical conditions often occur unpredictably and without warning, and the family may feel vulnerable and helpless at that moment without clear knowledge of what to expect from the medical staff or regarding injuries or the expected outcome of treatment (10). Stress caused by a family mem-

ber's illness can affect how other family members cope with their condition, and thus may interfere with the support that the patient requires (11). The nurse's relationship with family members is very important, especially if the relationship between a patient and their family is disrupted because of the patient's physical condition, such as the patient's inability to speak due to stroke or sedation due to mechanical ventilation. Changes in the patient's condition may occur suddenly and may require extensive or complicated treatment procedures. In such cases, physicians and nurses must rely on family members to consent to specific treatment procedures (10). In order to reduce the level of anxiety and psychological crisis in the patients' families, their immediate needs need to be identified and met (11).

Nurses were the first among medical staff to show interest in the needs of family members of patients in the ICU (12). In 1979, Molter studied and ranked family needs in a detailed descriptive study. In structured interviews with 40 family members of critically ill patients, he used a list of 45 "needs", developed from a review of literature and a survey of 23 nursing students (10). A control study conducted by Leske in 1991 developed 45 identified needs into an instrument known as the "Critical Care Family Needs Inventory" (CCFNI) (10). The results from 55 family members at three separate hospitals supported the validity of the content of the instrument. Leske studied the intrinsic psychometric properties and factor analysis of THE CCFNI tool with 677 family members over a 9-year period (1980-1988) (10). This instrument contains 45 items divided into 5 dimensions: information (need for real information about a family member), proximity (need for contact and staying with a family member), assurance (need for hope for desired outcomes), comfort (need for comfort) and support (includes means, support system or structure) (12). The importance of these five major areas was defined by Leske in the American Association of National Critical-Care Nurses (10). In addition to CCFNI, there are other tools for the assessment of the needs of the critical care patient's family and their satisfaction that share similar characteristics. Most of these instruments are based on CCFNI, which is the most widely used instrument worldwide (12).

A study conducted in Chile aimed to identify the most important needs of families whose members were treated in the ICU according to the dimensions identified by Molter and Leske (12). They concluded

that the most important needs of family members belong to the dimension of "assurance", but "honesty of information" and "knowing the outcome" are also important. The least important needs are related to the spiritual support of family members ("information on the availability of religious service" and "visit of a priest"). Basic needs and needs for comfort ("good food in the hospital", "comfortable furniture in the waiting room" and "availability of a telephone near the waiting room") have proven to be more important than religious needs and religious support (12).

Recognizing the dimensions of different needs of family members is crucial to developing cohesion, effective communication and useful collaboration, aimed at providing the best possible care and support for the patient and their family (11).

### Patient diaries

During their stay in the ICU, patients are exposed to extreme physical and psychological stressors, including fear, lack of privacy, noise, pain, lack of sleep, delirium tremens and the work environment of the ICU. This exposure influences a patient's recovery and can cause physical and psychological impairments.

Advances in treatment and care increase the number of patients experiencing various problems caused by their stay in the ICU. There are various strategies which help patients, one of them being keeping patient diaries (13).

Patient diaries were presented by Danish nurses in the 1980s as a tool for patient follow-up after discharge from the ICU. The involvement of medical professionals in keeping patient diaries seemed important for the reduction of anxiety in family members (14). Patient diaries provide an account of events during a patient's stay in the ICU. By following the design of the timeline, they provide insight into the background of the causes of admission to the ICU and a description of daily activities. In practice, patient diaries are written in different ways, including variations in structural, content and process elements. They are usually written prospectively, and they are referred personally to the individual patient. The diaries are structured: they contain a summary, listing the reason and event leading to a patient's admission to the ICU, a daily entry about the patient's condition and closing notes on discharge or transfer from the ICU (13). Patient diaries can be written by family members or by the medical staff (14).



The aim of patient diaries is to give the patient an accurate and informative collection of events and to facilitate the memorizing of factual data, filling in gaps in memory and minimizing the impact or overcoming imaginary phenomena and hallucinations. It is also recommended to use diaries for family members to encourage the healing process after witnessing a traumatic event, or as a basis for discussing a patient's experience of the illness (7). In families that wrote diaries, extremely low levels of post-traumatic stress symptoms were observed over a 12-month period after the ICU stay, in both the patient and their family members (9).

In France, interviews were conducted in 2012 and 2013 with 32 families of patients in the ICU to investigate their experience regarding patient diaries written by family members and medical staff (14). Based on the collected data, major areas were identified in which patient diaries improved communication between the patient, family members and medical staff. The diary served as a source of reliable information about the patient's health status during the stay in the ICU, benefiting both the patients and their families. Medical information entered by doctors was greatly appreciated by family members because they felt it improved their understanding of the patient's status (14). The study concluded that patient diaries help improve the relationship between medical staff and the patient's family. The diaries serve as a vector that brings together the patient, family and medical staff into a single "story" (14).

## Open ICU concept

The open ICU concept can be limited or open. An ICU with a limited visiting concept allows visits only at predetermined hours and limits the number of visiting family members. The open ICU concept allows visits over 24 hours, with a limited or unlimited number of visitors. The open visiting concept is common in paediatric ICUs but is still rare in adult ICUs (5).

Due to the complexity of health care in the ICU, earlier studies have raised concerns that the open concept of visitation may harm the patient by exacerbating psychological stress, interfering with timely and safe health care, impairing patient privacy and increasing exposure to infection (15). Further research has shown that the open ICU concept is associated with a reduction in symptoms of depression, anxiety and post-traumatic stress, as well as an improvement

in family member satisfaction (16). Not only does the open concept not harm the patients - it creates a support system for them and shapes family environments (4).

The concept of open visits to the ICU provides the patient with family support, improving communication between the patient's family and the medical staff and improving satisfaction with treatment (5). Research-based evidence shows that visiting hours for patients in the ICU must be tailored to the patient's needs and there should be no time limit on the visit and no limit on the number of people visiting (4).

In Brazil a study was conducted in 2013 about medical staff's perception regarding the open ICU concept (16). The questionnaire contained 3 questions that gave a negative perception of the open ICU concept: 53.3% of respondents feel that the open ICU concept does not increase family satisfaction with patient care; 59.4% of respondents state that the open ICU concept disrupts the organization of patient care; 72.7% of respondents believe that their work is interrupted more often. Although more than 50% of respondents stated that the open ICU concept does not reduce anxiety and stress in family members, most (67.9%) would like to be hospitalized in an ICU having an open visits concept if they had to stay in an ICU (16).

Hospitals wishing to use the open visits concept in their ICU must first monitor visits over several months and ask patients, family members, nurses and physicians about their opinion on the open visits concept. (4). In order for the ICU medical staff to embrace the open ICU concept, it is important to emphasize that it is not the same for all hospitals. Also, the open visits concept does not mean that anyone is allowed to enter, or that visitors can enter the ICU whenever they want. It is important to emphasize that communication with visitors is a complex process which means that the interests and needs of the patient are considered, medical professionals must have communication skills and visiting family members must be prepared in advance. Changing the terms "open" and "unlimited" to "flexible" and "liberal" could help alleviate some of the reservations that medical professionals have against the open ICU concept (17).

## Aim

The aim of this paper is to examine the perception of ICU staff regarding visits.

The specific aim is to determine:

- whether ICU staff has a written visiting policy (visiting hours, number of visitors)
- whether staff is educated about communication with visiting family members
- staff perception of children visiting the ICU
- staff perception of infections associated with visitors
- staff perception of the open ICU concept

## Methods

The study was conducted in three clinics at the UHC Zagreb: the Clinic for Pulmonary Diseases Jordanovac, the Clinic for Thoracic Surgery Jordanovac and the Clinic for Anaesthesiology and Intensive Medicine.

An anonymous questionnaire was specially designed for use in this study. The questionnaire consisted of 17 closed-ended questions including demographic data, questions about visits and questions about the open ICU concept.

The questionnaire was filled in by 68 nurses; 16 questionnaires were invalid because multiple answers were selected. 6 questionnaires were not filled in completely. The total number of questionnaires analysed in the study is 44.

## Results

Most respondents (16) belong to the age group between 25 and 34 years (36%). 14 respondents (32%)

belong to the age group between 35 and 50 years. 12 respondents belong to the age group between 18 and 24 years (27%), while 2 respondents belong to the age group above 50 years (5%).

Average length of service for all respondents is 11 years. Of the total number, 14 respondents have less than 3 years of service (14%), 10 respondents have 3-9 years of service (23%), 10 respondents have 10-20 years of service (23%) and 10 respondents have more than 20 years of service (23%).

The distribution by qualification indicates that most respondents are Bachelors of Nursing (20 respondents, 45%), followed by nurses with secondary education (17 respondents, 39%) and 7 respondents who are Masters of Nursing/graduate nurses (16%). The data is shown in table 1.

Table 1. Respondents' demographic data

Age	Frequency	Percentage
18 - 24 years	12	27
25 - 34 years	16	36
35 - 50 years	14	32
50 years or more	2	5
<b>Years of service</b>		
Less than 3 years	14	14
3 - 9 years	10	23
10 - 20 years	10	23
20 years or more	10	23
<b>Level of education</b>		
Secondary school education	17	39
Bachelor of Nursing	20	45
Master of Nursing	7	16
<b>Total</b>	<b>44</b>	<b>100</b>

25 respondents answered that they had a booklet for visitors at their workplace, while 19 responded that no such booklet existed at their workplace.

When asked which information is provided to patients' families, a majority of respondents (42) gave the following answer: information about the patient's condition, items that can be given to the patient, hours when the physician is available for information and rules for visitors; only 2 respondents answered that they do not provide information about the patient.

When asked whether they feel they have sufficient training to communicate with families, 27 respondents (61%) answered positively, while 17 respondents (39%) answered negatively.

Questions about respondents' perceptions of visits show that most respondents (25 or 57%), think that visits sometimes have a positive effect on the patient's condition, while 18 respondents (41%) think that visits have a positive effect and 1 respondent says they do not have a positive effect (2%). The data is shown in table 2.

**Table 2. Do you feel that visits sometimes have a positive effect on the patient's condition?**

	Frequency	Percentage
Yes	18	41
No	1	2
Sometimes	25	57
Total	44	100

When asked "Do you think visiting hours should be limited", 37 respondents answered "yes" (84%), 4 respondents answered "no" (9%) and 3 respondents answered "sometimes" (7%). The data is shown in table 3.

**Table 3. Do you think visiting hours should be limited?**

	Frequency	Percentage
Yes	37	84
No	4	9
Sometimes	3	7
Total	44	100

The answer to the question "Do visits interfere with your work?" is interesting. 9 respondents (20%) answered "yes", 6 respondents (14%) answered "no" and 29 respondents (66%) answered "sometimes".

**Table 4. Do you feel that visits interfere with your work?**

	Frequency	Percentage
Yes	9	20
No	6	14
Sometimes	29	66
Total	44	100

When asked "Do you think children's visits should be restricted", 24 respondents (54%) answered "yes", 13 respondents answered "no" (30%) and 7 respondents answered "sometimes" (16%). The data is shown in table 5.

**Table 5. Do you think children's visits to the ICU should be restricted?**

	Frequency	Percentage
Yes	24	54
No	13	30
Sometimes	7	16
Total	44	100

When asked "Do visits contribute to the spread of infections", 26 respondents (59%) answered "yes", 16 respondents (36%) answered "no" and 2 respondents (5%) answered "other" ("only if visitors are not sufficiently informed").

**Table 6. Do visits contribute to the spread of infections?**

	Frequency	Percentage
Yes	26	59
No	16	36
Other	2	5
Total	44	100

The following questions refer to the open ICU concept. Most nurses answered that they were not familiar with the open ICU concept (30 respondents, 68%), while 14 respondents (32%) said that they were familiar with the concept.

**Table 7. Are you familiar with the concept of the open ICU?**

	Frequency	Percentage
Yes	14	32
No	30	68
Total	44	100

Of the total number of respondents, 14 answered the following questions. When asked "Do you think that the open ICU concept could be applied in your workplace?", 10 respondents (71%) answered "no", 4 (29%) answered "yes".



Of the 14 respondents, 9 respondents (64%) felt that an open ICU concept would provide better quality patient care and 5 respondents (36%) felt that it would not provide better quality care.

When asked "Do you think an open ICU concept would provide better patient safety?", 9 respondents (64%) answered "yes" and 5 respondents (36%) answered "no".

When asked "What should in your opinion be done to implement the open ICU concept?", 13 respondents said that it would be necessary to organize training for staff and families and to provide more staff, as well as to invest in infrastructure; 1 respondent thinks that it would be necessary to organize staff training.

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## Discussion

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A total of 44 respondents participated in this study. Out of the total number of respondents, 24 respondents state that there are booklets on the manner and time of visits that they hand out to families, while 19 respondents state that they do not have such booklets. A Canadian hospital provides an interesting booklet on how and when to visit. In addition to information about visiting hours (which are flexible), the booklet also provides information about the ICU, the ICU staff, guidelines on visitor assistance in patient care and useful information about where to park, where to stay (for visitors who do not live in the area) and where to eat (18).

Studies about communication and providing information about patients are closely related to the needs of the family, as they try to examine how family members perceive and use the informational support they get from medical professionals. In his study, Olding examines the time, type, amount and consistency of communication between medical professionals and family members, as well as the way in which this affects family member satisfaction, decision making and quality of care (19).

61% (27) of respondents in our study believe that they have sufficient training to communicate with family members, while 39% (13) of respondents be-

lieve that they do not have sufficient training to communicate with family members. Nurses often do not appreciate the visitors' contribution to the ICU and the benefit it provides for the patient. McAdam et al. state that patients at high risk of dying feel more secure and comfortable when their family is with them. They state that the family provides support and encouragement to the patient, and takes over the role of the patient's advocate and defender (3).

According to Cappelilini et al., patients believe that family presence gives them emotional support and helps them to better understand the information they receive from medical staff (4). The results of this study show that 41% of respondents feel that visits have a positive effect on the patient's condition, 57% feel that they sometimes have a positive effect and just 2% of respondents feel that visits have no such effect.

Prior research suggests that limited visiting hours can have a negative effect on the patient and their family. Liu et al. state that in 606 hospitals in the USA, 89,6% of ICUs have a restricted visiting policy. However, in practice, almost the majority of ICUs allow some exceptions when it comes to visits (15). According to the respondents in this study, visiting hours should be limited (84%), should not be limited (9%) or they should sometimes be limited (7%). The findings show agreement with research results in America, where a restricted visiting policy is implemented in most hospitals.

Family presence in the ICU is still a controversial topic. According to Gibson, nurses feel it takes a long time to provide information to families and that this can interfere with patient care (3). He also states that nurses see the time they spend providing information to visitors, answering their questions and answering phone calls as obstacles to patient care. It seems that nurses feel that interaction with visitors makes their job more difficult (3). This study shows different results. Only 20% of respondents state that visitors interfere with their work, while 66% of respondents state that this is just sometimes the case. With appropriate education, nurses could understand the benefits of more flexible visiting hours and greater openness of visits.

The main finding of this study is that only 32% (11) of respondents are familiar with the open ICU concept. Da Silva Ramos states that there are significant differences in visiting policies, but that the largest

percentage of institutions with an open ICU concept are located in the US region of New England and in Great Britain (5). However, this statistic can also be deceptive, because in most cases "open" merely refers to the visiting hours and most ICUs that state having an open ICU concept limit the number and age of visitors (17).

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## Conclusion

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More than half of the respondents stated that they have a written visiting policy on ICU wards, and that they are trained to communicate with family members of patients. Although the positive impact of visits on ICU patients has been proven, most respondents feel that visits contribute to the spread of infections and that limiting children's visits to the ICU is necessary. The respondents' poor knowledge of the open ICU concept creates one of the barriers to introducing it in their wards. Additional staff training, infrastructure adjustments and employment of additional staff could facilitate the implementation of the open ICU concept.

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## PERCEPCIJA MEDICINSKIH SESTARA NA ODJELIMA INTENZIVNE SKRBI O POSJETIMA BOLESNICIMA

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### Sažetak

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**Uvod.** Posjeti bolesnicima dio su pozitivne i učinkovite strategije koja pomaže bolesnicima i njihovim obiteljima da se bolje prilagode stresu koji nastaje prilikom prijama na odjel intenzivnog liječenja.

**Cilj.** Cilj je rada utvrditi percepciju medicinskih sestara na odjelima intenzivne skrbi o posjetima bolesnicima.

**Metode.** Istraživanje je provedeno u KBC-u Zagreb. Presječno istraživanje uključivalo je medicinske sestre koje rade na odjelima intenzivne skrbi. Primenjena je anonimna anketa kreirana za ovo istraživanje, koju je ispunilo četrdeset i četiri ispitanika. Anketa se sastojala od 17 pitanja zatvorenog tipa koja su se odnosila na demografske podatke, pitanja povezana s informacijama o posjetima te pitanja o konceptu otvorenih posjeta.

**Rezultati.** Od ukupnog broja od 44 ispitanika, 25 ispitanika navodi da postoje brošure o načinu i vremenu posjeta koje daju obitelji, dok 19 ispitanika navodi kako kod njih ne postoje takve brošure. Dovoljnu edukaciju za komunikaciju s obitelji bolesnika navodi da ima 61 % ispitanika. Da posjeti imaju pozitivan učinak na stanje bolesnika odgovorilo je 41 % ispitanika, a samo 2 % ispitanika smatra da posjeti nemaju pozitivan učinak. 57 % ispitanika smatra da posjeti ponekad imaju pozitivan učinak na stanje bolesnika. Od ukupnog broja ispitanika čak ih 84 % smatra da bi vrijeme posjeta trebalo biti ograničeno. Ispitanici smatraju da posjeti ponekad ometaju njihov rad (66 %), a 59 % ispitanika smatra da posjeti pridonose širenju infek-

cija. Od ukupnog broja ispitanika samo 32 % navodi kako im je poznat koncept otvorenog JIL-a.

**Zaključak.** Više od pola ispitanika navodi kako imaju pisanu politiku posjeta na odjelima jedinice za intenzivno liječenje te da su educirani za komunikaciju s članovima obitelji bolesnika. Većina ispitanika smatra kako posjeti pridonose širenju infekcija te bi ograničili posjete djece u JIL-u. Slabo poznavanje ispitanika o konceptu otvorenog JIL-a stvara jednu od barijera za njegovo uvođenje na njihovim odjelima.

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**Ključne riječi:** koncept otvorenog JIL-a, politika posjeta, ograničavanje posjeta, djeca u posjetu, infekcije povezane s posjetima

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