Visiting in ICUs: the opinions of nurses and patients' relatives

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INTRODUCTION

The intensive care unit (ICU) is an environment in which patients with serious medical problems are cared for. ICUs differ from other hospital departments with regard to their physical structure, trained medical and nursing team, special tools and equipment (Erkal, 1998; Madenoglu, 1988). Another difference is visiting by relatives; it influences the patients, their families and the nurses (Gurley, 1985). Many hospitals do not allow relatives to visit patients in ICUs. If visitors are allowed, their visits are severely restricted, including the number of visitors, the degree of closeness of the relationship, and the frequency and duration of visits (Kirchoff *et al*., 1993).

During the patient's stay in ICU, the relatives want very much to help make the patient feel comfortable, to be supportive and to be close to him (Gurley, 1985). However, hospital policies impose limitations on relatives' visits (Cleveland, 1994). Studies have shown that the separation of patients from their relatives leads to psychological problems, both in the patient and relatives, as well as physiological changes in the patient's vital and other signs (Madenoglu, 1988; Dramali *et al*., 1990; Gorak, 1997).

AIMS OF THE STUDY

A descriptive survey was used. The study aimed to determine the opinions regarding visits, both of nurses working in ICUs and of the relatives of patients in ICUs, with the purpose of guiding future changes in ICU visiting policies.

The study was conducted between 1 April and 15 September, 1999. It involved nurses in the coronary, internal medicine, surgery and general ICUs of university, Ministry of Health and Social Insurance hospitals, as well as relatives of the patients in the ICUs. Only relatives of patients aged over 18 years were enrolled. A total of 169 nurses and 100 relatives took part.

DATA COLLECTION

Data on the relatives' visits were collected using two survey questionnaires, one designed for the nurses and the other for the patient's relatives. The surveys included questions about the characteristics of the visits, as well as eliciting the opinions of the nurses and relatives regarding the visits. Some of the questions were designed to determine whether the opinions of the nurses and relatives were the same. Nurses completed their surveys themselves after an initial discussion with the researchers, while the relatives completed their surveys in face-to-face interviews.

Data were evaluated with percentile and χ^2-tests by computer using the Statistical Package for Social Sciences (SPSS) program.

RESULTS AND DISCUSSION

Of the 169 nurses enrolled in the study, 50.9 % (n = 86) were aged between 23 years and 27 years, 65.7% (n = 111) were single, and 42.6% (n = 72) had completed undergraduate training. The nurses worked in the coronary, internal medicine and general ICUs of university, Ministry of Health and Social Insurance hospitals. The nurses were divided among the different categories of hospitals in the following way: 65.7% (n = 96) worked in hospitals attached to universities, 27.2% (n = 46) in hospitals of the Ministry of Health, and 16% (n = 27) in Social Insurance hospitals. Almost one-third of nurses in the survey (33.7%, n = 57) had between 1 and 3 years' experience of working in ICUs. In addition, 45.6% (n = 77) of the nurses said they worked more than 40 hours weekly, 64.6% (n = 109) said their daily working duration was more than 8 hours, while 77.5% (n = 131) said the number of staff working in their ICUs was below the required numbers.

A total of 100 relatives of patients took part in the study, of whom 44% (n = 44) were aged 38 years old or more, and 29% (n = 29) had graduated from university. Three-quarters (75%) of patients' relatives (n = 75) said they were immediate relatives of the patient, 51% (n = 51) said they had never been in ICUs, and 60% (n = 60) found the ICU environment to be reassuring.

A review of the literature shows that the type of visits to ICU, their duration and frequency, and the number of the visitors were limited, with continued discussion about whether visits have a positive or negative effect (Kirchoff *et al*., 1993). This study found significant differences between the characteristics of

visits according to the type of institution for which the nurses worked (Table 1). Although regular and limited visits were found to be more common in university hospitals, it was found that visits were usually not allowed in the Ministry of Health and Social Insurance hospitals (χ^2 = 15.98; SD = 4; p <0.01). In addition, when the duration of visits was compared, the study showed that visits were longest (15 minutes - 1 hour) in Social Insurance hospitals, and shortest (<5 minutes) in Ministry of Health and university hospitals. These differences between the institutions were significant (χ^2 = 37.38; SD = 6; p <0.001).

A majority of nurses (80.5%, n = 136) were able sometimes to make exceptions to the usual policy for visiting, while 42.6% (n = 72) stated that the physician was the person who made decisions on visits in exceptional situations. When a comparison was made of decision-makers in different institutions, the study found that it was physicians who made these decisions in the Ministry of Health and Social Insurance hospitals, while the physician and nurse made such decisions together in university hospitals (χ^2 = 11.84; SD = 4; p <0.05).

The results of our study indicate that nurses are more able to make decisions in collaboration with physicians in university hospitals compared to nurses in Ministry of Health and Social Insurance hospitals. A study by Ergün (1999) agrees with our findings. Ergün found that nurses in Ministry of Health and Social Insurance hospitals had more disputes in making decisions in general with physicians than those in university hospitals.

Table 2 compares the opinions of nurses and relatives of patients concerning visits to ICU. 68.6% (n = 116) of the nurses said that visits by relatives were necessary, while 56% (n = 56) of relatives considered visits to be unnecessary. The result was statistically significant (χ^2 = 186.00; SD = 2; p <0.001). The reason given by relatives for visits being unnecessary was the risk of introducing infection to the patients (48%, n = 48). However, half the nurses said the visits were necessary because of the psychological support given by relatives to the patient (50.9%, n = 82).

These results highlight the holistic approach of nurses to the patient, as part of their professional approach. In contrast, the relatives view their contribution to the patient's care from a disease viewpoint only. These findings are supported by Kirchoff *et al.* (1993).

More than the half the nurses and relatives taking part in the study agreed on the need for set visiting hours and that children should not be allowed to visit. No significant differences were found in these opinions between the nurses and relatives (Table 2). Dramali *et al.* (1990) has previously shown that relatives of patients did not want children to visit the patients.

A few nurses and relatives said they thought that every patient should be allowed visitors; this finding was not statisti-

Table 1. Comparison of visit specifications according to institutions

Institution	Visit specification												
	Type of visit				Duration of visit					Person who makes decisions in case of exceptional situations concerning visits			
	Regular	Limited	Not Allowed	Total	5 min	6–15 min	16 min to 1 hr	Different duration	Total	Nurse	Physician	Nurse–physician	Total
University	8 (5.7)	84 (79.0)	4 (11.4)	96 (56.8)	35 (34.6)	22 (19.7)	9 (12.5)	14 (13.1)	80 (59.8)	10 (9.2)	32 (41.2)	33 (24.6)	75 (57.3)
Ministry of Health	0 (2.7)	35 (37.8)	11 (5.4)	46 (27.2)	21 (13.9)	6 (7.9)	0 (5.0)	5 (5.3)	32 (23.8)	4 (4.4)	25 (19.8)	7 (11.8)	36 (27.5)
Social Insurance hospitals	2 (1.6)	20 (22.2)	5 (3.2)	27 (16.0)	2 (9.5)	5 (5.4)	12 (3.4)	3 (3.6)	22 (16.4)	2 (2.4)	15 (11.0)	3 (6.6)	20 (15.2)
Total	10 (5.9)	139 (82.3)	20 (11.8)	169 (100)	58 (43.3)	33 (24.6)	21 (15.7)	22 (16.4)	134* (100)	16 (12.2)	72 (55.0)	43 (32.8)	131* (100)
Significance	χ^2 = 15.98; SD = 4; p <0.01				χ^2 = 37.78; SD = 6; p <0.001; *Unanswered: 35					χ^2 = 11.84; SD = 4; p <0.05; *Unanswered: 38			

Table 2. Nurses and relatives opinions concerning relatives' visit to ICU

Opinions	Nurse (n = 169)		Relatives (n = 100)		χ^2	SD	p
	n	%	n	%			
Are visitors to ICU necessary?					186.00	2	<0.001
Yes	116	68.6	44	44.0			
Psychological support	86	50.9	14	14.0			
Right of patient	8	4.7	–	–			
To see a dying patient for the last time	11	6.5	20	20.0			
Unanswered	11	6.5	10	10.0			
No	53	31.4	56	56.0			
Unhealthy environment is formed	27	16	48	48.0			
Alters patient's psychology	–	–	6	6.0			
Unanswered	13	7.7	2	2.0			
There should be a predetermined visit	90	53.3	56	56.0	1.53	1	>0.05
Children should not be allowed to visit	117	69.2	69	69.0	0.60	2	>0.05
Each patient is allowed to be visited	29	17.2	25	25.0	2.40	1	>0.05
Number of visitors should be limited	141	83.4	64	64.0	13.08	1	<0.001
Conditions of visit should be the same for each patient	30	17.8	28	28.0	3.90	1	<0.05
Patients and visitors should be left alone	49	29.0	19	19.0			
Degree of relationship							
Immediate (first-degree) relative	154	91.1	86	86	22.14	2	<0.001
Second-degree relative	3	1.8	3	3			
Others	12	7.1	11	11			

cally significant. A significant majority of nurses (83.4%) compared to relatives said the number of visitors had to be limited (χ^2 = 13.08; SD = 1; p <0.001). A significant number of relatives compared to nurses (28%) stated that conditions of visits should be the same for each patient (χ^2 = 3.90; SD = 1; p <0.05).

The majority of nurses and relatives said that patients and their families should not be left alone with the patient. When the degree of relationship was considered, 91.1% of nurses and 80% of relatives said that visitors should be immediate relatives (χ^2 = 22.14; SD = 2; p <0.001). However, there was a significant difference between both groups when it was asked whether other relatives should be allowed to visit a patient. Dramali *et al.* (1990) found that patients stated they wanted to be visited only by immediate relatives.

Table 3 summarises the opinions of nurses concerning the visiting policy. Of all the nurses sampled, 34.3% (n = 58) stated that relatives' visits influenced the patients' physiological status negatively, while 45% (n = 76) stated that visits influenced the patients' psychological status positively. In a previous study on this subject, nurses emphasised that visits had a positive effect on psychological status rather than physiological status (Kirchoff *et al.*, 1993). In addition, Madenoglu (1998) found that the blood pressure and pulse rate increased in patients in a coronary ICU during visits by relatives. However, there is the risk of visitors introducing nosocomial infections (Dramali *et al.*, 1990).

When nurses were asked about the effects of visits on nursing tasks, 75.7% (n = 128) said there was an effect, of whom (34.3%) said tasks were delayed. These results confirm previous findings (Gorak, 1997; Gurley 1985). Krichoff *et al.* (1993) stated that the time taken to give explanations to relatives during visits resulted in delayed care to patients and in less time being given to patients during visits.

There were no significant correlations between the training status of nurses or their experience of ICU nursing, and the attitude of nurses towards the necessity of visits or their answers on the physiological and psychological effects of visits on patients (p >0.05).

Many of the nurses stated that the most appropriate type of visit was a limited visit, both for the patient, the relatives and the ICU staff. In the Kirchoff *et al.* (1993) study, nurses were found to have a negative attitude to the open visit, while they viewed the limited visit as having benefits in not making the patients or their family tired and for not disturbing the work of the ICU staff. Our study supports Kirchoff *et al.* (1993) in this respect.

Regarding the duration of the visit, 49.7% (n = 84) of nurses stated visits had to be limited to 5 minutes, while 23.1% (n = 39) stated that the duration should be different for each patient. A previous study has supported the idea of shorter visits in ICU, with the actual duration depending on the status of the patient (Kirchoff *et al.*, 1993; Whitis, 1994).

Our study found that about 50% of nurses believed that the unconscious patients should be visited, but there was no overall consensus on this question among the nurses.

63.3% (n = 107) of nurses said there should be a predetermined time for providing information, and that this should take place when staff were less busy and not during visiting time or when care was taking place. This result is an expected result if visits have a negative affect on nursing tasks.

A majority of nurses of 76.3% (n = 129) said they wished to make decisions on visits in collaboration with physicians. True teamwork involves the joint determination of policies, aims and approaches between nurses and physicians (Velioglu, 1994).

Table 4 summarises the physiological and psychological effects of visit type on patients, as well as on nursing tasks. There were no significant differences (p >0.05) between these categories in the effect of visits. The results show that, whatever the type of visit, there are significant effects (p <0.05) on nursing tasks, which are affected negatively by visits, and also significant physiological and psychological effects on the patients. However, the duration of the visits appeared to have no significant effect on nursing tasks or on patients (p >0.05).

Concerning waiting areas, 69% of the relatives of patients (n = 69) said they would like to want in a room adjacent to the ICU, while 61% (n = 61) said the current waiting room was not appropriate. Many relatives found the physical environment of the waiting rooms were poor, they were far away from ICU, or

Table 3. Opinions of nurses about visiting policy

Opinions concerning visiting		n	%
What are the physiological effects of visiting?	Positive	31	18.3
	Negative	58	34.3
	No effect	25	14.8
	Unanswered	55	32.5
What are the psychological effects of visiting?	Positive	76	45.0
	Negative	23	13.6
	No effect	36	21.3
	Unanswered	34	20.1
Does visiting affect nursing tasks?	Yes	128	75.7
	No	41	24.3
– If yes, why?	Delays working	58	34.3
	Interferes with care	33	19.5
	Unanswered	78	46.2
– If no, why?	Visits are restricted to outside care hours	15	8.9
	Visits are of short duration	7	4.1
	Visits have to be tolerated	5	3.0
	Unanswered	142	84.0
What type of visit is appropriate for the patient	Regular	9	5.3
	Limited	130	76.9
	Not allowed	30	17.8
What type of visit is appropriate for the relatives	Regular	16	9.4
	Limited	135	79.9
	Not allowed	18	10.7
What type of visit is appropriate for the ICU staff	Regular	5	3.0
	Limited	128	75.7
	Not allowed	36	21.3
How long should the visit be?	5 minutes	84	49.7
	6 to 15 minutes	39	23.1
	Different for each patient	39	23.1
	Visits not allowed	7	4.1
If the patient is unconscious, should visiting be allowed?	Yes	90	53.3
	No	72	42.6
	Unanswered	7	4.1
Should a visit include time for information?	Yes	107	63.3
	No	58	34.3
	Unanswered	4	2.4
– If yes, why ?	Since some times of the day are less busy	66	39.1
	Day visits	5	2.9
	Night visits	6	3.6
	Unanswered	92	54.4
– If no, why ?	Patient confidentiality	16	9.5
	Rapid changes in status of patient	26	15.4
	Unanswered	127	75.1
Who gives permission to visit?	Physician	7	4.1
	Nurse	28	16.6
	Physician and nurse	129	76.3
	Other	5	3.0
TOTAL		169	100

Table 4. Effects of type and duration of visits on patients and nursing tasks

Effects on patient and nursing tasks	Physiological effect on patient				Psychological effect on patient				Effect on nursing tasks		
Visit type	Positive	Negative	No effect	Total	Positive	Negative	No effect	Total	Does affect tasks	Does not affect tasks	Total
Regular visit	3 (1.6)	3 (3.1)	0 (1.3)	6 (5.3)	6 (4.5)	2 (1.4)	0 (2.1)	8 (5.9)	9 (7.6)	1 (2.4)	10 (5.9)
Limited visit	26 (26.4)	49 (49.4)	22 (21.3)	97 (85.1)	64 (64.2)	21 (19.4)	29 (30.4)	114 (84.5)	104 (105.3)	38 (33.7)	139 (82.3)
Visit is not allowed	2 (3.0)	6 (5.6)	3 (2.4)	11 (9.6)	6 (7.2)	0 (2.2)	7 (3.5)	13 (9.6)	15 (15.1)	5 (4.9)	20 (11.8)
Total	31 (27.2)	58 (50.9)	25 (21.9)	114* (100)	76 (56.3)	23 (17)	36 (26.7)	135* (100)	128 (75.7)	41 (24.3)	169 (100)
χ^2 and p	$\chi^2 = 2.99$; SD = 4; $p > 0.05$; *Unanswered: 55				$\chi^2 = 9.17$; SD = 4; $p > 0.05$; *Unanswered: 34				$\chi^2 = 1.17$; SD = 2; $p > 0.05$		
Duration of visit											
5 minutes	10 (10.8)	21 (21.1)	9 (8.2)	40 (43)	23 (27.6)	11 (9.8)	15 (11.6)	49 (44.5)	50 (44.1)	8 (13.9)	58 (43.3)
6–15 minutes	9 (6.7)	12 (13.2)	4 (5.1)	25 (26.9)	20 (15.8)	3 (5.6)	5 (6.6)	28 (25.5)	20 (25.1)	13 (7.9)	33 (24.6)
16 minutes to 1 hour	2 (3.2)	9 (6.3)	1 (2.5)	12 (12.9)	9 (8.5)	3 (3.0)	3 (3.5)	15 (13.6)	16 (16.0)	5 (5.0)	21 (15.7)
Different to above	4 (4.3)	7 (8.4)	5 (3.3)	16 (17.2)	10 (10.1)	5 (3.6)	3 (4.3)	18 (16.4)	16 (16.7)	6 (5.3)	22 (16.4)
Total	25 (26.9)	49 (52.7)	19 (20.4)	93* (100)	62 (56.4)	22 (20)	26 (23.6)	110* (100)	102 (76.1)	32 (23.9)	134* (100)
χ^2 and p	$\chi^2 = 4.89$; SD = 6; $p > 0.05$*; Unanswered: 76				$\chi^2 = 5.69$; SD = 6; $p > 0.05$; *Unanswered: 59				$\chi^2 = 7.75$; SD = 3; $p > 0.05$; *Unanswered: 35		

there were no waiting rooms. Previous studies have shown that the admission of a family member into ICU is a source of stress and anxiety, and that because of this, relatives have a desire for frequent information about the patient and to be physically near the patient (Kirchoff *et al*., 1993; Wilkinson, 1995).

CONCLUSIONS

The study has drawn the following conclusions:

- Limited visiting is widespread in university hospitals, while visits are not usually permitted in Ministry of Health and Social Insurance hospitals.
- When there are exceptional conditions concerning the type of visit, duration of the visit, and the visit itself, decisions about visiting vary greatly depending on the person making them.
- Most nurses in the survey regard visiting by relatives as necessary to provide psychological support to the patient, even though the visit itself, depending on the type and duration, may have a negative effect on nursing tasks.
- Although patients' relatives wanted to visit patients and give them psychological support, more than half of them were anxious that they would introduce infection and so did not want to visit for this reason.
- The intensive care environment has a reassuring effect on relatives of patients.
- Both nurses and relatives agree that visiting should take place at a predetermined time; visitors should not be children; not all patients should be allowed visitors; immediate relatives, at least, should be allowed to visit.
- Nurses would like to limit the number of visitors and that visits should be individualised for each patient.
- Nurses believe that limited visits are best for the patients, relatives and the ICU staff.
- Nurses would like the visit to be limited to five minutes and to a time when the unit is less intensive.
- Nurses would like to be able to provide information on changes in the patient's condition.
- Relatives of patients would like to wait close by the ICU to be nearer physically to their relatives, but they regard currently available waiting room facilities as inadequate.

RECOMMENDATIONS

According to these conclusions, the authors make the following recommendations:

- ICU conditions should be reviewed and new visiting policies should be developed where appropriate.
- Relatives of patients should have appropriate waiting rooms in which they feel comfortable. These should be located very near to the ICU.
- Individual cases should be taken into account according to the patient's condition and intensive care environment.
- Written information should be given to patients' relatives about the regulations of the ICU, and from whom, when, and how, they can obtain information.

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