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Open Visiting Hours in the Adult ICU

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Open visiting hours are part of a global policy to help families cope with the stress and difficulties of having a relative hospitalized in an ICU, especially during the patient's end-of life.

Introduction

The usual consequences for the family of hospitalization of a relative in an ICU include stress, anxiety, loss of communication, and disorganization of family life. The family needs to adapt to a hostile and unknown environment, which is highly technical and has strict organizational rules. The great majority of ICUs have restricted visiting policies, specifying hours and number of people (Quinio et al. 2002). These rules contribute to a feeling of exclusion in families, for which reason we advocate open visiting hours.

Visiting Hours and Meeting the Needs of Families

Several studies have shown the advantages for families and patients of allowing visiting at any time. Such a policy reduces stress and anxiety, encourages better communication, allows families to become more involved in the patient's care and enables them to organize visits alongside their usual commitments (Ramsey et al. 1999; Roland et al. 2001; Simon et al. 1997). Open visiting hours does not create organizational problems if the care constraints of an ICU are fully explained to families. Drawing up a 'contract' with families about visiting hours has been suggested (Moseley and Jones 1991; Simon et al. 1997).

When a patient reaches the end-of-life stage, it is most important to enable families to be present during the last days. All families should systematically be offered the possibility to stay continuously with or near their relative, if they so wish, in order to say goodbye (Carlson et al. 1998; Younger et al. 1984). Though changing visiting hours is stressful for the nursing staff (Roland et al. 2001), the worry about families being continuously present can be reduced if the decision is made and supported by everyone (Mosenthal et al. 2002; Simpson et al. 1996).

Equally important to allowing more people to visit (relations, friends) without restrictions, staff should also remain vigilant to prevent any possible family feuds. It should be remembered that not all families may wish to remain with their relative until the end, but all need to know that they will be informed whenever the patient's health deteriorates and/or death becomes imminent.

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Open visiting hours need to be accompanied with additional measures:

• Encouraging family members to communicate with their loved one: families often express their sadness and regret at not being able to verbally communicate with the patient and feel deprived of the opportunity to say their last goodbyes. The family must be encouraged to speak to and touch their loved one, say goodbye and perform any rituals desired (Mosenthal et al. 2002);

• Preserving privacy: the family needs to be alone with the patient to talk and to share memories. It is important to leave people time on their own, if they wish.

Personal Experience and Evaluation of this Type of Support for Families

Similar to most adult ICUs, visiting hours in our tertiary care hospital 12-bed medical ICU were restricted to two hours per day until 2000. There was not much flexibility, even when a patient was at an end-of-life stage, and nearly all patients died without their relatives close to them. The medical and nursing team felt that this was not meeting the families' needs during this painful period.

To respond to what we felt was a shared expectation, we introduced several measures, starting in January 2001, which are systematically offered to families of end-of-life patients:

• 24-hour open visiting policy;

• Number of people in the patient's room extended to four;

• Possibility for a member of the family to sleep in a "family room," which was created for the purpose, with drinks and biscuits available;

• Flexible nursing organization to encourage privacy without compromising quality of care;

• Allowing families to reduce the lighting, play music softly, and practice religious rituals, if they wish. We evaluated family satisfaction of both visiting policies in 2002 (Boles et al. 2004). The closest relatives of the 196 patients who died in our ICU between January 1999 and December 2001 were sent a questionnaire. We received 70 answers (35.7%).

Twenty-nine answers (42%) concerned patients who had died in 1999 and 2000, before the opening of visiting hours: 87.5% of family members felt great pain at not being present with their loved one at the moment of death. This suffering was often expressed in aggressive wording. Up to three years later, some people felt "lost" and unable to progress through the bereavement process. Satisfaction with the team at the moment of death was low 37.5%.

Thirty five answers (50%) concerned patients who had died in 2001, for whom families had been able to stay with their relative during the last moments of the patient's life. Improved communication with staff was reported by 76.5% of family members, linked with an increased availability of staff (67.7%). Seventy percent of family members felt that they had been prepared for the death of their loved one and expressed their feelings using words such as "calm" and "compassion".

Families did not want more friends and family members to be present at the same time in the patient's room (60.2%), didn't mind wearing a white blouse (72%) and did not wish the number of times members of staff entered the room to be reduced (59%).

All staff favoured the open visiting hours for families of terminally ill patients. Reasons given were the impression of improved communication and warmer relationships with families and more time to support families without jeopardising quality of care. Without being asked, staff members were able to change treatment routines to meet the families' needs.

Conclusion

Families need a technically competent medical team, comprising members who can also build a warm human relationship and who will respect both their wishes and those of their loved one, when he or she is in an end-of-life stage.

Opening visiting hours and developing flexibility in nursing organization, as well as listening, supporting and providing respect are complementary, to help families to remain present to the end and to cope with the death of a relative in the ICU. Let us not forget that "families are not just visitors to intensive care" (Molter 1994).

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