

Title page

Assignment Question:

- Students are given a list of topics drawn from the School's research matrix.
- Students will undertake a short structured reflection (500 words) in which they specify their choice of topic and identify an associated issue or problem from practice. The reflective account should include the relevance and significance of the problem or issue for clinical practice.
- Students will produce an annotated bibliography (1,500) comprised of three published research papers on this problem or issue.

Assignment Title:

Should Irish ICU nurses be looking to make ICU visiting policies less restrictive and more tailored towards individual patients needs and preferences?

Module Code: NU3S03

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A structured reflection using Rolfe et al.'s (2001) three-stage reflection model as adapted by Morrissey and Callaghan (2011) precedes this annotated bibliography.

Stage 1

The topic I have chosen from the School Research Matrix is "Improving the Health and Wellbeing of Women, Children and Families" (School of Nursing & Midwifery 2013). As a childrens student nurse I have an interest in Family Centred Care (FCC). After two personal experiences, it appeared that the ethos of FCC should also be followed in Intensive Care Unit settings. I observed that visiting times, duration, and frequency varied between different hospitals.

Stage 2

Upon reviewing the literature, I found that ICU visiting policies varied from being restricted to having no restrictions (Damboise & Cardin 2003, Berwick & Kotagal 2004, Davidson *et al.* 2007). Hardin *et al.* (2011) defines unrestricted visiting as visiting without limits on time, duration, frequency, or number of visitors, and liberalised visiting as visiting that is less restrictive than before. There has been much research that promotes making ICU visitation less restrictive. (Stillwell 1984, Chamel *et al.* 1988, Hamner 1990, Burchardi 2002, Slota 2003, Levy 2007, Kleinpell 2008, Davidson 2009). However despite this Hunter *et al.* (2010) reported that 80.1% of ICU's in the U.K. still had restricted visiting policies.

Inconsistency among nurses on visiting practices has been reported to result in confusion, frustration and mistrust by families worldwide (Plowright 1998, Hupcey 1999, Soderstrom et al. 2003, Livesay 2005, Agard & Lomborg 2011). As nurses we are the ones who implement visiting policies and family presence forms a part of our holistic nursing care. We are responsible for the patients' physical, psychological and

social wellbeing. Our practices should be in the best interest of patients and families and based on research, not tradition or staff convenience. It is also important that we as healthcare professionals do not act in a way that undermines the public's confidence in the service we provide.

Stage 3

No research literature was found on ICU visitation in Ireland, apart from one phenomenological study on; family members' lived experiences in an ICU (McKiernana & McCarthy 2010). The only guidance on ICU visitation in The National Visiting Policy (HSE 2006) is the ambiguous statement that: "visiting is restricted to immediate family members for short periods of time only" (p. 4).

It would appear that much research is required in the field of critical care visitation in Ireland and those guidelines may need to be revised on a hospital and national level.

Hence, I decided to base my research assignment on the question: 'Should Irish ICU nurses be looking to make ICU visiting policies less restrictive and more tailored towards individual patient's needs and preferences?'

There is a great diversity of terminology used to define different visiting practices making it difficult to comprehensively review policies and, compare and apply findings between different studies. As a result of this, I found that using a multitude of key words such as: open visiting, restrictive, unrestrictive, liberalised, contractual, structured, unstructured, tailored, and individualised visiting were not returning all the citations on visiting. Moreover, because of the broad variety of terms used in critical care, linking the search with ICU and associated terms was yielding limited results also. Hence, I decided to do a broad search on the major concept "visiting to patients" and manually refine the search myself to ensure no relevant research was missed (Appendix 1).

When I had successfully reduced the number of papers down to 33, I chose 3 recent papers with a mixture of both quantitative and qualitative research methods. I wanted to focus mainly on the patients' response to family presence in the ICU. Therefore, I choose one paper on the patient's physiological response, one on their psychological perspective and another on nurses' views on the effects of unrestricted visitation on patients.

Unfortunately, most of the research involved small, non-probability samples which curtailed the validity of the individual findings and their universal application. It was noted that in the three papers there was no mention of the target population size, e.g. annual national or hospital figures on ICU patients. Hence, the adequacy of the studies in representing the population is questionable (Polit & Beck 2006). Fumagalli *et al.* (2006) found in a rigorous and tightly controlled pilot study that infection control was not a reason to restrict visiting but rather less restrictive visiting reduced cardio-circulatory complications.

Marco *et al.* (2006) was the only study that gave a reliability measurement of the instruments used but autonomy, consent and anonymity were questionable. The significant positive correlation between nurses' beliefs and attitudes may be a useful consideration for policy makers. Hardin *et al.* (2011) found that patients preferred visitation that was tailored for individual patient's and family's needs. However, the data collection method was questionable in this study. Further work needs to be done on obtaining representative samples of ICU patients under conditions that will elicit accurate information. It would appear that more work needs to be done to establish evidence-based, clear and concise guidelines on best practice in ICU visitation policy and that all nurses should support this.

Fumagalli S., Boncinelli L., Lo Nostro A., Valoti P., Baldereschi G., Di Bari M., Ungar A., Baldasseroni S., Geppetti P., Masotti G., Riccardo P. & Marchionni N. (2006) Reduced cardiocirculatory complications with

unrestrictive visiting policy in an intensive care unit: results from a pilot, randomised trial. *Circulation* **113**(7), 946-952.

This research was undertaken in Italy by the University of Florence and accepted for publication by the American Heart Association. Out of the 12 authors, 11 had masters' degrees and one also had a PhD. The paper has also been cited by at least 25 others in the last seven years.

The above article was chosen for the annotated bibliography, because it was the only true experimental research study the author found that sought to formally compare the effect on clinical outcomes of restricted visiting policy (RVP) versus unrestricted visiting policy (UVP) in an ICU. The major drawback of this research is that it was only a pilot study. Hence, it was a single centre trial, with a small non-probability sample which affects how the findings can be generalised.

The study was tightly controlled, took place over two years and involved a random, computer generated 2 month sequences of either RVP or UVP. Although the two visiting policies described in the study alternated, the infection control policy was kept constant. The staff was unaware of the sequence until the beginning of each new period. Also in the last week of each period, no new patient was admitted to the ICU to allow for study participants to be discharged and a 4-day washout of the ICU. All participants had been discharged by the end of the study and there was no over-lap between groups.

The researchers sought to accurately collect the data using international equipment as per manufacturer's instructions and well recognised scales and scoring systems. Detailed explanations of what, when, where and how the concepts under consideration were systematically assessed, established the appropriateness of the instruments chosen. However, no test of the instruments was referred to, which would improve the perceived reliability and validity of the designs (Polit & Beck 2006).

All ICU patients were screened for eligibility. The number of patients was 226. Enrolments and exclusions were well balanced between both groups.

Reasons for exclusion were cognitive impairment, psychosis, less than 24-hour stay, re-admission, transferred from another department or absence of consent.

Ethics approval was granted using the principles of the Declaration of Helsinki. Written information on the trial design and visiting guidelines were distributed to patients and visitors and written informed consent required for participation (Burns & Grove 1999).

The research report presents the steps of the research process in a clearly linked and logical manner. There is no theoretical framework identified in this study, but Robson (2002) points out that this is not uncommon and not always applicable depending on the research question.

The data was comprehensively validated using methods of analysis recommended by Clegg (1990).

The UVP had higher environmental microbial contamination but patients did not have more septic complications. The risk of cardio-circulatory complications was 2.0 times greater with RVP but no significantly higher mortality rate. The UVP had a greater reduction in anxiety score and a significantly lower increase, from admission to discharge, in hormonal stress profile.

The findings of this study suggest that liberalising visiting hours does not increase infectious complications, but may have a positive influence in reducing severe cardiovascular complications. However, more research is required involving larger, multi-centre samples to establish concrete data.

Marco L., Bermejillo I., Garayalde N., Sarrate I., Margall M.A. & Asiain M.C. (2006) Intensive care nurses' beliefs and attitudes towards the effect of open visiting on patients, family and nurses. *Nursing in Critical Care* **11**(1), 33-41.

Previous research and The Theory of Reasoned Action (Ajzen & Fishbein 1980) support the idea that nurses have the ability to change established norms by making visiting more flexible or more restrictive. Hence, Marco *et al.* (2006) thought it important to explore what nurses' attitudes and beliefs towards open visiting were and if there was any correlation between the two variables, to ascertain what effect it could have on future flexibility in the visiting policy of ICU.

All six authors were nurse specialists in critical care; three were associate lecturers in a university and two were also clinical nurse managers. The use of the steps of the research process is very clearly shown in this study. There is not a full literature review in this paper, but what the authors describe as a bibliography. This consists of 27 citations from between 1976-1999 and includes national studies on visiting policies from over three different countries. Although the citations are mostly 10 years or older, this is probably due to the fact that the research has been calling for liberalisation of visiting policies since the mid-1980s (Kirchhoff 1982, Stockdale & Hughes 1988) but changes at a local level have been very slow (Berwick & Kotagal 2004).

Questionnaires were used and derived from empirical results and previous studies. The results of the reliability measure were also given. Data analysis was carried out using various well-known tests and in accordance with Clegg (1990).

Ethical approval was obtained for the study. However, the methods for the distribution and collection of the questionnaires appear to lack anonymity. This could have made some nurses feel coerced into participation, being surrounded by their peers, and also likely acquainted with those undertaking the research. It would also have been better to obtain written consent rather than assuming consent if the nurse completed a questionnaire.

The correlation between the two variables proved positive and significant ($p=0.03$). The qualitative results were classified into 10 categories and

were mainly of a positive nature. It is not possible to fully expound the detailed findings reported in this bibliography. However, on the whole nurses' attitudes and beliefs in this study were very positive towards the benefits of open visiting on patients, families and nurses. However, 80% of nurses agreed that open visiting increased staff burden. Therefore, efficient ways of integrating open visitation and nursing care needs to be explored.

The sample in this study is a little unusual, as the authors were not seeking results that could be universally applied but that were reflective of their own ICU. They had 100% participation from their subject group. This made the findings significant to that unit as long as the participants adhered to not talking among themselves until the questionnaires were complete as requested by the researchers.

Despite the fact that the findings of this study cannot be universally applied, the positive results are encouraging and repeating the study elsewhere could inform other policy makers if they are likely to be successful in implementing more liberalised visiting practices.

Hardin S.R., Bernhardt-Tindal K., Hart Ann., Stepp A. & Henson A. (2011) Critical-Care Visitation: The Patients' Perspective. *Dimensions of Critical Care Nursing* **30**(1), 53-61.

The above paper studied the patients' perspectives on ICU visitation as the title suggests. The research question reflected a gap in the literature, as the acuity of illness in ICU's makes it difficult to obtain a sample of patients who are able to answer questions and represent the general ICU population. The Synergy Model for Patient Care by American Association of Critical-Care Nurses described the hypothesis that optimal outcome is achieved when nurses meet patient specific needs.

There were five authors who had a variety of qualifications and a knowledge in the field of critical care. They were a research liaison and an

associate professor in a university, a clinical nurse specialist, a clinical facilitator, a certified family nurse practitioner at an emergency department and a facilitator of the critical care evidence-based practice research committee (Conkin Dale 2005).

There did not appear to be any need for concern with the ethics, confidentiality or consent in this research study. The instrument used was a questionnaire taken from literature, and modified by the unit-based critical care panel and research committee. Surprisingly, the authors stated that no reliability or validity of the instruments used existed. Polit & Beck (2006) state that the researchers are expected to provide the appropriate evidence in relation to validity and reliability of instruments. No pilot study was undertaken to establish if the instrument was clear and unambiguous. Therefore, one could not be certain that the concept was studied in an unwavering and consistent way.

The data was analysed as recommended in Clegg (1990). The authors in this study presented the findings in tables and marked those that were statistically significant (probability ≤ 0.05), increasing the validity of those results. Intercoder reliability was performed on qualitative results with a 96% agreement.

Discussion of the findings flowed logically from the data and was continually related back to the literature, placing the findings in context (Russell 2002). The results supported previous findings and the model identified, as they demonstrated patient individuality. Hence, the recommendation was that nurses should endorse a visitation policy unique to each patient. A care plan for integrating family is suggested.

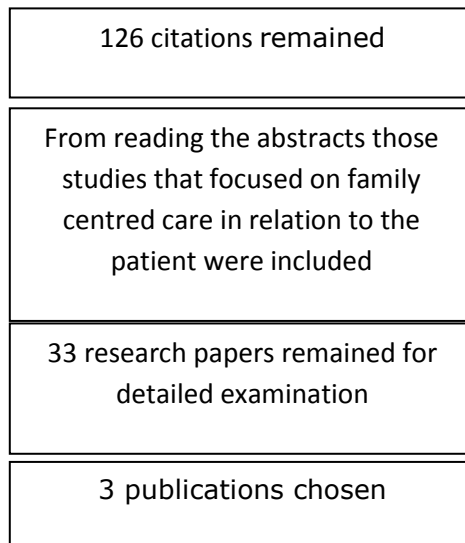
The sample included all patients' without impaired cognition, admitted to any of the 5 ICU's of the hospital, provided they were healthy enough for discharge, spoke English and were over 21 years of age. The use of a small convenience sample (122 patients) in this study may have resulted in response bias as noted by Polit and Beck (2006). Further studies with larger sample size need to be conducted for findings to be generalised.

Those that didn't speak English may have had a different perspective on visiting policies and current research needs to be representative of our multicultural population. Also, the data collection method was a major limitation to the significance of the findings, as the questionnaire was distributed upon discharge. This did not allow for fluctuations in perspective throughout the duration of the patients' stay and relied on their recall of what they experienced, which has been shown to be poor in ICU patients (Olsen 2009).

It is suggested that should such a study be replicated; preference should be assessed on admission, during their stay and at discharge to get a more valid set of findings.

Appendix 1: Flow diagram of search record

<p>"Visitors to patient" concept-232 citations retrieved</p> <p>(Limiters set were peer reviewed, English language and research type publication)</p>
<p>Papers studying cultures, pets, young children, infection control policies and areas other than intensive care were eliminated after screening of</p>



References

Ågård A.S. & Lomborg K. (2011) Flexible family visitation in the intensive care unit: nurses' decision-making. *Journal of Clinical Nursing* **20**(7/8), 1106-1114.

Ajzen I. & Fishbein M. (1980) *Understanding Attitudes and Predicting Social Behaviour*. Prentice Hall, New Jersey.

Berwick D.M. & Kotagal M. (2004) Restricted visiting hours in ICUs: time to change. *The Journal of the American Medical Association* **292**, 736-737.

- Burchardi H. (2002) Let's open the door! *Intensive Care Medicine* **28**, 1371-1372.
- Burns N. & Grove S. (1999) *Understanding Nursing Research*, 2nd edn. W.B. Saunders Company, Philadelphia.
- Chamel E., Trattler M. & Maddox J. (1988) Visiting in the ICU: time for change. *Critical Care Nurse* **8**(6), 2-12.
- Clegg F. (1990) *Simple Statistics: A Course Book for the Social Sciences*, 2nd edn. Cambridge University Press, Cambridge.
- Conkin Dale J. (2005) Critiquing research for use in practice. *Journal of Pediatric Health Care* **19**, 183-186.
- Damboise C. & Cardin S. (2003) Family-centered critical care: how one unit implemented a plan. *American Journal of Nursing* **103** (6), Critical Care Extra: 56AA-CC, 56EE.
- Davidson J.E. (2009) Family-centred care: meeting the needs of patients' families and helping families adapt to critical illness. *Critical Care Nurse* **29**, 28-34.
- Davidson J.E., Powers K., Hedayat K.M., Tieszen M., Kon A.A., Shepard E., Spuhler V., Todres I.D., Levy M., Barr J., Ghandi R., Hirsch G. & Armstrong D. (2007) Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004-2005. *Critical Care Medicine* **35**(2): 605-622.
- Fumagalli S., Boncinelli L., Lo Nostro A., Valoti P., Baldereschi G., Di Bari M., Ungar A., Baldasseroni S., Geppetti P., Masotti G., Riccardo P. & Marchionni N. (2006) Reduced cardiocirculatory complications with unrestrictive visiting policy in an intensive care unit: results from a pilot, randomized trial. *Circulation* **113**(7), 946-952.
- Hammer J.B. (1990) Visitation policies in the ICU: a time for change. *Critical Care Nurse* **10**(1), 48-53.
- Hardin S.R., Bernhardt-Tindal K., Hart Ann., Stepp A. & Henson A. (2011) Critical-Care Visitation: The Patients' Perspective. *Dimensions of Critical Care Nursing* 30(1), 53-61.
- HSE (2006) *National Visiting Guidance*. National Hospitals Office, Dublin.
- Hunter J.D., Goddard C., Rothwell M., Ketharaju S. & Cooper H. (2010) A survey of intensive care unit visiting policies in the United Kingdom. *Anaesthesia* **65**(11), 1101-1105.
- Hupcey J.E. (1999) Looking out for the patient and ourselves – the process of family intergration into the ICU. *Journal of Clinical Nursing* **8**, 253-262.
- Kirchhoff K.T. (1982) Visiting policies for patients with myocardial infarction: a national study. *Heart Lung* **11**, 571-576.
- Kleinpell R.M. (2008) Visiting hours in the intensive care unit: more evidence that open visitation is beneficial. *Critical Care Medicine* **36**, 334-335.

Levy M.M. (2007) A view from the other side. *Critical Care Medicine* **35**, 603-604.

Livesay S., Gilliam A., Moracek M., Sebastian S. & Hickey J. (2005) Nurses' perceptions of open visiting hours in neuroscience intensive care unit. *Journal of Nursing Care Quality* **2**, 182-189.

Marco L., Bermejillo I., Garayalde N., Sarrate I., Margall M.A. & Asiain M.C. (2006) Intensive care nurses' beliefs and attitudes towards the effect of open visiting on patients, family and nurses. *Nursing in Critical Care* **11**(1), 33-41.

McKiernan M. & McCarthy G. (2010) Family members' lived experience in the intensive care unit: A phenomenological study. *Intensive & Critical Care Nursing*, **26**(5), 254-261.

Morrissey J. & Callaghan P. (2011) *Communication Skills for Mental Health Nurses*. Open University Press, Berkshire.

Olsen K.D., Dysvik E. & Hansen B.S. (2009) The meaning of family members' presence during intensive care stay: a qualitative study. *Intensive & Critical Care Nursing* **25**(4), 190-198.

Plowright C.I. (1998) Intensive therapy unit nurses' beliefs about and attitudes towards visiting in three district general hospitals. *Intensive and Critical Care Nursing* **14**, 262-270.

Polit D. & Beck C. (2006) *Essentials of Nursing Care: Methods, Appraisal and Utilization*, 6th edn. Lippincott Williams and Wilkins, Philadelphia.

Robson C. (2002) *Real World Research*, 2nd edn. Blackwell Publishing, Oxford.

Russell C. (2005) Evaluating quantitative research reports. *Nephrol Nursing Journal* **32**(1), 61-64.

School of Nursing and Midwifery (2013) *Research Strengths*
<http://www.nursing-midwifery.tcd.ie/research/strengths/> Retrieved 2nd April 2013

Slota M., Shearn D., Potersnak K. & Haas L. (2003) Perspective on family-centred, flexible visitation in the intensive care unit setting. *Critical Care Medicine* **31**, 362-366.

Soderstrom I., Benzein E. & Saveman B.I. (2003) Nurses' experiences of interactions with family members in intensive care units. *Scandinavian Journal of Caring Sciences* **17**, 185-192.

Stillwell S.B. (1984) Importance of visiting needs as perceived by family members of patients in the intensive care unit. *Heart and Lung* **13**, 238-242.

Stockdale L.L. & Hughes J.P. (1988) Critical care unit. Visiting policies: a study. *Focus on Critical Care* **15**, 45-48.