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A study on nurses' viewpoint about methods of free visit in intensive care units in Besat hospital affiliated to Kurdistan University of Medical Sciences, Iran, 2015-2016

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Original Article

Abstract

BACKGROUND: In spite of the evidence of advantages of visitation, the ban on visit in Iran's intensive care units (ICUs) is still underway, and this issue is always a challenging topic that encounters different behaviors in dealing with the phenomenon of visiting. The purpose of this study was to investigate the barriers and strategies for establishing a free visit system in ICUs from the viewpoints of health care providers.

METHODS: In this descriptive study, 100 nurses working in ICU were evaluated. The data were collected using a demographic information registration form and a questionnaire on attitudes and views about visit in special units which were analyzed by SPSS software using t-test and chi-square test.

RESULTS: 33.3% of cases were men and 66.7% of them were women. Most of the cases (67.9%) were married. The shortest work experience in the ICU was 5 months and the longest was 132 months. The average work experience of the cases in the ICU was 60 months.

CONCLUSION: The majority of nurses believe that free visit can interfere with nursing cares. This interference involves direct intervention, more time spent explaining to the patient's family, and creating a busy environment that is the cause of the errors. The time of the visit is largely regulated by healthcare providers, their attitudes towards the topic, as well as their concerns about this issue.

KEYWORDS: Viewpoint, Intensive Care Units, Nurses

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Introduction

Many families experience having one of their loved ones admitted to the intensive care unit (ICU) each year. Hospitalization in these units has potentially damaging implications for the patient and the family, and they suffer from many problems that their negative effects are unavoidable.[1,2]

Fear of losing a family member, fear of the future, fear of financial burden of illness on the family, changes in family roles, anxiety and confusion, depression, loneliness, and disappointment are among the threats that affect the integrated family system at this time.[3,4]

According to this fact that over 75% of patients admitted to the ICU are not able to participate in making decision for therapeutic purposes and in half of them the decision is made by family members, these threats and stress with a lack of awareness can significantly reduce the ability to decide for

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medical purposes as well as the interaction between the family and the treatment team, and in a long period can cause many physiological and psychological illnesses and post-traumatic stress disorder (PTSD) symptoms can be found in more than one third of cases.[5-8]

The needs of patients admitted to the ICU and their families have been studied many times and the presence of the patient along with the family and vice versa has been identified as one of the five basic needs. Providing information, support, reliability, comfort, and convenience for the patient and the family are among other needs for both groups.[9,10]

In the other studies, being away from family members or limitation of visit is one of the stressful conditions. On the other hand, the benefits of free visits to the patient should not be ignored. These benefits include: increasing patient satisfaction, paying attention to patient needs, emotional effects, increasing sensory stimulation, accelerating the recovery process, and reducing stress due to recovery of physiological conditions such as blood pressure, heart rate, intracranial pressure, and hormonal markers of stress.[11-15]

The benefits of free visit for the family such as increased satisfaction, paying attention to family needs, and reduction of stress, anxiety, depression, and PTSD symptoms have been proved. Nurses also are not deprived of advantage as persons who have the most interaction with these two groups.[16]

On the other hand, there is no evidence of increased risk of infection, increased psychological and psychological stress for the patient and the family, or intervention in treatment that the treatment team members are worried about.[17]

With all above, special units have always had a limitation of visits and the personnel of these departments consider the patient's isolation as one of the unavoidable principles of treatment.[18] The idea of this project is presented by the researcher by touching the problems and the needs of the patients and the families in the field of visit in the ICU and their problems.[19,20]

This study is designed to investigate the obstacles and strategies of free visit administration with the approach of determining the factors related to the views and attitudes of nurses, doctors, and senior managers of hospitals toward free visit, determining the level of awareness about the needs of the patient admitted to the ICU and his/her family and the benefits of free visit, and determination of the most important cultural and physical obstacles.

Materials and Methods

This descriptive study was conducted in the ICU of Besat Hospital affiliated to Kurdistan University of Medical Sciences, Sanandaj, Iran, in 2015-2016. Sampling was done according to the studied population in three parts of the nurses and head nurses working in the ICU with a minimum education of bachelor degree, physicians practicing in ICU, and management systems with members of educational and clinical supervisors of hospital, matron, interior manager, and hospital chief. 100 samples were selected using available sampling method.

Data collection tools consisted of individual information form and a questionnaire of "views and attitudes about visiting in ICUs". Personal information included variables such as age, gender, level of education, marital status, kind of work shift, nursing history, and work experience in the ICU. "The view and attitude about visit in ICUs" questionnaire is based on the five-choice Likert scale (absolutely agree, agree, no idea, disagree, and absolutely disagree), which is graded from 0 to 4.

The researcher referred to research environments, and provided information about the importance and aims of the research

to the authorities of the centers. Then, the researcher referred to the chosen hospital in different shifts and selected the persons who had proper criteria for entering the study and informed them about the confidentiality of the information and made them confident. So the written testimonial was achieved before taking the questionnaires to the cases.

Sampling was continued until the sample size reached the predetermined value. Data were then analyzed using SPSS software (version 19, SPSS Inc., Chicago, IL, USA) and descriptive statistical tests (average, medium).

Results

The average age of the participants in the project was approximately 36 years with a standard deviation (SD) of 7.7 years, the lowest age was 25 years and the highest was 48 years.

The results showed that the lowest work experience in the ICU was 8 months and the highest was 112 months. The average work experience of the patients in the ICU was 50 months. 87% of the studied cases disagreed with free visit. 47% of the cases had one of their first-degree relatives admitted to the ICU during the recent year.

Table 1 shows that the studied cases considered nurses (40%) and their agreement as the key factor in the implementation of the free visit system.

Table 1. Distribution of groups about free visit in the viewpoint of the studied cases

Involved groups	Percent
Patients	20
Patient's family and relatives	24
Nurses	40
Doctors	10
Senior managers	6
Total	100

Table 2 shows that the studied cases considered patient's family and relatives (65%) as the most beneficiaries and doctors (3%) as the least beneficiaries in the implementation of the free visit system.

Table 2. Distribution of beneficiary groups by establishing a free visit system

Involved groups	Percent
Patients	20
Patient's family and relatives	65
Nurses	7
Doctors	3
Senior managers	5
Total	100

The results showed that with implementation of the free visit in the ICUs, nurses (45.4%) and patients (42.5%) were the most damaged ones. The average score of nurses' knowledge about the benefits of free visit was 8.25, which is a medium level of knowledge. The highest score was 20 and the lowest was 0. The total points were calculated in three groups of 0 to 7 (weak), 8 to 14 (moderate), and 15 to 20 (excellent).

The average score of doctors' knowledge about the benefits of free visit was 7.32, which is within the range of average knowledge.

The average score of senior managers' knowledge about the benefits of free visit was 9.78, which is within the range of average knowledge.

The average score of nurses' attitude toward free visit was 42.66, which is within the range of average attitude. The highest score was 100 and the lowest was 20. The total scores were calculated in three groups of 20 to 45 (weak), 46 to 75 (moderate), and 76 to 100 (excellent).

The average score for doctors' attitude toward free visit was 61, which is within the range of average attitude.

The average score of senior managers' attitude toward free visit was 46.84, which is within the range of average attitude.

Discussion

The recent study showed that nurses, doctors, and other treatment staff did not have a positive attitude toward visit without

limitation, which is because they believe that the free visit will interfere with nursing care and this interference will directly cause taking more time to explain to the patient's family and creating a busy environment that is the cause of the error.

The recent study showed that the studied cases, according to their patient's critical condition in the ICU, did not consider free visit beneficial and even considered it harmful to the patient. This was the most common reason for the negative attitude of the studied cases.[14]

The present study showed that 80% of the studied cases were unaware of the changes in patient's vital signs due to free visit, while the results of the research showed that free visiting could stabilize the patient's vital signs and physiological status.[13] A study showed that patients who had free visit had a more stable physiological status than patients who had no free visit.[12] Moreover, it showed that the high number of patients in the ICU according to the number of nurses and the necessary physical space was one of the obstacles for free visit, which defined strategies should be considered for it such as increasing nurses in ICUs.[11]

One of the major obstacles for free visit in ICUs was the increased probability of getting infected of the patients by the visitors, which necessary protective equipment such as gloves and masks and other protective equipment should be provided for visitors to prevent the transmission of infection to patients.

In a study, the levels of bacterial and fungal contamination in the air and surfaces in two units with free and limited visit were checked and no significant difference was found between them. Cumulative prevalence of pneumonia, urinary tract infection (UTI), and sepsis in the comparison group was not significantly different with the control group after assimilating age, sex, and duration of hospitalization.[10]

The recent study shows that the most important element in discussing cultural barriers of implementing free visit system is family. Therefore, the family faces a crisis when having one of its members hospitalized in the ICU. Hospitalization in the ICU is potentially unwelcome to the patient and family and has many problems that their negative effects are unavoidable. Fear of losing one of the family members, fear of the future, fear of financial burden of the disease on the family, changes in family members' roles, anxiety, distress, depression, loneliness, and hopelessness are among the threats that affect integrated family system. Having a patient hospitalized in ICU is accompanied by special stresses and challenges for family members which include loss of control, change in role, fear of the future and patient's health, and disappointment.

Conclusion

With the arrival of family members into the ICU and observation of their patient surrounded by the light, various sounds, and different types of tubes and monitors, they feel a lot of insensibility and ask about their patient from anyone they see, because they have entered an unknown and vague world. The experience of hope in the families with a patient admitted to the ICU is significantly different from a family having a patient hospitalized in other parts. Because these families' patients are in critical conditions and between death and life, even if the duration of hospitalization for the patient in the ICU would be short, life of family members are affected for weeks or months in different ways. Therefore, to eliminate these obstacles, educating families about visit and helping them with crisis management is very helpful.

Conflict of Interests

Authors have no conflict of interests.

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