



## Family Visitation in the Adult ICU

### Scope and Impact of the Problem

Evidence shows that the unrestricted presence and participation of a support person can enhance patient and family satisfaction, because it improves the safety of care. This is especially true in the ICU, where the patients are usually intubated and cannot speak for themselves. Unrestricted visitation of a support person can improve communication, facilitate a better understanding of the patient, advance patient- and family-centered care, and enhance staff satisfaction.

### Expected Practice

- ☑ Facilitate unrestricted access of hospitalized patients to a chosen support person (eg, family member, friend, or trusted individual) who is integral to the provision of emotional and social support 24 hours a day, according to patient preference, unless the support person infringes on the rights of others and their safety, or it is medically or therapeutically contraindicated.<sup>1</sup> [Level D]
- ☑ Ensure that the facility/unit has an approved written practice document (ie, policy, procedure, or standard of care) for allowing the patient's designated support person—who may or may not be the patient's surrogate decision maker or legally authorized representative—to be at the bedside during the course of the patient's stay, according to the patient's wishes.<sup>1-6</sup> [Level D]
- ☑ Evaluate policies to ensure that they prohibit discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and/or gender identity or expression.<sup>1-6</sup> [Level D]
- ☑ Ensure that there is an approved written practice document (ie, policy, procedure, or standard of care) for limiting visitors whose presence infringes on the rights of others and their safety or are medically or therapeutically contraindicated to support staff in negotiating visiting privileges.<sup>6</sup> [Level D]

### Supporting Evidence

- In practice, 78% of ICU nurses in adult critical care units prefer unrestricted policies<sup>7-13</sup>; yet, studies show that 70% of hospital ICU policies restrict family visitation.<sup>3,7-9,13-14</sup> This variability creates conflict between nurses and confusion in families.<sup>10,15</sup>
- Some ICU nurses believe that family visitation increases physiologic stress in the patient and interferes with the provision of care,<sup>16</sup> is mentally exhausting to patients and families,<sup>11,15-19</sup> and contributes to increased infection<sup>8,19</sup>; however, the evidence does not support these beliefs.<sup>8-9,20-29</sup>
- Evidence does suggest that for patients, flexible visitation decreases anxiety,<sup>17,20-21</sup> confusion, and agitation,<sup>22</sup> reduces cardiovascular complications,<sup>20</sup> decreases length of ICU stay,<sup>31</sup> makes

the patient feel more secure,<sup>32</sup> increases patient satisfaction,<sup>14, 20, 29,32-34</sup> and increases quality and safety.<sup>20,24-26,30, 35-36</sup>

- For family members, evidence suggests that unrestricted visitation increases family satisfaction,<sup>7,17,11, 20, 29, 36-38</sup> decreases family member anxiety,<sup>7,17, 29,36,39-40</sup> promotes better communication,<sup>11,14,17, 24, 29, 41</sup> contributes to better understanding of the patient,<sup>11,32,36</sup> allows more opportunities for patient/family teaching as the family becomes more involved in care,<sup>11</sup> and is not associated with longer family visits.<sup>36</sup>
- Finally, evidence suggests that some nurses in adult ICUs restrict children's visits based on the intuition that children will be harmed by what they see or based on a concern that they would be uncontrollable. These biases are not grounded in evidence or based on the patient's or the child's actual needs.<sup>8,42-44</sup> Yet, when allowed to visit relatives in the ICU, properly prepared children have less negative behavior and fewer emotional changes than those who did not visit.<sup>45-48</sup> It is recommended that they be allowed to visit unless they carry contagious illnesses.<sup>49</sup>

### **Actions for Nursing Practice<sup>3</sup>**

- Ensure that your health care facility has policies and procedures that support unrestricted visitation in the ICUs—ones that allow for the patient's unrestricted contact with a desired support person while, at the same time, protecting the privacy of other patients and the safety of patients and staff.
- Senior executives provide leadership and support for changing restrictive visiting policies and practices. These include:
  - Making it a priority to remove "visitor" signage and informational materials that communicate restrictive visiting policies to patients, families, and communities.
  - Developing organizational infrastructure to support this change in policy and practice, and ensuring that key stakeholders—including executive leaders, midlevel managers, front-line staff, and patients and families who are prepared to serve as advisers—are a part of the process.
  - Supporting a patient's right to identify individuals whom the patient views as "family" and chooses to be their "partners in care," without discrimination.
  - Creating policies, procedures, and educational programs for professional staff that include the following components:
    - The benefits of unrestricted family visitation
    - The right of family members, as defined by the patient, to have unrestricted access to the patient to provide support, comfort, and important information across the continuum of his or her hospitalization.
    - Written notification to patients and families of their rights to family visitation, including any reasons for clinical restrictions or limitations
- Proficiency standards that include the following:
  - Families and other partners are welcomed 24 hours a day according to patient preference.
  - When possible, at the beginning of the ICU experience, patients are asked to define their "family" and how they will be involved in care and decision making.
  - At this time, patients identify designated representatives such as health care power of attorney or a health care proxy.
  - Patient preferences are documented in the paper or electronic record and communicated consistently and comprehensively to all involved in patient care across all settings.

- When the patient is unable to communicate and cannot designate who should be present, hospital staff makes the most appropriate decisions possible, taking into account the broadened definition of family as “partners in care.”
- Nurses and others on the health care team provide guidance to patients, families, and other partners in care regarding:
  - How to partner with the staff to ensure safety and quality of care
  - How to be involved in care, care planning, and decision making, and how to support the patient during hospital care and transition to home
  - How to honor privacy and be respectful of other patients and families in close proximity or who share the same patient room
- Patients, families, nurses, and other members of the health care team can reevaluate and modify the presence and participation of families based upon safety criteria. All such collaborative decisions will be documented in the patient’s record.
- The number of people at the patient’s bedside at any one time will be determined in collaboration with the patient and family. In situations where there are shared rooms, this negotiation will include the other patient, his or her family, and their other partners in care.
- Families are encouraged to designate a family spokesperson to facilitate effective communication among extended family members and hospital staff.
- Children supervised by an adult family member are welcome.
  - Children are not restricted by age. Although younger children may be developmentally unable to remain with the patient for lengthy periods of time, contact with these children can be of significant importance to the patient.
  - Children are prepared for the hospital environment and the family member’s illness as appropriate.
  - Children are expected to remain with the adult who is supervising them unless there is a supervised playroom for siblings and other children.
  - Children’s behavior is monitored by a responsible adult and the nurse to ensure a safe and restful environment for the patient(s) and a positive and developmentally appropriate experience for children.
- A policy for restricting visitation by family and partners in care should include the following:
  - Family members and “partners in care” who are involved in abusive, disruptive, or unsafe practices will be addressed directly and promptly.
  - All partners in care and guests of the patient must be free of communicable diseases and must respect the hospital’s infection control policies.
  - If an outbreak of infection requires some restrictions for public health, the staff must collaborate with the patient and family to ensure that selected family members are still welcome, to ensure safety and offer emotional support to the patient.
- Determine your unit’s rate of compliance in ensuring patients have unrestricted access to designated support persons in the ICU stay. If compliance is  $\leq 90\%$ , develop a plan to improve compliance:
  - Consider forming a multidisciplinary task force (ie, nurses, physicians, chaplains, social workers, child life specialists) or a unit core group of staff to discuss approaches to improve compliance.
  - Re-educate staff about family visitation, and discuss the patient- and family-centered approach and the evidence-based practice of unrestricted visitation.
  - Incorporate content into orientation programs as well as initial and annual competency verifications.

- Develop a variety of communication strategies to alert and remind staff about the benefits of unrestricted visitation.
- Document standards for unrestricted visitation, including rationale for when restricted visitation would be necessary for the protection of the patient, the family, other care providers, or the staff.

#### AACN Levels of Evidence

<b>Level A</b>	Meta-analysis of quantitative studies or metasynthesis of qualitative studies with results that consistently support a specific action, intervention, or treatment
<b>Level B</b>	Well-designed, controlled studies with results that consistently support a specific action, intervention, or treatment.
<b>Level C</b>	Qualitative studies, descriptive or correlational studies, integrative review, systematic reviews, or randomized controlled trials with inconsistent results
<b>Level D</b>	Peer-reviewed professional and organizational standards with the support of clinical study recommendations.
<b>Level E</b>	Multiple case reports, theory-based evidence from expert opinions, or peer-reviewed professional organizational standards without clinical studies to support recommendations
<b>Level M</b>	Manufacturer's recommendations only

#### Need More Information or Help?

1. The Institute for Patient- and Family-Centered Care (IPFCC). Changing hospital "visiting" and policies and practices: supporting family presence and participation. Institute for Patient-and Family-Centered Care recommendation on how to bring system, process, and policies into alignment with latest 2010/2011 TJC recommendations. <http://www.ipfcc.org>.
2. Access the Clinical Practice section of the AACN website for resources and tools for revising hospital policies and for educating members of the health care team. In particular, the "Creating a Healing Environment" protocol series has chapters on "Family Visitation and Partners in the Critical Care Unit," keeping in mind the 2010/2011 definition of "family" changes. This protocol provides detailed information regarding who should visit, how to establish policies, visitation options, preparing families for visitation, facilitating family partnerships, and promoting family-centered care. The protocol also offers detailed information regarding children and animal visitation in critical care areas. You may order this product, #170690, from the [AACN Online Bookstore](#) or by contacting AACN Customer Care at (800) 899-2226.
3. Davidson JE, Powers K, Hedayat KM, et al. Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004-2006. *Crit Care Med.* 2007;35(2):605-622.

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