BACCN
British Association
of Critical Care Nurses

Position Statement on Visiting in Adult Critical Care Units in the United Kingdom

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Executive Summary

After receiving regular enquiries about best practice with regard to visiting policies on critical care units (ICU) the British Association of Critical Care Nurses commissioned this Position Statement on Visiting in Adult Critical Care Units in the United Kingdom. Intensive care units have been established in the United Kingdom since 1962 (Crocker 2007) and more recently the Department of Health (2000a) has modernised services and encouraged the combination of Intensive Care and High Dependency Units into Critical Care Units and therefore this is the term which will be utilised in this Position Statement together with the abbreviation ICU. Visiting policies create a great deal of debate regarding whether visiting should be open (unrestricted) or closed (restricted). Plowright (1996) found that many ICUs only allow two visitors at a time to each patient. Visitors are perceived to increase noise levels, take up space, take up nursing time, and hinder direct nursing care (Plowright 1998; Berti et al 2007; Farrell et al 2005; Quinnio et al 2002). Patients on the other hand felt a positive energy from their visitors and that their rights were protected through visitors acting as advocates (Bergbom & Askwall 2000; McAdam et al 2008). Nurses can gain a lot of useful information from visitors thus providing more individualised care for patients (McAdam et al 2008; Williams 2005; Marco et al 2006; Gonzalez et al 2004). As well as psychological well being visitors may have a positive physiological effect in aiding the weaning process (Happ et al 2007). However, some patients found visitors disruptive to rest and intensified pain (Carroll & Gonzalez 2009). There is no evidence to suggest that visitors pose a direct infection risk to patients (Adams et al 2011; Fumigalli et al 2006; Tang et al 2009). It is important to respect the rights of patients and allow them to decide whether or not they want visitors.

The physical and psychological well being of visitors is also an important issue. Visitors find waiting isolating, distressing and frustrating (Bournes & Mitchell 2002). They spend a great deal of time in waiting rooms and therefore the comfort of the waiting room is important, as is access to overnight accommodation in the vicinity of the ICU, refreshments, a bathroom, a telephone and a private discussion room for consultation with ICU staff (Kutash & Northrop 2007; Deitrick et al 2005; Fridh et al 2009; Lederer et al 2005).

Critical Care staff require accurate information about visitors including who is the next of kin, who will act as a point of contact and phone numbers. Visitors can provide information about the patient which may help direct treatment. Staff need to be cognisant of legislation and other information concerning, vulnerable adults, child protection and cultural diversity.

Dealing with child visitors to the adult critical care environment is a particular source of stress and uncertainty for staff working in critical care areas. A visit by a child can offer a diversion and help patients feel safe (Hupcey 2000). Patients found visits by children maintained their identity (Gjengedal 1994). Children cope with visiting an adult patient in ICU (Knutsson et al. 2008) and can be supported by their parent or guardian and staff. Critical care staff need support and education to help them facilitate child visitors to the adult ICU (Clarke & Harrison 2001).

Pets visiting the ICU are another controversial area. However, in the current era where "family" is hard to define a patient may have no next of kin and may live with a much beloved pet. Pets bring physical, social, psychological and general health benefits to people (Halm 2008). Animal Assisted Therapy and Pet Therapy Schemes are fairly well established but visitation by a patient's own pet is less so (Connor & Miller 2000; Giuliano et al 1999; Hooker et al 2002). Connor & Miller (2000) suggest that many nurses meet this need by sneaking animals into the hospital or bringing them to a window and the expert panel involved in the development of this Position Statement could provide many anecdotal examples of having done just that. Infection control may be an issue but critical care units should consider letting pets in to visit as long as it is appropriate, sensible infection control precautions are taken and the visit is limited to the pet's owner only.

Executive Summary - continued

The importance of visiting needs to be included in both pre and post registration education curricula. There has been a general call for Higher Educational Institutions to address more intensively the importance of visiting policies and to facilitate the development of higher reflexive competencies (Juchems et al 2008). All staff commencing work within critical care units should receive educational input through induction programmes highlighting the needs of family members and how those needs can be met effectively. Effective role modelling by senior staff members can be particularly powerful in educating junior members of the critical care team (Linton & Farrell 2009). This Position Statements sets out the standards patients and visitors should expect when visiting an adult critical care unit in the 21st century in the UK.

Conflict of interest statement

The production of this Position Statement was funded by the British Association of Critical Care Nurses. The Authors received no financial gain and have no conflict of interests.

British Association of Critical Care Nurses Position Statement
Standards on visiting in adult critical care units in the United Kingdom.

Patients should expect:

- To have their privacy, dignity and cultural beliefs recognised
- Confidentiality
- The choice of whether or not to have visitors
- The choice to decide who they want to visit including children and other loved ones
- The choice of care assisted by their relatives
- A critical care team who recognise the importance and value of visiting

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Relatives should have:

- A comfortable and accessible waiting room with bathroom facilities nearby
- Access to overnight accommodation in the vicinity of the ICU
- Easy access to food and drink
- A telephone nearby
- Access to relevant information regarding critical illness, the critical care environment and aftercare and support. This should be reinforced with written materials
- A separate area for private discussions with healthcare professionals
- Involvement in patient care as the patient would wish
- Written information regarding the unit procedures e.g. hand washing, times of ward rounds
- Information concerning patient progress on at least a daily basis
- Information when there are any significant changes to the patient's condition
- Not have to wait for long periods of time in the waiting room without regular updates
- Access to interpretation facilities if needed

Introduction

Intensive care units have been established in the United Kingdom since 1962 (Crocker 2007) and more recently the Department of Health (2000a) has modernised services and encouraged the combination of Intensive Care and High Dependency Units into Critical Care Units and therefore this is the term which will be utilised in this Position Statement together with the abbreviation ICU. Critical Care Units have long been recognised as highly stressful environments. Patients admitted to critical care units will be the sickest in the hospital and may require respiratory support and support for other organs. The patients are usually sedated and in certain circumstances may be receiving a paralysing agent. There is usually a ratio of one nurse to either one or two patients (Bray et al. 2010) and input from numerous medical teams and other professionals. Traditionally patients have been cared for in open bays with limited access to side rooms. These open bays may contain both female and male patients and this has led to concerns about privacy and proximity of other patients and relatives. Space is often limited and patients may be seriously ill or may be dying. This set of circumstances on the critical care unit has led to a long running debate about visiting policy, with some believing in unrestricted visiting for relatives, whilst others strongly advocate restricted visiting in terms of the number of individuals allowed in at any one time and the times at which visiting can take place. Opinions of patients support that there are concerns with privacy and dignity and being overheard by other patient's visitors (Whitehead & Wheeler 2008) The British Association of Critical Care Nurses (BACCN) is a leading organisation for critical care nursing in the United Kingdom (UK) and regularly receives enquiries about best practice regarding visiting policies. Therefore in keeping with the BACCN's commitment to provide evidence based guidance for nurses a Position Statement on visiting practices in adult ICUs was commissioned. This brought together experts from the field of critical care nursing and representatives from patient and relatives' groups to review visiting practices and the literature and produce a Position Statement.

Methodology

Following numerous enquiries to BACCN about visiting policies and practices the Professional Advisors were prompted to ask for expressions of interest from the BACCN membership to be involved in writing this Position Statement. It was also vital to have input from patients and relatives regarding their views on visiting and this was facilitated through ICUsteps (a charity founded in 2005 to support patients and relatives affected by critical illness) and The Patients and Relatives Committee of the Intensive Care Society (the Committee was established in 2004 to represent patients' and relatives' interests to the Intensive Care Society).

Dates were set for the group to meet and discuss the best strategy to develop the Position Statement. A comprehensive literature review was undertaken but the expert opinions and experiences of the group members have also been taken into consideration in the development of this Position Statement.

The following search databases were accessed: Blackwell Synergy, CINAHL, Medline, Swetswise, Cochrane Data Base of Systematic Reviews, National Electronic Library for Health, Institute for Healthcare Improvement and Google Scholar.

The following search terms were used:

- open visiting
- closed visiting
- restricted visiting
- unrestricted visiting
- relatives visiting
- family visiting
- care of family
- care of relatives

In addition to the above search terms the descriptor of ICU, ITU and critical care were also used to make the search more specific to the literature review. After obtaining selected articles, the references from these articles were then evaluated for their relevance to this Position Statement and were retrieved. Due to the complexities of translating papers, only literature written in English was reviewed. The search found a number of articles that originated from a number of different countries and professional journals. Although material from other countries has been utilised in the production of this Position Statement the Position Statement is aimed at a UK Audience. References were reviewed between 1990 and 2011 in an attempt to ensure that the work was relatively current; older references were included if the expert panel considered them to be seminal pieces of work.

A search of the evidence revealed limited Level 1 evidence on randomised controlled trials concerning visiting (NICE 2005). Indeed the study of visiting policies and practices perhaps does not lend itself to positivist research methodologies alone but also to surveys and qualitative research methodologies. Therefore in order to raise the profile of visiting and produce some guidance for nurses a broad range of evidence has been reviewed in this Position Statement. Expert opinion and formal consensus were also utilised as sources of evidence in the development of this Position Statement. In reviewing the evidence and producing this Position Statement the expert panel have been cognisant of the AGREE (2009) tool for the appraisal of guidelines.

Visiting policies and practices

Visiting policies create a great deal of debate regarding how best to manage visitors to the critical care unit. The debate is focused around whether or not visiting should be open (unrestricted) or closed (restricted). It is difficult to define these terms absolutely as critical care units who claim to practice open visiting related this to the fact that visitors can visit at any time but may still place some restrictions on number of visitors because of the practicalities of space etc. This part of the Position Statement attempts to discover the variety of visiting policies and practices and the justification for them.

Plowright (1996) found that many critical care units allowed only two visitors at a time as they perceived that more visitors would increase noise levels especially if the critical care area is busy, that there is a lack of space in most critical care areas, and that patient safety could be compromised as there would be reduced access in an emergency. Farrell et al. (2005) found the idea of a lack of space led to concerns that the confidentiality of other patients might be broken.

It has also been reported that nurses perceived visitors take up too much nursing time (Plowright, 1998). Berti et al. (2007) reported that nurses feel that a significant amount of time is taken up providing information to the family and that this can hinder direct nursing care and therefore nurses do not view open visiting in a positive way. Gurses & Carayon (2007) suggest that visitors are not a focus of care and they used a questionnaire to determine what ICU nurses saw as impediments to care and found that time spent educating visitors, answering their questions and taking telephone calls rated highly. Quinio et al. (2002) also found that visitors are seen as a drain on staff resources and time. Nurses seem to feel interacting with visitors makes their job more difficult (Levy, 2007).

Plowright (1998) found that visitors are asked to leave the critical care area regularly, and so did not believe visitors affect the functioning of the unit. Neurological-ICU nurses were questioned about when they ask visitors to leave and a variety of reasons were given from position changes, to invasive procedures, patient exhaustion or agitation, or if the nurse feels the visit has been too long (Livesay et al. 2005). Marco et al. (2006) found that while visiting may alter timings of interventions, many nurses believe it does not interfere with the overall care given and that they perceived themselves to be qualified to attend to family members' needs.

The concept of asking visitors to leave as a way of avoiding contact with them is explored by Plowright (1998). This can be seen as a coping strategy for nurses (Plowright, 1998). It has been suggested by Chesla (1996) that this is due to the type of nurse critical care environments attract. Chesla (1996) found some nurses concentrated on medical and technological aspects of care due to the pressure to keep the patient alive, being interested in the technological aspects of care or a lack of education. From a workplace socialisation perspective, it has been noted that if a unit focuses more on technical skills, it could affect holistic care (Plowright, 1998). However, Johnson et al. (1998) found that communication skills were perceived by families as equally important as technical skill in meeting their needs. It was reported that nurses also distance themselves from the bed space as nurses "need to be doing for people" (Quinn et al. 1996: 243)– for example by making coffee for visitors.

Livesay et al. (2005) found that nurses are seen as gatekeepers to the patient and that families who appear to be supportive and caring may be asked to leave less frequently. They also note that this is subjective. Lam & Beaulieu (2004), found families were concerned about alienating nurses as it may alter their ability to access information or the direct care given, and report relatives using jargon and taking on some tasks to "fit in". Hupcey (1999) found visitors tried not to impede the nurses, and tried to feel at ease with the nursing staff. She notes that it would have been inappropriate to ask the families themselves whilst they were "in the process of suffering" (Hupcey 1999: 261). She noted that nurses were seen as in a position of power, with families having to be careful of their actions and discussions and families having to cope with this situation.

Whether the needs of relatives are taken into account when staffing levels are decided is an interesting point (Gurses & Carayon, 2007). The Comprehensive Critical Care document states this should be based on "patient dependency rather than bed numbers" (DoH 2000: 20).

Not only are restrictions placed on the number of visitors and the times of visiting but also what visitors may wear. In Hunter et al.'s (2010) survey of ICU visiting, infection control issues were mentioned – all units required some form of hand cleaning, and in 10 (of 206 that answered), visitors are expected to wear gowns. Giannini et al. (2008) report there is no evidence for asking visitors routinely to wear gowns and notes that this reinforces the idea of visitors "not belonging".

Are there benefits to patients for recommending unrestricted visiting?

This section of the Position Statement will review the effects of visitors on patients and the critical care environment. Open visiting policies seem to be favoured by patients and visitors but does this have a detrimental or beneficial effect on the patient and the environment? Bergbom & Askwall (2000) conducted a survey of Swedish ICU patients and found, perhaps most significantly in terms of ultimate outcome, that patients felt "positive energy" from their visitors and this gave them a stronger will to survive. The presence of relatives during procedures also gave them a feeling of protection and security. They felt that their rights were protected. The role of protector was also reported by McAdam et al. (2008) who suggested that nurses should expect to learn about patients from their visitors (McAdam et al., 2008, Williams, 2005). Nurses recognise that relatives can interpret better for their loved ones (Berti et al. 2007, McAdam et al. 2008). These last two areas should enable nurses to give better, more individualised care to patients. In Spain nurses felt greater professional satisfaction – whilst at the time interacting with visitors can be considered burdensome, the benefits to the patient were seen as reward (Marco et al. 2006).

Gonzalez et al. (2004) researched visiting preferences of patients in ICU and a complex care medical unit. Patients rated visiting as a non-stressful event because the visitors offered reassurance, comfort and calming. Visitors were also able to interpret information for patients. Gonzalez et al. (2004) also found that visitors were beneficial to the nurses because they were able to impart information which helped nurses to understand their patients.

Happ et al. (2007) studied the effect of family presence during weaning and found that family presence resulted in significantly longer daily weaning trials. Family members were present at the patients' bedside during weaning trials and interacted with patients through touch, talking, and surveillance. A study from Japan investigated the effects of regular family visiting on the consciousness level of comatose, head injured patients and found that regular family visiting could induce stimulation of the patient who was in a coma (Abbasi et al. 2009).

The contribution of visitors to the care and well being of the patient often goes unrecognised and is often not valued by staff in ICU. McAdam et al. (2008) explored the contribution that family members can make to patients in ICU who are at a high risk of dying. Visitors reported that the patient felt safer and more comfortable when they were present. The visitors took on the role of advocate and defender of the patient. They were able to translate, explain and interpret information for both the patient and staff. Family members also used their in-depth knowledge of the patient, including past medical history and wishes to provide information for staff. Family members offered support and encouragement to the patient and participated in care activities.

It seems that the severity of illness may affect how visiting is perceived by patients. In a study by Carroll & Gonzalez (2009) which compared the preferences of cardiovascular patients in a cardiovascular intensive care unit (CICU) to those in a cardiac step down unit (CSDU), the authors found that the patients in the CICU perceived a higher value to visiting in terms of visitors interpreting and providing information, calming effect and help with care. The patients in the CSDU perceived visitors as being disruptive to rest and intensified pain (Carroll & Gonzalez 2009).

A small study undertaken in Norway found that patients wanted some limitation on visitors and wanted only those who were closest in daily life to visit. Visits promoted support for patients and families but also caused stress for patients (Olsen et al. 2009)

The right not to have visitors should also be upheld. Gonzalez et al. (2004) found that patients did not want visitors if they were unsure of the daily routine of the critical care area. They also did not want visitors if they were feeling unwell. If the patient was talking to doctors, this also was a time when visitors were not wanted. It is necessary for patients not to lose the right to have confidentiality (Slota et al. 2003).

Do visitors pose an infection risk to patients

A concern for health care professionals is that visitors can expose vulnerable patients to an increased risk of infection. Studies by Adams et al (2011) & Fumagalli et al (2006) found that infection rates do not increase with visitation. It is well recognised that most infections are transmitted from the hands of health care workers going between patients without appropriate hand decontamination. Therefore, if visitors apply appropriate hand washing before visitation, the evidence shows this should not increase infections within critical care. However, each hospital should have local arrangements related to specific infection control issues e.g. H1N1 or Clostridium Difficle.

Fumigalli et al (2006) investigated the safety and health outcomes of unrestrictive and restrictive visiting policies. Unsurprisingly they found significantly greater environmental microbial contamination during the unrestrictive times. However, septic complications for patients were similar during both unrestrictive and restrictive visiting. This contests the commonly held belief by some nurses that visitors cause greater level of infections and directly infect patients. In addition to this the same authors found that the risk of circulatory complications were twice as great during the restrictive visiting period and that the unrestrictive visiting period was associated with greater reduction in anxiety and a significantly lower increase in thyroid stimulating hormone. This study suggests that not only does unrestricted visiting not cause more infections but it has a beneficial effect on cardiovascular complications.

Tang et al. (2009) from Taiwan investigated the relationship between patient visiting and indoor air quality. They measured temperature, relative humidity, carbon dioxide, particulate matter, bacteria and fungi levels. The levels of all indoor air characteristics, except bacterial concentrations, were higher after patient visiting than before patient visiting. The authors also found an association between the particle concentration and the number of visitors. The levels of bacteria and fungi varied during the survey period. They concluded that limiting the number of visitors can improve indoor air quality but recommended that further studies be undertaken to determine the relationship between bioaerosol exposure and rates of nosocomial infections (Tang et al. 2009). Increasing ventilation during and after visiting may negate the effects visitors have on air quality.

The argument for refusing visitors into critical care units due to its impact on increasing infections in unfounded and does not appear to be based upon empirical evidence.

What visiting do visitors want?

The needs relatives identify are not always the same as nurses think they are, and do not have the same importance (Blackmore, 1996). Therefore this Position Statement has included a review of what visitors actually want. Many studies look at relatives' needs based on the Molter & Leske (1983) Critical Care Family Needs Index (CCFNI) but this does not measure how satisfied visitors are. Wasser et al (2001) developed the Critical Care Family Satisfaction Survey (CCFSS) and produced 5 themes against which they measured satisfaction. The themes were:

- Assurance
- Information
- Proximity
- Support
- Comfort

Recently, a survey of visiting policies and facilities related to critical care units in the UK was conducted in 271 hospitals (Hunter et al. 2010). There was a 76% response rate. Of all responding critical care units 99% of them provided a dedicated relatives' room and 62% had access to sleeping accommodation in the vicinity of the ICU. Other amenities included access to a television, DVD player, vending machines, magazines, comfortable seating and 4% of units provided lockers to enable visitors to secure their belongings. However, nearly 40% of responding units did not provide relatives with facilities to make tea and coffee and only 70% of responding units provided a dedicated room for breaking bad news.

Relatives consistently identify a dedicated waiting area as a necessity for quality care, (Hunter et al. 2010, Deitrick et al. 2005). Relatives spend a great deal of time waiting in critical care waiting rooms (Deitrick et al. 2005). In a study which examined the experience of waiting, Bournes & Mitchell (2002:58) identified waiting as "an anguishing doubt and uncertainty that is isolating, distressing and frustrating". Relatives can be near to exhaustion when waiting (Zazpe et al. 1997). A study in the United States of America (USA) of critical care units that have been identified as best practice examples in terms of their design, suggested that each patient bed space should have dedicated family space (Rashid 2006). This study also suggests family space should be healing and comfortable. Promoting a healing environment for relatives recognises that the family may provide a key component to the patient's well being (Stichler 2001). The UK Audit Commission (1999) report 'Critical to Success' suggested that the provision of a waiting room is a minimum standard requirement for critical care units.

Studies have demonstrated that rooms that are not perceived to be comfortable result in dissatisfaction amongst relatives (Karlsson et al. 2011, Vandijck et al. 2010, Zazpe et al. 1997). However, some studies suggest that improving the waiting room environment does not increase satisfaction (Lederer et al. 2005, Heyland et al. 2002). A multivariate analysis demonstrated that needs seen to be less important in isolation, became more important when assessed in association with other needs (Freitas et al. 2007). Thus, needs related to relatives' comfort, which were not considered important by the relatives themselves in isolation, could affect overall satisfaction scores when considered with other higher priority needs.

In particular, the décor is seen to be important and can affect the perception of quality of care, (Deitrick et al. 2005). One waiting room was described as 'a place to go, not a place to stay', (Kutash & Northrop 2007). Design should address the senses, offering visual environments with natural light, colour, art and pleasing views (Hamilton, 2000).

Studies have suggested that space for relatives should be as near to the patient as possible (Kutash & Northrop 2007, Davidson et al. 2007, Rashid 2006, Holden et al. 2002, Wilkinson 1995). The further the waiting area is from the patient the greater the level of stress the visitor experiences. There is a suggestion that whether the family area is located inside or outside the unit is an indicator of the degree to which families are integrated within the critical care unit (Rashid 2006, Verhaeghe et al. 2005).

Seating in waiting areas and clinical areas for visitors needs to be comfortable (Dietrich et al. 2005., Skelsky et al. 2005, Zazpe et al. 1997). One study of relatives who had a family member die in ICU did not complain if seating was uncomfortable, but were extremely grateful if staff showed concern by offering food, drink, or a comfortable chair (Fridh et al 2009). Seating needs to be grouped to enable relatives to sit in their own visitor groups, and give a sense of separation and privacy (Fridh et al. 2009). Some relatives avoid using the waiting room because of overcrowding, and the difficulty of sharing with other families. Conversely, social interactions have been seen to increase when waiting room furniture is arranged in small flexible groupings (Davidson et al. 2007). There should be one and a half seats available in the waiting room per ICU bed (Society of Critical Care Medicine, 1995).

There needs to be a telephone available for the use of relatives (Dietrich et al. 2007, Zazpe 1997). Relatives dealing with a close family member who was dying found lack of a telephone, where they could talk in private, disturbing (Fridh et al. 2009).

Some relatives felt unable to access food and drink easily (Zazpe et al. 1997). Studies suggest that relatives felt that access to food and other services were important to them (Skelsky et al. 2005, Wilkinson 1995) and influenced their assessment of service quality (Dietrich et al., 2005). Skelsky et al. (2005) referred to Maslow's hierarchy of needs suggesting that if a relative's basic needs are met this allowed them to concentrate on their critically ill family member. Providing relatives with access to food, drink and rest enables them to cope better with the stress of having a relative in ICU, including processing information and decision-making (Nelms & Eggenberger, 2010, Browning & Warren, 2006). It is important to foster an environment that protects the physical and emotional health of severely stressed relatives (Lederer et al. 2005). Alvarez & Kirby (2006) suggested that critical care unit managers should sit in the waiting room in their department to get a feel for what it is like to sit there for hours, for a chance to see a loved one, with no access to food or the outside world. A bathroom for the use of relatives should be provided near to or within the waiting room, (Dietrich et al. 2005, Verhaeghe et al. 2005, Society of Critical Care Medicine, 1995). Lee & Lau (2003) suggest that sleep deprivation and fatigue were common amongst relatives they studied on a unit that did not have a waiting room or comfortable furniture. This put the relatives at risk of physical illness, decreased attentiveness and irritability. The UK Audit Commission (1999) report suggested that provision of overnight accommodation is a minimum standard requirement for critical care units.

A volunteer in the waiting room area, who had been coached by critical care nurses, increased relatives' satisfaction with the meeting of their needs (Appleyard et al. 2000, Bournes & Mitchell, 2002). One study described participants as 'wanting to be checked on whilst waiting' (Kutash & Northrop 2007). Deitrick et al. (2005) found that the role of a receptionist in the waiting room was seen to be a key facilitator for families. This receptionist also appeared "to be an important intermediary in facilitating communication between ICU staff and patient families" (Deitrick et al. 2005: 22). A suggested title for the waiting room receptionist was that of 'ICU ambassador'.

Deitrick et al. (2005) found that a lack of private areas for relatives was highlighted as an issue requiring work to improve the quality of the environment. The quality, frequency and length of interactions between staff and relatives generally increase in more private spaces, (Rashid 2006). The UK Audit Commission (1999) report suggested that provision of a dedicated room for breaking bad news is a minimum standard requirement for critical care units and that this room should be separate from the Sister's or Consultant's office.

Additional amenities are provided by some UK critical care units including access to a television, DVD player, magazines, bleepers, and lockers (Hunter et al. 2010). Music in the waiting room can be therapeutic (Skelsky et al. 2005, Stichler, 2001). The provision of personal care supplies for use by relatives was seen as very helpful in two units in the USA involved in the American College of Critical Care Task Force Family Assistance Programme, (Skelsky et al. 2005, Davidson et al. 2010).

What visiting do visitors want? - continued

Miracle (2006: 124), wrote about meeting the needs of families of critically ill patients *"It must be remembered that proximity to the patient is a highly rated need of family members. Waiting rooms should be close to the unit, comfortable, and functional. Some family members may be there for several hours a day or, in some cases, overnight. Volunteers can be used to staff waiting areas and can act as a receptionist, someone who can assist family members. Waiting rooms should be comfortable and some amenities such as beverages, snacks, televisions, and blankets should be readily available. These services are important to family members and sometimes these little efforts can make all the difference."*

ICUsteps asked relatives attending a drop-in meeting what they wanted to know when their relative was a patient in the ICU. They were asked to pick no more than 10 questions from a list of 19 provided or add any questions they felt were missing. All of these options were picked by over half those asked.

- What can patients hear when they're sedated / why should you talk to patients?
- What the machines do and what the alarms mean?
- ICU routine (visiting hours, bedside rules, parking, accommodation etc.)
- What can relatives do to help?
- What are normal / acceptable readings on the monitors?
- Explanation of sedation
- Who to contact with concerns and questions
- Who are the ICU staff, what are their roles and responsibilities?
- What issues might the patient face during their recovery?
- What are patient diaries and how they can help patients and relatives and how photographs can help the patient understand how ill they've been later on.

When asked if they had any additional comments about what they're told when the patient was first admitted, relatives responded:

- Please repeat information several times. At the time you cannot take it in because of the worry
- A telephone number you can call any time to know how the patient is doing
- Information about visiting times
- Accommodation options if not in a hospital close to home
- Who will be looking after the patient and who to ask about any concerns

Supporting the family is a vital part of the nursing role. Damboise & Cardin (2003) notes the nurses have a professional obligation to try to understand the needs of relatives but that family support should be a multidisciplinary task. It gives the family the ability to continue their vigil (Williams, 2005) and to preserve themselves (eating, sleeping etc) (Hupcey, 1999).

It should be noted that the effect of having a relative in ICU can have a major impact on relatives. Paul & Rattray (2008) note that this can be positive with greater bonding between family members, but can also have less positive sides. These are identified as effects on "quality of life, career and lifestyle for up to 2 years after hospital discharge" (Paul & Rattray 2008: 288). Hence it is important to recognise the needs of relatives.

Whilst the physical environment is important nurses need to also consider psychological and social support for visitors. Wilkinson (1995) found that social support protected relatives against the adverse affects of stress. This social support may come from other relatives but nurses were also an important aspect of social support. Relatives also need access to medical information about the patient and they need their questions answered. Nurses play a vital role in facilitating access to information either verbal or written and to maintaining accurate documentation to allow clear communication and continuity of care. One Swedish study found that relatives felt that whilst they were given good clear answers to questions they had been given too little information by physicians. Relatives also highlighted the importance of constantly knowing what was happening (Karlsson et al 2011). An earlier study by Hinkle et al (2009) supports the fact that relatives required treatment information.

Information staff should have about relatives of patients

As well as knowing what visitors want it is important as professionals that nurses have accurate information about relatives. The expert group reviewed the literature and formal consensus was attained in the following areas:

Establish a main person who acts as a point of contact for other family members, this person will usually be the next of kin or someone close to them. Next of kin is not defined in any legislation, in most cases this will be a person or persons identified by the patient. However in critical care the patient may not be well enough to name their next of kin. In these situations generally close members of the family or a partner may be the next of kin with whom to consult, unless there is some indication to the contrary. In these cases ultimately it is the clinicians who will decide what is in the patient's best interests. The clinicians should always be able to justify how they made their best interest decision (Mental Capacity Act 2005).

Nurses should ensure that they have obtained telephone numbers for relatives so that they can be contacted and have identified the times it is convenient to contact the relatives. When relatives are unable to travel to the hospital to visit the critically ill patient, nurses should identify how much information can be provided over the telephone, and to whom, and that this sometimes requires the need for a password system.

Information relatives should have about the patients

The ICU staff are required to provide information to the patient only, unless that patient has given consent for another person to receive information. However, in the ICU, it is common for a patient not to be able to provide the necessary information. Staff may then ask a member of the family, usually the identified next of kin to provide any information that might help treat the patient. It is helpful to staff if one person can be the main contact, this helps to protect a patients' confidentiality. Further information can be obtained from the following *http://www.ics.ac.uk/patients_relatives/patients_and_relatives*

What staff should do if patients are vulnerable adults?

A vulnerable adult is defined in the 'No Secrets' guidelines:
"A person aged 18 years or over who may be in need of community care services by reason of mental or other disability, age or illness" (Department of Health 2000b: 8)
And
"who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"
(Department of Health 2000b : 9)

This includes patients (and/or their relatives) who:

- Suffer from mental illness
- Are confused or suffer from dementia
- Lack mental capacity and are unable to make decisions for themselves
- Are elderly and very frail
- Are from different cultural backgrounds and with limited English
- Have a physical or sensory disability
- Have a learning disability
- Suffer from a severe and incapacitating physical illness
- Are under the influence of alcohol or drugs
- Are homeless people

All patients who are admitted to ICU can be seen as vulnerable, however where patients or their relatives have vulnerabilities such as those described above it is important to consider these in care planning and communication.
A useful website about the care of vulnerable adults can be found at *http://www.ageuk.org.uk/health-wellbeing/relationships-and-family/protecting-yourself/?paging=false*

Particular resources that may help assist nurses plan care for patients with learning difficulties are:

http://www.keele.ac.uk/nursingandmidwifery/mnphald/guidetousingthetoolkit/guide-to-toolkit.pdf

http://www.mencap.org.uk/page.asp?id=14968

http://www.easyhealth.org.uk content/ hospitalpassport

What staff should do when child protection is an issue?

The Children Act (2004) places a specific statutory duty on agencies such as the NHS to co-operate in the interests of vulnerable children, to provide services for children in need and to assist in enquiries where there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm (Section II Children Act 2004). This requires staff in adult units who may care for children being conversant with the child protection legislation but also considering the implications for children of an adult patient.

What staff should do when cultural diversity is an issue?

When a family member is admitted to an ICU, it is a stressful time; this can be made more stressful if ICU staff are not aware of cultural differences and sensitivities. Although little research is available in this area several authors have recommended the need for culturally sensitive care (Høye & Severinsson, 2010; Marrone, 2008; Simpson & Carter, 2008).

A study by Åstedt-Kurki et al. (1997), exploring the experiences of family members visiting next of kin admitted to hospital identified that over a half 60% (n=21) of family members said that the hospital failed to take into account the family's own customs and daily routine. The authors did not state whether study participants were from varying cultures. However, the results suggest that we may not be sensitive to our own cultural diversity, let alone those with which we may not be familiar. The results of a Norwegian study which aimed to illuminate the experiences of multicultural family members suggest that families struggle to preserve the families' cultural traditions (Høye & Severinsson, 2010). Examples of specific behaviours included not telling the patient they were dying, as culturally it would be inappropriate to tell the truth and the traditional gathering of large family groups to help support each other during a crisis. Practical methods of help included allowing the religious symbols to be displayed and practical solutions to aid communication, where language might be a barrier. The authors concluded there was a need for further research on cultural diversity and family perspectives within the healthcare system. A study surveying nursing staff from New York, suggested that knowledge and prior experience caring for diverse patients and families are a requisite to cultural competency (Marrone 2008).

In addition to this the issue of language and the need for interpreters must not be overlooked. ICUsteps has endeavoured to address this problem by translating their information booklet into several different languages.

Should children be allowed to visit an adult critical care unit?

Dealing with child visitors to the adult critical care environment is a particular source of stress and uncertainty for staff working in critical care areas. Therefore evidence was reviewed in order to try to determine if the visitation of children who have a critically ill loved one is beneficial to both the patient and the child.

Vint (2005) conducted a study involving 46 adult and cardiothoracic ICU's and describes a lack of written policy on children visiting and dearth of resources to support critical care staff in accommodating visiting practice. This was also supported by a Swedish study by Knutsson et al. (2004). The literature exploring the impact for the adult patient offers insight and value in accommodating the child visitor. A visit from a child can offer a diversion, hope and a sense of normality (Halm & Titler 1990) and help them feel safe (Hupcey 2000). Patients found that visits by children maintained their identity (Gjengedal 1994) and that visits are appreciated (Gjengedal 1994, Hupcey 2000; Bergbom & Askwall 2000). There are very few studies analysing patients' perspectives. However, Clarke & Harrison (2001) state that the benefits of a child visiting their loved one may assist in the reduction of the factors that contribute to delirium and post ICU psychosis.

Research exploring the perceptions of child visiting by their parent/guardians highlighted a number of considerations (Knutsson & Bergbom 2007). This research concluded that most visits were initiated by the family and not the critical care staff however the importance of preparation for the child prior to visiting by both the parent and staff was essential.The custodians reported that their child's reactions to the visit differed:

- reactions reflecting happiness but also sadness
- the visit was good for the child; increased awareness of their relative's condition and appreciation of the hospital staff and their work;
- if the visit did not take place the custodian was concerned that the child's well being would be harmed as they would be left with unanswered questions and conjectures.
- their children were not frightened when they saw the equipment and instead they became curious
- older children were more focused on the patient while younger children were interested in both the equipment and the patient

Understanding the psychological needs of the child visitor is an important element in developing visiting policies. Visiting by children will lessen perceived fears if they are allowed to visit as they will develop an increased understanding, and they will not be frightened as they get a sense of relief and joy when able to see their loved one (Knutsson et al. 2008). Children visiting will reduce feelings of separation and abandonment and reduce misconceptions of the environment and may generate questions (Clarke & Harrison 2000). The child who visits is able to make sense of what was happening dependent on their cognitive development (Kean 2010). Children visiting is essential as it will facilitate the ongoing relationship with the family member (Knutsson et al. 2004) and help with the coping of the distress caused by the nature and impact of the critical illness (Cullen et al. 2003).

Nursing staff caring for critically ill patients have a number of concerns when facilitating the visitation of children. They have concerns around the perceived emotional impact a child visiting will have on staff and the patient (Clarke 2000). They fear that visitation of a child will cause stress and exhaustion to the adult patient. Nursing staff also feared that they will not be able to support the child and relative when visiting through lack of knowledge and understanding of how to approach the child and there is a lack of education and resources to support staff to facilitate visitation. Often the decision about whether a child can visit or not is made by others i.e. the nurse in charge (Vint 2004). It is clear from the literature that there is a deficit in the education and resources required to support staff in this area. The reality of facilitating the visitation of the child to the critical care environment proved to be a positive experience for staff. When the benefits to the patient, child and the wider family were observed, staff recognised the value of this

(Clarke 2000). However, there are examples of good practice such as the joint work undertaken by St Georges Hospital and The Royal Marsden in London who have produced a document called 'Should Children Visit?' This takes families through many of the concerns and questions they may have, to enable them to make appropriate choices and provide support to the child.

Should pets be allowed to visit the critical care unit?

In the current era it is difficult to define what a traditional family is or indeed who is the next of kin of a patient. The concept of "family" should reflect societal changes and for some patients this may include their pets (Giuliano et al 1999). A review of the literature suggests that Animal Assisted Therapy (AAT) is reasonably well established in the USA (Connor & Miller 2000 Giuliano et al. 1999, Cullen et al. 2003) and the benefits of pet therapy is long established (Hooker et al 2002). However, the patient's individual pet visiting the ICU remains a very controversial issue. Connor & Miller (2000) suggest that many nurses meet this need by sneaking animals into the hospital or bringing them to a window and the expert panel involved in the development of this Position Statement could provide many anecdotal examples of having done just that.

Connor & Miller (2000) suggest that therapy animals can help orientate patients, improve body image and stimulate comatose patients. Coakley & Mahoney (2009) found that pet therapy improved mood and was meaningful to hospitalised patients whilst Brodie & Biley (1999) and Halm (2008) in their reviews of this subject found evidence of physical, social, psychological and general health benefits.

The main reasons for not allowing visits by pets seems to be spread of infection, either zoonotic disease or cross infection from patient to patient, patient safety in terms of bites from the pet or pet fleas and allergic reactions (Brodie et al. 2002). There is evidence to support the fact that animals do spread infections (Brydon 2008) yet Brodie et al (2002) following their review concluded that sharing our lives with animals, either at home or in hospital, far outweighs the risks. Giuliano et al. (1999) and Connor & Miller (2000) give advice on setting up a pet visitor programme with reference to infection control.

Animals are part of our lives. There is a strong bond between humans and animals and in the 21st century where the traditional family is hard to define some people are more attached to their animal companions than to other humans. Some critically ill patients will have no next of kin or living relatives but live with a much beloved pet. Critical care nurses have to consider if it is justified to let that pet visit as long as it is appropriate and that sensible infection control precautions are taken and the visit is limited to the pet's owner only. The hope and joy raised by the visit of a beloved adult, child or pet might make all the difference to the patient in terms of will to survive.

What education is required by nurses to understand the role and purpose of visiting within adult critical care?

During a recent consultation exercise the Nursing & Midwifery Council (2010) highlighted that family members and carers are an integral part of the health care team. This was cited in relation to pre-registration nurse curricula at degree level. As many Higher Education Institutes (HEIs) are currently writing new pre- registration curricula, it is the perfect opportunity to ensure high visibility of the needs and indeed the contributions that family members and carers can make to the sickest patients within acute clinical areas.

It is generally acknowledged that paediatric intensive care units (PICUs) have for some time optimised visiting of relatives (Endacott 2007) including siblings; a further area that many adult ICUs still struggle with (Plowright 2007). Therefore, it seems logical to utilise their curriculum frameworks of family centred care. Combine this with patient and relative involvement in curriculum development at both pre and post registration level and in ongoing quality monitoring at programme sub-committee level or equivalent; the voice of patient and relative can then be joined with health care professionals to ensure care that is focused around the patient and his/her family.

In the absence of any generic curriculum guidance for post-registration Continuing Professional Development (CPD) it is particularly relevant that National Guidelines such as this Position Statement are incorporated into CPD modules that can contribute towards first degree and masters qualifications. There has been a general call for HEI's to address more intensively the importance of visiting policies and to facilitate the development of higher reflexive competencies (Juchems et al 2008). A primary recommendation of this Position Statement is to appraise the wealth of literature on identifying and meeting the needs of relatives in critical care units together with an opportunity to reflect and debate the tensions involved in moving towards an "open" rather than "closed" visiting policy. This should be embedded into both pre and post registration nursing curricula as nurses are the primary "gatekeepers" in allowing visitor access. It is noted that despite a body of literature emphasising the value of visitation there is a divide between theory and practice (Hunter et al. 2010, Spreen & Schuurmans 2011).

All staff commencing work within critical care units should receive educational input through induction programmes highlighting the needs of family members and how those needs can be met effectively. Effective role modelling by senior staff members can be particularly powerful in educating junior members of the critical care team (Linton & Farrell 2009). Staff also require support and education in relation to receiving child visitors in to the critical care units as highlighted previously (Clarke & Harrison 2001). Strategies to deal with aggression, an emotion which may be precipitated by a variety of factors, should also be incorporated. Nurses need to be educated about the appropriate occasions when to refuse entry to visitors; for example if they are drunk, violent or abusive in line with the NHS's campaign to stop violence against its staff (Slota et al. 2003) Nurses must have the knowledge of how to call local security services.

Ongoing, informal CPD can be facilitated by feedback from follow up clinics, thereby closing the loop; formalised evaluation tools have been devised by Steel et al. (2008) to evaluate individual units practice. Critical care nurses have to ask themselves "who is visiting whom?" and remember that health care institutions and professionals are the visitors in the patients' lives, not the other way around (Giannini 2008).

Conclusion

This Position Statement was developed with the aim of providing evidence for critical care nurses in the United Kingdom to help establish appropriate and evidence based visiting policies. The evidence suggests a disparity between what nurses believe is best practice and what patients and visitors actually want.

In the past visitors were perceived as being responsible for increasing noise, taking up space, taking up nursing time, hindering nursing care and spreading infection (Plowright 1998; Berti et al 2007; Farrell et al 2005; Quinnio et al 2002). The evidence reviewed for this Position Statement suggests there are many benefits to nursing and other staff from visitors. Visitors can provide a great deal of useful information thus enabling nurses to provide more individualised care for patients. Visitors reported that the patient felt safer and more comfortable when they were present. The visitors took on the role of advocate and defender of the patient. They were able to translate, explain and interpret information for both the patient and staff. Family members also used their in-depth knowledge of the patient, including past medical history and wishes to provide information for staff. Family members offered support and encouragement to the patient and participated in care activities (McAdam et al 2008). There was no evidence to suggest that visitors pose a direct infection risk to patients (Adams et al 2011; Fumigalli et al 2006; Tang et al 2009). In addition the evidence suggested there were many benefits to patients from visitors which included psychological well being, protection of rights, aiding in the weaning process and reduction in cardiovascular complications (Happ et al 2007).

In the current era the concept of the family is difficult to define. Nurses must have accurate information about relatives or other visitors and establish a point of contact. Next of kin is not defined in any legislation and the patient may not be well enough to name a person they would like as their next of kin. Nurses also need to be cognisant of guidelines and legislation relating to vulnerable adults, child protection and cultural diversity.

Dealing with child visitors to the adult critical care environment remains a particular source of stress and uncertainty for staff working in critical care areas. There are often no clear hospital guidelines or policies regarding children visiting an adult ICU. The decision to allow children to visit is often made by the nurse in charge and may be arbitrary. In addition the decision may be different on each shift because a different nurse is in charge. The evidence reviewed in this Position Statement suggested visits by children can offer a diversion and help patients feel safe and maintain patient identity (Hupcey 2000); Gjengedal 1994). Critical care staff need support and education to help them facilitate child visitors to the adult ICU and children need to be prepared for the visit (Clarke & Harrison 2001).

Pets visiting the ICU are another controversial area and whilst this position statement is not advocating turning the ICU into a menagerie the judicial facilitation of pets visiting individual owners may provide a massive psychological boost for the patients and remind them of the normality of life outside of the ICU.

The importance of visiting needs to be included in both pre and post graduate education curricula. There has been a general call for Higher Educational Institutions to address more intensively the importance of visiting policies and to facilitate the development of higher reflexive competencies (Juchems et al 2008). All staff commencing work within critical care units should receive educational input through induction programmes highlighting the needs of family members and how those needs can be met effectively. Effective role modelling by senior staff members can be particularly powerful in educating junior members of the critical care team (Linton & Farrell 2009).

This Position Statements sets out the standards patients and visitors should expect when visiting an adult critical care unit in the 21st century in the UK and demonstrates that visitors provide many benefits to patients and staff. Clear policies on visiting practices based on evidence will negate arbitrary decisions by nurses regarding who can visit, and will lessen confusion and dispel myths which can only bring benefits to patients, staff and organisations.

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