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Research paper

Flexible visiting positively impacted on patients, families and staff in an Australian Intensive Care Unit: A before-after mixed method study

Marion L. Mitchell RN, PhD, FACCCN[a,*],
Leanne M. Aitken RN, PhD, FACN, FACCCN, FAAN[a,b]

[a] School of Nursing & Midwifery, NHMRC Centre for Research Excellence in Nursing (NCREN), Centre for Health Practice Innovation, Menzies Health Institute Queensland, Griffith University and Princess Alexandra Hospital, Brisbane, Australia
[b] School of Health Sciences, City University London, UK

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ABSTRACT

Background: The admission of a relative to intensive care is stressful for families. To help them support the patient, families need assurance, information and an ability to be near their sick relative. Flexible visiting enables patient access but the impact of this on patients, families and staff is not clear.
Objective: To assess the impact of flexible visiting from the perspective of patients, families, and Intensive Care Unit (ICU) staff.
Methods: A before-after mixed method study was used with interviews, focus groups and surveys. Patients were interviewed, family members completed the Family Satisfaction in ICU survey and ICU staff completed a survey and participated in focus groups following the introduction of 21 h per day visiting in a tertiary ICU. The study was conducted within a philosophy of family-centred care.
Results: All interviewed patients ($n=12$) positively evaluated the concept of extended visiting hours. Family members' ($n=181$) overall 'satisfaction with care' did not change; however 85% were 'very satisfied' with increased visiting flexibility. Seventy-six percent of family visits continued to occur within the previous visiting hours (11 am–8 pm) with the remaining 24% taking place during the newly available visiting hours. Families recognised the priority of patient care with their personal needs being secondary. Three-quarters of ICU staff were 'satisfied' with flexible visiting and suggested any barriers could be overcome by role modelling family inclusion.
Conclusion: Patients, families and ICU staff positively evaluated flexible visiting hours in this ICU. Although only a minority of families took advantage of the increased hours they indicated appreciation for the additional opportunities. Junior staff may benefit from peer-support to develop family inclusion skills. More flexible visiting times can be incorporated into usual ICU practice in a manner that is viewed positively by all stakeholders.
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1. Introduction

An admission to an Intensive Care Unit (ICU) is a stressful and anxiety producing time for family members,[1–6] as frequently the admission is unplanned and/or life threatening. The needs of families include reassurance, information about their sick relative's condition and prognosis and a desire to be physically near their relative.[7–9] Family members of critically ill patients require information that is consistent and repeated on a number of occasions in recognition that at times of stress, cognitive ability and recall of information may be impaired.[4] Furthermore, communication is consistently cited by families as an important area in need of improvement within critical care areas.[10–13] When these needs are met, the stress and anxiety of family members decrease,[14] and the decision-making processes related to the care of a critically ill relative improves.[15] Restrictive visiting hours limit the ability for health care professionals to meet family members' needs and develop open lines of communication.[4]

Being in close proximity to a critically ill family member is one of the primary needs of families.[9,16] However, family members receive varying levels of access. Staff in paediatric and children's ICU accept and recognise families are integral and a recognised contributor to the child's wellbeing.[17] Yet the same recognition is not universally afforded to families of adult patients, where policies often restrict family interaction by maintaining strict visiting

* Corresponding author at: School of Nursing & Midwifery, 170 Kessels Rd., Nathan 4111, Australia. Tel.: +61 7 3176 7772; fax: +61 3735 5431.
E-mail address: Marion.mitchell@griffith.edu.au (M.L. Mitchell).

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hours.[18] Importantly, ICU patients are extremely ill, vulnerable and frequently unable to make their own health care decisions. Consequently, in collaboration with the medical team, decision-making falls to the family members who need to be well informed and cognisant of available treatment options and potential outcome scenarios. To be well informed, family members need to be present and unrestricted visitation supports this.

A survey of current practices in 206 ICUs in the United Kingdom confirmed that around 80% (n = 164) of the units restricted visiting in regard to both duration and number of visitors at a time.[19] Similarly, in 68–100% of units in various geographical areas of Europe and the United States of America visitation was restricted.[20–25] Sweden was the least restrictive with 30% of ICUs limiting visiting.[26] These restrictions are contrary to evidence of the benefits associated with flexible visiting and are not supported by critical care professional organisation guidelines.[4,27,28]

Flexible visiting practices have the potential to benefit both the family and the patient. Family members can have the proximity they desire at a time that suits them[16] and patients frequently find the presence of their family supportive and comforting.[29,30] Despite limited memory of their time in ICU, patients use words such as "help", "safety" and "comfort" to describe the support their family contribute to their wellbeing in ICU.[31(p193)]

The aim of this study was to understand the impact of flexible visiting from the viewpoint of key stakeholders – patients, family members, and ICU staff.

1.1. Methodology

This study was based on the philosophy of family-centred care where family are seen as partners in healthcare and are valued for what they bring and contribute to the wellbeing of the patient.[4] A before-after mixed method approach was taken, incorporating surveys, interviews and focus groups for data collection from patients, family members and staff. The mixed method enabled a comprehensive understanding of the use of flexible visiting practices.

1.1.1. Setting

The study was conducted in a public general medical, surgical and trauma ICU in Australia with 25 beds admitting approximately 2.200 patients per year.

1.1.2. Visiting hours prior to commencement of the project

The nursing model for the unit was one-on-one care provided by registered nurses (RNs), which is usual practice in Australia but is atypical in some ICU settings around the world. RNs were responsible for all aspects of care including mechanical ventilation. Before the commencement of the project the unit had a closed visiting policy with daily visiting between 11 am and 8 pm.

1.1.3. Instrument

An assessment of family satisfaction using a modified version of the Family-Satisfaction in Intensive Care Unit survey (FS-ICU),[32] to take into account the Australian ICU context had occurred for six months prior to the commencement of flexible visiting. Other instruments were considered, however, the FS-ICU was felt to be closest in terms of language, organisation of ICU and the most appropriate in terms of breadth of items. The selection of this survey is supported by a recent comprehensive systematic review where 27 family satisfaction in ICU instruments were assessed for their psychometric properties.[33] The authors assessed the quality of the instruments using Cohen et al.'s model[34] and found that only four exhibited Level 1 quality. These four included: Molter's Critical Care Family Need Inventory (CCFNI)[9]; Society of Critical Care Medicine Family Needs Assessment[35]; Critical Care Family Satisfaction Survey[36] and the FS-ICU survey.[32] The CCFNI and FS-ICU tools were assessed to have the best psychometric properties.[33] The authors highlighted that the concept of family members' needs being met (as with the CCFNI), does not necessarily equate to family satisfaction which is clearly measured by the FS-ICU survey.[33]

1.1.4. Design of the intervention – flexible visitation in ICU

Extensive consultation was undertaken with all groups of staff and guidelines for family members and staff were developed (see supplementary material). Feedback on the family member guidelines was sought and received from three consumers independent to the project who considered the guidelines to be comprehensive and easily understood. No changes were made. Family members were not incorporated into patient rounds in this ICU and medical officers requested visitor-free time between 8 am and 11 am during their main clinical round. Thus the intervention had patient visiting hours change from 9 h per day to 21 h. University and hospital ethical approval was received before the project commenced. It was carried out with the ethical standards set out in the Helsinki Declaration of 1975.

1.1.5. Data collection

Data were collected from family members, patients and staff:

1. Family members' completed the FS-ICU survey with five added items on flexible visiting, Patients were interviewed, and
2. Staff completed a survey and participated in focus groups.

1.1.6. Family members

Feedback was invited from family members over the age of 16 years with one survey per family. The surveys were in English. Notices were placed in the visitors' waiting room informing them of the project and inviting all of them to complete the survey. A locked box was provided for the return of surveys. Completion of the survey conveyed consent.

A self-reporting survey was used with three sections: demographic data (eight items), items relating specifically to the flexible visiting (five items) and the FS-ICU survey.[32,37] Some of the wording of the items was modified to reflect Australian language and personnel. The FS-ICU survey has two sections – overall care and decision-making. The items have a five point scale with possible responses from poor to excellent.

1.1.7. Patients

Purposeful sampling was used for patient recruitment to ensure a broad cross-section of age, gender, distance of residential location from the hospital and length of ICU stay. Patients needed to be able to converse in English as translators were not available. Potential participants were identified from the ICU discharge list and were approached in the ward by the researcher after confirming with the direct care ward-nurse that the patient was willing to speak with the researcher. Explanation of the study was provided and informed written consent sought.

Demographic data were collected (age, length of ICU stay, admission type, ethnicity) and questions were developed to obtain a patient's view of flexible visiting. These were obtained within two days following their discharge from ICU. The interviews were conducted in the patient's room in the general ward by the first author who played no part, at any stage, in the patient's care. Verbatim notes and comments were made and read back to the participant at the conclusion of the interview to ensure accuracy.

1.1.8. ICU staff

All members of the ICU staff were invited to participate in the study (n = 260). Survey Monkey® provided the platform for the staff survey delivered by internal work email accounts. A reminder email was generated three weeks after the original email communication.

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