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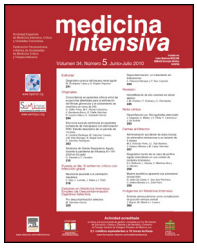

POINT OF VIEW

For an open-door, more comfortable and humane intensive care unit. It is time for change☆

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KEYWORDS
Intensive Care Unit;
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Abstract The Intensive Care Unit is a wonderful place where lives are saved, but it is also a very harsh and unpleasant place where critically ill patients face terrible diseases in very adverse environmental conditions. We must change the design of the ICU and its organization; we must improve privacy, welfare and comfort of patients and families, following their personal and emotional demands. To free up the visiting hours and to improve family care are among our most urging matters, which we should delay no further. We must equip the ICUs with modern monitors and respirators but we must also invest in organization, design, environmental comfort and humanization. We need to redesign clinical practice so that ICU care becomes more agreeable and humane. We should put off this change no longer, since it is an imperative social and professional demand.

PALABRAS CLAVE
Unidad de cuidados intensivos;
Bienestar;
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Opiniones

Por una UCI de puertas abiertas, más confortable y humana. Es tiempo de cambio

Resumen La Unidad de Cuidados Intensivos (UCI) es un lugar hermoso donde se regala vida, pero también es un lugar hostil donde los pacientes se enfrentan a una enfermedad terrible en condiciones ambientales muy adversas. Es necesario adaptar tanto el diseño como la organización de la UCI para mejorar la privacidad, el bienestar y la confortabilidad de pacientes y familias, cuidando especialmente sus demandas personales y emocionales. Abrir las puertas de la UCI liberalizando el horario de visitas y mejorar los cuidados dirigidos a la familia es una de las asignaturas pendientes que no debemos retrasar más. Debemos dotar a las UCI de modernos respiradores y equipos de monitorización, pero también debemos invertir en organización,

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diseño, bienestar ambiental y humanización. Necesitamos rediseñar la práctica clínica para que la atención en la UCI sea más confortable y humana. No se debe aplazar más el cambio ya que es una demanda social y profesional ineludible.

Restricting visits in the ICU is not kind, compassionate or necessary.

Berwick D., Kotagal M.

Introduction

Scientific and technological advances have clearly improved medical practice, but such advances have not been accompanied by parallel progress in its *humane* aspects. Teamwork in hospitals eliminates the role of the single supervising physician and contributes to make medical care more impersonal. Patients are rendered naked physically and metaphorically, and although they are perfectly identified by means of a wristband, they are depersonalized by the system, which forgets about their emotional needs and transforms them into a *medical study object*. Hospitals are hostile places, and the patients and their families experience admission with anguish and concern. In the Intensive Care Unit (ICU) these emotions are intensified in the face of extreme life or death situations. Critical patients need especially humane and comfortable care, since they are very vulnerable and must face terrible illness with great discomfort associated both with the disease process and the structure/organization of the ICU.[1–3] The ICU is a wonderful place where lives are saved, but it is also a hostile place, with too much light and permanent noise caused by respirators, monitor alarms and frequent (and often inadequate) conversations among healthcare professionals. All these cause discomfort, distorted by the administered medication, and lead to greater confusion. The patients moreover suffer pain and fear, with sleeping difficulties and disorientation, and are separated from their families by a restrictive visiting policy.

As early as 1979, Molter[4] drew attention to the fact that professional effort was mainly focused on patient care, with scant attention to family care, and underscored the need to also extend care to the *family unit*–the latter being understood as patient family and friends. In line with this more integrating philosophy, nursing care in the ICU has changed, and is now also being extended to the family unit. Many studies underscore the importance of such change,[5–11] since the family members experience a high prevalence of post-traumatic stress, anxiety and depression.[11] The family needs are *cognitive* (the need to receive clear information on the diagnosis and prognosis), *emotional* (a consequence of sadness caused by the illness), *social* (the need to maintain ties with friends as a source of emotional support) and *practical* (environmental aspects that can improve wellbeing during the stay in the ICU).

Consolation and emotional support of the patient/family should be seen as a fundamental part of our work. We need to provide relief from suffering while encouraging confidence in being able to cope with the disease and with hospital stay, and must improve aspects of our organization with a view to creating a more comfortable and humane ICU.

The open-door Intensive Care unit. Expanding visiting hours

Visiting policy in Spain is very restricted, with a *closed ICU* culture despite the fact that many studies recommend an open-door approach with incorporation of the family to patient care.[12–19] Families demand more time and flexibility in visiting. There is no reason for being restrictive in this regard, and it has been demonstrated that visits improve patient wellbeing, lessen family anxiety and increased perceived quality of care–thereby improving the image and humane dimension of the organization. A freer, expanded and more flexible visiting regimen allows families to adapt patient care to their working obligations and the care of other family members, such as children or the elderly. Closeness to the patient in critical situations or when death is imminent is even more necessary, and is of help in the mourning process. In cases of particularly vulnerable patients such as those with Down syndrome, mental disorders, very young patients or subjects with intense stress, permanent accompaniment by the family should be allowed.

Pediatric visits

Considering the risk of infections and potential psychological trauma, the visiting policy referred to children has been even more restrictive. However, in the pediatric and neonatology ICUs, where visiting is allowed, no increase in infections has been reported.[20] Some studies have found that patients see visits by their small children as a potent stimulus for recovery, and it has been demonstrated that children who have been able to visit their ill relative have been able to better understand the situation and the disease.[20–22] If the patient/family so wishes, visiting by children should be allowed, adopting an individualized approach. This requires organizing the visit, providing information in simple language, offering all professional support for the child, and following a scheme or protocol established according to different age groups.

Different international recommendations consider that family visits should have no restrictions, although logically visiting must be adjusted to the patient desires and clinical conditions.[15,23] Our patients have the right to receive the affection and care of their relatives, and so an open-door policy should be a priority issue in the organization of the ICU.