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# Perceptions of Intensive Care Nurses Regarding Open Visitation Policy in Türkiye: A Qualitative Study

## Türkiye'de Yoğun Bakım Hemşirelerinin Açık Ziyaret Politikasına İlişkin Algıları: Nitel Bir Çalışma

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## ABSTRACT

**Objective:** Patients' families cannot stay with their relatives in intensive care units (ICUs). Consequently, patients and patients' families experience many problems such as insomnia, anxiety, depression. Due to these situations, the recovery period of patient is prolonged and the quality of life of patients' relatives is decreased. To prevent these problems, open visiting policy in ICUs is recommended. Open visiting policy gives patients' families the opportunity to visit their relatives at any time. This policy is recommended by studies, but is not widely implemented in Türkiye. Some reasons are responsible for not applying this policy. The study was conducted to determine the perceptions of intensive care nurses about an open visitation policy.

**Methods:** The study group consisted of 14 intensive care nurses selected through purposive sampling. Data were collected using a semi-structured interview form, and the interviews were recorded with a voice recorder. Data analysis was performed by content analysis.

**Results:** Based on the research results, "opportunity to feel family presence," "barriers to open visitation," and "facilitators of open visitation" themes were identified. Participants generally evaluated the open visitation policy positively. However, it was noted that certain arrangements were needed for the implementation of open visiting policy.

## ÖZ

**Amaç:** Hastaların aileleri yoğun bakım ünitelerinde (YBÜ) yakınlarıyla birlikte kalamaz. Bu nedenle hastalar ve aile üyeleri uykusuzluk, anksiyete, depresyon gibi birçok sorun yaşarlar. Bu durumlar nedeniyle hastanın iyileşme süreci uzar ve hasta yakınlarının yaşam kalitesi düşer. Bu sorunları önlemek için YBÜ'de açık ziyaret politikası önerilmektedir. Açık ziyaret politikası aile üyelerine yakınlarını her zaman görme fırsatı verir. Bu politika literatürde önerilmektedir ancak Türkiye'de uygulanmamaktadır. Bu politikanın uygulanmamasının bazı nedenleri vardır. Çalışma yoğun bakım hemşirelerinin açık ziyaret politikası hakkındaki algılarını belirlemek amacıyla yürütülmüştür.

**Yöntemler:** Çalışma grubu amaçlı örnekleme yoluyla seçilen 14 yoğun bakım hemşiresinden oluşmuştur. Veriler yarı yapılandırılmış görüşme formu kullanılarak toplanmış ve görüşmeler ses kayıt cihazı ile kaydedilmiştir. İçerik analizi kullanılarak veri analizi yapılmıştır.

**Bulgular:** Araştırma sonuçlarına göre, "aile varlığını hissetme fırsatı", "açık ziyaretlere yönelik engeller" ve "açık ziyaretleri kolaylaştırıcılar" temaları belirlendi. Katılımcılar genel olarak açık ziyaret politikasını olumlu değerlendirdiler. Ancak açık ziyaret politikasının uygulanması için bazı düzenlemelere ihtiyaç duyulduğu belirtildi.

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**ABSTRACT**

**Conclusion:** Overall, participants favored open visitation; however, consistent with the literature, successful implementation requires structural (single rooms, privacy), staffing and policy arrangements.

**Keywords:** Family presence, intensive care nursing, intensive care unit, open visitation, patient, content analysis

**ÖZ**

**Sonuç:** Katılımcılar genel olarak açık ziyareti tercih ettiler; ancak literatürle tutarlı olarak, başarılı bir uygulama yapısal (tek kişilik odalar, gizlilik), personel ve politika düzenlemeleri gerektirir.

**Anahtar Kelimeler:** Aile varlığı, yoğun bakım hemşireliği, yoğun bakım ünitesi, açık ziyaret, hasta, içerik analizi

## Introduction

For patients and their families to see each other, a restricted visitation policy is applied in most of the intensive care units (ICUs), and short-term patient visits are allowed at certain time zones of the day. In case of an emergency, the already limited visits can be prevented altogether for a while (1).

The restricted visitation practice has many negative effects on both patients and their families (2-8). To eliminate the negative effects of restricted visitation, an "open visitation" policy has been introduced. Based on the definitions, by open visiting, family or support person, as defined by the patient, has unrestricted access to the patient 24 hours a day, 7 days a week (24/7) in the ICU (7,9-11). Some countries practice an open visitation policy in their ICUs (12). A study conducted in Brazil showed a positive correlation between visitation length and the satisfaction level of the patient's families (7). Various studies have also reported that an open visitation policy helps reduce the incidence of delirium, length of ICU stay, and anxiety in patients (4,13). On the other hand, open visitation has also led to negative situations such as increase in the incidence of burnout among health professionals in the ICU (4,7). Impact may vary depending on context (physical conditions, personnel, policy).

Despite the predominant positive effects of an open visitation policy, some factors can prevent it from being implemented in most ICUs. Some of the barriers are unsuitable physical conditions within the ICUs, insufficient staff, patients' families not acting in accordance with visitation rules or having excessive expectations, patients' families' behaviors that put patient safety risk, negative attitude of health care professionals toward open visitation, and the opinion that open visitation disrupts the daily routines within the ICU and may cause infection (11,14,15). On the other hand, establishment of private rooms for patients in ICUs, legislation of specific internal regulations for families' open visiting and considering nursing as a humanitarian profession facilitate open visiting (14). Yakubu et al. (10) reported that the nurses preferred restricted visitation practices. The study conducted by Alonso-Rodríguez et al. (16) reported that although health care workers believed against an open visitation policy, they thought that open visitation would benefit patients and their families.

Türkiye is a country where open visitation is not practiced in the ICUs. Staff shortage, inappropriate structure of ICUs for open visiting, organizational policies, infection risk, attitudes of patient families towards open visiting and inadequate knowledge and practice level of families regarding intensive care are the reasons not to be applied open visiting policy in Türkiye (1). Besides it is known that the attitudes of health care professionals working in intensive care have a significant impact on the implementation and maintenance of the process.

However, a limited number of articles have been published in the field of intensive care patient visits in Türkiye. Although some of them are reviews, the studies conducted were about the expectations of patients' families who had patients in ICUs in Türkiye regarding patient visits (17,18). Patient visits are very common in Türkiye due to religious and cultural beliefs, therefore, the restricted visitation policy can also cause great difficulties among nurses and family visitors. In light of this information, it is aimed to determine the perceptions of intensive care nurses toward an open visitation policy.

## Methods

### Research Design

A qualitative content analysis approach was used in this study.

### Sample and Setting

In this study, the participants were chosen by using the maximum diversity sampling method, which is a purposive sampling method in state hospitals, university hospitals and private hospitals.

The study group consisted of nurses who had at least one year of intensive care nursing experience and voluntarily participated in the study. Participants with different sociodemographic characteristics (such as age, gender, marital status, work duration, etc.) were included in the sample to create different situations or maximum variety. The study group consisted of nurses working in the ICUs of different types of hospitals (city hospital, training and research hospital). Not wanting to participate in the study was a criterion for exclusion, but we did not encounter such a situation.

### Data Collection Tools and Data Collection

The authors had experience in collecting data, conducting and analyzing qualitative research. Data were collected using a form for descriptive characteristics and another for a semi-structured interview.

### Descriptive Characteristics Form

This form collects data regarding the descriptive characteristics of the participants and includes seven questions describing age, sex, the mean work duration in the profession, the mean work duration in ICU, experience of being a patient in an ICU, having

a family member in the ICU and the ICU where the participant was working.

**Semi-structured Interview Form**

This consists of four open-ended questions prepared to determine the participants' perceptions on open visitation by utilizing relevant sources (1,10,14). The questions are provided below. What do you think about the effects of open visitation on patients?

• What do you think about the effects of open visitation on patients' families?

• What do you think about the effects of open visitation practice on nurses/health staff?

• What do you think about whether open visitation should be implemented or not?

**Data Collection**

Data were collected by the second and fourth authors (A.S. and V.D.) through semi-structured interviews. A.S. is female and her credential is PhD. V.D. is male and he is a registered nurse. A.S. is academical personal at the time of the study while V.D. is nurse. The study group consisted of 14 nurses. There was no relationship between authors and participants prior to the study commencement. The intensive care nurses were called by phone and informed about the study and that the interviews would be recorded. Appointments were made for a semi-structured interview from the nurses called by phone. On the appointment day, the purpose of the meeting, how it would be done and the audio recorded explained again. The participants' consent was then obtained. The interview was conducted in a room suitable for interviewing in the hospital, where only the researcher and the interviewer were present. Smartphones were used to record audio in the interviews.

The research questions were directed to the nurses and they were asked to answer them.

In qualitative research, when the concepts and processes obtained begin to repeat each other, sampling adequacy is confirmed (19). For this reason, data collection continued until the stage when concepts and processes that could answer the research question started to repeat. Three additional interviews confirmed saturation; no new codes emerged; these were excluded from analysis but documented in the audit trail. The interviews were terminated when the nurses had nothing more to say. Then the authors validated the transcripts with the participants. Although the interview duration with each participant varied, the average interview duration was 35 minutes.

**Data Analysis**

Content analysis can be used in a deductive or inductive manner depending on the purpose of the research. Inductive content analysis was used in our study. The first transcriptions of all interviews were made by the fourth researcher. In this step, the audio recordings kept during the interview were listened to, written verbatim without any changes, and summarized (20). Considering all the written content, the titles in the text were read repeatedly and the comments of the participants were received. Categories for the similar or different titles of the participants' statements were created independently by the first and third authors (E.B. and S.K.), and the resulting categories were compared. Coding was done by focusing on these categories. Then, the codes that were close to each other were reviewed again and 3 main themes were created (Table 1). Finally, the research findings, which included more specific descriptions and quotes from the participants, were written.

Statistical analysis was not used in this study.

**Ethical Considerations**

Approval to conduct the study was obtained from the Ethics Committee of Artvin Çoruh University (approval no: E-18457941-050.99-41529, date: 02.03.2022). In addition, each participant was informed about the purpose of the study and that the interview would be recorded with a recording program and informed consent of the participant was obtained. Informed consent was obtained and audio-recorded prior to each interview.

**Reliability of the Research**

In this study, triangulation technique was used to ensure reliability. The data were independently coded, analyzed, and interpreted by E.B. and S.K., the authors. E.B. and S.K. are PhDs too. The authors then compared their perspectives until they agreed on the best interpretation. This method reduced the possibility of researcher bias (21). In order to represent the data accurately and meaningfully, the themes and sub-themes were read over and over by the research team and finalized. Finally, transparency was achieved using reflexivity (22). The guidelines

**Table 1.** Main and sub-themes

| Main themes | Sub-themes |
|---|---|
| Opportunity to feel family presence | Supporting the patients emotionally |
| | Supporting the patients' families' emotionally |
| Barriers to open visitation | Burden of unlimited visits |
| | Unfavorable physical structures and insufficient number of personnel |
| | Risk of not protecting patient safety |
| Facilitators of open visitation | Providing training |
| | The human aspect of nursing profession |

for Consolidated Criteria For Reporting Qualitative Research checklist was followed.

**Rigor and Trustworthiness**

For the internal validity, the semi-structured interview form was created based on the literature. For external validity, the participants were informed about the research process, including the purpose of the research, its model, data collection method, and data analysis; additionally, interviews were held with the voluntary participants using a purposive sampling method to determine the events and facts as well as their varying features. For internal reliability, all the findings are presented directly in the text without adding any comment; also, the analysis of the data was carried out independently by the two researchers, and then the suitability of the themes was examined, and it was seen that they matched at a high level; and for external reliability, two experts were consulted about the raw data, coding, themes, and findings for confirmation.

## Results

The mean age of the participants was 31.86±6.84 years (range, 24-45 years). Of the included participants, 78.6% (n=11) were female. The mean work duration in the profession was 11±8.80 years, and the mean work duration in ICU was 9.57±7.43 years. Moreover, 64.3% (n=9) of the participants were working in the anesthesia and reanimation ICU. None of the participants had been treated in the ICU and had a family member in the ICU.

The three main themes and eight sub-themes generated as a result of the research are provided in Table 1.

**Opportunity to Feel Family Presence**

This theme was divided into two sub-themes: supporting the patients emotionally and supporting the patients' families' emotionally.

**Supporting the Patients Emotionally**

Being away from patients' families and not being able to see them increase patients' anxiety. Given that patients and patients' families are part of a whole, the individual should be in a physiological and emotional balance. The majority of participants (n=13) stated that when patients saw their families, they relaxed, felt safe, calmed down, and were discharged from ICU faster. Participants stated that open visits would allow patients to see their families more often. In addition, the participants stated that seeing the family would be good for the psychological health of the patients.

*"They feel safe, they can express their problems more easily, and it is of course better to have a family for privacy, patients are not ashamed in front of their families. Also, they can express their problems better without hesitation."* [Participant (P) 2]

*"Patients in intensive care usually show signs of agitation and delirium. Even after limited visits, I can see that these have diminished. Open visitation will make patients feel better psychologically."* (P7)

Some participants (n=3) stated that the patient's condition and the emotional state of the patient's families could negatively affect the patients during the visit.

*"If the patient family is agitated or if the patient family is more hopeless than the patient and will wear the patient down, then no visit should be made."* (P6)

**Supporting Patients' Families Emotionally**

There are feelings of fear, anxiety and curiosity between the family waiting outside the ICU and the patient inside. In the ICU, patients' families need to see, support, and be close to their patients. The majority of participants (n=13) stated that the visits calmed the patient families, increased their confidence, and relieved their anxiety. The participants also noted that open visitation could provide rest for patient families.

*"Seeing the patient and seeing where the patient is calm down the patient's family. Because they leave their patients in an enclosed place (means intensive care). That's why they don't have a clear picture of what might happen inside. When they see that their patients are being treated, cared for and in a safe environment, the patients' families obviously calm down. The unknown no longer exists."* (P1)

*"It is also good for the patient family as the patient sees many people and there is a constant circulation. Since the companion constantly changes, patient families can have a rest. Since they can rest, they can support their patient better."* (P5)

Some participants (n=3) also stated that open visitation might negatively affect the patients' families.

*"Seeing every moment of the patient whenever they want to, having opinions about what they don't know may lead to negative emotions."* (P9)

**Barriers to Open Visitation**

Participants' views on the barriers to open visitation were divided into three sub-themes: the burden of unlimited visits, unfavorable physical structures and insufficient number of personnel, and the risk of not protecting patient safety.

**Burden of Unlimited Visits**

Nurses who take care of the intensive care patient face many stressors caused by the characteristics of the unit, while on the other hand, they have to deal with the problems of patients and their relatives. The majority of the participants (n=13) stated that the workload in the ICU was excessive and dealing with patients' families with open visitation may increase their workload and make them feel like they are being observed.

*"We may also feel as if we are being observed by patients' families all the time."* (P3)

*"When patients' families pay a visit, we have to accompany them... Open visitation is a practice that will tie the hands of health workers."* (P4)

*"Case management will be difficult when a sudden event develops. This increases the workload of the staff."* (P8)

Some participants (n=4) noted that increased workloads due to open visitation could lead to disruptions in treatment and care.

*"When there is an emergency intervention, it will be difficult to manage patients' families. There will definitely be a need to relieve the anxiety experienced by patients' families and to comfort them. Then, intervention to the patient might be delayed."* (P9)

**Unfavorable Physical Structures and Insufficient Number of Personnel**

The suitability of the physical structures of an ICU and the number of staff can determine the applicability of an open visitation policy. Most participants (n=9) stated that open visitation was not feasible due to the unfavorable physical conditions of the ICU and limited number of nurses.

*"The number of patients we have to take care of is very high. We are few nurses. If larger areas, larger opportunities were created, perhaps open visitation could be implemented. I also think if patients were in larger single rooms open visitation could be introduced."* (P3)

Some participants (n=3) stated that the language difference among migrants in Türkiye posed a problem in communication, which may constitute a barrier to open visitation.

*"There is a language difference in our country. We are a country receiving migrants. This is a huge obstacle for the open visitation system. Let our native people come and see their patients, ask their questions during that time and I will answer them, it will take me 5 minutes. However, with someone who speaks a different language , this can take me 1 hour."* (P4)

Some participants (n=3) pointed out that violence in health care was increasing and health workers were afraid. They also noted that violence could be a barrier to open visitation.

*"There is a lot of violence against health workers. Now we are afraid. The physician is also scared, the nurse is also scared. This is an obstacle to open visitation."* (P13)

*"Some families of patients can cause unrest. Patients get even worse. Families can shout and scream. There is verbal violence, and sometimes we are even exposed to physical violence."* (P11)

Most of the participants (n=11) emphasized that open visitation could be possible after proper planning of the physical conditions of the ICU, increasing the number of staff, and taking appropriate measures.

*"Under current conditions of our country, if the physical conditions and the shortage of nurses are improved, maybe it can be done, but security measures should also be taken."* (P10)

*"...In the area, there are beds separated by curtains. We try to provide privacy with a curtain. Patients' families will not be as comfortable when there is open visitation. We won't be comfortable either. Because sometimes those curtains are not enough when treating or intervening with another patient. There should be a room for each patient and a nurse to accompany the patients' families."* (P12)

**Risk of Failure to Maintain Patient Safety**

Patients hospitalized in ICUs are at higher risk for medical errors and patient safety. Patient safety covers practices such as correct identification of patients, ensuring safe drug administration, reducing the risks caused by falls and ensuring medical device safety. Most participants (n=8) stated that open visitation could increase infection, decrease privacy, and jeopardize patient safety by failing to accompany patient families due to insufficient staff.

*"Open visitation can negatively affect patient privacy. Because the patient might be receiving care and an intervention might be carried out. When patients' families visit, they will be allowed to see every patient. It applies to isolated single rooms as well. Because the rooms are single but with glass. We can see the patient inside. It will violate privacy during care or an intervention."* (P9)

*"Infection is more likely to develop in an open visit. Carrying infection both from the inside out and from the outside in will be more likely."* (P12)

*"...Without realizing it, a patient family may unknowingly disconnect a patient's vital machine. During any IV application, their hand may touch, pull, tear some part and they may not notice it."* (P13)

**Facilitators of Open Visitation**

The views of the participants on the applicability of open visitation were divided into two sub-themes: providing training, and the human aspect of nursing profession.

**Providing Training**

By education, it may be possible to create a way of thinking, concepts, beliefs, attitudes, behavior and lifestyle about health and to change in health culture. Some participants (n=6) emphasized the need to raise public awareness on open visitation procedures and provide training to both health care professionals and patients' families/community on what should be followed during open visitation.

*"The negative attitude of health workers toward open visitation can be changed. For this, it is necessary to provide the necessary infrastructure and train the personnel on the subject first."* (P8)

*"Patients' families and health care personnel need to be informed about the issue, and trainings on the subject need to be planned."* (P9)

**The Human Aspect of the Nursing Profession**

Nursing has not been defined as a profession that gives physical care only in any period of the history of nursing. The spiritual peace and pleasure that nurses feel in giving individual care to individuals stems from the respect for the human rights in the nature of the profession and the value of human rights. Some participants (n=6) stated that open visitation would make them feel good spiritually.

*"...we would become out of robotization and we would feel better spiritually..."* (P3)

*"Some people come and pray. That's enough for us, really. The spiritual side is very sufficient for us. They say good things, they wish us well."* (P11)

*"Patients are more determined, they try much harder to get better and they are happier. Their happiness makes us happy too."* (P6)

## Discussion

The absence of patients' families in ICUs facilitates physiological and psychological problems in both patients and their families (5,23,24). Participants who participated in this study said that both patients and their families would be emotionally supported. According to a number of studies, nurses believe that family presence is a supportive factor for patients and their families (16,25,26). da Silva Ramos et al. (27) found in their study conducted among ICU staff that more than half of the team members thought that open visitation would accelerate patients' recovery and reduce patient anxiety.

The idea that open visitation will have positive effects on patients and their families is mentioned in the literature (16). Increased emotional support is expected for both patients and families. But there are some obstacles to implementation. They are infrastructure, personnel and security. Despite the prevalence of this idea, open visitation cannot be practiced in ICUs. In our study, participants expressed that the increased workload caused by open visitation, the unfavorable physical conditions within the ICU, the insufficient staff, and the risk of not being able to maintain patient safety hindered the implementation of an open visitation policy. Consistent with our findings, one study showed that according to the intensive care professionals, excessive expectations of families, staff shortages, and the physical structure of the ICU were among the barriers to the implementation of an open visitation policy (14). Similarly, various studies found that the physical structure of ICUs was not specifically designed to protect patient privacy and the possibility of behaviors that may pose a physical threat to the patients by their families constituted an obstacle to open visitation (27-30). Milner et al. (31) found that the frequent entry and exit of some patients' families into and out of ICUs and interruption of patient care were obstacles hindering the switch to an open visitation policy. In a different study, according to more than half of intensive care nurses, patient safety could be better ensured with an open visitation policy (15). In our study, some participants pointed out to violence in health and emphasized that health workers were afraid. They also stated that violence was an obstacle to open visit. Almost 38% of health workers are subjected to physical violence at any time period of their working lives (32). Violence against health workers is performed by most patients or visitors. While violence in health is most commonly defined in North America and the United Kingdom, recent research states that there are similar violence and characteristics in other parts of Europe, Asia, Africa and Australia (33). In a meta-analysis, Liu et al. (34) stated that 42.5% of health workers were exposed to non-physical violence by patients and visitors and 24.4% were subjected to physical violence in the last one year. Contextual differences (room type, visiting protocol, security measures, cultural expectations) determine outcomes.

In our study, the participants identified the physical structure of the ICU, shortage of personnel, increased workload, and risks to patient safety as barriers to open visitation and stated that the implementation of an open visitation policy could be made easier by organizing training programs and improving infrastructure. They also stated that the human aspect of nursing was a facilitating factor in open visitation. A study, whose findings were similar to ours, found that the organization of the physical structure of ICUs to provide private spaces for patients and the presence of consultant health personnel to provide information regarding the patient to the family were factors that facilitated an open visitation policy (14). Zupanets et al. (35) found that an open visitation policy could be implemented by training both health personnel and families.

### Implications for Nursing and Health Policy

This study focused on the perceptions of intensive care nurses. But, patients and their relatives are the other important parts of this process. So, to apply open visiting policy, new studies to investigate patients' and patients' families' thoughts should be conducted. Also, by making arrangements in ICUs, this policy can be integrated in ICU visiting process in Türkiye.

### Study Limitations

In our study, most of the nurses working in the ICU consisted of young nurses. This is the first limitation of our study. Because age may be an important factor for this study. On the other hand, studies on the open visitation policy in Türkiye have been quantitative in nature. In our study, a complex issue that was not recognized or defined in Türkiye was discussed. Another limitation of our study was that this study was conducted after coronavirus disease 2019 pandemic. So, it is not known that if the nurses' attitudes towards open visiting have changed. The strengths of our study include its qualitative design and information regarding the perceptions of intensive care nurses regarding the open visitation policy.

## Conclusion

Our study showed that intensive care nurses generally viewed the open visitation policy positively, but its applicability remained limited without ensuring physical infrastructure, staffing, security and training requirements. To apply open visitation policy, there are some recommendations:

- Single patient rooms should be created in ICUs.
- Patient families should be trained on open visits.
- More nurses should be assigned to inform patient families.

### Ethics

**Ethics Committee Approval:** Approval to conduct the study was obtained from the Ethics Committee of Artvin Çoruh University (approval no: E-18457941-050.99-41529, date: 02.03.2022).

**Informed Consent:** The participants' consent was then obtained.

**Footnotes**

**Authorship Contributions**

Design: E.B., A.S., S.K., V.D., Data Collection or Processing: E.B., A.S., S.K., Analysis or Interpretation: S.K., Literature Search: E.B., A.S., S.K., V.D., Writing: E.B., A.S., S.K., V.D.

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