VISITING TIMES

Sadia Ismail and **Graham Mulley** discuss the evolution of rules about visiting patients in hospital

From 2 pm they gather at the entrance to the ward, occasionally drifting through the doors, only to be reminded by sister that "visiting starts at 2 30 pm." Doctors cower in the office, completing paperwork and dreading that journey to the bedside for a drug card, fearing they may pay the price with a long tirade from a patient's relative. Nurses rush from one patient to another, trying in vain to complete the afternoon drug round. An eager student nurse rings the bell to indicate end of visiting, causing a collective sigh of relief.

Many health professionals will recognise this scene. Visiting sick people in hospital has always been comforting to patients and reassuring for visitors, but restrictions have been the subject of emotive debate (newspaper cutting). Over the past three centuries patterns of limitations on visiting have varied widely, from open policies to more restricted ones. We have used various terms to describe these restrictions (see box).

Patient choice is increasingly a driver for improvements in the National Health Service and is specified by the Department of Health as a priority. Making patients partners in decisions on visiting can, however, lead to conflict when relatives want unrestricted visiting but managers and clinicians prefer limitations because of concerns about disrupting clinical care.

We studied published histories of several UK hospitals, which gave us an intriguing sample of visiting policies from the 18th century onwards. We also undertook a literature review to determine why restrictions have changed so much and what may be considered the optimal pattern of visiting.

Definitions of visiting types

Open visiting—visiting at any time and of any duration (for example, in hospices, intensive care units, paediatric wards)

Restricted visiting—visiting bounded by rules on timings, duration, and number of visitors or who can visit

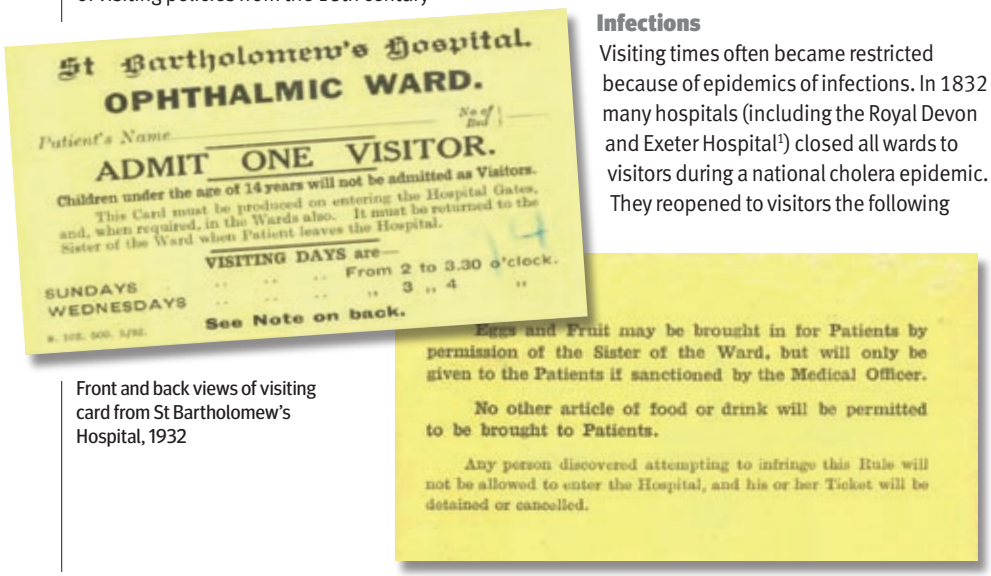
Flexible visiting—visiting with some restrictions but which can be altered according to needs, choice, and circumstances of patients and visitors

Historical context

In the 1700s and 1800s many hospitals had few restrictions on visiting—for example, the Royal Devon and Exeter Hospital had open visiting.[1] In 1767 regulations were introduced at St Bartholomew's Hospital, allowing visits of up to one hour a day.[2] Leicester Royal Infirmary limited duration of visits to two hours, with special arrangements being made for the visitors of dying patients.[3] Other hospitals were more authoritarian: Doncaster Royal Infirmary allowed visiting three afternoons a week in the 1870s[4] and the Royal Berkshire allowed only 15 minutes twice a week.[5]

Infections

Visiting times often became restricted because of epidemics of infections. In 1832 many hospitals (including the Royal Devon and Exeter Hospital[1]) closed all wards to visitors during a national cholera epidemic. They reopened to visitors the following year, four weeks after the last case. Measles and smallpox outbreaks in Doncaster led to the Royal Infirmary closing to visitors in 1883,[4] and a scarlet fever epidemic in 1887 resulted in St Bartholomew's restricting visiting to one hour a week.[2] In more recent times hospitals have been closed to visitors during the outbreak of severe acute respiratory syndrome.



Front and back views of visiting card from St Bartholomew's Hospital, 1932

Visiting cards

Visiting cards were introduced in Leicester Royal Infirmary in 1787[3] and in St Bartholomew's Hospital in 1894[2] as a means of restricting numbers of visitors. The card stated the patient's name, ward, and bed number; it allowed one visitor aged more than 14 years and had to be presented on each visit and returned on the patient's discharge (figure).

Some hospitals used passes on particular days,[6] some used passes colour coded for the ward,[7] and some even charged nominal fees for visiting. Doncaster Royal Infirmary[4] introduced visiting cards as late as 1924.

Children

In some hospitals, visiting cards stated that only older children could visit.[2] In 1952 Harefield Hospital did not allow any child visitors[6]—they had to wait in the memorial hall.

Restrictions were supposed to protect the children from stress and the patients from infection—especially in intensive care units. A survey of intensive care units in the United States in 1984 showed that only 11% allowed visits from children, including immediate family.[7] Even on general wards child visitors were discouraged because of concerns about "poorly supervised children" left under the responsibility of nursing staff or patients.[8]

Evidence of the benefit to children of visiting is clear; children who visit critically ill relatives show fewer negative changes in behaviour and emotions and are more prepared for any loss than those who are not allowed visiting.[9] Not visiting also increases the stress and fear of hospitals.

Despite these advantages to the family unit, children still seem to be targeted first in any increased restrictions on visiting. In 2006 an author noted that during a norovirus outbreak rather than banning those with symptoms or a contact history from visiting, children were specifically banned.[10]

The past 50 years

At the inception of the NHS in 1948, many hospitals had stringent visiting policies,[11] even for younger patients; parents were thought to unsettle their children by visiting them.[12]

The impetus for change was the Platt report in 1959.[13] This outlined the case for open visiting in


examination as NHS trust changes hospital visit times

York Hospital is cutting its visiting times to pay more attention to deadly diseases such as MRSA and the cleanliness of the hospital. What does the public think?

Patients' fury as visiting hours cut

Visiting hours is an emotive topic (*York Press* 25 August, 2007)

children's wards to improve the emotional and mental health of the children and to prevent isolation from the family. The attitudes of better informed and more inquisitive parents also influenced visiting policies. With greater emphasis on patient centred care, more open visiting policies again became accepted practice in both adult and children's wards.

Change, however, was slow. An article in the *Nursing Times* in 1970[14] referred to a normal pattern of visiting as one hour on three afternoons a week and 30 minutes on four evenings a week.

In the 1980s and 1990s many hospitals started restricted visiting again. This was in response to nursing staff, concerned that disruption by and demands of visitors could interfere with the running of wards and hamper patient care. Other concerns were about privacy and stress levels of patients and confidentiality during ward rounds.[15]

A letter to the *BMJ* in 1988[15] described open visiting at Arrowe Park Hospital as a disaster; "because of abuse of the system by visitors. Many would arrive promptly at 8 am and stay all day. They would bring sandwiches and flasks . . . and camp out by their relative's bed . . . Others would eat patients' food, ask for extra cups of tea etc." Visiting was soon restricted to two short periods a day.

Standard restrictions currently include two visitors per patient; having afternoon and early evening visiting only; and not allowing visiting during meal times, ward rounds, or ward cleaning.

Evidence

The Patients' Charter[16]—produced by the Department of Health to define what patients can expect from the NHS—states that flexible visiting hours improve patients' experience. Many think, however, that this would undermine the practicalities of running a ward. Often, visiting hours vary between wards in the same hospital and there seems to be little consensus about what is best. A 1988 survey showed significant regional variation in UK visiting policies.[17]

Several studies have focused on visiting in relation to critical and coronary care.[8-10 18-20] Patient centred care is particularly important in these areas, where allowing time for adjustment can improve the emotional health of the whole family.

One research team[18] did a survey of visitor and nursing satisfaction with an open visiting policy and found the same conflict of patients' care needs compared with patients' and relatives' emotional needs. They found that nursing staff allowed more flexible visiting depending on patient and family needs and circumstances. They suggested this informal arrangement could be formalised by visiting contracts agreed between nursing staff, patients, and the family. These would be clearly documented but would rely on cooperation rather than enforcement.

Another study[9] found that intensive care units restricted visiting either in time, number, or type of visitors. They also suggested that contracts may be the happy medium between rigidly enforced policy and lack of regulation.

A survey in 2005 during an open visiting policy found that patients and visitors appreciated flexibility of hours but preferred a quiet hour with no visiting, and uninterrupted mealtimes.[8] Conversely, most staff preferred set times with little flexibility.

Why do staff members have such different preferences to patients and visitors? This may in part be a result of negative perceptions of visitors and bad experiences.[8] One author[19] stated three concerns of doctors and nurses about open visiting as increased physiological stress, physical and mental exhaustion of the patient, and interference with provision of care. Some of these concerns are unsubstantiated; some evidence suggests that stress, measured by heart rate and blood pressure, is reduced by the presence of close family members.[19]

A recurrent concern is that of infection control. A pilot randomised study showed, however, that despite increased quantities of bacteria in an intensive care unit during open visiting, similar rates of sepsis were found and also a reduction in cardiocirculatory complications.[20] They postulated this may be due to decreased anxiety resulting in favourable hormonal profiles in these patients.

SUMMARY POINTS

- Patterns of limitations on visiting patients have varied over the past 300 years
- Patients, relatives, and health professionals have different opinions about who should visit and when
- One solution may be visiting contracts that are agreed on admission

Conclusions

The evolution of visiting hours has fluctuated from open visiting, to restrictions to suit health professionals' priorities, to patient centred and family centred visiting. Many health professionals continue to have concerns about patient stress, risk of infection, and the practicalities of running a ward if visiting is unrestricted.

It seems strange that close family members may be seen as interfering with provision of care. Surely most would understand and encourage the optimum delivery of care? Indeed some would be happy to participate in the nursing and personal care of their relative, including feeding at meal times.

We believe that a shift in culture is needed to ensure the best practice on visiting policies. Any visiting restrictions should be based on mutual respect and consideration. Health professionals should consider the rights, worries, and needs of patients and their families, and visitors need to understand the roles and pressure on staff and the needs of patients other than their own relative. Perhaps patients' control of their visiting hours in the form of a contract may help, and this merits formal study.

A balance needs to be struck between patients' and relatives' emotional needs and the need to carry out clinical duties. It is often during visiting time when staff can connect with patients and their carers. This can lead to new perspectives on a patient's home and social circumstances and greater understanding of the interactions and dynamics of the family. Ultimately, flexibility in visiting hours and mutual understanding will lead to more satisfied visitors.

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