Restricted Visiting Hours in ICUs
Time to Change

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THE SICKEST PATIENTS LIE IN INTENSIVE CARE UNITS (ICUs) facing fearful illness; surrounded by overwhelming noise from pulsating ventilators and monitors; invaded by the necessary ministrations of nurses; and overhearing, if they are awake, strange and portentous conversations. Professionals buzz about them, but these patients are mostly alone, separated from those who love them by restrictive ICU visiting policies, except at rigidly specified times or with the doled-out permission of the ICU staff. Restricting visiting in ICUs is neither caring, compassionate, nor necessary.

Restricted hospital visiting hours began in the late 1800s for nonpaying patients in an attempt to establish order in the general wards.[1] For many decades afterward, paying patients remained free to have visitors at almost any time in their private or semi-private rooms. In the 1960s, however, in an effort to protect the patient and the family from exhaustion caused by too many visitors (Kenneth Ludmerer, MD, Washington University, oral communication, April 23, 2004), hospitals instituted visiting hours broadly for both paying and nonpaying patients in ICUs (which were then being introduced) and the general wards.

Today, most hospitals have liberalized visiting policies on intermediate care units, but strict ICU visiting hours are enforced despite increasing awareness that families have an active role in care, and despite increasing recognition among hospital staff of the rights and abilities of patients to make informed decisions. Perhaps the question to be answered is "Who is visiting whom?" In an effort to stabilize the details of ICU operations, health care institutions and professionals neglect the plausible assertion that they are the visitors in patients' lives, not the other way around.

Several months ago, the Institute for Healthcare Improvement (IHI) challenged a number of hospitals working on improvement of care to open their ICUs by instituting a totally unrestricted visiting policy. Several took up that challenge and have come forward to share what they learned from their tests of open visitation policies.[2]

Even proposing the idea of liberalizing ICU visiting hours, let alone implementing it, generates considerable resistance among nurses and physicians, who are largely focused on 3 worries: increased physiologic stress for the patient, interference with the provision of care, and physical and mental exhaustion of family and friends. While these concerns may seem reasonable, the evidence from the recent experiences at hospitals working with IHI, as well as from a small but growing body of literature, tell quite a different story.

Physiologic Stress for the Patient. The concern that the patient should be left alone to rest incorrectly assumes that family presence at the bedside causes stress. The empirical literature suggests that the presence of family and friends tends to reassure and soothe the patient, providing sensory organization in an overstimulated environment and familiarity in unfamiliar surroundings.[3] Visits of family and friends do not usually increase patients' stress levels, as measured by blood pressure, heart rate, and intracranial pressure, but may in fact lower them. Nursing visits, on the other hand, often increase stress.[4,5]

However, liberalizing visiting hours may not be good for every patient. The goal is not universal implementation of unrestricted ICU visiting policies, but rather the achievement of patients' control over the circumstances of their own care. It is important that patients be able to decide who can visit them and when, and accomplishing this requires that there not be a universal restriction outside the control of individual patients and families. Instead, patients who can do so should be allowed to determine their own visiting hours, and this information should be relayed to their family and friends. In other circumstances, family preferences may appropriately control the decision.

Barriers to Provision of Care. The second concern is that the unrestricted presence of loved ones at the bedside will make it more difficult for nurses and physicians to do their jobs and may interfere with the delivery of care. The evidence suggests, however, that the family more often serves as a helpful support structure, increasing opportunities for patient and family education, and facilitating communication between the patient and clinicians.[4] Family members may also be able to provide feedback to nurses and physicians more effectively than the critically ill patient can, creating a better working relationship for all.[4]

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Hospitals that are more comfortable with a less bold change could stipulate that there may be times when a patient's room or the entire unit must be closed for procedures or emergencies. This reservation provides clinicians with the option to ask family members to leave the ICU if there is real concern that the family's presence may seriously hinder the provision of care.

Exhaustion of Family and Friends. The third concern is that constant visiting with the patient may prove exhausting for family and friends who fail to recognize the need to pace themselves. While that does sometimes happen, it is also true that open visiting hours help alleviate the anxiety of family and friends, allowing them to spend time with the patient when they want and to feel more secure and relaxed during the time they are not with the patient.[6] One study found that open visitation had a beneficial effect on 88% of families and decreased anxiety in 65% of families.[6]

Overall, available evidence indicates that hazards and problems regarding open visitation are generally overstated and manageable. To open ICUs to families involves substantial cultural change that can occur with proper determination (Karen McKinley, RN, and Lani Kishbaugh, RN, BSN, Geisinger Medical Center, oral communication, February 23, 2004). Open visitation policies do not harm patients but rather may help them by providing a support system and shaping a more familiar environment.[2] Open visitation policies engender trust in families, creating a better working relationship between hospital staff and family members.

Unrestricted ICU visitation is best implemented in concert with systematic, unit-by-unit evaluation of its effects in order to adapt the specific policy to local contexts, relying on those whom the policy affects—nurses, physicians, patients, and their families—for unvarnished, comprehensive, and continuing feedback.

Hospitals should open their ICUs, ask their patients and families, their nurses, and their physicians what works, assess the impact of these changes openly and objectively, and move toward a defined but unrestricted ICU visitation policy. To skeptics, for whom such a broad liberalization seems too risky, we suggest testing an unrestricted visiting hour policy for a few months, and then reflecting on the successes and obstacles actually experienced. The result will be better patient- and family-centered care for those patients who are most in need of such care.

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