

Impact of Family Presence in the Healthcare Setting

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A Senior Thesis submitted in partial fulfillment
of the requirements for graduation
in the Honors Program
Liberty University
Spring 2014

Acceptance of Senior Honors Thesis

This Senior Honors Thesis is accepted in partial fulfillment of the requirements for graduation from the Honors Program of Liberty University.

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Abstract

Family presence at the patient's bed side is promoted and encouraged within the healthcare arena. Healthcare staff strive for reports of satisfaction from patients and families. Positive and negative outcomes of family presence on units within the hospital have been assessed, with suggestions for visitation practices and solutions for common concerns. Positive patient outcomes, including accelerated recovery time, increased reports of comfort, and decreased duration of hospital stay are the ultimate goals of hospital care. Research shows that patient outcomes are impacted greatly by family presence. Patient- and family-centered care represents the future model of healthcare. Knowledge of these policies and potential consequences of their implementation will guide the practice of nurses and other healthcare professionals.

Impact of Family Presence in the Healthcare Setting

Family Visitation

There are over 36 million admissions to hospitals in the United States annually according to a 2012 study conducted by the American Hospital Association (American Hospital, 2014)., Nurses make up the largest percentage of the healthcare team and provide bedside care around the clock to every patient (American Association, 2014). Caring for a patient also involves caring for that patient's entire family. A major focus of healthcare providers is family-centered care. All patients within the hospital can be affected by family presence through open visitation policies. The results of these policies can also affect the healthcare staff and medical facility. There are many positive outcomes from having a strong family presence at the bedside through open visitation policies. Family members who remain at the hospital provide vital information about the patient, and their presence increases communication and the continuity of care. Present family members also ensure a greater level of accountability demanded from the healthcare providers. Studies have shown that when the patient and family desire open visitation, an increase in comfort and morale is observed in both the family and the patient, and the patient experiences more positive outcomes (Agard & Lomborg, 2011; Falk, Wongsu, Dang, Comer, & LoBiondo-Wood, 2012; Family Presence, 2012; Fisher et al., 2008; Gray et al., 2011; Karlsson, Tisell, Engstrom, & Andershed, 2011).

Many challenges are raised by the practice of open visitation as well, and these issues must be evaluated and compared with the positive outcomes. Considerations of open visitation may incorporate how the role of the nurse must be expanded to include educating, involving, and comforting the family members at the bedside. Facilities must

have the capacity to accommodate additional people, being family members, on the hospital units. Overcrowded rooms impair the staff's ability to work and perform procedures, and increase the stress level within the room (Ciufo, Hader, & Holly, 2011; Gray et al., 2011). Nurses must also be ready to address the questions and concerns of patients' children visiting a foreign and stressful environment (Falk et al., 2012; Kean, 2010; Knutsson, Samuelsson, Hellstrom, & Bergbom, 2008; O'Brien, Brady, Anand, & Gillies, 2011). Safety considerations must be evaluated and implemented to avoid exposing vulnerable immunocompromised patients to infections brought in by visiting family members. Privacy and periods of rest for the patients must also be provided. Remaining at the bedside during procedures could be traumatic for some patients or visitors, and every visitor should be given the option to either stay in the room or leave during the treatment provided that the patient gives consent (Bishop, Walker, & Spivak, 2013; Compton et al., 2011; Hung & Pang, 2011). Patient care is the core of nursing. Evidence-based practice supports positive patient outcomes when family is included and involved at the bedside (Bishop et al., 2013). Challenges to this practice must be evaluated and resolutions established.

Patient-centered care and family presence is relevant to every unit in every hospital. Positive patient outcomes include rapid recovery times, decreased length of stay on the hospital unit, and increased morale and satisfaction reported by the patients and their families. Studies have shown that open visitation policies contribute to these positive outcomes (Agard & Lomborg, 2011; Falk et al., 2012; Family Presence, 2012; Fisher et al., 2008; Gray et al., 2011; Karlsson et al., 2011).

Throughout this review open visitation will denote that patient-approved visitors of any age may remain with the patient at all hours of the day, although guidelines may restrict visitors with active infections or other safety considerations from staying with immunocompromised patients. This integrative literature review will explore the many positive outcomes, as well as the challenges, of these open visitation policies. The implications of open visitation policies will also be discussed.

Through this review, 19 scholarly peer reviewed articles were compiled and analyzed. Articles published outside of scholarly journals, and those published prior to 2008 were excluded from the literature review. Search keywords used to locate the articles in EBSCO host included open visitation, family presence in the hospital, patient and family centered care (PFCC) model, and patient-centered care. All articles were published between 2008 and 2013 and presented information concerning the links between family presence and patient care. Similar themes and conclusions were identified and compiled from among the aggregate of information.

Promoting Family Presence

Facilitating family presence and providing exceptional patient care involves many groups of people. The patient must desire the presence of visitors and give consent. The family must come to the bedside and stay with the patient. The nurses and medical staff are integral to the process and are required to ensure that the patient has given consent and to include the family within the care of the patient. Evidence has shown the effectiveness of PFCC can be dependent upon the attitudes and beliefs of the nurses. Fisher et al. (2008) reported on the attitudes and behaviors of nurses regarding family presence in the hospital. A questionnaire was completed by 89 nurses in order to survey

their views on visitation and family presence. A four or five point Likert scale was used for 18 items on the questionnaire, and two open ended questions were included concerning management of family presence and the perceived effect that family presence had on the delivery of care to the patient. The nurses who were surveyed agreed that family should be allowed to remain at the bedside of their relative during daily routine care, and that the presence of family was usually positive and comforting to the patient. The nurses expressed the belief that family members should also be included in the daily care of the patient. While the majority of nurses agreed that family should be allowed to visit any time the patient wanted them present, close to a third of the nurses expressed disagreement and wanted to retain the ability to limit visitation when they thought it would be beneficial to the patient's care. Overall this study showed that nurses held a positive view of family visitation and presence at the bedside (Fisher et al., 2008).

Because nurses and hospitals recognize that family visitation is important, hospitals now hold the responsibility to enable and encourage family presence. Evaluating the experiences of parents visiting infants in the neonatal intensive care unit (NICU) gives unique insight into the factors that promote or inhibit visitation. When the patient is a prematurely born infant, there are no conflicts that arise from the patient preference, and the facilitation of visitation becomes more fully dependent upon the facility, care of the staff, and limitations on the family members. Wigert, Berg, and Hellstrom (2010) conducted research to assess the visitation patterns of parents and identify visitation-friendly practices. The two NICUs involved within this study had an open visitation policy. The time spent in the NICU by each of the 67 parents of 42 infants involved was logged and tracked. The 67 parents also participated in structured

interviews to discuss the factors that affected the time they spent on the unit. The main factors affecting the time spent visiting by the family were identified as accommodations, care provided by the staff, environment, and other personal responsibilities.

The hospitals included in this study were equipped with parent rooms adjacent to the NICU. One hospital had two rooms where parents could stay while remaining close to their infant. That hospital also had additional housing offered in a family hotel that was located on the hospital property. This convenience allowed the parents more time to spend in the NICU. This hospital also had the NICU located in the same building as the maternity ward which facilitated easy visiting for newly post-partum mothers still receiving treatment. The second hospital had five family rooms for parents but did not offer other on-property housing and the maternity ward was located in a different building of the hospital (Wigert et al., 2010).

The survey completed by the parents in the study identified good treatment by the staff and a family-friendly environment as the best influences for facilitating family presence. Coming and going freely, as well as getting regular information, were also cited as positive influences on their visiting experiences. Common reasons why parents spent time away from their child were to care for their other children and homes (Wigert et al., 2010). The findings of this study, in relation to factors promoting the accessibility of family presence, can be applied to hospital units of any specialty. To provide PFCC, family visitation must be facilitated. Patient and family centered care can be accomplished through providing a family-friendly environment with adequate accommodations, open or flexible visitation hours, high quality care, and regular, accurate information.

Within the Intensive Care Setting

An exploratory study was conducted within Danish intensive care units (ICUs) to identify perceptions and practices of registered nurses (RNs) concerning family presence at the bedside (Agard & Lomborg, 2011). Qualitative interviews were conducted in 2005 and 2008 with 11 RNs from three different hospitals. From among the semi-structured interviews three main strategies were identified for addressing family presence within the ICU. First, the nurse must have clarified the relationship between the visitor and the patient. The patient always retained the right to refuse the company of a visitor, and as the advocate and gatekeeper for the patient, the nurse must have enforced the wishes of the patient. Finally, when the patient was unconscious as was often the case within the ICU, the RN needed to evaluate the appropriateness of the presence of some relatives. It was the responsibility of the nurse to make decisions based upon what would have been in the best interests of the patient.

Other requirements identified by the Danish ICU nurses included defining the situation and guiding the relatives through the patient's hospital stay. Support and education for the family were found to be vital components of positive visitation experiences. In order to help maintain the patient's circadian rhythm the nurse needed to explain to the family the importance of rest times for the patient and ensure this was enforced. During treatments or procedures the family needed to be fully informed on the events taking place, and be given the option of remaining in the room or stepping out to the waiting area until the procedure was complete. Judging the appropriateness of family presence at the bedside was a task that fell to the nurse. The RN needed to continually

assess the situation and make recommendations to the family as to whether to be in the room or not based upon those assessments (Agard & Lomborg, 2011).

Collectively, the nurses included within this study agreed that family presence reduced the anxiety levels and occurrence of hallucinations among the patients. Visitors offered support and comfort to the patient, often supplying valuable information about the patient to the healthcare team allowing for better individualized care. The nurses also determined that the families' needs for information, support, presence with the patient, and reassurance that the patient was getting the best care, were most fully achieved from the bedside. As the member of the healthcare team that is present with the patient and the family most often, the nurses identified themselves as the main coordinators of family visitation and presence (Agard & Lomborg, 2011).

The needs of adult family members visiting in the ICU were also researched by Obringer, Hilgenberg, and Booker (2012). A survey was administered to 45 adult family members of patients who were admitted to the ICU for a minimum of 24 hours. Findings suggested that family members of ICU patients experienced high levels of stress and anxiety. Also, a lack of knowledge of the surroundings, procedures, and monitors present contributed to their anxiety. Providing education and regular updates to the family on the patient's condition served to alleviate this anxiety. One of the most desired needs of the family members was for reassurance. It was desired that nurses provide reassurance within culturally appropriate parameters and without giving false hope. Honesty resulted in the highest desired need. Honesty from the nurses was necessary in order for the family members to build a trusting relationship with the health care providers (Obringer et al., 2012). In respecting the needs of the family members of ICU patients and in

providing PFCC, nurses are required to provide clear and accurate information to the family that is regularly updated, including reassurance that their relative is being given the best care possible.

The American Association of Critical-Care Nurses (AACN) conducted a study on peer reviewed professional organizational standards regarding family presence in the ICU setting through a comprehensive literature review and data analysis. They found that 78% of ICU nurses surveyed from over 300 units prefer unrestricted visitation policies while 70% of hospitals place restrictions on bedside visitation. While family presence does place increased demands upon the healthcare providers and facilities, having unrestricted presence of a support person has been shown to increase patient satisfaction, increase the safety of care given, increase communication at the bedside, facilitate better understanding of the patient, improve PFCC, and enhance overall staff satisfaction (Family Presence, 2012). The recommendation of the AACN was to restrict visitation only when necessary due to illness, safety, disruption of care, or legal issues. In every instance, the privacy and confidentiality of the patient should be protected. The AACN highlighted the need for more written policies to guide safe and compliant visitation (Family Presence, 2012).

Varying opinions exist concerning family presence during complicated or painful procedures. Family presence has been shown to decrease the anxiety of the patient and to better inform the family, but apprehension remains concerning the family's possible emotional response to witnessing procedures or dressing changes. Beginning in 2009 at the University of Louisville Hospital in Kentucky family members were given the option to remain in the room during dressing changes in the burn ICU. A study was conducted

using data and surveys from 37 patients from March 2009 through December 2011 to evaluate patient and family response to this policy change. These surveys and data were compared to 35 patients from January 2007 through February 2009 (Bishop et al., 2013). The change in policy was made to address the need for family to be educated on and involved in the patient's care. Increased survival rates of patients within the burn ICU coupled with decreased lengths of stay resulted in family members needing to provide home care after the patient was discharged. Allowing the family to remain present for procedures is also advocated for by the American Association of Critical Care Nurses and the American College of Critical Care Medicine through their efforts to promote patient and family-centered care (PFCC) (Bishop et al., 2013).

Family, as defined by the PFCC model, is whomever the patient identifies as family. The core concepts of PFCC include dignity, respect, collaboration, participation, and information-sharing (Bishop et al., 2013; Ciufu et al., 2011). These concepts were practiced when family was included within the room during procedures and dressing changes at the University of Louisville Hospital in Kentucky. Barriers to this practice included any unwillingness of the staff to include the family for fear of causing an increase in infection rates following the procedure or that the family member would be emotionally traumatized by the sight of the wound. The physical space within the room would also limit the number of people allowed to be present and involved during procedures (Bishop et al., 2013).

The study conducted at the University of Louisville Hospital burn ICU monitored for adverse family responses during dressing changes. Assessment looked for adverse family reactions such as lightheadedness, fainting, nausea, vomiting, or inability to

remain within the room throughout the procedure. Family members only remained in the room if they desired to do so, and after they had been educated on the wound dressing change process. Every person in the room was required to follow isolation precautions in order to avoid infections. The study found no adverse family reactions from 2009 to 2011, and patient satisfaction scores increased. There was also no rise in infection rates seen. The staff developed an increasingly positive attitude toward visitors remaining at the bedside, and reported dressing changes to be a good opportunity for family education and involvement in the patient's care. Patients and their families expressed, through surveys, an increased feeling of preparedness for discharge home after being included in all of the patient's care during the hospital stay (Bishop et al., 2013).

Procedures and treatments can be painful, invasive, and traumatic to witness. Most commonly, in the past, family members were asked to leave the room during aggressive and emotional interventions such as cardiopulmonary resuscitation (CPR). The widely held fear was that family members would be traumatized by seeing their relative undergo chest compressions, intubation, and defibrillation that often occurs during CPR. Another fear is that anxiety levels would also be increased for the family members because they would not understand why these interventions were being done, and they would be fearful while waiting to see if their relative would regain spontaneous cardiac and pulmonary functioning. While these fears exist, there is also research supporting family presence during CPR to promote coping, gaining closure, and understanding that everything possible was done for their loved one. There have been cases of posttraumatic stress disorder (PTSD) and depression in patients and their family members following aggressive treatment in the ICU. Staff in emergency departments and

ICUs also expressed concern that there would be an increase in the amount of litigation filed by family members after witnessing CPR, or that distraught family members would obstruct the CPR procedure while in the room (Compton et al., 2011).

In order to determine the effects of family witnessed CPR, Compton et al. (2011) conducted a quasi-experimental comparison study of adult family members whose relatives had CPR. The goal of this study was to determine if relatives who chose to remain in the room during resuscitation efforts had increased incidents of PTSD or depression in the days and months following. The study was conducted in two large urban hospitals in Detroit, Michigan. Of the participants, 24 witnessed a relative's CPR from within the room, and 41 chose to leave the room during CPR. Interviews were conducted with the family members 30 and 60 days after the CPR event. Results showed no significant change in the rate of PTSD or depression in the family members. When a family member chose to remain in the room, the hospitals did assign one staff member to function solely as a support person for the relative. That staff member was able to explain the procedure as it was performed and to provide any assistance to the family member that might have been needed. This practice contributed to the positive outcomes of family presence during CPR. Benefits that family members experienced from witnessing CPR efforts included knowing that the medical staff did everything possible for their loved one, and the ability to experience closure after a family member passed away (Compton et al., 2011).

In response to the changing practices in the United States regarding family preferences for being present during CPR, health care providers in Hong Kong hospitals have begun their own research on family witnessed CPR. One of the policy suggestions

that prompted this research included the American Heart Association and the Emergency Nurses Association recommendation in 2005 that family members be given the option of remaining in the room during resuscitation efforts (Hung & Pang, 2011).

Researchers in the emergency department at a hospital in Hong Kong recognized that the view of family members as visitors in the hospital is shifting to family being considered integral members of the illness, treatment, recovery or death of the patient. Interviews were conducted and data were collected from 2007-2008 during which time there were no guidelines in place pertaining to family presence. Eighteen family members participated in interviews following their relative receiving CPR in the emergency department. None of the family was present during the interventions, but five entered the room at the end of CPR. The majority of those interviewed expressed a desire to have been present if they had been given the option. The first interview with each family member was conducted within 24 hours of CPR. Follow up interviews were performed one to three months following the CPR (Hung & Pang, 2011).

Family members who wished to have been invited to remain present during the resuscitation of their relative gave several reasons for that desire. The main reason discussed was for emotional connectedness and the ability to provide emotional support to the patient. The family stated that being present would keep them informed on what was being done for the patient and allow them to stay engaged with what was happening. Challenges perceived from the staff included the family member's lack of knowledge about resuscitation procedures, space constraints within the emergency department rooms, and the staff's apprehension about performing CPR in front of a family member. These challenges must be addressed as the researchers create policies that allow family

members to have the option of remaining present during CPR on their relative (Hung & Pang, 2011).

Visiting with Children

On many hospital units, age restrictions are enforced for visitors, such as for a family member who is under the age of 12, visiting a sick parent or sibling is not allowed. This policy is enforced to protect immunocompromised patients from acquiring infections from the visiting children. Children are often perceived as having more common colds, sicknesses, and infections than adults, and age restrictions became a standard practice that was rarely questioned. The University of Texas MD Anderson Cancer Center in Houston had this policy until one family called it into question (Falk, Wongsu, Dang, Comer, & LoBiondo-Wood, 2012). The family's repeated requests for the patient to have her children come to her bedside prompted the nurses to conduct research on the topic. They began with a literature review that yielded no evidence supporting the belief that children carried more sicknesses. Factors such as immunization status, presence of a fever, and hand washing were shown to influence infection transmission more than age. The RNs then conducted interviews with the physicians of the medical center. The majority of the physicians of the facility had no objection to children visiting on the medical units provided that they were immunized and had no active infections (Falk et al., 2012). Following this research, the medical center revised the visitation policy. Children of any age could visit provided that they were up to date on their vaccinations and had their temperature taken at the front desk before coming into contact with any patients. The ability for young family members to visit with the patients significantly increased patient satisfaction and also served to help the children cope with

their relative's illness. The number of yearly written complaints from patients decreased from 16 to one, and patient satisfaction surveys indicated high satisfaction (Falk et al., 2012).

The majority of research conducted on family visitation in the ICU is focused on adult family members. Children visiting within an intensive care area raise a greater number of considerations that must be addressed. From 2002 to 2005, Kean (2010) conducted nine family interviews including 12 adults and 12 children. Kean used a constructivist grounded theory approach to study how children responded to visiting the ICU. The age and developmental stage of the child had the greatest impact upon that child's perception of the ICU. Younger children under the age of 14 demonstrated concrete thinking and focused on the environment and machines when describing the ICU. Young adults aged 14 to 25 were capable of high levels of thought and could understand why there were so many machines and policies within the ICU. These young adults used their abstract thinking to evaluate the ICU by its function and were able to focus more on the patient than the environment whereas the younger children were not (Kean, 2010).

Patient and family centered care focuses on the involvement of the entire family. To achieve the goals of PFCC the children of critically ill patients must be included within the visitation policies of the units. Establishing the inclusion of the children involves identifying the reasons why children are commonly excluded from visiting, and creating solutions for these barriers. Kean's (2010) research identified the two main groups of adults who restrict youth visitation as parents and nurses. Parents wanted to shield their children from being scared by the environment of the ICU and from seeing

their relatives sick or injured. Nurses responded based upon their personal fears that the children would have adverse reactions to being in the ICU environment, but no research was indicated to support these fears (Kean, 2010).

Studies have shown that explaining the ICU to children and offering them the choice of visiting resulted in positive visiting experiences, while forcing children to visit a relative produced increased levels of anxiety for the children (Kean, 2010). Children included within this study demonstrated an eagerness to learn about the ICU. Because younger children focused more on the machines and the environment, they had less negative reactions when visiting the ICU for the first time. The young adults focused on their relative amongst all the machines and wires, and experienced more frequent emotional reactions including crying or anger. All ages of youth needed to be taught about why their sedated relative would not respond to them, what the machines did, and what the monitors meant. Even among those who had emotional reactions, the youth included within this study expressed an increased ability to cope with their relative's illness after being allowed to visit in the ICU (Kean, 2010).

Kean (2010) suggested implementations for practice involving youth visitation in the ICU. Education needed to begin with the nurses. This education could be achieved through classes and literature. Nurses must understand the developmental stages of the children in order to best communicate with them about the ICU. Next the parents needed to be taught the benefits of children visiting the ICU. This parental education could be accomplished through communications between the nurse and parent, as well as through informational brochures.

Further insight into children's perceptions of visiting the ICU was gained through a study conducted by Knutsson et al. (2008) in which 28 children were interviewed. The participants included 14 girls and 14 boys whose ages ranged from four to 17 years old. The interviews took place three months following their time visiting at the hospital. The four most common perceptions expressed by the children were that the ICU was cold and white, it was difficult waiting to see the relative, the place was strange, and that overall it was good. The waiting to see the relative and enter an unfamiliar environment caused some anxiety and concern for the children, and upon entering the ICU room the machines and foreign environment produced more curiosity than fear (Knutsson et al., 2008).

Children who were raised in the twenty first century were quick to accept new technology when it is shown to them and explained at a cognitive level that they could understand. The children interviewed expressed a sense of relief after being able to visit with their family member and see where they were and what was being done (Knutsson et al., 2008). This study further supports the allowance of child visitation in the ICU setting.

Child visitation within mental health facilities has been studied very little, but presents many similar challenges as visitation within the ICU. O'Brien et al. (2011) conducted a qualitative exploratory study through interviews of nine staff members to examine the outcomes of child visitation and the staff perceptions of this practice. Concerns included the child not being able to understand why their relative was in the hospital or what was being done on the unit. Positive outcomes of child visitation included a decrease in anxiety felt by the children at the absence of their parent, increased understanding of the medical care being given, and an increased ability to cope with

having a relative with a mental illness. The staff at these units expressed support for children visiting their parents, but they felt unqualified to explain mental illness to children of different ages. Professional development would be required for the staff in order to equip them for managing child visitors on the unit. Policies and guidelines would also be required in order to effectively facilitate this practice (O'Brien et al., 2011).

Outcomes for Patients and Staff

Patient and family centered care is facilitated by the healthcare staff for the wellbeing of the patients. As a result the practice of PFCC affects both the patients and the staff. The staff at St. Columbia's Hospice in Edinburg participated in facilitated interviews to study, in depth, the staff's views on positive and negative effects of open visitation. These interviews included 25 nurses, volunteers, chaplains, doctors, and social workers. The same skilled facilitator conducted all the interviews with groups of eight staff members at a time. All interviews were recorded and transcribed for further evaluation. While overall the staff had a positive view of open visitation, the interviews presented several positive and negative aspects of open visitation that must be taken into consideration (Gray et al., 2011).

The most common advantage offered by the staff at St. Columbia's Hospice was that family could visit at convenient times for them, and this flexible accommodation relieved the patient of anxiety and guilt over impeding upon the family's schedules. Open visitation also allowed family members to space out their visits throughout the day to avoid overwhelming the patient and the facility all at once. Having the family present promoted bonds to form between the staff and the family members, and the staff could then involve the family in patient care. Family presence increased the comfort levels of

the patient, decreased the anxiety of the family members by giving them a way in which to help their relative, and reduced the workload of the staff. Those bonds that were formed also served to open communication between the family and staff to increase the staff's knowledge about the patient, and to increase the staff's perception of the value of the patient as a person. The family was able to build an increased confidence in the staff by seeing the considerate and consistent care that they provided every day and night (Gray et al., 2011).

The staff at St. Columbia's Hospice also discussed concerns related to open visitation. The nurses identified themselves as the advocates and gatekeepers for their patients. The nurses felt responsible for intervening when open visitation began to negatively affect the patient or the family members. Guilt was identified by the staff as a main source of problems with open visitation. When families were told that they may have someone stay with the patient continually, many relatives experienced guilt if the patient was then ever left alone. Relatives would become exhausted but refuse to leave the bedside without assurances from the staff that it was acceptable to do so. Conversely, the patient would become tired and desire quiet time to rest, but would feel guilty saying no to visitors or asking family members to leave (Gray et al., 2011).

The staff also discussed how some family dynamics could agitate the patient and create a stressful environment within the room. All of these considerations were present when the patient had a private room. Further challenges to open visitation arose when discussing shared patient rooms. It became increasingly more difficult for the staff to ensure privacy and confidentiality of multiple patients in the same room with multiple visitors. The rest and comfort of one patient must also be protected and advocated for by

the nurse when it is disrupted by the visitors of the patient's roommate (Gray et al., 2011).

The staff of St. Columbia's Hospice advocated for open visitation provided that the patient was able to control visiting, and that the nurse could act as the gatekeeper between the patient and visitors. The hospice center developed an informational leaflet for the family to read on the importance of quiet times for rest and the dynamics of open visitation. The staff was also required to attend training for communication and visitation management. This training equipped the staff to facilitate the best possible outcomes from open visitation while protecting the patient and the patient's family (Gray et al., 2011).

The satisfaction of patients and family members is a major indicator of the quality of care given on a hospital unit and can serve to positively impact patient outcomes. High satisfaction leads to decreased stress and better healing for the patients. If a family is happy with the care received from a hospital, they are more likely to seek medical care from that facility again. A study was conducted in Swedish ICUs by Karlsson et al. (2011) to describe family members' satisfaction with the care received. Much like the findings from Obringer et al. (2012) and Agard and Lomborg (2011), the major components considered to be needs of the families included reassurance, information, close proximity to the patient, support, and comfort. Participants included 35 family members of patients who had been cared for in the ICU for greater than 48 hours. A survey including 18 questions answered on a Likert scale ranging from one to five and two open ended questions was administered retrospectively to these family members to attain qualitative and quantitative data regarding family satisfaction. The results

illustrated a high level of satisfaction felt by the families. Among the categories of family needs, flexible visiting hours were cited as one of the highest satisfying services provided by the ICU staff in addition to receiving support from the staff in the foreign environment of the ICU (Karlsson et al., 2011).

Communication is vital when developing a therapeutic relationship between the medical staff and the patient's family. O'Connell, Stare, Espina-Gabriel, and Franks (2011) at Northshore University Health System identified increased anxiety and a breakdown in that therapeutic trust during the time when the patient was transferred from an ICU to a general medicine unit. The nurses conducted research and surveyed 25 patients preparing for transfer. The nurses then developed a teaching intervention that involved educating the entire family about the transfer process. Pamphlets were developed and distributed to the family during conversations with the nurse. Surveys were then administered to another 25 families to evaluate their satisfaction with the nursing care and transfer process. The increased communication and involvement of the family decreased the levels of anxiety reported by the families and the patients. The surveys reported 100% satisfaction following these interventions (O'Connell et al., 2011). Patient and family centered care focuses on the family's need for information and involvement. This policy development by O'Connell et al. demonstrated the positive outcomes of implementing PFCC.

One of the tasks of nurses is counseling patients and families. Counseling happens in all units of the hospital including the emergency department (ED). Research has shown positive outcomes from involving family members in patient counseling. Paavilainen, Salminen-Toumaala, Durikka, and Paussu (2009) administered a questionnaire to 107

patients in the ED in order to further explore the extent of counseling that occurs there. Of the patients who present to the ED, 42% bring a relative with them. Of the patients who received the questionnaire 75% responded that family presence was important to them.

When giving information to a patient the nurse must be incredibly cautious to maintain the patient's confidentiality and privacy. Only after consent has been given should a nurse discuss a patient's illness or plan of care with a family member present. Patients who had a family member present while being given information and receiving counseling required less counseling and reported increased satisfaction with the information they received. On the other hand, only half of the participants in the survey expressed the desire to have all their information shared with their family members (Paavilainen et al., 2009). This evidence can serve to inform nurses to encourage family presence during illness education and counseling, but the nurse must always respect the patient's right to privacy and confidentiality.

In an effort to meet patient and family expectations and increase satisfaction hospitals are adopting many hospitality services. Many hospital rooms and services resemble hotel buildings. The main focus of a hospital is to provide medical care. As technology has advanced and filled hospital rooms, utilitarian practices have consumed the functioning of facilities causing hospitals to become cold clinical environments. Hospitals are presently focusing more resources on providing friendly environments with advanced hospitality in order to attract patients from competing health care facilities, while fulfilling the PFCC mandate for patient and family satisfaction. In addition to these findings Wu, Robson, and Hollis (2013) also identified high patient satisfaction as a key

indicator for the Hospital Consumer Assessment of Healthcare Providers and Systems which publicly reports patients' perspectives on satisfaction with care received at the hospital.

Challenges

The change in practice to PFCC has been changing the structure and policies of hospitals across the United States. Maguire, Burger, O'Donnell, and Parnell (2013) conducted a survey to discover the ease of transition for an institution into PFCC, and the length of time required by clinicians to adjust to the new policies and practices. Maguire et al. (2013) studied the stress levels of hospital staff throughout a move into a new pediatric hospital building with all single patient rooms. The Perceived Stress Scale instrument was utilized along with three clinical questions that were asked of the staff regarding the change pertaining to perceived stress levels and practices associated with PFCC connected to the new environment. A Likert scale survey on single patient room nursing was also administered. These questions were asked before the move and at one, eight, and fifteen months following the move. The survey was administered online to the 160 staff members. All identifying information was removed from the surveys upon submission to ensure confidentiality. Stress levels of the overall staff elevated from baseline one month after the move, but began to decrease by the eight month measurement. The staff groups with the lowest levels of stress included the registered nurses and those who had been working in the hospital for less than three years. Satisfaction surveys of the patients reflected an increase in satisfaction. Family members who would recommend an inpatient stay rose from 75% to 90% after the move to the new hospital. The increased family satisfaction may have positively impacted the nurses'

stress levels because of the continuous interaction between the nurses and families.

Happier nurses could also have contributed to more satisfied families. Staff responses did indicate a significant shift in practice towards PFCC (Maguire et al., 2013). While the shift in practice produced stress among those staff members who were trained and practiced in the old system, PFCC was implemented resulting in increased patient and family satisfaction, and a less stressful, healthier work environment for the nurses.

A study conducted by Ciufu et al. in 2011 reviewed 13 studies on PFCC and open visitation. Of those studies, six were qualitative and seven were quantitative. It was concluded from this literature review that unrestricted open visitation policies increased the workload of the RN. In addition to standard patient care the nurse needed to ensure the patient got rest periods during continual family visiting, maintain confidentiality and the privacy of the patient among groups of visitors, and manage family dynamics which could be aggravated by the stressful event of having a loved one in the hospital. In any instance the patient had the right to limit visitors. RNs could also make clinical decisions and restrict visitation when it impeded upon patient care. This study suggested that flexible visitation hours directed by the nurse and the patient provided the best model for managing family presence in the hospital (Ciufu et al., 2011).

Conclusion

Patient and family centered care is the current standard for medical practice. This affects care in every unit of the hospital and at every level of healthcare administration. Facilities must have the resources to accommodate family presence at the patient's bedside. Consideration must be given to family members who wish to stay overnight with the patient. Hospitals that encourage family presence and provide services to promote

families to remain with the patient receive higher levels of satisfaction from the patients and the families (Agard & Lomborg, 2011; Family Presence, 2012; Karlsson et al., 2011; Obringer et al., 2012). There are several ways that PFCC can be promoted and executed.

Private rooms facilitate family presence the best. Nurses and other healthcare providers must always respect the patient's right to privacy and confidentiality. Only after a patient has given consent, can the nurse speak about the patient's diagnoses or treatments in front of visitors. Maintaining confidentiality becomes much more challenging in a room shared by multiple patients with family members from both patients visiting. A single patient room also provides privacy and facilitates more communication between the patient, the family, and the healthcare team (Gray, 2011).

The family of a patient is often a great source of information. Developing a trusting therapeutic relationship between the nurse and the family early is important for patient care. Increased communication between the family and the nurse contributes to positive patient outcomes by giving the medical team further insight into the patient and their wishes, increasing the accountability between the medical team and the family, and contributing to the medical team's ability to view the patient as a person with value and purpose (Agard & Lomborg, 2011; Fish et al., 2008).

Open or flexible visitation policies are a significant factor in PFCC. Allowing the family to visit the patient when the timing is most convenient reduces stress and anxiety for the family and for the patient. Patients are then relieved of any guilt they might develop for impeding upon their family's schedules. Open visitation also allows family members to space out their visits across a given timeframe instead of all crowding into the hospital room during the same few hours. Having a family member remain at the

bedside long-term also benefits the continuity of care between the nurses and doctors. The patient must have times of rest and always retains the right to restrict visitors. The nurse's role as a patient advocate requires routine assessment of the situation and management of visitation (Gray et al., 2011; Karlsson et al., 2011).

Family presence has been shown to bring comfort to the patient. The ability to remain present with a relative in the hospital has also been shown to enhance a family member's ability to cope. At the bedside, the family member can gain frequent updates from the medical team and witness the care that is being given (Family Presence, 2012; Gray et al., 2011; Wu et al., 2013). These positive outcomes also apply when children visit relatives in the hospital or when family members witness resuscitation efforts on their relatives (Compton et al., 2011; Falk et al., 2012; Hung & Pang, 2011; Kean, 2010; Knutsson et al., 2008; O'Brien et al., 2011).

Managing increased family presence and executing PFCC has been shown to increase the stress of some health care providers. Facilities must serve the families. Nurses must provide continuous care, support, education, and reassurance to the families of many different knowledge levels and developmental stages. Despite these challenges, PFCC has been shown to positively influence the workplace environment for nurses and reduce stress (Ciufu et al., 2011; Maguire et al., 2013).

Limitations

The topics of family presence and PFCC are popular within healthcare, but more research must be done. Very little experimental research, or research that is purely quantitative in nature, is currently available. The majority of studies included within this literature review are qualitative in nature and several have sample sizes of less than 30

participants. Seventeen of the 19 studies included qualitative data within the study results. Of these 19 studies seven had small sample sizes.

Suggestions

As more hospitals adapt to PFCC more research will be done. Information regarding long term satisfaction of families and staff has yet to be attained and published. Current research overwhelmingly concludes that families are highly satisfied with PFCC. Patient outcomes of increased comfort, decreased healing time, increased communication, and decreased length of stay have been demonstrated. Families report increased trust in their relative's care, increased abilities to be involved in and informed of their relative's care, and increased ability to cope with their relative's illness even when faced with a terminal diagnosis (Agard & Lomborg, 2011; Family Presence, 2012; Gray et al., 2011; Karlsson et al., 2011). Hospitals and staff must work to include family members and facilitate family visitation. Solutions exist for many of the challenges of PFCC including more extensive training for nurses in communicating with different developmental stages of children visiting the hospital (Kean, 2010; O'Brien et al., 2011). The more research conducted on the topic, the more PFCC is indicated to be the future of medical care delivery.

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