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A multicenter survey of visiting policies in French intensive care units

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Abstract *Objective:* To determine the visiting policies of French intensive care units. *Design and setting:* Descriptive study in intensive care units. *Methods:* A questionnaire on their official visiting policies was sent to 200 French ICUs. *Results:* Ninety-five ICUs completed the questionnaire (47.5%). Ninety-two (97%) ICUs reported restricted visiting-hour policies, allowing visits at only one or several preassigned times. Mean total daily visiting time was 168 min (range 30–370). The number of visitors was restricted in 90 ICUs (95%). The type of visitors (immediate relatives only) was restricted in 57 (60%). Visiting was forbidden for children in 10 (11%), and 41 (44%) fixed an age limit for visiting. A gowning procedure was imposed on visitors in 78 (82%). Eighteen (19%) ICUs had no waiting room available, 35 (37%) used a special room for providing families with information in addition to the waiting room, 61 (64%) provided an information leaflet. A structured first meeting was organized in 68 (71%). A last structured family meeting at the ICU discharge was provided in 6 (6%). *Conclusions:* Responding ICUs provide homogeneously restrictive visiting policies concerning visiting hours, number and type of visitors. However, family reception cannot be reduced to some quantitative factors and depends on multiple other parameters such as the organization of family meetings and the use of an information leaflet. These results should be an interesting starting point to observe any change in mentalities and practices in the future.

Keywords Visiting policy · Intensive care unit · Family meeting · Information leaflet · Waiting area · Gowning procedure

Introduction

Hospitalization in an intensive care unit (ICU) is a major physical and psychological stress for the patient and the entire family. The challenge facing intensive care teams is to deliver state-of-the-art care to the patient and to help families cope with the hospitalization of their relatives. Since the Critical Care Family Needs Inventory was introduced by Molter's [1] original study, multiple studies particularly in North America have focused attention on the family of the critically ill patient [2, 3, 4, 5, 6, 7]. This research led the United States Society of Critical Care Medicine to promote communication and information in ICUs and to provide opportunities for families to maintain their familial roles with the critically ill patient [8]. As intensive care patients are frequently temporarily unable to speak for themselves [9], the family is not only a passive actor during a stressful experience but must take on the new role of a decision-maker. To help families cope with this role, caregivers must identify the most competent relatives for establishing effective and intelligible communication with them.

Recently several studies from European medical teams have focused on factors associated with the fami-

Table 1 Characteristics of responding ICUs, compared with ICUs overall in France

	ICUs in France[a] (*n*=350)		Contacted ICUs (*n*=200)		Responding ICUs (*n*=95)	
	n	%	*n*	%	*n*	%
Community hospital ICUs	228	65	123	61.5	56	59
University hospital ICUs	61	17.5	42	21	19	20
Private hospital ICUs	61	17.5	35	17.5	20	21
Mixed medical/surgical ICUs	191	55	90	45	46	48
Surgical ICUs	100	28	71	35	34	36
Medical ICUs	59	17	39	20	15	16
Median number of beds per unit	12	–	13	–	13	–

[a] Adult, surgical, medical, and mixed surgical and medical ICUs, of more than six beds, data from the directory of French ICUs edited by the French Society for Critical Care Medicine

ly's satisfaction and comprehension [10, 11, 12]. Most of these factors are caregiver-related and directly depend on the quality of the visiting policies. What are the visiting policies of ICUs in Europe at the present time? There are no recent published descriptive studies on this subject, and we therefore conducted a national survey of visiting policies in the French ICUs.

Materials and methods

A questionnaire was sent by post in February 2001 to 200 ICUs, selected from the directory of French ICUs edited by the French Society for Critical Care Medicine. The inclusion criteria were: adult medical, surgical, or mixed ICUs from either university, community, or private hospitals of more than six beds and a homogeneous distribution throughout France. The questionnaire contained questions pertaining to: (a) number, time, and lengths of visits; (b) number, age, and type of visitors allowed at one time; (c) use and description of hospital gowning procedures; (d) use of a waiting area; (e) organization of meetings with relatives, telephone information; (f) use and description of an information leaflet. A letter was enclosed with the questionnaire asking ICUs to include an information leaflet with their response if they provided one to families. No stamped response envelope was available, and no postal or telephone recall was planned. Of the 200 ICUs that were contacted, 95 completed the questionnaire between February and May 2001 (47.5% response rate). Characteristics of the responding ICUs compared with the overall spectrum of ICUs in France are shown in Table 1.

Results

Visiting hours

Ninety-two (97%) ICUs used restricted visiting-hour policies, allowing visits at one or several preassigned times. Mean total daily visiting time was 168 min (range 30–370), divided into one or more predefined time slots. Visits were always allowed in the afternoon except for one ICU at which visits were allowed between 7.30 and 8 am. Three ICUs allowed open visitation whereby family members could visit patients at any time during the 24-h period (Table 2).

Table 2 Restrictions on visits in French ICUs

	n	%
Limit on number of visiting slots in 24 h		
One visiting slot	31	33
Two visiting slots	59	62
Three visiting slots	2	2
No visiting slot	3	3
Limit on number of visitors at one time		
One visitor	14	15
Two visitors	72	76
Three visitors	3	3
Four visitors	1	1
No limit on visitors	5	5
Limit on who visits		
Immediate relatives only	57	60
No restrictions on who visits	38	40

Number and type of visitors

The number of visitors at one time was restricted in 90 ICUs (95%; median number of visitors 1.9, range 1–4). The type of visitors (close relatives only) was restricted in 57 (60%; Table 2). Children were not allowed to visit in 10 (11%). In 44 (46%) children were allowed to visit without any age limitation, while 41 (44%) fixed a minimum age limit for visits of 8 years (*n*=1), 10 years (*n*=3), 12 years (*n*=6), 14 years (*n*=4), 15 years (*n*=17), or 16 years (*n*=10; mean 12 years). Concerning visiting hours and number and type of visitors, 30 ICUs spontaneously stated that visiting policies were often adapted to individual cases.

Gowning procedures

In 78 ICUs (82%) a gowning procedure was imposed on the visitors. Overgowns were used in 77 ICUs, overshoes in 30, caps in 3, and surgical mask or gloves each in one. The various combinations of gowning specification are detailed in Table 3.

Table 3 Family gowning procedures in French ICUs

Gowning procedures	*n*	%
Overgowns	46	48
Overgowns + overshoes	27	28
Overgowns + overshoes + cap	2	2
Overgowns + cap + surgical mask	1	1
Overgowns + gloves	1	1
Overshoes	1	1
No gowning procedures	17	18

Table 4 Information tools for families in French ICUs

Information tools	*n*	%
Leaflet[a]	27	46
Information sheet (A4 format)	18	30
Booklet[b]	11	19
Visiting card	3	5
Total	59	100

[a] A sheet of paper folded in two or three
[b] Two or more sheets of paper bound together

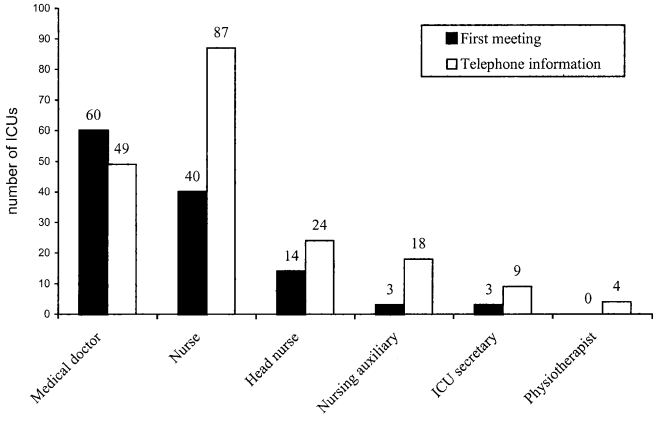

Fig. 1 ICU caregivers involved in family giving information at first meeting and by telephone

Waiting and communication area

No waiting room was provided by 18 ICUs (19%), 35 (37%) used a special room in addition to the waiting room for providing families with information, and 61 (64%) provided an information leaflet. Characteristics of the 59 leaflets that we received are presented in Table 4. Four ICUs provided a specific internet website.

Telephone

Families could contact the ICU by a direct telephone line in 89 ICUs (94%). They were compelled to call the hospital telephone switchboard first in 6 (6%). Preassigned hours for telephone information were fixed in 37 (39%). Nurses were the main telephone information givers (Fig. 1). The questionnaire allowed additional comments on the issue of telephone information and medical privacy. Of the 75 ICUs that answered this specific question 21 gave all the information needed to an identified relative only, 26 gave no medical information over the telephone (prognosis, diagnosis, treatment), and 28 communicated with identified relatives only and gave no medical information over the telephone.

Family meetings

A structured first meeting with families was systematically organized in 68 ICUs (71%). Subsequent meetings were provided systematically in 10 (11%), at the family's request in 25 (26%), and both systematically and at the family's request in 60 (63%). A last family meeting at ICU discharge was provided in 6 (6%). A satisfaction questionnaire was available in 34 (36%).

Discussion

The limited number of contacted ICUs and the low percentage of completed questionnaires can represent a limitation on the accuracy of this description of ICU visiting policies in France. However, as shown in Table 1, characteristics of the responding ICUs appears to be representative for the ICUs in France. Moreover, the expected response rate for such a questionnaire study ranges between 17% and 33% according to previous e-mail [13] and postal questionnaire studies [14]. A 47.5% response rate with a wide variety of answering ICUs offers an interesting insight into the everyday practice of French ICUs. Three types of visiting policies can be found in the literature [5, 15, 16]. Open visiting allows families to visit at any time without any limitation of visiting slots during a 24-h period. Liberalized visiting consists of allowing visitors access during a 24-h period but curtailing visits at specific times stipulated by the staff for each family. Restrictive policies allow a fixed number of visitors at the same specific time slots for all families. Most of the responding ICUs impose restrictive policies regarding time, frequency, and length of visits as well as number and type of visitors. The literature is filled with studies which address the pro's or con's of open visiting policies [13, 14, 17, 18]. This debate can be summarized by the opposition of caregivers' and families' points of view.

From the relatives' point of view, one of their ten most frequently identified needs is to be able to visit the patient frequently [1]. Increased visitation has many positive effects on patients, including decreased sensory deprivation, decreased stress and anxiety, and increased

sense of well-being [4]. From the caregivers' point of view, the rationales for a restrictive policy are the protection of the patient and the protection of caregivers' work and avoidance of a psychological stress induced by the family: visits may be physiologically damaging to the patient, visitors run the risk of infection, and visiting disrupts the unit, draining the staff's time and energy, and distracting them from care [3, 16]. Intensive caregivers are at high risk of emotional and physical stress, and the sight of families being exposed to the same stress can lead to a protective response such as restrictive visiting policy [19] and even dehumanization of the critically ill person [20].

Patients, families, and caregivers traditionally agree to limiting children's visits. A previous survey of ICU visiting policies in 78 ICUs in the United States showed that only 11% had official policies allowing children to visit [3]. The reasons why children's visits remain restricted in ICUs are always the same: parents, patients, and caregivers want to protect children (and themselves) from additional stress and also to protect both patients and children from the risk of infection [20, 21].

Nowadays the situation seems to be reversed in France, where most of responding ICUs now permit children to visit. One pilot study showed that children who visited a critically ill family member demonstrated less negative behavior and emotional changes for than children who did not [22]. The most important aspects of facilitating visiting children are to prepare the child at an age-appropriate level and to prepare caregivers and parents with pediatric assessment and teaching skills [21, 22].

Contracting for visitation with families seems to be the best compromise between rigid rules and unregulated visitation [4, 23]. In this way the frequency, length of visits, and set of approved visitors are discussed and adapted to the needs of each individual family [4] and can be modified on a day-to-day basis [24, 25]. Many additional comments of the study questionnaire show that one-third of the responding ICUs do not take restrictive official policies literally, and that visiting policies are often adapted to individual cases. This probably anticipates an official contract visiting procedure.

A large majority of French ICUs impose a gowning procedure on the visitors. We found no other similar data about gowning in adult ICUs. The reason why visitors should be dressed in this way was not specifically asked in our study. One of the main reasons is perhaps to protect patients and visitors from infections. The efficacy of such a procedure has been studied in pediatric ICU and remains controversial [26, 27]. In fact, gowning may also act as a symbol of a restrictive visiting policy.

Waiting is one of the most difficult tasks for families [25]. One of the first needs identified by waiting families pertained specifically to the waiting area, which is one of the predictors of family satisfaction [11, 13, 23, 24, 25, 28]. This may help the 19% of French ICUs in this study which have no waiting room to advocate for one.

Providing an information leaflet is one of the recommendations for addressing the families' information needs [8, 24, 26]. It has been shown that families who have access to both open visiting and an information leaflet are the most satisfied [5]. The absence of an information leaflet is one of the factors independently associated with poorer comprehension [10]. A recent multicenter randomized and controlled trial has confirmed that a family information leaflet significantly improves comprehension [12]. We received 59 information leaflets differing in form and quality. The French Society for Critical Care recently provided a standardized information leaflet which could help French ICUs write or improve their own [29].

Telephone interruptions by patients' family members create an additional burden for the ICU staff, especially for the nurses [10, 30]. Moreover, telephoning can be a problem for the confidentiality of medical information. A study showed that the number of incoming calls from families could be reduced thought daily telephone communication of the patient's condition by the nurse to a designated relative at a time which has been previously agreed upon [30]. The telephone burden can also be reduced by fixing specific hours for obtaining telephone information, as 36% of the responding ICUs did so in our study. Other communication means are available: a program of telemedicine has been developed in a neonatal unit allowing a videoconference between the staff and the family at home [31]. It is surprising that only four ICUs provided internet websites in our study.

Family meetings are an important component of a structured communication program. The quality of the first meeting appears to be of fundamental importance, and a recent study demonstrated that the duration of this first meeting was associated with family comprehension [10]. The same work showed the lack of influence of the duration of subsequent meetings on comprehension, emphasizing the importance of the initial meeting. Most of the responding ICUs provide a structured initial meeting and seem to take into account its importance.

Many families claim that they receive information only after they explicitly request it [32]. Several authors think that information should be anticipated and given on a regular basis [24], especially since one-half of the families fail to ask to see the physician [10]. This should lead the 26 ICUs in our study who only give information after families request to change their practices.

Our study shows that very few ICUs provide a structured transfer program to prepare patients and their families for leaving the ICU. Both patients and family members perceive the transfer from the ICU to be a significant event, and it has been shown that 40% of patients and families consider the ICU discharge as a negative change in the level of care [33]. The lack of information

and education related to what to expect after transfer from the ICU to a general hospital unit appears to be one of the major factors which causes relocation stress [34]. A gradual decrease in nursing attention without compromising the quality of care [34], an information leaflet about the transfer [33, 34], and a checklist of subjects to cover in predischarge conversation with patients and families [34] have been reported as being helpful.

Providing a specific evaluation and preparation of patients at the ICU discharge can decrease transfer stress but can also play a role in the outcome. A significant number of patients die on general wards following ICU discharge because of potentially treatable complications that could have been prevented by a better evaluation of the patient's health status at discharge [35].

In conclusion, providing family member with information and emotional support through'out an ICU patient's hospitalization is an integral part of critical care, as are diagnosis, treatment, and technical monitoring procedures. Collecting data about ICU visiting policies is a good way of assessing caregivers' practices and mentalities about this important aspect of care. As our study shows, French ICUs provide quite homogeneously restrictive visiting policies concerning visiting hours and number and type of visitors. However, families reception cannot be reduced to quantitative factors and depends on multiple other parameters. Nowadays the French Society for Critical Care is promoting recommendations to help French ICUs improve their visiting policies [29], and the results of our study should be an interesting starting point to observe any change in mentalities and practices in the future. It would be interesting to reproduce such a study in other European countries to standardize the European ICUs' visiting policies.

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