Intensive care unit staff will not go back to restricted visiting hours

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Editor—The well-being of patients and their families in the stressful environment of the intensive care unit (ICU) is of prime concern for the modern intensivist and the ICU staff. Several scientific societies strongly recommend a 24 h visiting policy in the ICU, modelling the 21st century ‘patient-centred’ ICU. Nevertheless, a great geographical disparity exists; ICUs with liberal visiting hours account for only 70% of ICUs in Sweden, 32% in the USA, 7% in France, and 2% in Italy.

The positive outcome of this measure is well documented from a patient and his or her family’s perspective. However, fewer studies have focused on the staff’s perception of such a policy. The most cited drawbacks regarding unrestricted visitation are as follows: fear of care disorganization; loss of control; and fatigue of both patients and staff. We aimed to evaluate the evolution of the staff’s perception of this measure over a 3 yr period. Given the initial lack of consensus, this evaluation was a commitment made to our staff, with a return to a restricted visiting policy as a possible result.

Our regional trauma centre adopted an unrestricted visiting policy in April 2010. Nurses’ perception of this measure was analysed 9 months (T1) and 3 yr (T2) after the switch. The survey evaluated the staff’s satisfaction with the extension of visiting hours (impact on quality of care and organization, and effect on staff’s relationship with patients’ families) and their wish to go back to a restricted visiting hours policy. It also included staff data on sex, age, and years of ICU experience. It was developed from a survey used in previous research on the subject and was tested prior to investigation. In order to avoid social desirability bias, it was anonymous and self-administered.

Statistical analysis was performed using Fisher’s exact test, a Mann–Whitney U-test and a logistic regression.

Forty-four staff members responded to each step (participation rate of 72%). There were no differences between the two time points in terms of age, sex, and years of experience of the staff members. All respondents had experienced both restricted and liberal visiting hours in their practice. In the years after this major change, a slight disorganization of care schedule (but not its quality) is still perceived but has diminished thanks to the adaptation of our team. This drawback is largely outweighed by the benefits derived from an improved relationship with patients’ families. With time, fewer staff members wish to return to restricted visiting hours (Table 1).

We believe that this study may encourage ICU staff and health-care leaders to accept the urgent challenge of liberalizing our visiting policies.

Declaration of interest

None declared.

Table 1 Evolution of staff’s opinion after implementation of a 24 h open visiting policy

<table>
<thead>
<tr>
<th>Opinion</th>
<th>9 months after the switch (n=44)</th>
<th>3 yr after the switch (n=44)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative impact on care quality (%)</td>
<td>14</td>
<td>11</td>
<td>0.5</td>
</tr>
<tr>
<td>Negative impact on care organization (%)</td>
<td>57</td>
<td>27</td>
<td>0.01</td>
</tr>
<tr>
<td>Improved relationship with patients’ families (%)</td>
<td>63</td>
<td>89</td>
<td>0.02</td>
</tr>
<tr>
<td>In favour of returning to a restricted visiting hours policy (%)</td>
<td>23</td>
<td>2</td>
<td>0.007</td>
</tr>
</tbody>
</table>
Editor—Venous thromboembolism (VTE) is a known cause of death. Approximately 25 000 people die from preventable hospital acquired VTE every year in the UK and 71% of patients at risk of developing VTE do not receive prophylaxis.1 National Institute of Clinical Excellence (NICE) guidelines do not recommend routine VTE prophylaxis during ophthalmic surgery under regional anaesthesia.2 This advice is perhaps applicable to cataract surgery. Complex and prolonged vitreoretinal (VR) surgery with intravitreal gas injection, requiring special postoperative posture, immobilizes patients and the VTE risk increases commensurately.

We conducted an electronic survey (Google Docs™) of 33 international anaesthetists involved in the management of VR surgery. These anaesthetists had participated as speakers in three consecutive World Congresses of Ophthalmic Anaesthesia from 2004–2014. One anaesthetist from each country was included in the survey. Twenty responses (response rate 60.6%, 16 consultants and 4 specialists) were received and the responding anaesthetists had >11 years’ experience. Forty five percent of respondents had seen cases of VTE after VR surgery. Although a majority of respondents felt that the intraoperative use of VTE prophylaxis was important regardless of anaesthesia technique used, preventive measures were not routinely instituted. While 65% of respondents felt that VTE prophylaxis should be used routinely during special postoperative guidelines, 30% were of the opinion that it was unnecessary. Respondents were cognizant of simple and other combined methods of preventing VTE such as good hydration, pneumatic compression, anti-embolic stockings, frequent leg exercises (on the operating table in awake patients), mobilizing break every hour and thermoelastic socks, however, they would not utilize these methods for their patients. More than 95% of respondents were concerned in the scenario when systolic blood pressure was higher than 180 mm Hg and diastolic pressure higher than 100 mm Hg; 90% of respondents would be very concerned if platelet count was <50 000, if there was a history of bleeding (haemophilia, von Willebrand disease, Factor VIII deficiency) or recent stroke, and in patients receiving antithrombotic agents.

Only 10% were aware of departmental guidelines, while 90% did not know if any local, national or international guidelines existed; 40% stated that there were routine checks for indications or contraindications to anti-embolic stockings in preassessment clinics, while 60% were unaware. Only 25% of respondents routinely assessed for postoperative signs and symptoms of VTE such as calf pain, calf swelling, dyspnea, hypoxemia, chest pain and desaturation.

This survey has certain limitations. We would have liked to increase the sample size by including more countries and perhaps more anaesthetists from each participating country but the logistics were prohibitive. The response rate was less than desired because some had retired from active clinical practice, some probably did not receive our request because of change in the email addresses, whilst some might have felt this issue clinically unimportant.

We have identified that anaesthetists are aware of the risk of VTE during prolonged VR surgery and postoperative posturing. Despite the availability of simple preventative measures, prophylaxis is not routinely offered. We also identified that there are no published robust guidelines for VTE prophylaxis, in patients undergoing VR under regional anaesthesia. Results of an earlier survey of 24 members of British and Eire Association of Vitreoretinal Surgeons (BEAVRS),3 which recommended that VTE risk assessment should be undertaken on patient over the age of 60, undergoing a procedure under general anaesthesia and even regional anaesthesia, should the patient be required to lie still for the prolonged surgery. Our survey supports BEAVRS findings. Perhaps a large multicentre study is desirable and future data will help in producing international guidelines.

Declaration of interest
None declared.

References
2. NICE Clinical Guideline 92. Venous thromboembolism: reducing the risk. Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients

Venous thromboembolism prophylaxis during vitreoretinal surgery – a snapshot survey of international ophthalmic anaesthetists

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References

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