AACN Practice Alert

Family Visitation in the Adult Intensive Care Unit

Scope and Impact of the Problem

Evidence shows that the unrestricted presence and participation of a support person (ie, *family* as defined by the patient) can improve the safety of care and enhance patient and family satisfaction. This is especially true in the intensive care unit (ICU), where the patients are usually intubated and cannot speak for themselves. Unrestricted visitation from such a support person can improve communication, facilitate a better understanding of the patient, advance patient- and family-centered care, and enhance staff satisfaction.

Expected Practice

1. Facilitate unrestricted access of hospitalized patients to a chosen support person (eg, family member, friend, or trusted individual) who is integral to the provision of emotional and social support 24 hours a day, according to the patient's preference, unless the support person infringes on the rights of others and their safety, or the support person's presence is medically or therapeutically contraindicated.[1] [level D]
2. Ensure that the facility/unit has an approved written practice document (ie, policy, procedure, or standard of care) for allowing the patient's designated support person—who may or may not be the patient's surrogate decision maker or legally authorized representative—to be at the bedside during the course of the patient's stay, according to the patient's wishes.[1-6] [level D]
3. Evaluate policies to ensure that they prohibit discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and/or gender identity or expression.[1-6] [level D]
4. Ensure that an approved written practice document (ie, policy, procedure, or standard of care) for limiting visitors whose presence infringes on the rights of others and their safety or whose presence is medically or therapeutically contraindicated is available to support staff who are negotiating visiting privileges.[6] [level D]

AACN Levels of Evidence

Level A Meta-analysis of quantitative studies or metasynthesis of qualitative studies with results that consistently support a specific action, intervention, or treatment (including systematic review of randomized controlled trials)

Level B Well-designed, controlled studies with results that consistently support a specific action, intervention, or treatment

Level C Qualitative studies, descriptive or correlational studies, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results

Level D Peer-reviewed professional and organizational standards with the support of clinical study recommendations

Level E Multiple case reports, theory-based evidence from expert opinions, or peer-reviewed professional organizational standards without clinical studies to support recommendations

Level M Manufacturer's recommendations only

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Supporting Evidence

In practice, 78% of ICU nurses in adult critical care units prefer unrestricted policies[7-13]; yet, studies show that 70% of hospitals' ICU policies restrict family visitation.[3,7-9,13,14] This disconnect creates conflict between nurses and confusion in patients' families.[10,15]

Some ICU nurses believe that family visitation increases physiological stress in the patient and interferes with the provision of care,[16] is mentally exhausting to patients and their families,[11,15-19] and contributes to increased infection[8,19]; however, the evidence does not support these beliefs.[8-9,20-29]

Evidence does suggest that for patients, flexible visitation decreases awnxiety,[17,20,21] confusion, and agitation,[22] reduces cardiovascular complications,[20] decreases length of ICU stay,[30] makes the patient feel more secure,[31] increases patient satisfaction,[14,20,29,31-33] and increases quality and safety.[20,24-26,34-36]

For patients' family members, evidence suggests that unrestricted visitation increases satisfaction,[7,11,17,20,29,36-38] decreases anxiety,[7,17,29,36,39,40] promotes better communication,[11,14,17,24,29,41] contributes to better understanding of the patient,[11,32,36] allows more opportunities for patient/family teaching as the family becomes more involved in care,[11] and is not associated with longer family visits.[36]

Finally, evidence suggests that some nurses in adult ICUs restrict children's visits on the basis of intuition that children will be harmed by what they see or a concern that visiting children would be uncontrollable. These biases are not grounded in evidence or based on the patient's or the child's actual needs.[8,42-44] Rather, when allowed to visit relatives in the ICU, properly prepared children exhibit less negative behavior and fewer emotional changes than do children who do not visit.[45-48] It is recommended that children be allowed to visit unless they carry contagious illnesses.[49]

Actions for Nursing Practice[3]

Ensure that your health care facility has policies and procedures that support unrestricted visitation in the ICUs—rules that allow unrestricted contact between patients and welcome members of their support systems while also protecting the privacy of other patients and the safety of patients and staff.

Senior executives provide leadership and support for changing restrictive visiting policies and practices. Actions include the following:

1. Prioritizing clear communication of policies regarding unrestricted visitation to patients, patients' families, and communities through appropriate informational materials
2. Developing organizational infrastructure to support this change in policy and practice, and ensuring that key stakeholders—including executive leaders, midlevel managers, front-line staff, and patients and family members who are prepared to serve as advisers—are a part of the process
3. Supporting a patient's right to identify individuals whom the patient views as "family" and chooses to be their "partners in care," without discrimination
4. Creating policies, procedures, and educational programs for professional staff that include the following components:
    a. The benefits of unrestricted family visitation
    b. The right of family members, as defined by the patient, to have unrestricted access to the patient to provide support, comfort, and important information across the continuum of the patient's hospitalization
    c. Written notification to patients and patients' families of their rights to family visitation, including any reasons for clinical restrictions or limitations

Proficiency standards that include the following:

1. Families and other partners are welcomed 24 hours a day according to the patient's preference
2. When possible, at the beginning of the ICU experience, patients are asked to define their "family" and how family members will be involved in care and decision making
3. At this time, patients identify designated representatives such as health care power of attorney or a health care proxy
4. Patients' preferences are documented in the paper or electronic record and communicated

consistently and comprehensively to all involved in patient care across all settings
5. When the patient is unable to communicate and cannot designate who should be present, hospital staff make the most appropriate decisions possible, taking into account the broadened definition of family as "partners in care"
6. Nurses and others on the health care team provide guidance to patients, patients' families, and other partners in care regarding:
    a. How to partner with the staff to ensure safety and quality of care
    b. How to be involved in care, care planning, and decision making, and how to support the patient during hospital care and transition to home
    c. How to honor privacy and be respectful of other patients and their families in close proximity or who share the same room
7. Patients, patients' families, nurses, and other members of the health care team can reevaluate and modify the presence and participation of families on the basis of safety criteria; all such collaborative decisions will be documented in the patient's record
8. The number of people at the patient's bedside at any one time will be determined in collaboration with the patient and his or her family; in situations where rooms are shared, this negotiation will include the other patient, his or her family, and the other partners in care
9. Families are encouraged to designate a family spokesperson to facilitate effective communication among extended family members and hospital staff

Children supervised by an adult family member are welcome.

1. Children are not restricted by age; although younger children may be developmentally unable to remain with the patient for lengthy periods of time, contact with these children can be of significant importance to the patient
2. Children are prepared for the hospital environment and the family member's illness as appropriate
3. Children are expected to remain with the adult who is supervising them unless there is a supervised playroom for siblings and other children
4. Children's behavior is monitored by a responsible adult and the nurse to ensure a safe and restful environment for the patient(s) and a positive and devlopmentally appropriate experience for children

A policy for restricting visitation by family and partners in care should include the following:

1. Family members and "partners in care" who are involved in abusive, disruptive, or unsafe practices will be addressed directly and promptly
2. All partners in care and guests of the patient must be free of communicable diseases and must respect the hospital's infection control policies
3. If an outbreak of infection requires some restrictions for public health, the staff must collaborate with the patient and the patient's family to confirm that selected family members are still welcome, to ensure safety and offer emotional support to the patient

Determine your unit's rate of compliance in ensuring patients have unrestricted access to designated support persons during the ICU stay. If compliance is ≤ 90%, develop a plan to improve compliance.

1. Consider forming a multidisciplinary task force (eg, nurses, physicians, chaplains, social workers, child life specialists) or a unit core group of staff to discuss approaches to improve compliance
2. Reeducate staff about family visitation, and discuss the patient- and family-centered approach and the evidence-based practice of unrestricted visitation
3. Incorporate content into orientation programs as well as initial and annual competency verifications
4. Develop a variety of communication strategies to alert and remind staff about the benefits of unrestricted visitation
5. Document standards for unrestricted visitation, including rationale for when restricted

visitation would be necessary for the protection of the patient, the family, other care providers, or the staff

Need More Information or Help?

1. Contact a clinical practice specialist for additional information: go to www.aacn.org/practice-resource-network
2. Institute for Patient- and Family-Centered Care (IPFCC). Changing hospital "visiting" policies and practices: supporting family presence and participation. http://www.ipfcc.org/visiting.pdf. Published 2010. Accessed October 12, 2015.
3. The AACN website, which offers resources and tools for revising hospital policies and for educating members of the health care team. In particular, the "Creating a Healing Environment" protocol series has chapters on "Family Visitation and Partners in the Critical Care Unit," keeping in mind the 2010/2011 definition of "family" changes. This protocol provides detailed information regarding who should visit, how to establish policies, visitation options, preparing families for visitation, facilitating family partnerships, and promoting family-centered care. The protocol also offers detailed information regarding children and animal visitation in critical care areas. You may order this product, #170690, from the AACN Online Bookstore or by contacting AACN Customer Care at (800) 899-2226.
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September 2011

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March 2015

Reviewed and approved by the AACN Clinical Resources Task Force, 2015

Financial Disclosures
None reported.

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