The “open” ICU: not just a question of time

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“Restricting visiting in ICUs is neither caring, compassionate, nor necessary”
Berwick DM, Kotagal M (JAMA 2004)

Traditionally, visiting in Intensive Care Units (ICUs) was severely restricted or even prohibited, as being at best an irrelevance at worst as downright dangerous. Indeed, it was long feared that relatives and visitors represented both a threat to patients (via the risk of infection and increased stress) and a hindrance to patient care; however, we now know that there is no sound scientific basis for limiting visitors’ access to ICUs.1-3

Not only are the reasons for restricting visits groundless, but there are strong arguments in favor of liberalizing access to ICUs for patients’ families. Current studies show that separation from family is a significant cause of suffering for ICU patients,4 and that for the family, proximity to their loved one — while largely disregarded by nurses and physicians — represents one of their principal needs (together with reassurance, information, support and comfort).5

Moreover, for patients in adult ICUs, liberalization of visiting has been found to significantly lessen cardio-circulatory complications, as well as reducing patient anxiety and hormonal stress indicators.6 It is worth noting that admission of a loved one to the ICU is an important stressor for relatives, with one-third of family members suffering from post-traumatic stress symptoms.7 By contrast, an open visiting policy can lessen anxiety in family members of ICU patients.8

All of these benefits have led to a widespread consensus that the liberalization of visiting in the critical care setting is a useful and effective strategy in meeting the needs both of patients and of their families.1, 2 It has been recommended that visiting, particularly in pediatric units, should be open to families 24 hours a day.9 In spite of this, restricted visiting policies persist to a varying extent in many countries,10 so that admission to the ICU continues to be accompanied by a kind of additional (and needless) “price” to pay, not related to the illness that triggered the admission but due instead to isolation and reduced contact with loved ones.

In Italian ICUs, there is a marked and widespread tendency to maintain restrictive visiting policies10: only 0.4% of units allow relatives 24-hour bedside access. However, current policies are now being re-evaluated, and a process of change has begun.10

The interesting study by Biancofiore et al. published in the current issue of Minerva Anestesiologica11 describes the beliefs and attitudes of physicians and nurses in units in Tuscany about the “open” ICUs. The work highlights the persistence of a certain resistance and a number of prejudices regarding the liberalization of visiting policies, particularly among nurses. Interestingly, roughly one quarter of respondents were “neutral” towards open ICU and almost half acknowledged that they needed more information about this type of approach.

From the picture outlined in this study, we may deduce that in the surveyed ICUs there is not yet a full awareness that the presence of loved ones at the bedside is beneficial for the patient and that in the critical care setting family is actually a resource rather than a hindrance.12

However, I would like to propose a shift in perspective. Creating the “open” ICU is not just a question of time: we also need to consider “open-
ness” in terms of physical and relational dimensions. The physical dimension includes all of the barriers suggested to or imposed upon the visitor, such as no physical contact with the patient, gowning procedures (of no value in infection control), etc. The area of relationships involves the communication — often fragmentary, compressed or even non-existent — among ICU staff, patients and families. If we also address these aspects, an “open” ICU may be defined as a unit in which one of the caregivers’ objectives is a carefully considered reduction or elimination of any limitations imposed on these three dimensions (temporal, physical and relational) for which there is no justified reason.³

In my view, there are at least four courses that we must now pursue in Italy. The first concerns information and education of ICU physicians and nurses. We must invest time and resources in increasing the knowledge of and the sensitization to these issues (visiting policies, patient and family needs, patient-centered ICU, etc.) among caregivers.

Second, there is a great need for research into these issues and, in particular, investigation into any difficulties that liberalizing visiting could cause for ICU staff (e.g., anxiety, stress and overwork). It is essential to create a picture of the problems, to understand their causes and extent, in order to identify possible solutions and offer nurses and physicians appropriate support.

Third, communication skills must be fully recognized as a specific area of professional competency for ICU caregivers that need to be improved or updated. In addition, as recently recommended, ⁹ ICU staff should also receive training in conflict management, meeting facilitation skills, and assessment of family needs and family members’ stress and anxiety levels. Today, the cultural baggage of the intensivist can no longer be limited exclusively to practical “knowhow”; in the care of the ICU patient, clinical skills and familiarity with technology are a necessary but not sufficient condition.

Finally, unrestricted visiting should be made a requirement for a hospital’s accreditation in the Italian National Health Service.

Those who already operate in an “open” ICU know that working in full view of family members helps to reassure relatives, strengthening their conviction that their loved one is being cared for with commitment and continuity. Moreover, “open” access improves communication between family and caregivers, increases trust in and appreciation for the ICU team, and offers the possibility to face death with greater care, with different language and gestures from the customary ones.

It is not always easy to “open” our ICUs. It necessarily involves disrupting the rhythms and rules of a well-established and reassuring tradition. But what is needed above all is a certain degree of cultural change and serious consideration regarding the value and quality of relationships with patients and their families.

References