

**PERCEPTIONS AND PREFERENCES OF PATIENTS,  
FAMILY/FRIENDS AND NURSES ON VISITING TIME IN ICU**

by

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Student number: 834-966-5

## DECLARATION

I declare that **PERCEPTIONS AND PREFERENCES OF PATIENTS, FAMILY/FRIENDS AND NURSES ON VISITING TIME IN ICU** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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# PERCEPTIONS AND PREFERENCES OF PATIENTS, FAMILY/FRIENDS AND NURSES ON VISITING TIME IN ICU

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## ABSTRACT

Advances in science and technology have made nursing practice in acute care settings complex, rapid and demanding. Hospital visiting hours and rules are established for the comfort and safety of patients and their loved ones. In addition, there is the need to focus on the needs of 'the customer'.

The researcher adopted a descriptive, exploratory approach to determine the perceptions and preferences of patients, family members/friends and nurses of visiting time in ICUs. The aim was to recommend mechanisms and measures with regard to the desired visiting schedule that would enhance patient-centred integrated care in ICUs.

The study found that patients and family members/friends preferred extended visiting time and perceived this as beneficial to them, while the majority of the nurses preferred scheduled visiting time.

## KEY CONCEPTS

Expanded visiting time; open visiting time; patient; family; intensive care unit; perception; preferences.

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## List of abbreviations

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ICU Intensive care unit

RN Registered nurse

## List of annexures

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# CHAPTER 1

## Orientation to the study

### 1.1 INTRODUCTION

Hospitals establish daily visiting hours and rules for the comfort and safety of patients and their loved ones. The need to minimise disruption to the therapeutic environment of critically ill patients while giving patients and their families' time to be together is an integral part of patient-centredness and patients' recovery.

Scheduled visiting hours are emphasised to reduce physiological stress for the patient, to allow for the adequate provision of routine care to the patient and to prevent exhaustion of the patient. The American Institute for Health Care Improvement stresses improved care, which includes open or unrestricted visiting policy by health care institutions (Berwick & Kotagal 2004:736). This view is in line with the increasing shift in the management of the patient from a clinical-centred or disease focus to patient-centredness.

The National Research Corporation and Picker Survey identified tenets of patient-centred care including respect for patients values, preferences and expressed needs (National Research Corporation and Picker Brochure 2005:4). Open visitation is encouraged to enhance flexibility and the presence of family, which helps to improve the patient's well-being and serves as diversion from hospital routine (Sims & Miracle 2006:177).

In this study the researcher wished to describe the perceptions and preferences of patients, nurses and family on visiting time in an intensive care unit (ICU).

### 1.2 BACKGROUND TO AND MOTIVATION FOR THE STUDY

Advances in science and technology have made nursing practice in acute care settings highly complex and rapid and demanding. Critical illness is associated with panic, anxiety, loss of control, and crisis functioning therefore the patient and the family need support to cope positively with the situation. Positive coping mechanisms include more

liberalised visitation which are often beneficial in facilitating communication between family, patient and health care team (Roland, Russell, Richards & Sullivan 2001:24).

Berwick and Kotagal (2004:737) and Petterson (2005:72) maintain that open visiting times do not harm patients but rather may help them by providing a support system and shaping a more familiar environment.

According to Peterson (2005:70-72), open visiting policies are meant to provide a support system and trust in families. Families want proximity to and information about their loved ones, but the benefits of having a patient's family members present during hospitalisation depends on the patient's condition and the visiting time policies. Open visiting policies engender trust in families, creating a better working relationship between hospital staff and family members (Peterson 2005:72).

Flarey and Blancett (1996:7) state that "health care professional's view the patient and family as a unit in need of care". Caring for the patient's family is another way of caring for the patient, says Stannard (2000:382). In order to contain cost, "it is very likely that patients will be discharged in the dependant stage; hence the need for families to observe therapy and visit more frequently" (Federwisch 1998). Messner (1996:28) points out that cost containment combined with the increased competition for healthcare dollars is forcing hospitals to focus on the needs of "the customer" and adopt a more "patient-centred" approach with liberalised visiting time.

Roland et al (2001:24) and Clark (2005:10) found that changing to more liberalised/open visitation led to improved patient and family satisfaction with the overall ICU experience. Marfell and Garcia (1995:87) also state that by implementing flexible visiting time consumer satisfaction is influenced, relationships are enhanced thereby ultimately promoting quality patient care. Hupcey (1999:255), Peterson (2005:70) and Krapohl (1995:254) state that having family and friends present lessened anxiety levels in patients.

Despite the research and literature stressing the advantages of open visiting time, ICU's visiting time remains restricted at the hospital in which the researcher is employed. The researcher works in a twelve-bed coronary/neuro-surgical ICU in a private hospital in KwaZulu-Natal, in the city of Durban. Patients nursed in ICU and especially in coronary

and neuro-surgical units require very little stimuli. Visitors are allowed between 15:00 and 16:00 and again between 19:15 and 20:00. Visiting times are restricted to immediate family and only two members per time. Visiting duration totals 1 hour and 45 minutes in 24 hours. This background led the researcher to undertake the study.

## **1.2 RESEARCH PROBLEM**

Visiting time allows the family of critically ill patients to be with their loved ones. However, nurses are sometimes uncomfortable with the family presence in ICU. Their discomfort may create a barrier to family involvement. According to Berwick and Kotagal (2004:736), keeping family physically away from patients by restricting visiting time implies that families are a problem. Those patients in ICU, especially neuro/coronary patients, require decreased stimulation is a realistic concern. Nevertheless, family members should not be deprived of an opportunity to support patients (Stannard 2000:384).

ICU health professionals recognise the importance of the patient-centred approach, and the role of the family in the recovery of patients in ICU. The physiological effects, such as over stimulation, disruption and minimising of infection, remain crucial factors that affect visiting time in ICU and may in part account for nurses' concern regarding visiting time (Sims & Miracle 2006:177). Family members express a desire for more contact with their critically ill patients.

In the study done by Fumagalli, Boncinelli, Lo Nostro, Valoti, Baldereshi, Di Bari, Ungar, Baldasseroni, Geppetti, Masotti, Pini and Marchionni (2006:952) found that liberalising visiting time did not increase septic complications but might reduce cardiovascular complications. However, families and significant others often feel disenfranchised from frequent contact due to the scheduled visiting times (Barclay & Lie 2007:1).

The literature reviewed advocates the advantages of more liberalised visiting times. Despite this, ICU visiting time remains restricted in the ICU where the researcher is employed. The researcher found no research on the topic conducted in South Africa.



## **1.4 RESEARCH QUESTION**

The study wished to answer the following question:

- What are the perceptions and preferences of patients, family/friends and nurses on visiting time in ICUs?

## **1.5 PURPOSE OF THE STUDY**

The purpose of this study was to determine the perceptions and preferences of patients, nurses and family/friends on the visiting time in ICUs.

## **1.6 OBJECTIVES**

To answer the research question, the study wished to

- describe the perceptions and preferences of patients, family members/friends and nurses of visiting time in ICUs
- recommend mechanisms and measures with regard to the desired visiting schedule that would enhance patient-centred integrated care in ICUs

## **1.7 PARADIGMATIC PERSPECTIVES AND ASSUMPTIONS**

According to Polit and Hungler (2003:63), research should be based on the foundations of accepted knowledge and theory of assumptions. Researchers' actions require a reference to a paradigm. A paradigm is a world-view of a predictive or envisaged set of beliefs. Lincoln and Guba (1985:15) state that as "the man thinks so is he". Patton (2002:252) views a paradigm as a way of breaking down the complexity of the world, and as such is deeply embedded in the socialisation of the inquirer. It is a collection of sequential, connected concepts and assumptions that provides a theoretical perspective or orientation that frequently guides the researcher's approach (Field & Morse 1985:138). These assumptions are related to the nature of reality (the ontological), the nature of origin of the researcher's knowledge of what is being researched (the epistemological), and the process of research (the methodological) (Creswell 1998:74).

Paradigms represent a distillation of what is known about the world. They are general perspectives, a way of breaking down the complexity of the real world.

In this study the researcher selected certain assumptions from the quantitative positivism approach in response to her interaction with the phenomenon under study.

### **1.7.1 Assumptions of the study**

An assumption is a proposition or statement whose truth is considered self-evident of what has been satisfactorily established by earlier research. Assumptions are basic principles that are accepted as true on the basis of logic or reasoning without proof of verification. These assumptions influence the development and implementation of the research process. Assumptions influence the logic of the study; their recognition leads to more rigorous study development (Burns & Grove 2001:146). According to Chinn and Kramer (1999:76), assumptions are not intended to be empirically tested but are underlying givens, which can be challenged.

#### **1.7.1.1 Epistemological assumptions (knowledge of what is being researched)**

Epistemological assumptions are assumptions about the nature of knowledge and science, or about the content of truth and related ideas (Mouton 1996:123). They offer the epistemic pronouncement. Epistemological assumptions are theoretical perspectives and interrelated sets of assumptions, concepts and propositions that constitute a view of the world (Henning, Van Rensburg & Smit 2004:15). In this study the researcher conducted a literature review and selected theoretical assumptions from patient family-centred approach and patient centred-approach.

The researcher assumed that:

- Open/expanded visiting time does not increase infection rates or have significant physiological effects on the patient in ICU.
- Allowing family members/friends to visit more often has a positive influence on a patient's recovery and care in ICU.
- Open/expanded visiting time will therefore enhance patient-integrated care.

### **1.7.1.2 Methodological assumption**

Once the researcher had made epistemological assumptions, it was necessary to make methodological assumptions. The researcher adopted the quantitative approach of the research method. She aligned herself with Babbie and Mouton (2002:48) who are of the opinion that individuals attitudes, perceptions and preferences can be quantified by assignment of numbers to perceived qualities. In this study the researcher was not interested in the description of the written or spoken words of subjects. The intention was to obtain a statistical picture of the respondent's views on the topic. Methodological assumptions explain the method and specific means the researcher uses to understand the phenomenon (Polit & Hungler 1995:11). The researcher assumed that:

- quantifying the subjects preferences and perceptions would give the researcher a statistical indication of the of the participants views and opinions on visiting time in ICU.

## **1.8 DEFINITION OF TERMS**

For the purposes of this study, the following terms are used as defined below.

- **Expanded visiting time**

To **expand** means “to make or become greater in extent, volume, size or scope; increase; to spread out; unfold; stretch out” (*Collins English Dictionary* 2006:275).

**Expanded visiting time** in this study means that scheduled visiting times are extended to four times a day as follows: 10:00-11:00; 15:00-16:00; 19:15-20:00, and 21:00-22:00.

- **Family**

A family can be defined as any group of people who live together whether a nuclear family or extended family (Taylor, Lillies & Le Mone 2005:28). In this study family refers to a group of people related by blood.

- **Intensive care unit (ICU)**

Adam and Osborne (2004:1) define an ICU as a clearly defined area within a hospital where the skills of specialist personnel and technology can be combined in the management and care of the critically ill patients. In this study patients admitted to the ICU refer to those that are admitted as a result of medical and/or surgical intervention, or in an emergency where the reason for clinical diagnosis/deterioration is uncertain, who require close observation and or specialised treatment that cannot be provided in a general ward(Adam & Osborne 2004:1).

- **Nurse**

The *Encyclopaedia Britannica* (2002:834) defines a **nurse** as “a person who is skilled or trained in nursing” and **nursing** as “a healthcare profession concerned with providing physical and emotional care to the sick and disabled and with promoting, maintaining and restoring health in all individuals”. In this study, a nurse refers to registered professional nurses, enrolled nurses and nursing auxiliary registered with the South African Nursing Council and enrolled under section 16 of the Nursing Act, 50 of 1978, as amended, as a nursing auxiliary, enrolled nurse or registered nurse; as these are the categories who could render patient care in ICU (South Africa 1978:13).

- **Open visiting**

“Open” means, “not closed or restricted; to make or become open, give access to” (*Oxford Dictionary Thesaurus and Word Power Guide* 2005:474). In this study open visiting refers to unrestricted friends or family visits to patients with the acceptance and understanding of the set guidelines (see chapter 3).

- **Patients**

A patient is “a person who is receiving medical care” (*Collins English Dictionary* 2006:596). In this study, patients refer to all persons admitted to the ICU for a minimum period of 24 hours and subsequently transferred to the ward.

- **Perception**

Taylor et al (2005:178) define perception as “a concern with describing the world as experienced by human beings and with relating this world to the physical environment, the structure and physiology of the organism and impact of prior environmental conditions on the currently perceived world and the act of perceiving; insight or intuition; the ability to perceive; way of viewing”. In this study, perceptions refer to the views and understanding of patients, family members/friends and nursing staff.

- **Preference**

*Collins English Dictionary* (2006:641) defines preference as “a liking for one thing above the rest; a person or thing preferred; preferred – meaning to like better”.

- **Scheduled visiting time**

*Collins English Dictionary* (2006:734) defines schedule as “to plan and arrange (something) to happen at a certain time”.

*Collins English Dictionary* (2006:935) defines visiting hours as “the times when visitors are allowed to see someone in a hospital or other institution”. In this study, scheduled visiting time refers to the time that family/friends are scheduled to visit the patient as per hospital policy. The scheduled ICU visiting time according to hospital policy is as follows: 15:00 – 16:00 and 19:15 – 20:00.

## **1.9 SIGNIFICANCE OF THE STUDY**

It was envisaged that this study would add to the body of knowledge on visiting times in ICU. Knowing and honouring patients and family view would promote patient-centred care, could influence policy on current visiting time practices in ICU and would add to the existing literature on enhancing patient care.

## **1.10 OUTLINE OF THE STUDY**

Chapter 1 briefly discusses the research problem and study objectives and methodology.

Chapter 2 describes the research design and methodology.

Chapter 3 discusses the literature review undertaken for the study.

Chapter 4 covers the data analysis and interpretation.

Chapter 5 discusses the findings and limitations of the study, and makes recommendations for practice and further research.

## **1.11 CONCLUSION**

This chapter discussed the research problem, the purpose, objectives, paradigmatic perspectives and significance of the study, and presented a brief outline of the study.

Chapter 2 discusses the research design and methodology.

## **CHAPTER 2**

### **Research design and methodology**

#### **2.1 INTRODUCTION**

This chapter discusses the research design and methodology. A method is a way of doing something and refers to the steps, procedures and strategies employed for collecting, organising and analysing data (Henning et al 2004:17). In this study the researcher adopted a quantitative descriptive research design.

#### **2.2 RESEARCH DESIGN**

Mouton (2004:55) and Burns and Grove (2005:211) define a research design as a plan or blueprint for a study. Brink (1996:100) describes it as a framework of how a researcher intends conducting the research process in order to solve a problem. It is a set of logical steps taken by the researcher in an attempt to answer the research question. The choice of design depends on the expertise of the researcher, the problem, and the purpose of the research (Brink 1996:59). A research design helps a researcher to be objective and ensures a systematic approach to knowledge (Mouton 2004:55-57).

In this study the researcher adopted a non-experimental, quantitative, descriptive and exploratory design to answer the research question and achieve objectives of the study.

##### **2.2.1 Quantitative**

A quantitative design is based on the assumption of quantification of constructs. in Quantitative researchers believe that individuals' attitudes, perceptions and preferences can be quantified by assigning a number to the perceived qualities of things (Babbie & Mouton 2002:48).

According to Polit and Beck (2004:20), a quantitative descriptive design focuses on prevalence, incidence, size and measurable variables. In this study the phenomenon was observed, described and quantified. The researcher adopted a quantitative design

because the perceptions and preferences of patients, family members/friends and nurses of open/expanded visiting time were quantified numerically.

This study utilised the survey method to describe the identified area of concern. According to Burns and Grove (2005:233), descriptive studies use surveys to describe an identified area of concern. This study used a questionnaire as the survey tool for data collection.

### **2.2.2 Exploratory**

According to Talbot (1995:90), exploratory research “is commonly conducted when a review of the literature reveals that little is known about some phenomenon. This approach attempts to explore the dimensions of a phenomenon; the manner in which it is manifested and any other factors that may be related to the area under investigation.” Using this approach, the researcher aimed to gain a richer understanding of “visiting time in ICU”.

### **2.2.3 Descriptive**

Once a phenomenon has been explored, it is necessary to describe what has been observed. According to Strauss and Corbin (1990:22), the purpose of descriptive studies is “to emphasise the description of a specific individual, group, situation, interaction or social object”. Burns and Grove (2005:232) state that a descriptive design may be used for the purpose of developing theory, identifying problems with current practice, justifying current practice, making judgments or determining what others in similar situations are doing and is critically important for acquiring knowledge in an area in which little research has been done.

Surveys are excellent tools for measuring attitudes and orientations in a large population. The data may be obtained from a total population or from a representative sample from which generalisations may be made (Polit & Beck 2004:56). The researcher used a survey because this study was non-experimental and focused on obtaining information regarding the respondents’ perceptions and preferences.



## **2.3 POPULATION**

A population refers to “the entire set of individuals having some common characteristic” (Burns & Grove 2005:342). A population includes the target and the accessible population (De Vos 2000:198). The target population refers to all the individuals who meet the criteria for inclusion while the accessible population consists of the individuals who conform to the criteria and are available for a particular study (De Vos 2000:198; Polit & Hungler 1995:230). However, the target population might not be manageable due to size, location and other practical considerations. In such cases, the accessible population becomes practical (Burns & Grove 2005:342).

In this study, the population consisted of three categories, namely:

- All patients admitted to the ICU for a minimum period of 24 hours and then transferred to the ward from the unit, prior to discharge.
- All patients’ families/friends who visited the patients while they were still admitted in ICU.
- All nurses working in the ICU who were willing to participate and had given written consent.

## **2.4 SAMPLING**

Sampling is a process of selecting a portion of the population to represent the entire population. The selected elements are then referred to as the sample (De Vos 2000:198; Polit & Hungler 1995:230-231). There are two methods of sampling; one yields a probability sample in which the probability of selection of each respondent is assured. The other yields a non-probability sample in which the probability of sample selection of the respondent is unknown (Polit & Hungler 1995:38). This study used non-probability or convenience sampling because the population was small and not everyone in the population met the inclusion criteria. It also enabled the researcher to use participants with similar experiences with regard to the visiting time practice in the ICU. In addition, this method did not require an elaborate sampling frame in view of the limited population of the ICU patients. According to Brink (2001:135), convenience sampling has two advantages: convenience in terms of time and money, and readily

available elements. The sample was obtained from ICU patients, family members/friends and nursing staff.

Inclusion criteria refer to all the characteristics that the researcher wants the sample to possess that would prevent the accuracy of the results from being adversely affected.

To be included in this study, the respondents had to be:

- Patients who had been admitted to the ICU for a minimum of 24 hours, who must have had visitors and were fully conscious and well orientated during their stay in ICU. The reason for this was that only conscious patients can relate their feelings about and experiences of visiting time during their stay in ICU.
- Family members/friends who visited these patients in ICU.
- Registered nurses working in ICU.
- Willing to participate in the study voluntarily.

## **2.5 RESEARCH SETTING**

The study was conducted in a 418-bed private hospital in KwaZulu-Natal, which is a member of the largest group of hospitals and clinics in South Africa. The hospital has four critical care units (Medical ICU, Surgical ICU, Coronary/Neuro ICU, Neo-natal ICU). The study was conducted in the three adult intensive care units (medical, surgical and coronary/neuro-surgical). There are 59 adult ICU beds and an average of 45 nurses per shift, as the staff-patient ratio is usually 1:1, depending on patient acuity. The researcher chose the critical care setting for two reasons, namely it is the environment in which she works and there is a recognised need for improvement in patient care.

## **2.6 DATA COLLECTION**

Data collection is a systematic way of gathering information relevant for the research purpose or question (Burns & Grove 2003:383). Data was collected in April 2006 using structured questionnaires. Before obtaining their informed consent, the researcher informed the respondents of the nature and purpose of the study and that participation was voluntary. They were further informed that they had the right to withdraw at any time should they so wish.

## 2.7 DATA COLLECTION INSTRUMENT

Data collection is the gathering of information to address the research question. The data was collected by means of a structured questionnaire. Three questionnaires were used, one for each category of participants. On the recommendation of the statistician and in consultation with the supervisor, the researcher constructed individualised questionnaires for the patients, family members/friends and nurses. The questionnaires contained both open-ended and closed questions. Open-ended questions addressed the issues of perceptions, experiences and feelings about the visiting times. A questionnaire was considered appropriate for the sample because it was the easiest and most effective way to determine preferences.

The questionnaires were based on the literature review. A structured questionnaire was considered appropriate for data collection because it has the following advantages (Burns & Grove 2003:420):

- There is a lack of interviewer bias.
- The possibility of anonymity and privacy encourages candid responses to sensitive issues.
- A great amount of data can be collected through the standardisation of the instrument.
- It allows for flexibility concerning the type and order of items, and the topics covered by the researcher.
- Data can easily be analysed and interpreted.

At the same time, Treece and Treece (1986:1279) and Talbot (1995:230) refer to the following disadvantages of a questionnaire:

- The instrument is unable to probe the topic in-depth.
- Some of the items may force subjects to select responses that are not actually of their choice.
- Data is limited to the information voluntarily supplied by the respondents.
- The sample might be limited only to those who are literate.
- It is difficult to determine what contributed to any observed differences in the data.

A five-point Likert scale was also used since it is the most widely used tool for determining the opinions or attitudes of subjects and contains a number of declarative statements with a scale after each statement. The purpose of the scale is to discriminate quantitatively among people with different perceptions by assigning a numerical score to subjects to place them on a continuum with respect to attributes being measured (Polit & Hungler 1995:279). In this study the five alternatives were: agree, strongly agree, disagree, strongly disagree, and uncertain, or satisfied, strongly satisfied, dissatisfied, strongly dissatisfied and uncertain. This assisted the researcher to collect data about the respondents' preferences of visiting time practice in ICU.

### **2.7.1 Format of the questionnaires**

All three questionnaires contained both open-ended and closed questions.

#### **2.7.1.1 Family members'/friends' questionnaire**

*Section A* dealt with the respondents' demographic information (Q1-5).

*Section B* contained information pertaining to experience of the visit to the patient (Q6-19).

*Section C* dealt with respondents' perceptions of visiting time practice (Q21-28).

This section used a 5-point Likert Scale (see annexure II).

#### **2.7.1.2 Patients' questionnaire**

*Section A* dealt with the respondents' demographic information (Q1-4).

*Section B* contained items on the respondents' stay in ICU (Q5-15) (see annexure I).

#### **2.7.1.3 Nurses' questionnaire**

*Section A* dealt with the respondents' demographic information (Q1-5).

*Section B* contained items on the respondents' perceptions of current visiting practice (Q6-12) (see annexure III).

A total of 45 questionnaires were distributed to the patients, 50 to the family members/friends and 45 to the nursing staff (n=140).

### **2.7.2 Data collection process**

The researcher obtained permission from the hospital management and the unit managers to conduct the study in the selected units (see annexure V).

The researcher first approached the nursing staff working in the ICUs individually. Only those willing to participate in the study sign written consent. The participants were given a questionnaire and asked to deposit the completed questionnaire in a box that was placed in a prominent place in the duty room.

Secondly, the researcher approached patients and their family members/friends individually. Both patients and family members/friends who participated in the study filled in consent forms (see annexure VI). Questionnaires were then numbered at each patient's bedside to enable the researcher and her assistant to correlate data. Family members/friends were required to complete the questionnaire during the visiting time in ICU and some were followed-up later in the wards. The patients were asked to complete their questionnaires upon their transfer to the ward. Some family members were interviewed when the patient was already in the ward; only those who visited the patient in ICU were interviewed. The researcher explained to the patients and family members that the aim was to obtain independent views, hence the two-pronged approach. Family members/friends were asked to place the completed questionnaires in a box that was prominently displayed in the unit. Patients were asked to deposit the completed questionnaires in the box in the duty room of the ward to which they were transferred. The assistance of the ward staff was also obtained to collect data.

## **2.8 VALIDITY AND RELIABILITY**

### **2.8.1 Validity**

Validity of the data-collection instrument refers to the extent that it measures what it is intended to measure; that is, the concept that it is supposed to measure accurately (De Vos 2002:166). This was achieved by testing for content validity. The researcher pre-tested the instrument on two subjects for each category. These six respondents were representatives of the study population but did not form part of the sample. Their responses were used to assess the ease and clarity of the questions. Two experts from critical care units were allowed to assess the tool for content and face validity. Compilation of the final tool was based on their recommendations.

### **2.8.2 Reliability**

Reliability of a data-collection instrument refers to the accuracy of the precision of an instrument (De Vos 2002:166-168). The researcher enhanced reliability and validity by

- clearly defining the research variables
- using standardised self-administered questionnaires for patients, family members/friends and nursing staff

Validity and reliability after pre-testing was achieved by

- eliminating ambiguous, unclear questions
- ensuring effectiveness of instructions
- utilising a standardised data collection instrument namely the questionnaire to collect data
- the questionnaire being constructed from existing literature on the phenomenon under study

## **2.9 DATA ANALYSIS**

Data analysis in this study included examining the data for completeness and accuracy, discarding incomplete questionnaires, and summarising and analysing the data (Brink

2001:60). Data analysis was done numerically, using statistical procedures with the assistance of a statistician and the use of the SPSS version 12 computer program.

Quantitative data was presented in frequency distributions of response categories based on the Likert scale and averages. Open-ended questions were coded and categorised into themes and thereafter analysed quantitatively. After analysis, the data and statistics were analysed. This culminated in the research findings and recommendations.

## **2.10 ETHICAL CONSIDERATIONS**

Ethics is “a form of philosophic inquiry used to investigate morality. It is based on scientific ethical principles that are used to justify actions and assist in the resolution of moral dilemmas” (Talbot 1995:36). Three basic ethical principles of research, namely, respect for person, beneficence and justice were identified (Regulations and Ethical Guidelines: the Belmont Report) (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1978). Prior to data collection the researcher considered the following ethical principles.

### **2.10.1 Human rights of the respondents**

A country's Constitution contains a description of basic human rights, with the aim of protecting the citizens. Nurse researchers have an ethical responsibility to the nursing discipline (Jackson 2002:347). In this study, the respondents were informed of the aims of the study, their rights, the procedures to be followed, the researcher's credibility, and how results would be published.

The respondents were given the option to withdraw from the study at any time should they so wish. Their rights to privacy and confidentiality were ensured and they were assured that information gathered would not be used against them at any point. Moreover, they would be informed of the findings.

Their rights as autonomous beings were considered. “Autonomy, as the right to self-determination, is respected in health research and individuals have the freedom to conduct their lives as autonomous agents without external control, coercion or

exploitation, especially when they are asked to participate in research” (Pera & Van Tonder 2005:152). All the respondents were informed that participation was entirely voluntary. They were allowed to withdraw from the study at any stage, without prejudice.

### **2.10.2 Rights of the institution**

Ethical clearance was obtained from the University of South Africa’s Department of Health Studies Research and Ethics Committee. Permission to conduct the study in the adult ICUs in a private hospital was obtained after the proposal was accepted and approved by the Department of Health Studies Research and Ethics Committee (see annexure IV).

### **2.10.3 Scientific honesty**

Scientific honesty refers to publication of true findings, and avoidance of plagiarism (Mouton 2004:239-241). In qualitative research this involves honesty in data collection, analysis and interpretation, giving the emic view of the phenomenon. In this study the researcher tried to portray the respondents’ views and not her own.

### **2.10.4 The *Belmont Report***

The Belmont Report attempts to summarise the basic ethical principles identified by the National Commission for the Protection of Human subjects of Biomedical and Behavioural Research. It is a statement of basic ethical principles and guidelines that should assist in resolving the ethical problems that surround the conduct of research with human subjects (Regulations and Ethical Guidelines: the Belmont Report) (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1978). Accordingly, the following ethical principles were considered:

#### **2.10.4.1 *Principle of beneficence***

- ***Freedom from harm***

This study was not considered to be physically harmful to any of the respondents involved.



- ***Freedom from exploitation***

The respondents were assured that the information they provided would not be used against them in any way (Polit & Hungler 1995:134).

- ***Benefits from the study***

It was explained that participation in the study would not necessarily benefit the respondents. However, the information they contributed could be used to enhance the service provided by the institution in the future.

- ***Right to full disclosure***

Prior to commencement of the study, the researcher described the nature of the study, the respondents' right to refuse participation, the researcher's responsibilities, and any likely risks/benefits that would be incurred to the respondents (Polit & Hungler 1995:135). The researcher also provided a contact number for respondents who might require clarification or have questions.

#### ***2.10.4.2 Principle of justice***

This principle includes the participants' right to fair treatment and their right to privacy.

- ***Right to fair treatment***

Participant selection for this study was based on research requirements. The sampling method was purposive to select people with experience of the phenomenon being studied. The respondents were also informed that they would suffer no prejudice if they declined to participate at any stage during the study.

- ***Right to privacy***

### ***Anonymity***

Anonymity occurs when even a researcher cannot link a participant with any information (Pilot & Hungler 1995:139). Consent to participate in the study was obtained from the patients and family members while they were in the ICU. The nursing staff completed the consent and questionnaire in the ICU. No names were provided. The questionnaires were assigned numbers. Only the researcher and statistician worked with the questionnaires.

### ***Confidentiality***

Information was destroyed on completion of the study. The questionnaires were kept safely and only the researcher and statistician had access to the completed questionnaires. The questionnaires were destroyed after the report.

### ***Participation***

All the respondents were informed that participation was voluntary and that there was no remuneration for participation. The respondents were permitted to decline to participate in the study at any stage without prejudice.

## **2.11 CONCLUSION**

This chapter described the research design and methodology, including the population, sampling, data collection and analysis, data-collection tool, measures to ensure validity and reliability, and ethical considerations. Chapter 3 covers the literature review undertaken for the study.

## **CHAPTER 3**

### **Literature review**

#### **3.1 INTRODUCTION**

Chapter 2 described the research design and methodology used in the study. This chapter discusses the literature review undertaken by the researcher.

A literature review is “the systematic search of published work to gain information about a research topic” (Polit & Hungler 1995:69). The researcher conducted a literature review prior to data collection and analysis to establish what was available on patients and others’ perceptions of visiting times in ICU. Henning et al (2004:67) point out that other studies often bring fruitful concepts and propositions that assist researchers to interpret data. In addition, reviewing relevant literature assists in “identifying the range of existing research, summarising current knowledge, differentiating between commentary and research, and identifying the theoretical base of knowledge”, thereby assist researchers to gain insight into methods that may be used (Polit & Hungler 1995:70).

Accordingly, in the literature review, the researcher concentrated on:

- The concept of visiting time and current visiting time practices in ICU.
- Nurses’ perceptions and preferences of visiting time in ICU.
- Family and patients’ perceptions and preferences of visiting time in ICU.

#### **3.2 VISITING TIME AND CURRENT VISITING TIME PRACTICE IN ICU**

The concept of restricted hospital visiting hours began in the late 1800s for non-paying patients in an effort to establish order in the general wards. For many decades thereafter, paying patients had the privilege of unrestricted visits at almost any time. In the 1960s hospitals instituted visiting hours in ICUs and wards to protect the patient and family from exhaustion caused by too many visitors (Berwick & Kotagal 2004:736). The purpose of visiting time was to enable friends and family members to visit their hospitalised friends or relatives at designated times.

Daily visiting hours and rules are established for the comfort and safety of patients and their loved ones. Visiting time allows the family of critically ill patients to be with their loved ones. Patients who are critically ill need a lot of rest. Neuro/coronary patients require decreased stimulation. Although health care professionals recognise the importance of the patient-centred approach and the important role played by family in the recovery of patients in the ICU, over stimulation, disruption and minimising infection remain crucial factors that affect visiting hour policy in critical care units (Hepworth, Hendrickson & Lopez 1994:704; Stannard 2000:384; Berwick & Kotagal 2004:736; Sims & Miracle 2006:177; Fumagalli et al 2006:949-951).

The critical care environment is one in which the physiological stability and patient's needs are recognised as primary concerns of the caregiver. According to Berwick and Kotagal (2004:736), the concern that the patient should be left alone to rest incorrectly assumes that family presence at the bedside causes stress. The presence of family and friends tends to reassure and soothe the patient, however, and provides sensory organisation and familiarity in an over stimulated unfamiliar environment. Marfell and Garcia (1995:87) found that visits by family and friends do not usually increase patients' stress levels as measured by heart rate, blood pressure and intracranial pressure, but may, in fact, lower them. Hepworth et al (1994:715) and Stannard (2000:384) conclude that, due to clinically significant decreases in the intracranial pressure of neurological patients during family presence, there is no physiological reason to limit or exclude family visitation. Mitchell and Mauss (1978:10) found that touch may help to decrease or stabilise intracranial pressure, but that conversation about the patient's condition should be minimised at the bedside.

According to Sims and Miracle (2006:177), open or extended visiting time helps patients by providing them with the support system they need. Flexibility should be encouraged to improve patients' well-being. Pre-visit education may be provided to the family during visiting time. Fumagalli et al (2006:952) found that despite greater environmental microbial contamination, liberalising visiting time in ICUs did not increase septic complications and that a liberalised visiting time is also associated with a reduction in severe cardiovascular complications.

### **3.3 NURSES' PERCEPTIONS AND PREFERENCE OF VISITING TIME IN ICU**

Carlson, Riegel and Thomason (1998:40) and Farrell, Joseph and Barcott (2005:19) refer to nurses as “gatekeepers of ICU that limit family visitation to protect the patient’s physiological status and promote rest”.

Berwick and Kotagal (2004:736) advocate liberalising visiting hours in ICU but maintain that nurses and physicians generate considerable resistance towards open visiting times. They are concerned about increased physiological stress for the patient, interference with the provision of care, and physical and mental exhaustion of friends and family. Marfell and Garcia (1995:87) indicate that visits by family and friends do not usually increase stress levels as measured by blood pressure, heart rate and intracranial pressure, but may, in fact, lower them. Peterson (2005:72) found that family and friends did not increase patients’ stress levels; having family/friends present lessened anxiety. Despite the view that visitors impede the delivery of nursing and medical care, families may instead be helpful in the provision of care, providing meaningful feedback about the patient’s medical condition and helping to facilitate communication between the patient and the medical and nursing staff (Sims & Miracle 2006:178; Ramsey, Cathelyn, Gugliotta & Glenn 2000:43-44; Carlson et al 1998:40; Berwick & Kotagal 2004:736).

According to Berwick and Kotagal (2004:737), considering an open visiting policy could alleviate the physical and mental exhaustion of family members and friends. Simon, Phillips, Badalamenti, Ohert and Krumberger (1997:210) found that open visiting practices were perceived as beneficial to family members and also to have reduced their anxiety levels. One of the responsibilities of nursing staff as holistic caregivers is to help ensure that physical and mental exhaustion of family and patients is minimised.

Various nurses’ perceptions are barriers to flexible visiting time. For example, some critical care nurses do not perceive liberal visitation as important to the patient’s recovery, and others believe that liberalisation of visiting policies will interfere with the nurse’s ability to provide nursing care (Kirchhoff, Pugh, Calme & Reynolds 1993:238; Ramsey, Cathelyn, Gugliotta & Glenn 1999:43; Sims & Miracle 2006:177). Few nurses perceive the role of family as a provider of basic care (Halm & Titler 1990:25; Roland, et al 2001:22). Nurses in ICU fear loss of autonomy with the continued presence of family

members during the provision of patient care. According to Federwisch (1998:3), open door policies “can also create an environment in which clinicians feel that they are constantly being observed”.

In a study on developing family-focused care units, Titler, Bombei and Schutte (1995:375) found that experienced nurses may have difficulty with changing their routine to include families when visiting time is not structured, while novice nurses may feel that they are being “scrutinised” and may experience difficulty when attempting to gain competence and technical skills when time is not structured and limited.

According to Federwisch (1998:3), a registered nurse (RN), at the Lucille Packard Children’s Hospital in Palo Alto, California, a common argument for limiting visitation is a concern about infection control and the theory that “more people translate to more germs”. As a move towards more family-centred care, that hospital revised its guidelines to allow parents to visit 24 hours a day. Infection rates were continuously monitored and were reported to be lower than before. Fumagalli et al (2006:949-950) found that despite greater environmental microbial contamination, a liberalised visiting time in ICUs did not increase septic complications and was associated with a reduction in severe cardiovascular complications.

Farrell, Joseph and Barcott (2005:22-27) found that critical care nurses have different approaches to visiting time in ICU and in dealing with visitors in daily practice acknowledged the following:

- Each situation is unique and should be evaluated and managed individually.
- Privacy and confidentiality of other patients in the unit is important.
- Families, cultures and people are different and have different ways.
- Family members have the potential to help alleviate or perpetuate anxiety.
- The physiological stability and safety of the patient is top priority.
- Anxious visitors can interfere with the nurse’s ability to complete the work.
- Asking family to leave the unit when the nurse needed to have total focus on the patient.

Moreover, family members visiting patient in the critical care setting required balancing a visitor's need for information and access to a loved one with the nurse's need to safely manage care for a critically ill individual.

In two general ICUs with open visiting hours, Soderstrom, Benzein and Saverman (2003:189-190) found that nursing interactions with family members were either inviting or uninviting. In non-inviting interactions, nurses considered themselves experts and technical and medical tasks most important, and had little or no time for family members. Nurses with inviting interactions, however, considered family members important in the nursing.

Livesay, Gilliam, Mokracek, Sebastian and Hickey (2004:182) studied nurses' perceptions of open visiting hours in a neuroscience ICU and how these affected family and patient satisfaction. The study was undertaken as a quality improvement project to determine the need for revision of the visitation policy. Livesay et al (2004:182-189) found that "open visitation" held different meanings amongst the nurses and without an institutional definition was open to interpretation. The interpretation and application of open visitation varied from nurse to nurse and created inconsistencies and frustration for the patient, family and nurses. Both family and staff felt unsupported when conflict arose. There was a need to educate staff about the policy and its implementation, to determine the validity of concerns regarding the negative effects on neuro patients from visitation, and to improve communication among nurses about visitation (Livesay et al 2004:188-189).

Careful consideration is needed before ICUs decide to lift restrictions on visiting hours. Rollins (2005:20) found that, despite guidelines for open visiting hours, the Baptist Hospital in Miami failed in its attempt to open ICU visitation. According to Rollins (2005:20), family members "became aggressive and it became a security issue for their staff. You have to look at the environment, patient population and demographics to be as patient centred and family centred as possible within those constraints." Kirchhoff et al (1993:238) assert that successful modification in visitation policies requires changing nurses' negative perceptions.

Sims and Miracle (2006:177) and Carlson et al (1998:40) indicate that family visitation is crucial to the patient's recovery as they provide emotional support. In the

implementation of a less restrictive visitation policy, Roland et al (2001:24) found that families became more involved in patient care, education of family members and communication between family and staff increased significantly; but staff satisfaction did not improve significantly.

### **3.4 FAMILIES' PREFERENCES AND PERCEPTIONS OF VISITING TIME IN ICU**

Advances in science and technology have made nursing practice in acute care settings highly complex, rapid and demanding. Within this challenging health care environment are patients and their families (Gonzalez, Carroll, Elliott, Fitzgerald & Vallent 2004:194). The benefits of having patients' family members present during their hospitalisation can depend on the patient's condition and the visitation times of the institution.

Sims and Miracle (2006:178) point out that critical care nurses "are very good at identifying the needs of patients and their family members and taking appropriate measures to meet those needs. The problem arises when not all nurses practise the same policy." If some nurses enforce a visiting policy strictly, for example, while others are more lenient, this may lead to confusion, conflict and resentment.

Although Lee, Friedenber, Mukpo, Conroy, Palmisciano and Levy (2007:497), Roland et al (2001:18), Ramsey et al (2004:420) and others have investigated visiting time in ICU, the researcher found no in depth research on the perceptions that ICU patients, family members and have of visiting time in ICU. Gonzalez et al (2004:194) and Barclay and Lie (2007:1) state that patients and families desire to spend longer periods with their families. Nevertheless, families and significant others are often not given adequate or extended visiting time to be with their loved ones in ICU.

When loved ones are critically ill, family want proximity to them. One way to accommodate the patient and family's needs is to consider a less restrictive visiting policy in critical care units. Visitation is not a privilege but a necessary component of family well-being (Brinker 2001:2). Nowadays, with cost containment, patients are discharged in the dependent stage, hence the need for families to observe therapy and visit more frequently (Federwisch 1998:1). Furthermore, increased competition for healthcare funding is forcing hospitals to focus on the needs of the "customer" (Meissner 1996:28).



Flarey and Blancett (1996:7) state that “health care professionals view the patient and family as a unit in need of care”. Caring for the patient’s family is another way of caring for the patient (Stannard 2000:382). One of the family’s main needs was to be physically near the patient to enhance emotional support therefore they desire a more open visiting policy, which is beneficial to the patient (Roland et al 2001:21). It is the nurse’s role as a holistic caregiver to meet the needs of the family as well as the patient. According to Roland et al (2001:18), when family members “became dissatisfied with a restrictive visiting policy in a combined coronary and medical ICU, this situation was seen as an opportunity to better meet patient and family needs”. Moreover, changing to a more liberalised visitation policy improved family and patients’ perceptions of the quality of care, families became more involved with patient care, written complaints dropped from 16 to 1 during the year in which the study was done, and communication between staff and family members increased (Roland et al 2001:24).

Families are an integral part of care and allowing families contact with their sick loved ones facilitates patients’ recovery (Federwisch 1998:3).

Auerbach, Kiesler, Wartella, Rausch, Ward and Ivatury (2005:202) emphasise the high level of emotional distress experienced by family members. Access to information about patients’ conditions and quality relationships with healthcare staff are high-priority needs for the families. Auerbach et al (2005:209) recommend more interpersonal contact with medical staff to help meet the needs of patients’ families. Nurses can assist in families’ adjustment by fostering a sense of optimism and encouraging family participation in patients’ care.

As ICUs increasingly adopt a policy of unrestricted visiting, families will play a greater role in the unit. Hupcey (1999:253) examined how families and nurses interact to increase or decrease the families’ involvement in the ICU and found that the family perceived their role as “being supportive and caring, protecting or looking out for the patient because the patient was unable to do so for him/herself, providing psychological/emotional support and performing physical acts such as feeding the patient”.

Although all the parties agreed that families have an important role in ICU, each had different perceptions of what the role entailed. The nurses perceived that the family

- played a significant role in helping the patient endure the ICU experience
- provided comfort (by being something familiar as opposed to staff who were strangers)
- were able to reduce agitation and confusion, just by their presence
- provided emotional support
- played a care-giving role (this usually occurred over time as nurse, patient and family developed a relationship)

According to Clark (2005:1), open visitation led to improved patient and family satisfaction with the overall ICU experience. In a study on whether the current visiting schedule and patient information at a clinical and surgical ICU satisfied the patients' visitors, Echer, Onzi, Da Cruz, Ben, Fernandes and Bruxel (1999:57) found the following: 70% of the visitors were satisfied with the current schedule; 54% asked for access outside scheduled visiting time, and only 69% were satisfied with staff information about patients. The most frequent suggestion was to increase the visiting time at the ICU.

Ramsey et al (2000:42) investigated whether a more liberal ICU visitation policy satisfactorily met the visitors' and nurses' needs and expectations. Ramsey et al (2000:42) compared the satisfaction levels of critical care nurses and visitors before and after the implementation of liberal visitation and found the following:

- Both nurses and visitors were generally satisfied with the new visitation policy despite the disparity of both wanting to spend more time with patients.
- Nurse/family conflict arose during control of visiting hour.
- Nurses indicated that visiting policies should not be rigidly followed.
- About 80% of the visitors responded positively in both the pre and post surveys on nurse/visitor information provided. All the nurses responded positively to both surveys. Although visitors had more contact with the patient and staff with the new policy, the need for more information about the patient increased from 42% to 66%.

Ramsey et al (2000:43) recommended considering contractual agreements between family and nurses and the allocation of additional waiting room space to avoid overcrowding, and reduce stress and noise levels.

The primary family needs of critically ill patients are the need for information, emotional/psychological support, and physical comfort (Roland et al 2001:18). Motler (1979:332) examined the needs of families of critically ill patients. Azoulay, Pouchard, Chevret, Lemaire, Mokhtari, Le Gall, Dhainaut and Schlemmer (2001:136) examined the ability of ICU staff to meet the needs of the family together with identifying those parameters that could be worked on to improve family satisfaction. Kleiber, Halm, Titler, Montgomery, Johnson, Nicholson, Craft, Buckwalter and Megivern (1994:70) examined the emotional responses (feelings) of family members of patients in ICU. Hupcey (1999:253) identified strategies used by nurses and families that helped/hindered the development of a relationship between them. Families felt that they had an important role in the ICU, including being emotionally/psychologically supportive, protecting (withholding bad or unpleasant information) and care giving (bathing and feeding) (Hupcey 1999:255). One way in which nurses can help meet family needs is to consider a less restricted visiting policy.

Peterson (2005:70) lists the following reasons for the implementation of an open family visitation policy in the ICU at St John's Mercy Medical Center, St Louis:

- Patients in the ICU are often in the critical or end stages of their lives. Families need to be together at such a time without restrictions.
- Positive reinforcement for the critically ill is vital, so it is best for family members to be present when they are needed- at any time around the clock.
- Family members working long days or hours, including healthcare workers, need to be able to visit at different times during the day and night.
- As a trauma center, St John's Mercy often receives patients who are not from the immediate area or whose families travel long distances to be with them. When patients are admitted, the first thing their families want to do is to see them. Open visiting allows them this comfort.
- Because critically ill patients need plenty of rest, open visiting hours allow family members to rotate in and out of the room according to the patient's needs instead of the clock.

In contrast to Peterson's recommendations, Bolton (Rollins 2005:20) maintains that careful consideration is needed before ICUs decide to lift restrictions on visiting hours. Kirchhoff et al (1993:245) assert that modifying in visitation policies will fail unless nurses' negative perceptions are changed.

### **3.5 PATIENTS' PREFERENCES AND PERCEPTIONS OF VISITING TIME IN ICU**

As health care continues to evolve from a "diseased-centred" towards a "patient-centred" model, patients become more active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to advice and counsel from health care professionals.

Admission to the ICU is a potentially stressful event in which pain and physiological disease may be associated with emotional disorders such as the fear of diagnostic or therapeutic procedures, sleep deprivation, restricted mobility and limitations to the visits that patients can receive Fumagalli et al (2006:946). This feeling is further emphasised when the patient is in a critical care environment, surrounded by the noise of monitors and ventilators and the necessary ministrations of the nurses (Berwick & Kotagal 2004:736). Helping patients become decision makers, who take an active role in their own care results in better patient adherence (Lowes 1998:1). Open/expanded visiting time will assist in facilitating the patient centred approach.

Few studies have been undertaken to determine the visiting preferences of patients in ICU. Gonzalez et al (2004:198) found that patients were satisfied with a visiting guideline flexible enough to meet their needs and those of their families. Patients also indicated times during which visitors should be restricted, including when

- patients are unsure of the daily routine
- patients are not feeling well
- the visitor dynamics are not optimal

Sims and Miracle (2006:176) found that flexible visitation did not increase complications due to infection; cardiovascular complications were reduced, and patients were happier with the more relaxed visitation policy.

Frazier, Moser, Daley, McKinley, Riegel, Garvin and Kyungeh (2003:19) point out that anxiety is associated with “increased in morbidity and mortality. Critical care nurses are uniquely positioned to reduce anxiety in their patients.” Utilising other strategies, such as an open/expanded visiting hour may lessen the patient’s stress level and lessen the anxiety of family members (Peterson 2005:72).

According to Hupcey (1999:255), the “overriding role that the patient saw for the family was to be there. Patients expressed a great need just to have someone there with them. They felt family watched over them, and made them feel safe and protected. Families also helped keep their spirits up and maintain hope. Patients said they needed the family to take over and make decisions for them.”

Regarding patients’ preferences for visitation in critical care, Roland et al (2001:21) found that of the patients, “65% indicated that a more open visitation was desirable, 90% felt that visitors were very important to them, 85% stated the desire to have family perform personal care for them, 75% denied feeling fatigued after visiting, 50% advocated child visiting and 60% expressed the opinion that there should be no restriction on who is allowed to visit and agreed that two at a time was a reasonable limitation”.

### **3.6 CONCLUSION**

This chapter discussed visiting hour practices in the context of patient-centred integrated care. Family, nurses and patient preferences were discussed. The literature review focused on perceptions and trends in countries overseas, due to a lack of current literature regarding visiting time practices in South Africa. Chapter 4 discusses the data analysis and interpretation.

## **CHAPTER 4**

### **Data analysis and interpretation**

#### **4.1 INTRODUCTION**

The purpose of this study was to determine the perceptions and preferences of patients, nurses and family/friends regarding the visiting time in ICUs. To achieve this purpose, the study wished to answer the following research question:

What are the perceptions and preferences of patients, family/friends and nurses regarding visiting time in ICUs?

Three questionnaires were developed for the study. This chapter presents the analysis and interpretation of the data collected by the questionnaires. The data is presented in frequency tables and percentages. A statistician analysed and interpreted the data using the SSPS computer program version 12.

#### **4.2 FORMAT OF QUESTIONNAIRES**

The three questionnaires were divided into sections and contained open-ended and closed questions. Closed questions are also called “fixed alternatives, and are worded in such a way that only a limited response is possible” (Talbot 1995:294).

##### **4.2.1 Patients’ questionnaire**

The patients’ questionnaire consisted of two sections, namely Section A on the respondents’ demographic information (Q1-4) and Section B on their preferences and feelings with regard to their stay in ICU (Q5-15).

##### **4.2.2 Family members’/friends’ questionnaire**

The family members/friends’ questionnaire consisted of three sections:

Section A on the respondents’ demographic information.

Section B on their experience of the ICU visits to the patients.

Section C on their experience, perceptions and feelings regarding visiting time in ICU, including satisfaction levels, anxiety, and duration of visits.

#### 4.2.3 Nurses' questionnaire

This questionnaire consisted of two sections, namely Section A on their demographic information and Section B on their preference of visiting times in ICU.

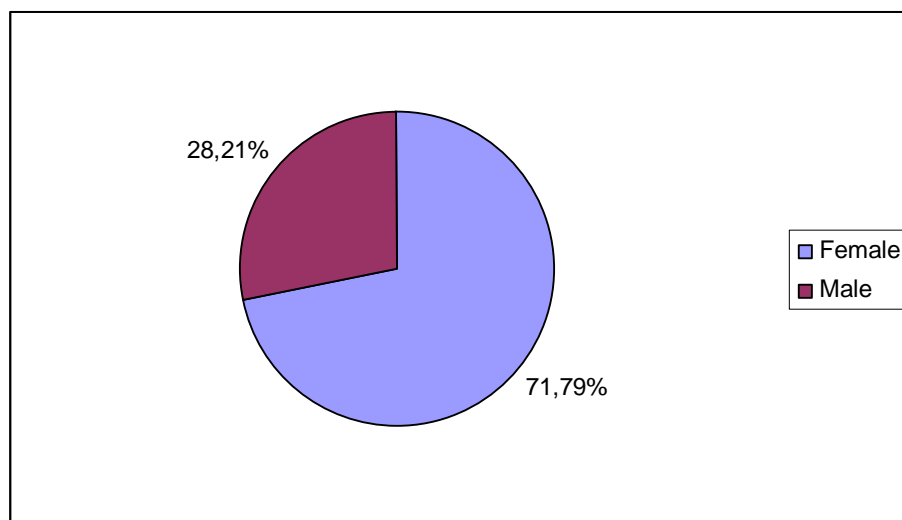
### 4.3 PATIENTS' RESPONSES

A total of 45 questionnaires were distributed to patients in three ICUs, but only 39 responses were received back. The sample was therefore composed of 39 respondents.

#### 4.3.1 Section A: Demographic data

##### 4.3.1.1 Item 1.1: Gender (n=39)

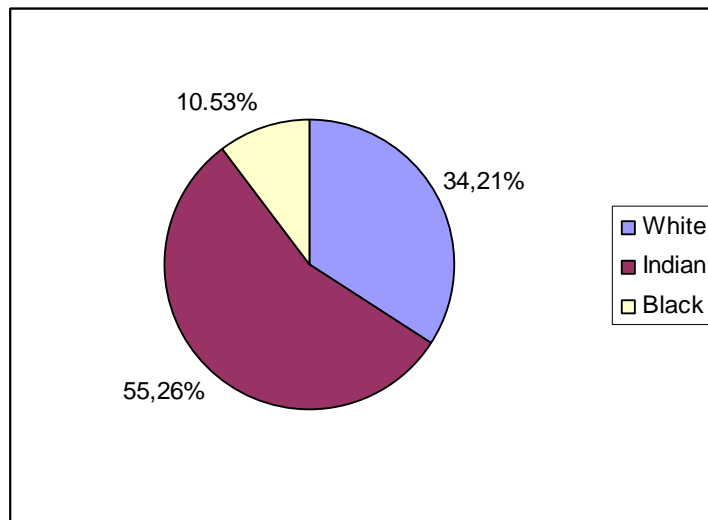
Of the respondents, 71,79% (n=28) were females and 28,21% (n=11) were males.



**Figure 4.1**  
**Respondents' gender**

#### 4.3.1.2 Item 1.2: Race (n=38)

KwaZulu-Natal has a multi-cultural society. Of the respondents, 34,21% (n=13) were Whites, 55,26% (n=21) were Indians, and 10,53% (n=4) were Blacks. There was 1 missing response. The majority of the respondents were Indian, which may be attributed to several reasons. Firstly, between 1849 and 1905, approximately 152 814 indentured Indian labourers were introduced into Natal (Richardson 1982:515). Secondly, according to the 2001 South African National Census (Statistics South Africa Census 2004:5), Indians or Asians were the second largest population group in Durban. Lastly, according to Enas and Kannan (2005:24), “the hospitalization rate for heart disease among Indian patients was four times that of non-Indian patients”.

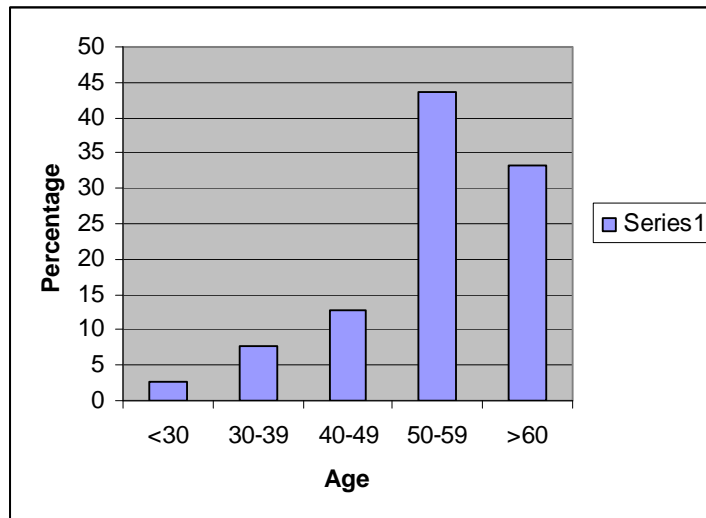


**Figure 4.2**  
**Respondents' racial groups**

#### 4.3.1.3 Item 1.3: Age (n=39)

Of the respondents, 43,59% (n=17) were 50-59 years old; 33,33% (n=13) were over 60; 12,82% (n=5) were 40-49; 7,69% (n=3) were 30-39, and 2,56% (n=1) was under 30. This was significant because cognitive and physiological changes occur with aging, hence the need to assess and plan patient care.



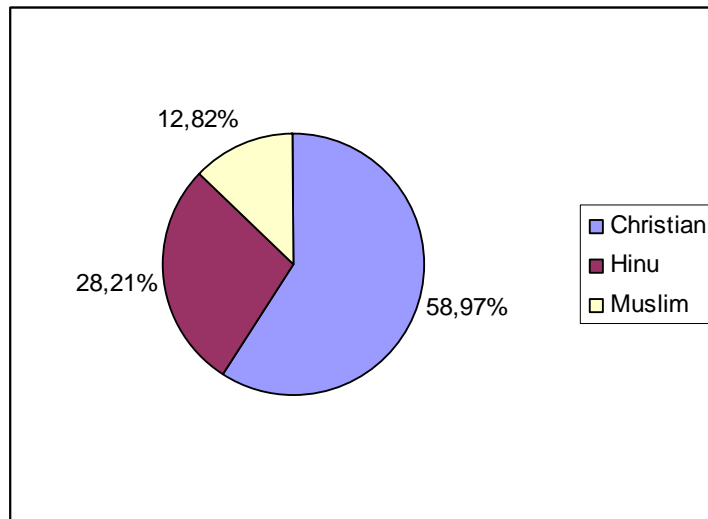


**Figure 4.3**  
**Respondents' ages**

**4.3.1.4 Item 1.4: Religious denomination (n=39)**

Of the respondents, 58,97% (n=23) were Christians; 28,21% (n=11) were Hindus and 12,82% (n=5) were Muslims.

Religion involves connections with shared beliefs and rituals. Religious beliefs have been found to influence patients' medical decisions. Patients are individuals with life stories, emotional reactions to illness, and social and family relationships that affect and are affected by illness. Enquiring about and supporting patients spiritually is considered "part of whole person health care" (Koenig 2004:1194). It is therefore important for nurses as members of the multi-disciplinary team to take cognisance of the above when planning and implementing nursing care.



**Figure 4.4**  
**Respondents' religious denominations**

#### **4.3.2 Section B: Patients' perceptions and preferences regarding visiting time in ICU**

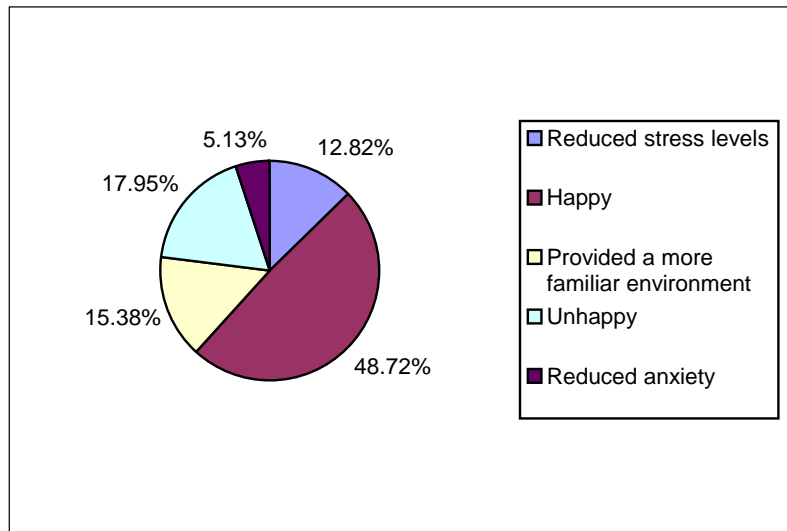
The researcher wished to determine the respondents' preferences and perceptions regarding visiting time in ICU.

##### **4.3.2.1 Item 1.5: Were you visited in ICU? (n=39)**

All the respondents answered "yes" to this question. The response rate was therefore 100% (n=39).

##### **4.3.2.2 Item 1.6: Feelings about the visit (n=39)**

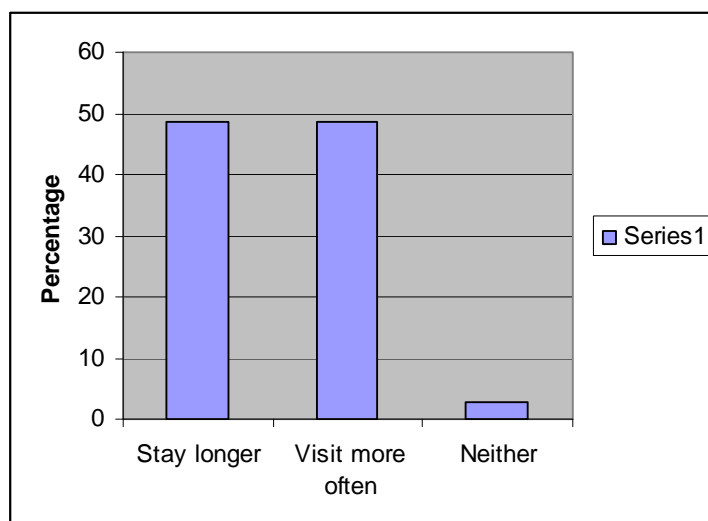
Of the respondents, 48,72% (n=19) were happy; 15,38% (n=6) stated that the visit helped provide a familiar environment; 12,82% (n=5) indicated it helped reduce stress levels, 17,95% (n=7) were unhappy with the visit and 5,13% (n=2) stated that the visit helped to reduce anxiety.



**Figure 4.5**  
**Respondents' feelings about visits**

**4.3.2.3 Item 1.7: Preferences for duration of visits (n=35)**

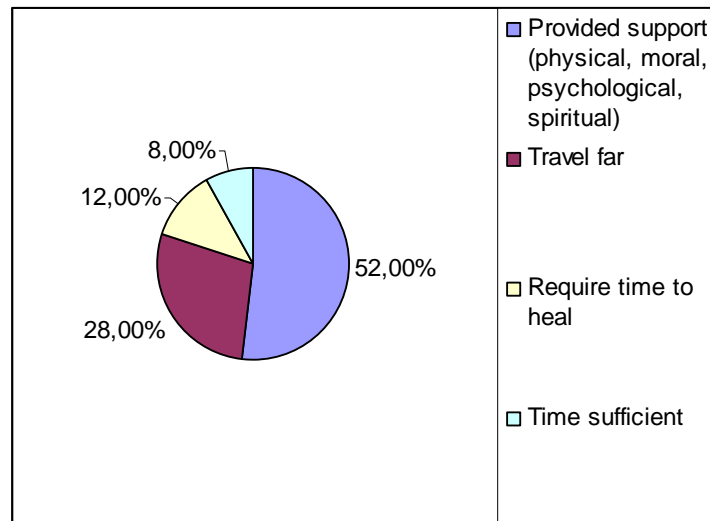
The respondents were asked to indicate their preferences for the duration of visits. Of the respondents, 48,57% (n=17) preferred a longer visit; 48,57% (n=17) preferred more frequent visits, and 2,88% (n=1) stated neither. There were 4 missing responses.



**Figure 4.6**  
**Preferences for duration of visits**

#### 4.3.2.4 Item 1.8: Reasons for preferences (n=25)

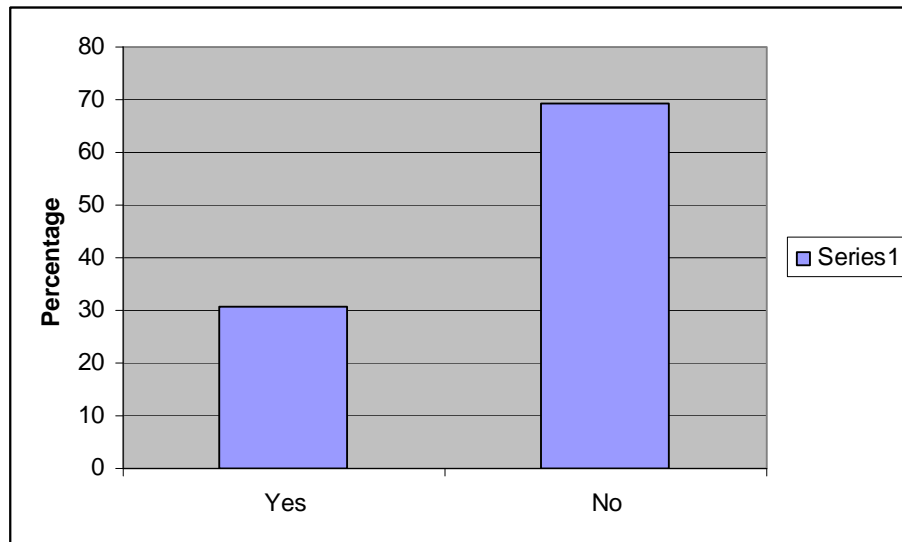
Of the 39 respondents only 25 responded to this question. Of the respondents, 52,00% (n=13) stated that family/friends provided support (physical, moral, psychological, spiritual); 28,00% (n=7) indicated their family members travelled from far; 12,00% (n=3) indicated they required time to heal, and 8,00% (n=2) stated that the visiting time was sufficient.



**Figure 4.7**  
**Reasons for preferences**

#### 4.3.2.5 Item 1.9: Prefer visitors to leave (n=39)

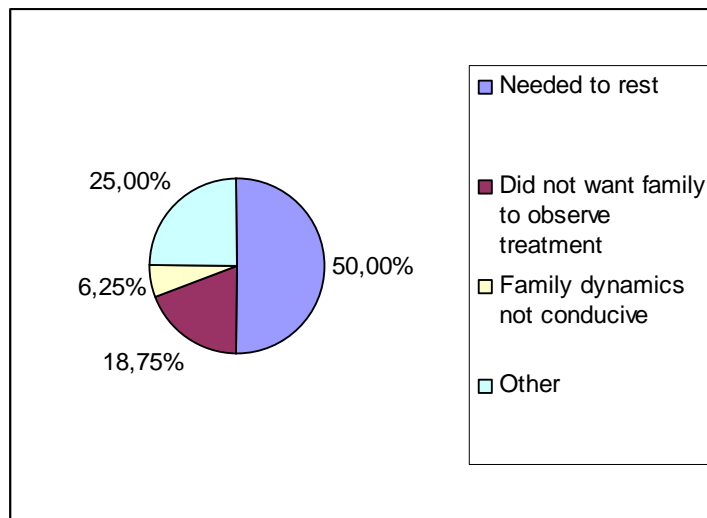
Of the respondents, 69,23% (n=27) preferred their visitors to stay, while 30,77% (n=12) preferred their visitors to leave.



**Figure 4.8**  
**Preferences for visitors to leave/stay**

**4.3.2.6 Item 1.10: Reasons why visitors should leave (n=16)**

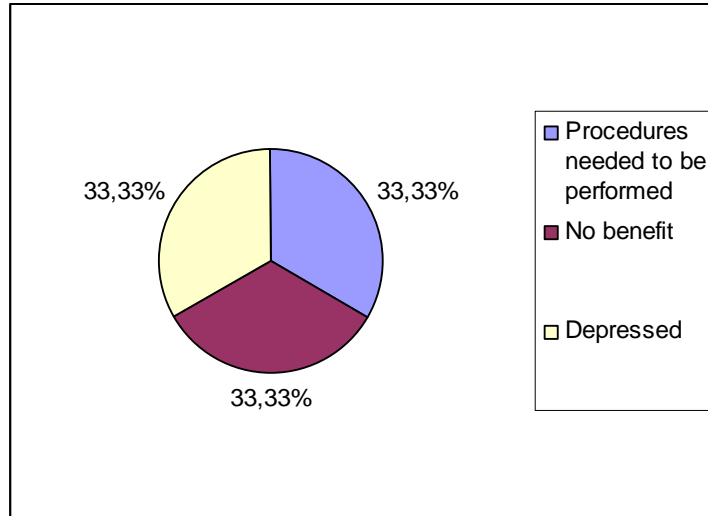
Of the 39 respondents, only 16 responded to this item. Of the respondents, 50,00% (n=8) stated that they needed to rest; 18,75% (n=3) did not want family to observe treatment; 6,25% (n=1) said that the family dynamics was not conducive, and 25,00% (n=4) indicated other reasons.



**Figure 4.9**  
**Reasons for preference that family leave**

**4.3.2.7 Item 1.11: Other reasons for visitors to leave (n=3)**

As a follow on question respondents were asked to indicate other reasons for preferring their visitors to leave. There was 1 missing response.



**Figure 4.10**  
**Other reasons for visitors to leave**

Of the respondents, 33,33% (n=1) stated that the visit was of no benefit; 33,33% (n=1) reported feeling depressed and not wanting family members to see them in that state, and 33,33% (n=1) reported that procedures needed to be performed.

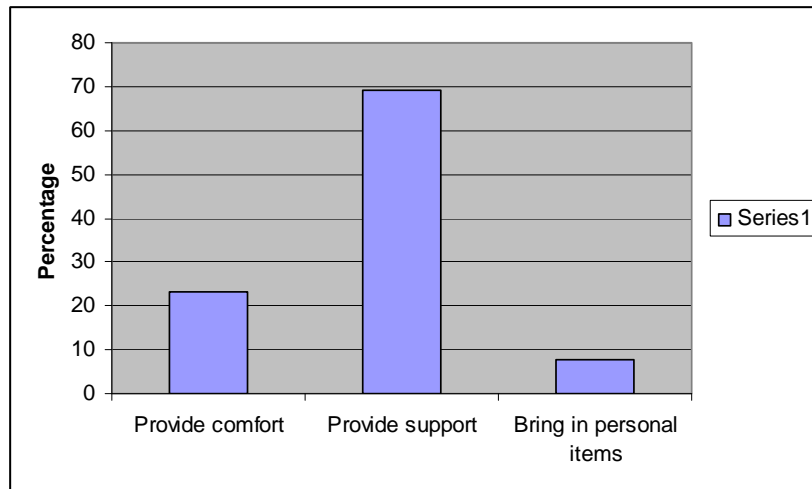
Gonzalez et al (2004:198) found that visitors should be restricted when patients are unsure of the daily routine; patients are not feeling well, and when visitors' dynamics are not optimal.

**4.3.2.8 Item 1.12: Visitors' role (n=13)**

In an open question the respondents were asked to indicate whether there was anything in particular that their visitors could do for them that the nursing staff could not do. There were 13 responses.

Of the respondents, 69,23% (n=9) stated that visitors provided support (spiritual, emotional and psychological); 23,08% (n=3) said that visitors helped to provide comfort,

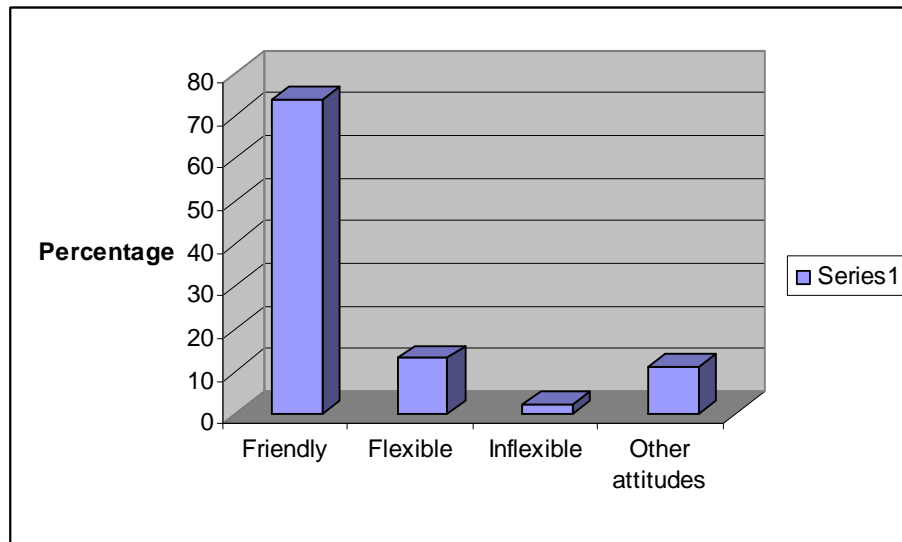
and 7,69% (n=1) reported that visitors brought personal items they needed. Hupcey (1999:255) found that families helped to keep patients' spirits up. Roland et al (2001:21-22) found that families strengthened patients' hope and patients wanted their families to personally care for them.



**Figure 4.11**  
**Visitors' role**

**4.3.2.9 Item 1.13: Perception of the nursing staff's attitude towards visitors (n=39)**

This question had more than one response which totalled to 46 responses. Some of the respondents described the nursing staff as having more than one attitude, therefore the number of responses received were 46. Of the respondents, 73,92% (n=34) described the nursing staff as friendly; 13,04% (n=6) said they were flexible; 10,87% (n=5) described them as having other attitudes and 2,17% (n=1) said they were inflexible.



**Figure 4.12**  
**Nurses' attitude towards visitors**

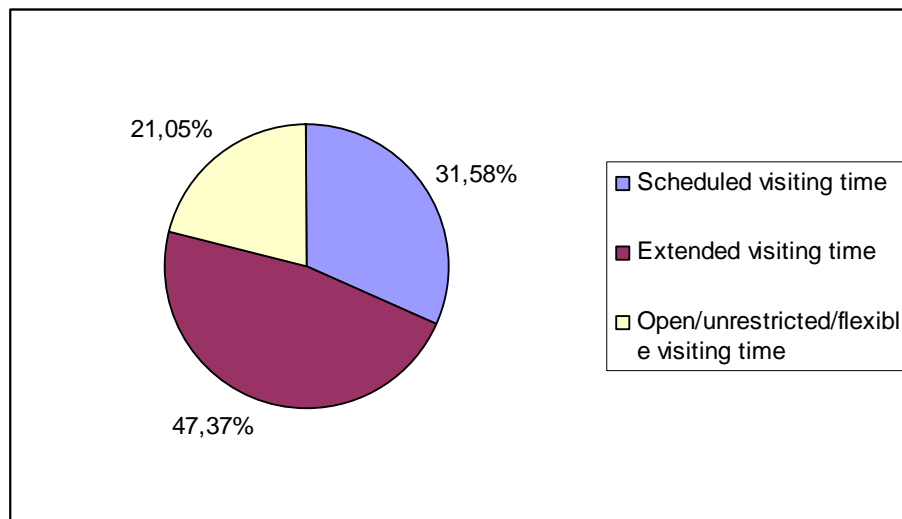
**4.3.2.10 Item 1.14: Other nursing staff's attitudes (n=4)**

In the next question the respondents who stated that they had experienced other attitudes (n=4) were asked to describe other attitudes experienced. The respondents answered as follows, 25,00% (n=1) said they were caring and cordial; 25,00% (n=1) described them as nasty; 25,00% (n=1) said attitudes displayed were shift dependent, and 25,00% (n=1) said they did not notice. There was 1 missing response.

**4.3.2.11 Item 1.15: Preference for visiting time (n=38)**

The respondents were asked their preference for visiting time. Of the respondents, 47,37% (n=18) preferred extended visiting time; 31,58% (n=12) preferred the scheduled visiting time, and 21,05% (n=8) preferred open/unrestricted/flexible visiting time. There was 1 missing response.





**Figure 4.13**  
**Preference for visiting time**

#### **4.4 FAMILY MEMBERS'/FRIENDS' RESPONSES**

Out of a total of 50 questionnaires distributed, 46 responses were received. The sample was therefore composed of 46 respondents and the response rate was 92,00%.

##### **4.4.1 Section A: Demographic data**

##### **4.4.1.1 Item 2.1: Relationship to the patient (n=46)**

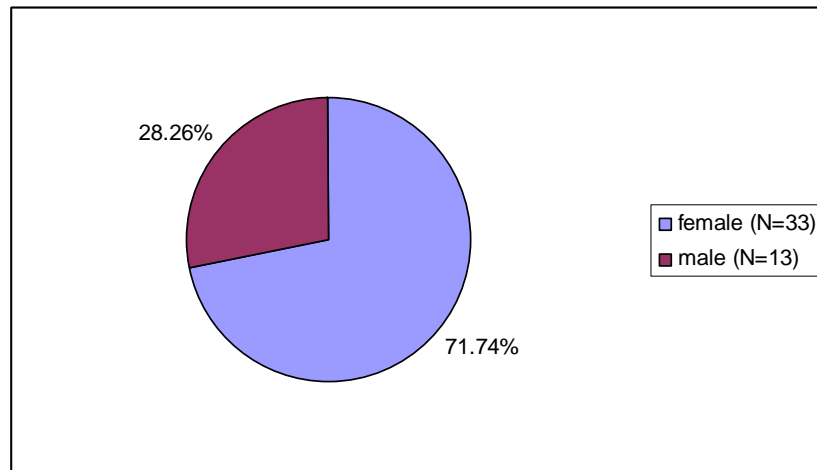
Of the respondents, 95,65% (n=44) were family, which was to be expected as the ICU visitation is restricted to immediate family members (institution's visiting policy), and 4,35% (n=2) were friends.

**Table 4.1 Relationship to patient**

<b>RELATIONSHIP TO PATIENT</b>	<b>N</b>	<b>PERCENTAGE</b>
Family	44	95,65
Friend	2	4,35
<b>Total</b>	<b>46</b>	<b>100,00</b>

#### 4.4.1.2 Item 2.2: Respondents' gender (n=46)

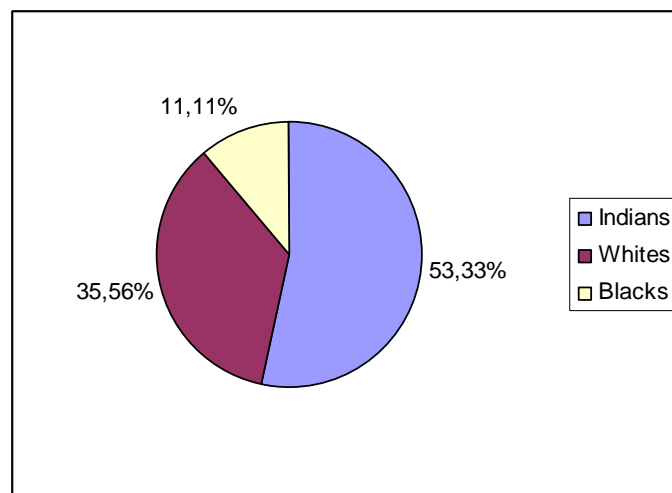
Of the respondents, 71,74% (n=33) were females and 28,26% (n=13) were males.



**Figure 4.14**  
**Respondents' gender**

#### 4.4.1.3 Item 2.3: Respondents' cultural groups (n=45)

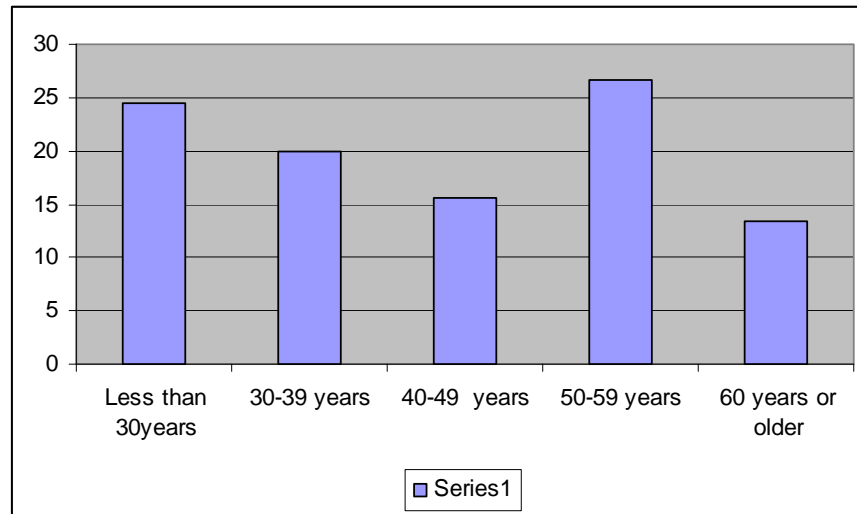
South Africa is a multi-cultural society. Of the respondents, 53,33% (n=24) were Indians; 35,56% (n=16) were Whites, and 11,11% (n=5) were Blacks. There was 1 missing response.



**Figure 4.15**  
**Respondents' cultural groups**

#### 4.4.1.4 Item 2.4: Respondents' ages (n=45)

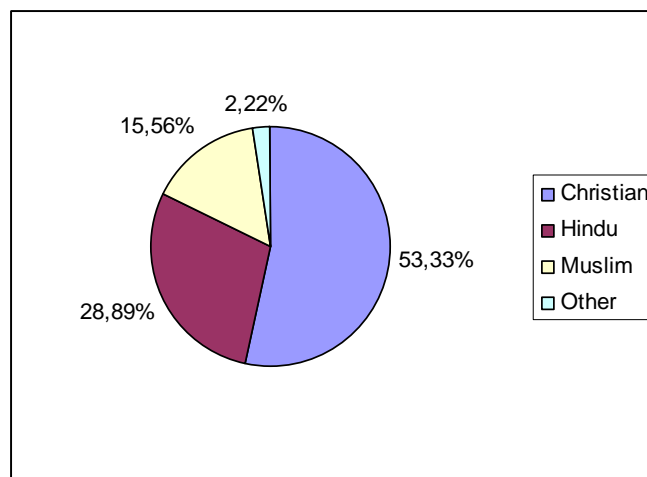
The respondents were aged under 30 and over 60, with 1 missing response.



**Figure 4.16**  
**Respondents' ages**

#### 4.4.1.5 Item 2.5: Respondents' religion (n=45)

Of the respondents, 53,33% (n=24) were Christians; 28,89% (n=13) were Hindus; 15,56% (n=7) were Muslims, and 2,22% (n=1) did not indicate religion. There was 1 missing response.

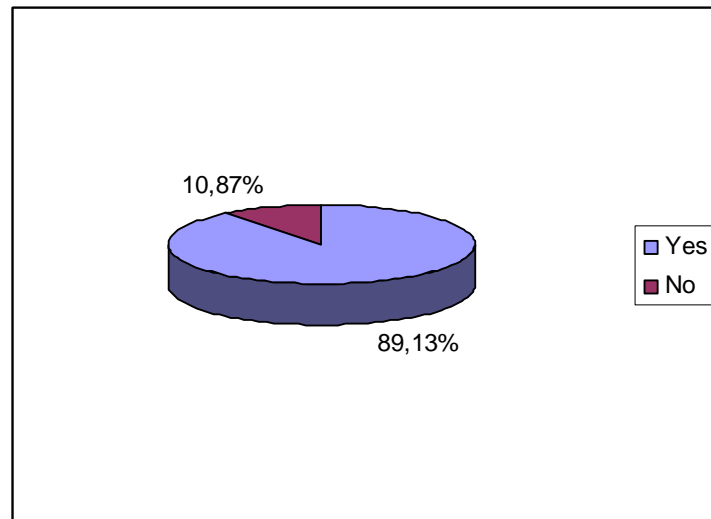


**Figure 4.17**  
**Respondents' religion**

#### 4.4.2 Section B: Family members'/friends' preferences and perceptions of visiting time in ICU

##### 4.4.2.1 Item 2.6: Were you informed of the visiting time in ICU? (n=46)

Of the respondents, 89,13% (n=41) indicated that they were informed of the visiting time in ICU, while 10,87% (n=5) stated that they were not.



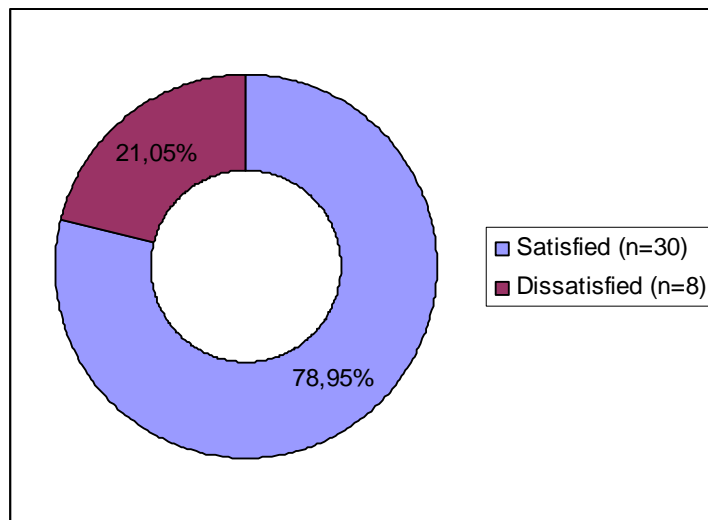
**Figure 4.18**  
**Respondents informed of visiting time**

##### 4.4.2.2 Item 2.7: Were you given an opportunity to visit the patient? (n=46)

All the respondents (100%; n=46) indicated that they were given an opportunity to visit the patient.

#### 4.4.2.3 Item 2.8: Visitors' experience (n=38)

The respondents were asked to indicate how they experienced the visit. There were only 38 responses. Of the respondents, 78,95% (n=30) were satisfied with the experience, but 21,05% (n=8) were dissatisfied.



**Figure 4.19**  
**Respondents' experience of visiting time**

#### 4.4.2.4 Item 2.9: Were you asked to leave? (n=46)

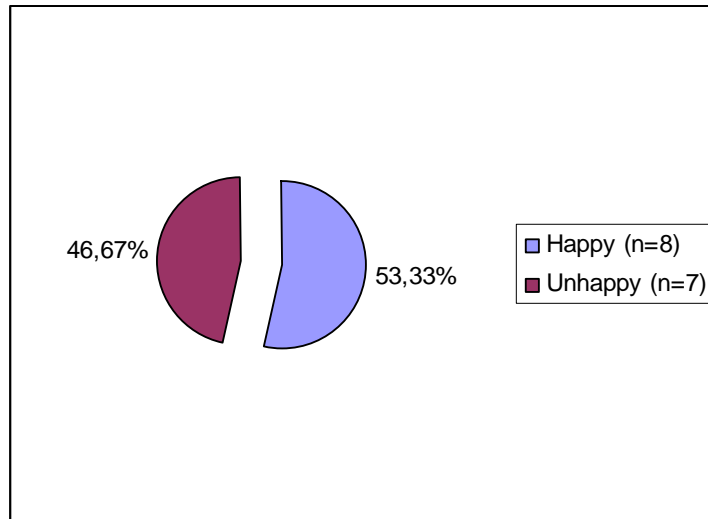
Of the respondents, 67,39% (n=31) stated that they were not asked to leave while 32,61% (n=15) were asked to leave.

**Table 4.2** Respondents asked to leave

RESPONSE	N	PERCENTAGE
No	31	67,39
Yes	15	32,61
<b>Total</b>	<b>46</b>	<b>100,00</b>

**4.4.2.5 Item 2.10: How did you feel about leaving? (n=15)**

The respondents who were asked to leave were asked to indicate how they felt about leaving. Of these, 53,33% (n=8) stated that they were happy and 46,67% (n=7) indicated that they were unhappy that they were asked to leave.



**Figure 4.20**  
**Respondents' feelings about leaving**

**4.4.2.6 Item 2.11: Was a reason given why you should leave? (n=15)**

Of the respondents, 87,67% (n=13) stated that they were given a reason for being asked to leave, while 13,33% (n=2) were not.

**Table 4.3** Reasons why respondents should leave

RESPONSE	N	PERCENTAGE
Yes	13	87,67
No	2	13,33
<b>Total</b>	<b>15</b>	<b>100,00</b>

**4.4.2.7 Item 2.12: Was the reason acceptable? (n=15)**

Of the respondents, 87,67% (n=13) felt that the reason given was acceptable, while 13,33% (n=2) felt it was unacceptable.

Roland et al (2001:24) found that among the families' main needs was the need to be physically near the patients to enhance emotional support.

**Table 4.4 Reason given for being asked to leave acceptable**

RESPONSE	N	PERCENTAGE
No	13	87,67
Yes	2	13,33
<b>Total</b>	<b>15</b>	<b>100,00</b>

**4.4.2.8 Item 2.13: Are you of the opinion that your visit was important to the patient? (n=46)**

Of the respondents, 89,13% (n=41) were of the opinion that their visit was important to the patient, while 10,87% (n=5) said no. This was consistent with Brinker's (2001:4) finding that visitation is not a privilege but a necessary component of family well-being.

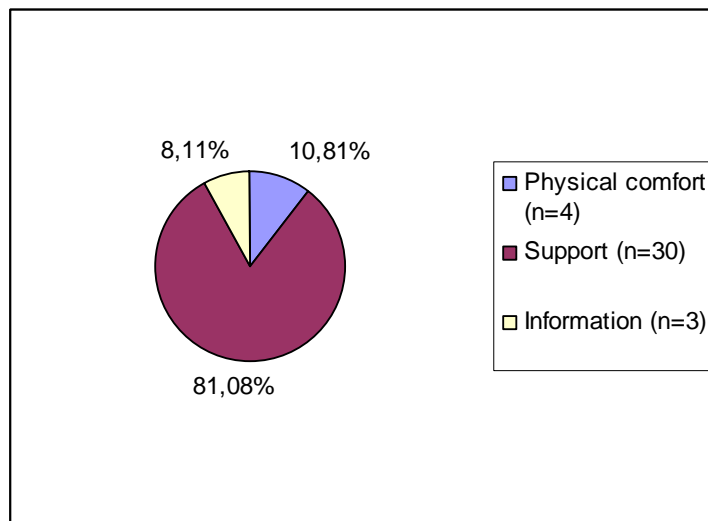
**Table 4.5 Visit important to patient**

RESPONSE	N	PERCENTAGE
No	41	89,13
Yes	5	10,87
<b>Total</b>	<b>46</b>	<b>100,00</b>

**4.4.2.9 Item 2.14: Importance of the visit (n=37)**

The respondents were asked their opinion on how important the visit was to the patient. Of the respondents, 81,08% (n=30) believed that they provided support (psychological, emotional, moral and spiritual); 10,81% (n=4) stated that they provided physical comfort, and 8,11% (n=3) stated that it was important to the patient that the visitor be kept informed of the patient's progress. There were 9 missing responses.

Hupcey (1999:255) found that families perceived their roles as being supportive, caring, protecting/looking out for the patients because they were unable to do so for themselves and performing physical acts such as feeding the patient.



**Figure 4.21**  
**Importance of visit**

**4.4.2.10 Item 2.15: Did the patient appreciate your visit? (n=45)**

Of the respondents, 100% (n=45) were of the opinion that the patient appreciated the visit. There was 1 missing response.

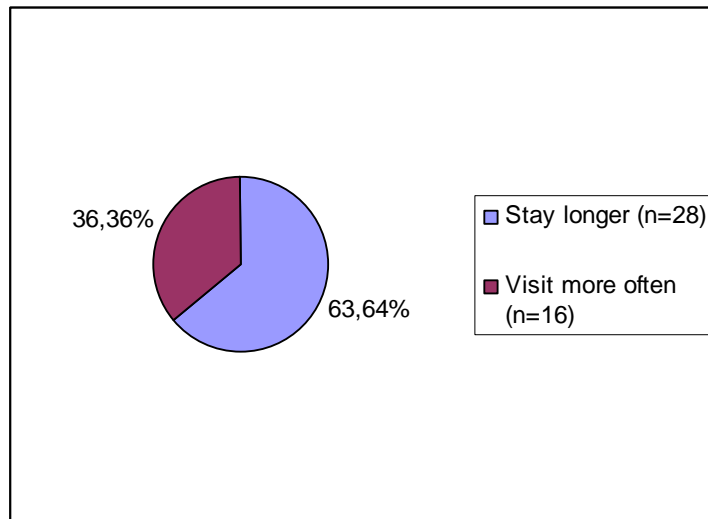
**Table 4.6 Patient appreciation of visit**

RESPONSE	N	PERCENTAGE
No	0	0
Yes	45	100,00
<b>Total</b>	<b>45</b>	<b>100,00</b>
Missing	1	-

**4.4.2.11 Item 2.16: Did the patient prefer that you stay longer or visit more often? (n=44)**

Of the respondents, 63,64% (n=28) said that the patient preferred that they visit more often, and 36,36 % (n=16) said the patient preferred them to visit for a longer time. There were 2 missing responses.





**Figure 4.22**  
**Patients' preference regarding visiting**

**4.4.2.12 Item 2.17: Could you be of assistance to the nursing staff? (n=45)**

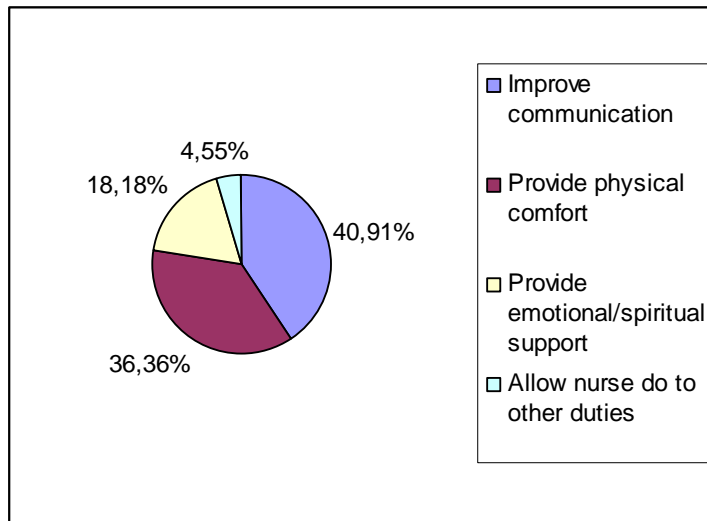
Of the respondents, 55,56% (n=25) stated that they could be of assistance to the nursing staff, while 44,44% (n=20) indicated that they could not be of assistance. There was 1 missing response.

**Table 4.7 Assistance to nursing staff**

RESPONSE	N	PERCENTAGE
No	25	55,56
Yes	20	44,44
<b>Total</b>	<b>45</b>	<b>100,00</b>
Missing	1	-

**4.4.2.13 Item 2.18: In what way could you be of assistance? (n=22)**

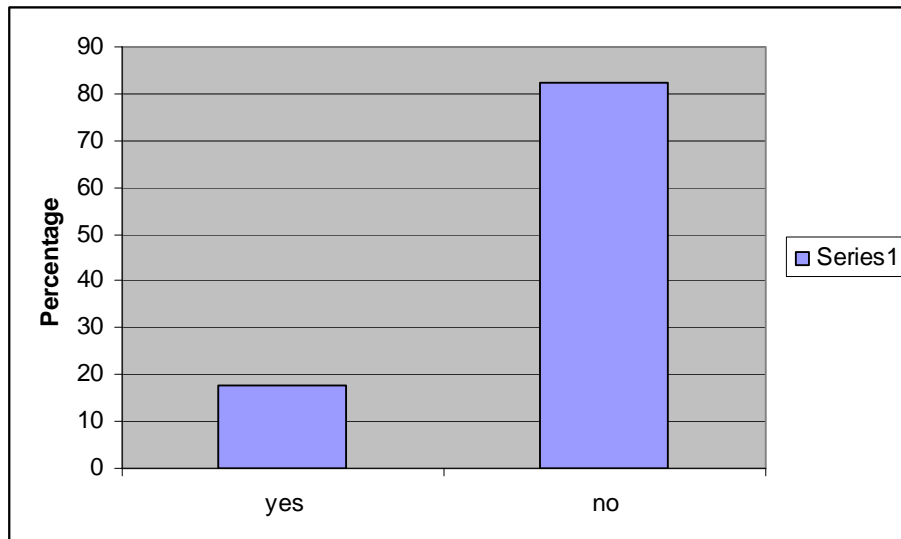
Of the respondents, 40,91% (n=9) stated that they assisted by improving communication; 36,36% (n=8) helped improve physical comfort; 18,18% (n=4) assisted by providing emotional/spiritual support, and 4,55% (n=1) allowed the nurse time to perform other duties. There were 24 missing responses.



**Figure 4.23**  
**Types of assistance**

**4.4.2.14 Item 2.19: Did you get the feeling that the nursing staff preferred that you leave? (n=45)**

Of the respondents, 80,43% (n=37) indicated no, and 17,39% (n=8) indicated yes. There was 1 missing response.

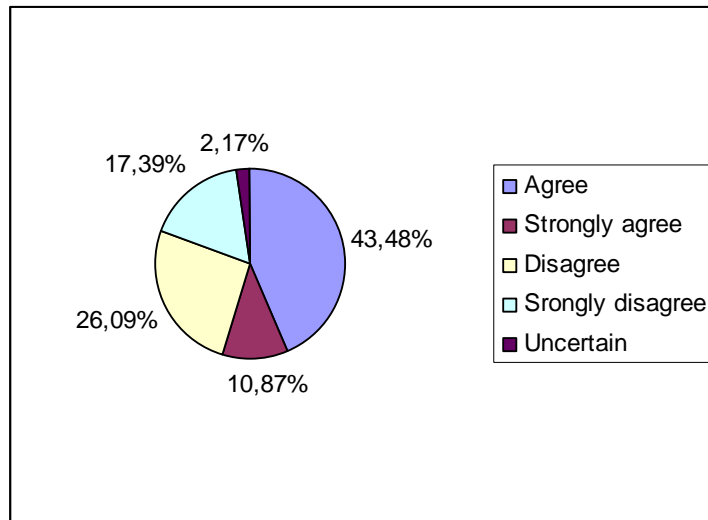


**Figure 4.24**  
**Response to feeling that nursing staff preferred you leave**

**4.4.2.15 Item 2.20: Visiting time in the ICU should be restricted (n=46)**

Of the respondents, 43,48% (n=20) agreed; 10,87% (n=5) strongly agreed; 26,09% (n=12) disagreed; 17,39% (n=8) strongly disagreed, and 2,17% (n=1) was uncertain. The respondents 54,59% (n=25) therefore generally agreed that ICU visiting time should be restricted.

Figure 4.25 indicates the level of agreement with the statement that visiting time in the ICU should be restricted.

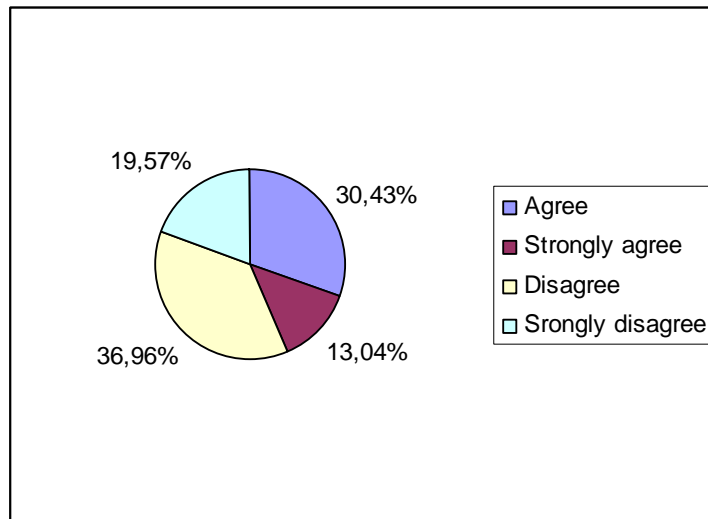


**Figure 4.25**  
**Visiting time in the ICU should be restricted**

**4.4.2.16 Item 2.21: Imposing restricted visiting time on family members of critically ill loved ones is acceptable (n=46)**

Of the respondents, 30,43% (n=14) agreed; 13,04% (n=6) strongly agreed; 36,96% (n=17) disagreed, and 19,57% (n=9) strongly disagreed. The majority (56,53%; n=26) thus disagreed that imposing restricted visiting time on family members of critically ill patients was acceptable.

Figure 4.26 indicates the level of agreement with the statement that imposing restricted visiting time on family members of critically ill loved ones is acceptable.



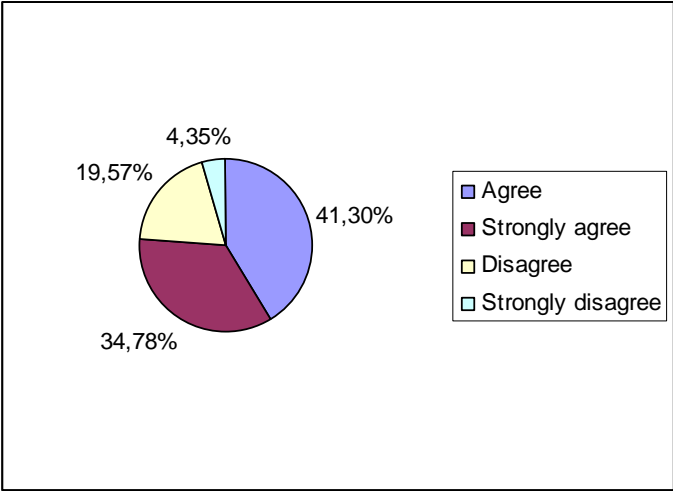
**Figure 4.26**

***Restricting visiting time on family members of critically ill loved ones is acceptable***

**4.4.2.17 Item 2.22: Family need to be allowed to spend more time with critically ill loved ones (n=46)**

Of the respondents, 41,30% (n=19) agreed; 34,78% (n=16) strongly agreed; 19,57% (n=9) disagreed, and 4,35% (n=2) strongly disagreed, hence the majority (76,08%; n=35) agreed or strongly agreed. The respondents therefore generally believed that family need to spend more time with critically ill loved ones. Roland, Russell, Richards and Sullivan (2001:22) found that 80% of the families desired a more open visiting policy and 82% of the staff believed that visitors were beneficial to the patient.

Figure 4.27 indicates the level of agreement that family need to be allowed to spend more time with critically ill loved ones.

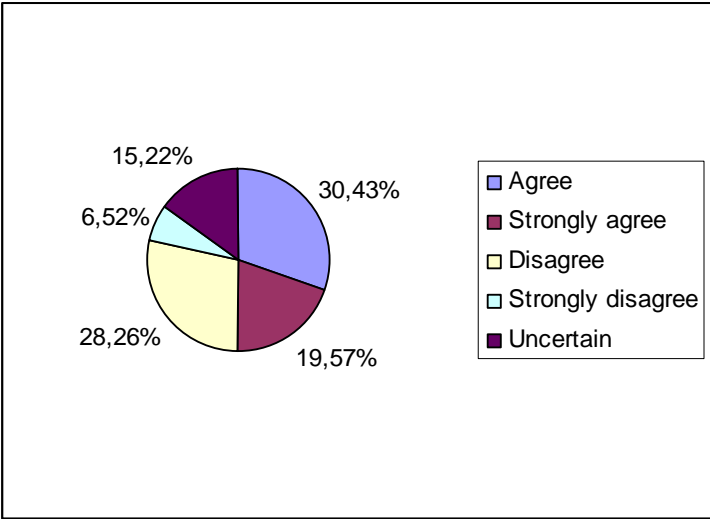


**Figure 4.27**

***Family need to be allowed to spend more time with critically ill loved ones***

**4.4.2.18 Item 2.23: Open visiting time will not disrupt routine care (n=46)**

Of the respondents, 30,43% (n=14) agreed; 19,57% (n=9) strongly agreed; 28,26% (n=13) disagreed; 6,52% (n=3) strongly disagreed, and 15,22% (n=7) were uncertain. The majority of the respondents (50%), then, agreed that open visiting time would not disrupt routine care. Figure 4.28 indicates the level of agreement with the statement that open visiting time will not disrupt routine care.



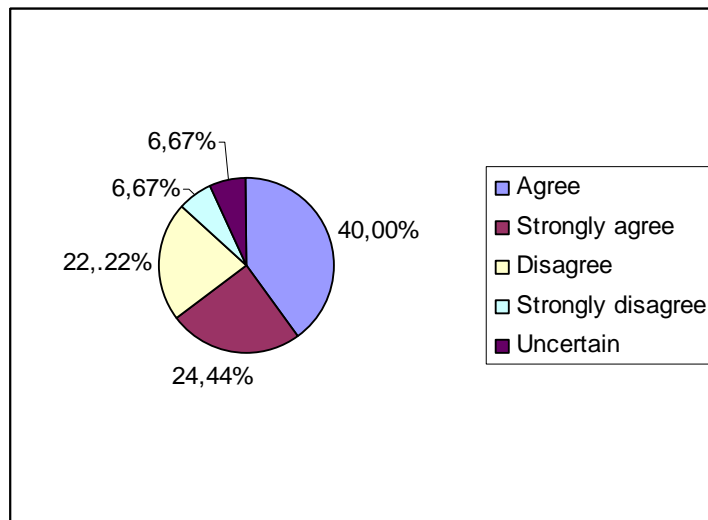
**Figure 4.28**

***Open visiting time will not disrupt routine care***

**4.4.2.19 Item 2.24: Extended visiting time will lead to greater patient/family satisfaction (n=45)**

Of the respondents, 40,00% (n=18) agreed; 24,44% (n=11) strongly agreed; 22,22% (n=10) disagreed; 6,67% (n=3) strongly disagreed, and 6,67% (n=3) were uncertain. There was 1 missing response. The majority of the respondents (64,44%; n=29) therefore agreed that extended visiting time would lead to greater patient/family satisfaction.

Figure 4.29 indicates the level of agreement that extended visiting time will lead to greater patient/family satisfaction.



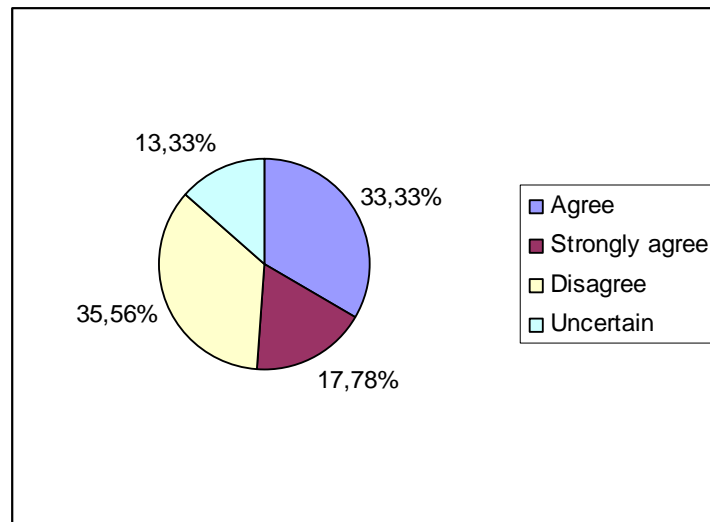
**Figure 4.29**

***Extended visiting time will lead to greater patient/family satisfaction***

**4.4.2.20 Item 2.25: Open visiting time will lead to greater patient/family satisfaction (n=45)**

Of the respondents, 33,33% (n=15) agreed; 17,78% (n=8) strongly agreed; 35,56% (n=16) disagreed; and 13,33% (n=6) were uncertain. There was 1 missing value. The respondents 51,11% (n=23) therefore generally agreed that open visiting time would lead to greater patient/family satisfaction.

Figure 4.30 indicates the level of agreement that open visiting time will lead to greater patient/family satisfaction.



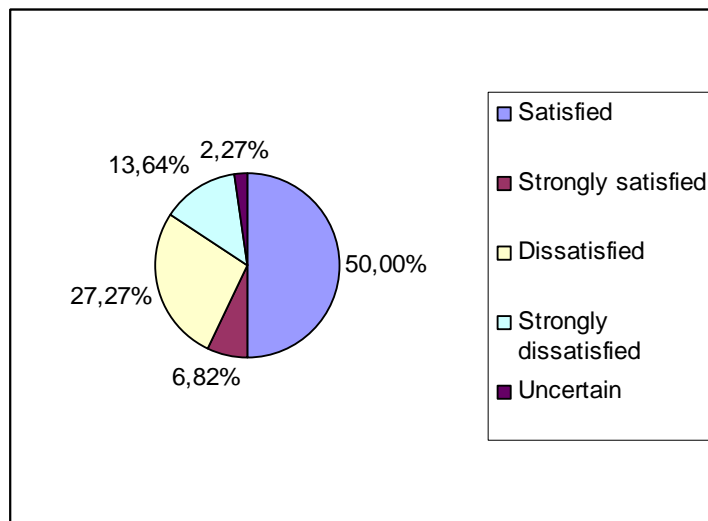
**Figure 4.30**

***Open visiting time will lead to greater patient/family satisfaction***

**4.4.2.21 Item 2.26: Satisfaction with current visiting times (n=44)**

Of the respondents, 50,00% (n=22) indicated that they were satisfied; 6,82% (n=3) were strongly satisfied; 27,27% (n=12) were dissatisfied; 13,64% (n=6) were strongly dissatisfied, and 2,27% (n=1) was uncertain. There were 2 missing responses. The majority of the respondents (56,82%; n=25) were satisfied with the current visiting times, while 40,91% (n=18) were dissatisfied.

Figure 4.31 indicates the level of satisfaction with current visiting times.



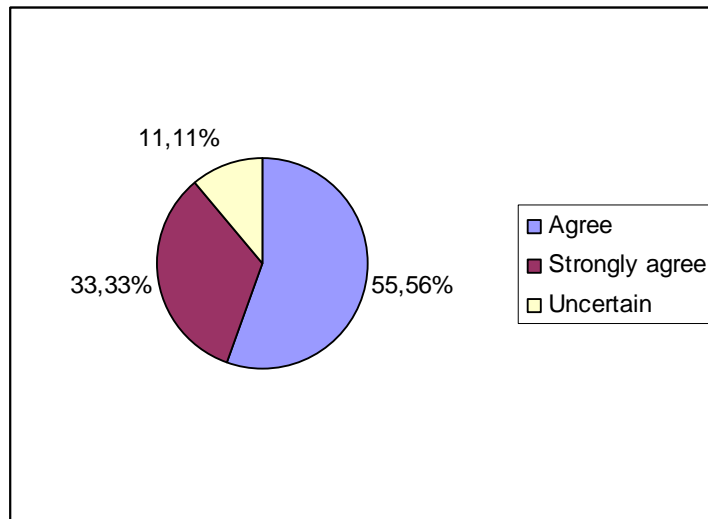
**Figure 4.31**  
**Satisfaction with current visiting times**

**4.4.2.22 Item 2.27: Family members visiting when patients are critically ill helps reduce anxiety (n=45)**

Of the respondents, 55,56% (n=25) agreed; 33,33% (n=15) strongly agreed and 11,11% (n=5) were uncertain. There was 1 missing response. The majority of the respondents (88,89%; n=40) agreed that visiting helps reduce anxiety. Petterson (2005:72) emphasises that family and friends' presence lessens stress and anxiety levels. Fumagalli et al (2006:952) found that liberalising visiting time in ICU does not increase septic complications, but has the potential to reduce cardiovascular complications, through reduced anxiety and more favourable hormonal profile.

Figure 4.32 indicates the level of agreement that family members visiting when patients are critically ill helps reduce anxiety.





**Figure 4.32**

***Family members visiting when patients are critically ill helps reduce anxiety***

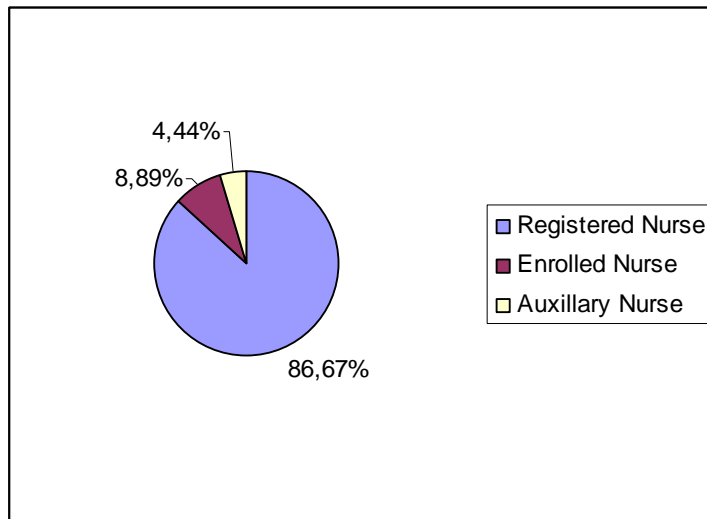
## **4.5 NURSES' QUESTIONNAIRE**

A total of 45 questionnaires were distributed and 45 responses were received. The sample was therefore composed of 45 respondents and the response rate for this category was 100%.

### **4.5.1 Section A: Biographical data**

#### **4.5.1.1 Item 3.1: Category of nursing staff (n=45)**

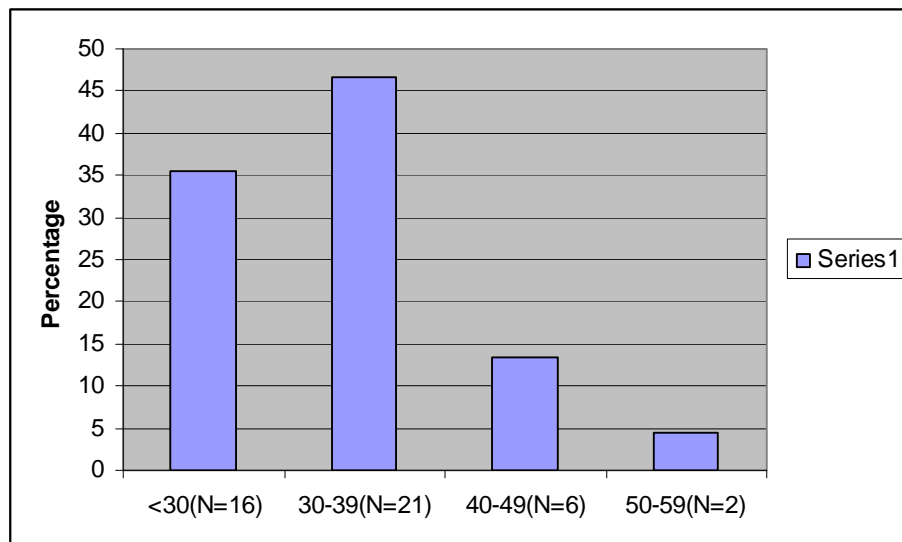
Of the respondents, 86,67% (n=39) were registered nurses; 8,89% (n=4) were enrolled nurses, and 4,44% (n=2) were auxiliary nurses.



**Figure 4.33**  
**Respondents' categories**

**4.5.1.2 Item 3.2: Age (n=45)**

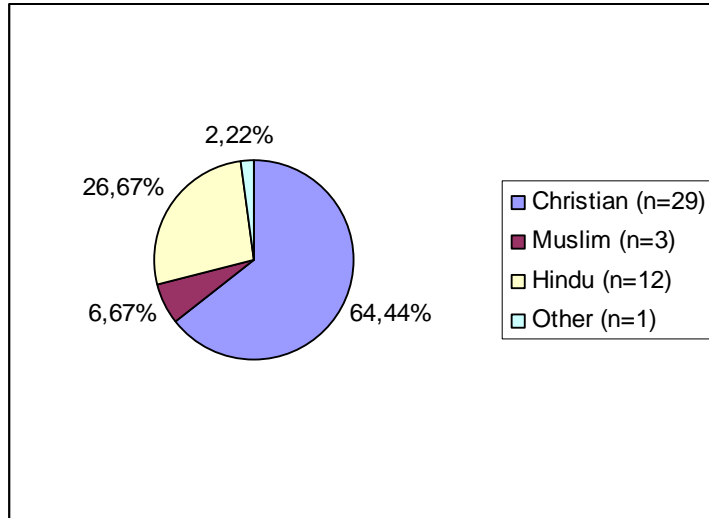
Of the respondents, 46,67% (n=21) were between 30 and 39 years old; 35,56% (n=16) were under 30; 13,33% (n=6) were between 40 and 49, and 4,44% (n=2) were between 50 and 59.



**Figure 4.34**  
**Respondents' ages**

**4.5.1.3 Item 3.3: Religious denomination (n=45)**

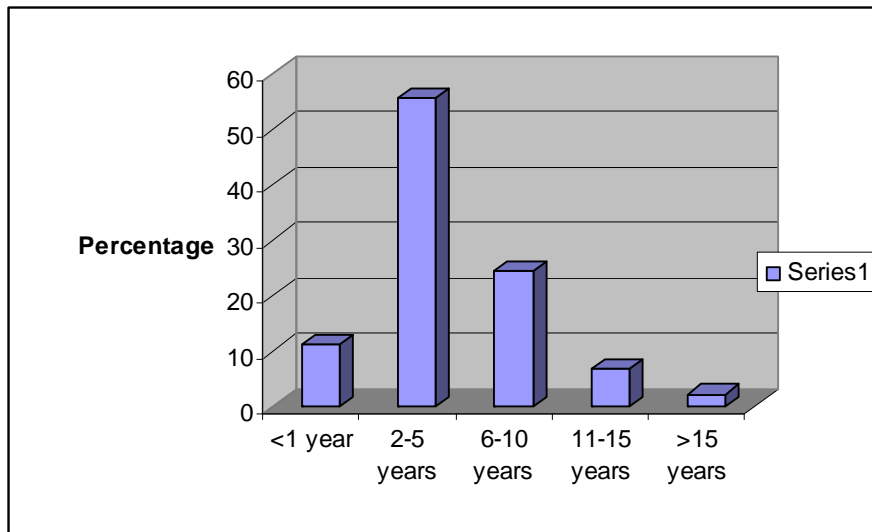
Of the respondents, 64,44% (n=29) were Christians; 26,67% (n=12) were Hindus; 6,67% (n=3) were Muslims, and 2,22% (n=1) did not indicate their religion.



**Figure 4.35**  
**Respondents' religious affiliation**

**4.5.1.4 Item 3.4: Work experience (n=45)**

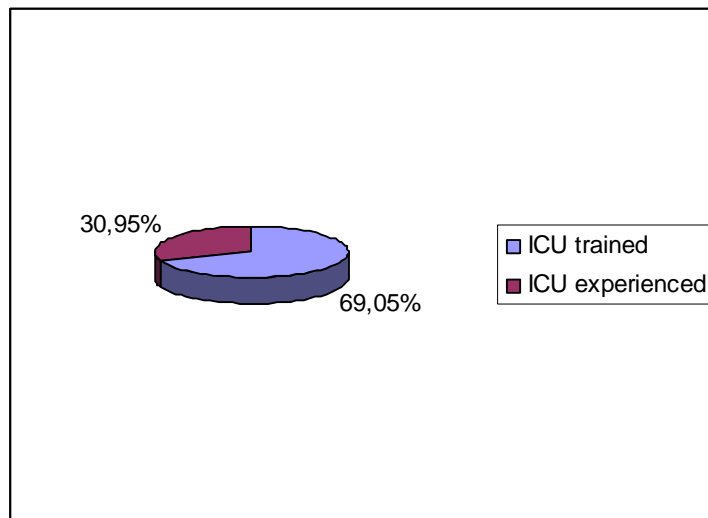
Of the respondents, 55,56% (n=25) had 2 to 5 years of ICU working experience; 24,44% (n=11) had 6 to 10 years; 6,67% (n=3) had 11 to 15 years; 2,22% (n=1) had over 15 years, and 11,11% (n=5) had less than 1 year's experience.



**Figure 4.36**  
**Respondents' working experience**

**4.5.1.5 Item 3.5: Educational training (n=42)**

Of the respondents, 69,05% (n=29) were ICU experienced, while 30,95% (n=13) were ICU trained. There were 3 missing responses.

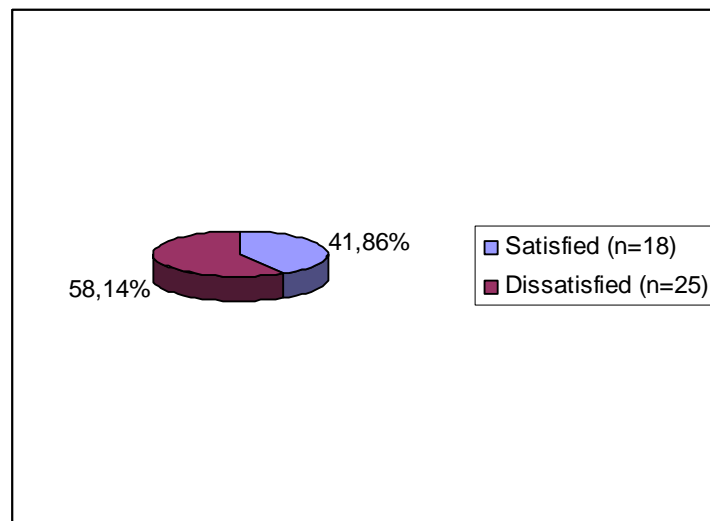


**Figure 4.37**  
**Respondents' ICU training**

## 4.5.2 Section B: Nurses' perceptions of visiting time in ICU

### 4.5.2.1 Item 3.6: Perceptions of the current visiting time in ICU (n=43)

The respondents were asked to describe their perceptions of the current visiting time. The responses were categorised into satisfied and dissatisfied. Of the respondents, 58,14% (n=25) were dissatisfied, while 41,86% (n=18) were satisfied. The dissatisfaction arose from lack of control, insufficient visiting time for family, visiting times scheduled too closely, and the number of people visiting. There were 2 missing responses.

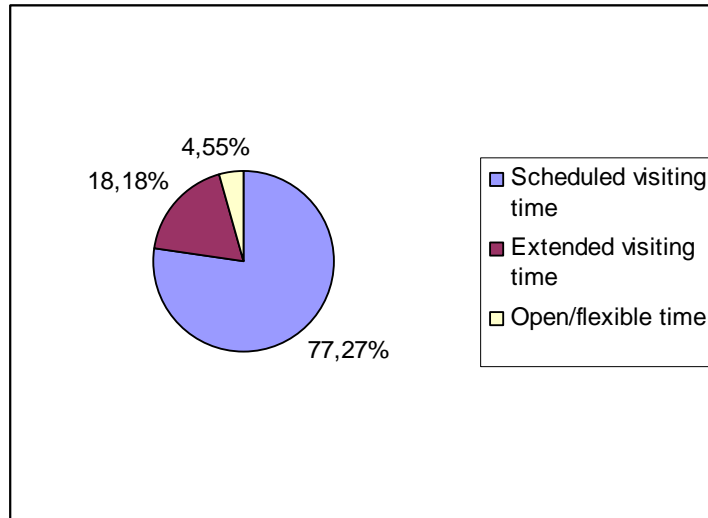


**Figure 4.38**

***Respondents' perceptions of current visiting time***

### 4.5.2.2 Item 3.7: Preference for open/scheduled/extended visiting time (n=44)

Of the respondents, 77,27% (n=34) preferred scheduled visiting times; 18,18% (n=8) preferred extended visiting times, and 4,55% (n=2) preferred open/flexible visiting times. There was 1 missing response.



**Figure 4.39**  
**Respondents' preference for visiting times**

**4.5.2.3 Item 3.8: Reasons for preference (n=41)**

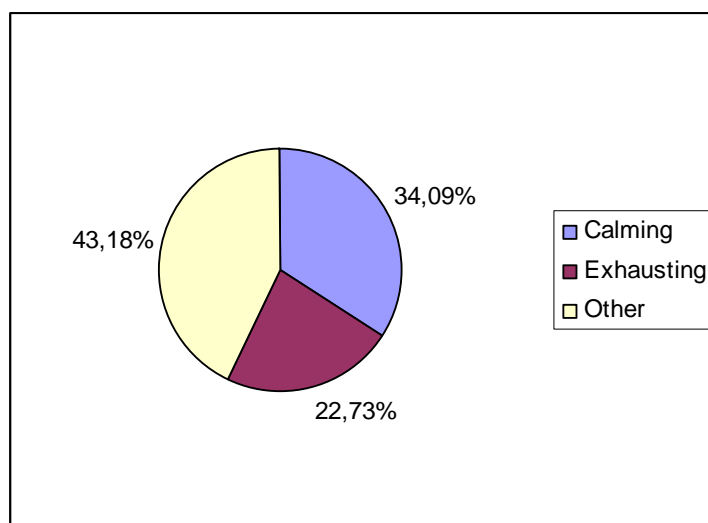
The respondents were asked to give reasons for their preferences. There were 41 responses and 4 missing responses. Of the respondents, 41,46% (n=17) preferred scheduled visiting time as it enabled nursing staff to provide quality nursing care and patients needed rest; 17,07% (n=7) said for better control purposes; 7,32% (n=3) stated that ICU was a busy environment; and 2,44% (n=1) felt that visiting time was insufficient as relatives wished to visit more often.

**Table 4.8 Reasons for respondents' preferences**

	<b>N</b>	<b>Percentage</b>
Control	7	17,07
Rest and provide quality nursing care	17	41,46
ICU busy environment	3	7,32
Insufficient time/relatives would like to visit more often	1	2,44
Extend visiting time	7	17,07
More flexible visiting time	2	4,88
Further restrictions on visiting time	1	2,44
Open visiting time	1	2,44
Scheduled visiting time	2	4,88
<b>TOTAL</b>	<b>41</b>	<b>100,00</b>
Missing responses	4	

**4.5.2.4 Item 3.9: Respondents' observation of patients' response to visit from family/friends (n=44)**

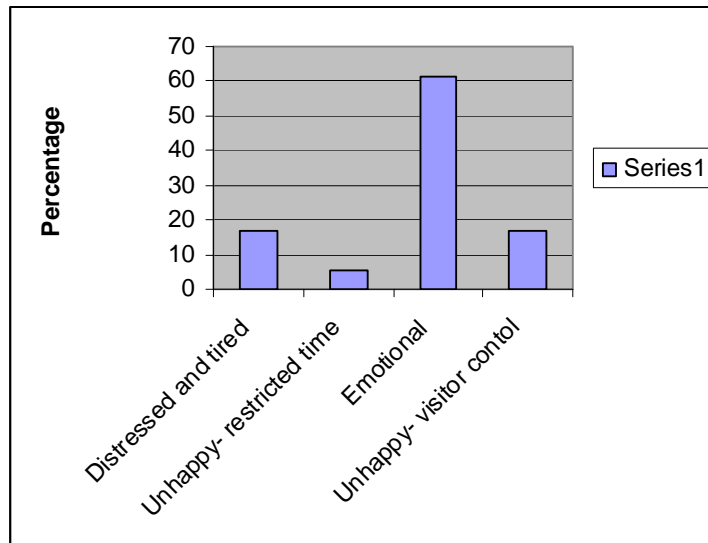
Of the respondents, 43,18% (n=15) stated that the visit was exhausting for the patient; 34,09% (n=10) said the visit was calming, and 22,73% (n=19) gave other responses. There was 1 missing response.



**Figure 4.40**  
**Nurses' experiences of responses observed**

**4.5.2.5 Item 3.10: Other responses observed (n=18)**

Of the respondents who indicated other responses, 61,11% (n=11) stated that patients became emotional; 16,67% (n=3) stated that they became distressed and tired; 16,67% (n=3) were unhappy with the control of visitors, and 5,55% (n=1) was unhappy about restricted visiting time. There were 27 missing responses.

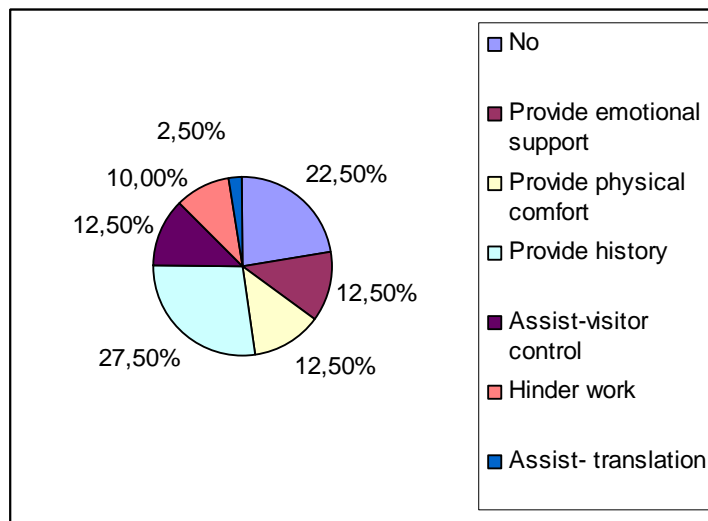


**Figure 4.41**  
**Other responses observed**

**4.5.2.6 Item 3.11: Were the visitors able to provide support? (n=39)**

The respondents were asked if the visitors were able to provide support. There were 39 responses and 6 missing responses. Of the respondents, 27,50% (n=11) said visitors helped provide history; 22,50% (n=9) said no; 12,50% (n=5) helped provide physical comfort; 12,50% (n=5) provided emotional support; 12,50% (n=5) helped assist with visitor control; 10,00% (n=4) hindered work; 2,50% (n=1) assisted with translation.



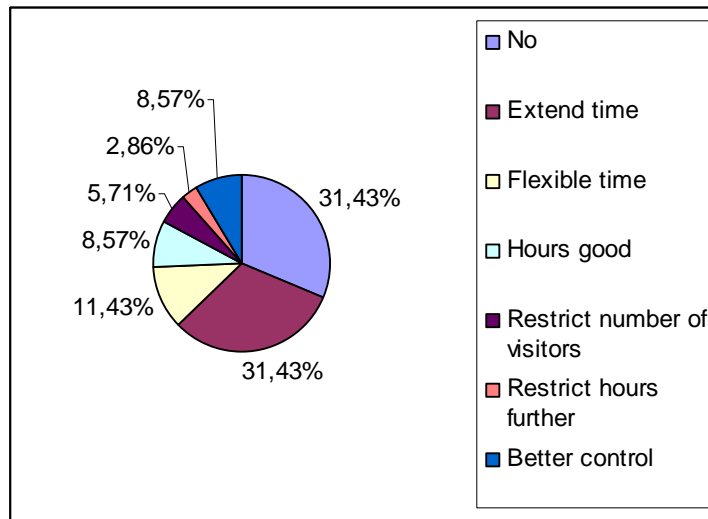


**Figure 4.42**  
**Types of support**

**4.5.2.7 Item 3.12: Other comments regarding visiting time in ICU (n=35)**

The respondents were asked if they had any other comments on visiting time in the ICU. Of the respondents, 31,43% (n=11) indicated a preference for extended ICU visiting time; 11,43% (n=4) preferred flexible visiting time; 2,86% (n=1) wanted further restrictions on present practice; 5,71% (n=2) called for a restriction on the number of visitors; 8,57% (n=3) expressed satisfaction with present practise; 8,57% (n=3) preferred better control and 31,43% (n=11) had no further comments. There were 10 missing responses.

Carlson et al (1998:40), Federwisch (1998), and Farrell et al (2005:19) refer to nurses as “gatekeepers of ICU that limit family visitation to protect the patient’s physiological status and promote rest”. It is noteworthy that none of the respondents mentioned infection as a concern or reason for their preference.



**Figure 4.43**  
***Other comments regarding visiting time in ICU***

#### **4.6 CONCLUSION**

This chapter presented the data analysis and interpretation. Chapter 5 concludes the study, discusses the findings, and makes recommendations.

## **CHAPTER 5**

### **Findings, limitations and recommendations**

#### **5.1 INTRODUCTION**

This chapter presents the findings of the study, discusses its limitations, and makes recommendations for practice and further research.

The purpose of this study was to determine patients, family members/friends and nurses' perceptions and preferences on visiting time in ICU. The objectives were to

- describe patients, family members/friends and nurses' perceptions and preferences regarding visiting time in ICU
- recommend mechanisms and measures with regard to the desired visiting schedule that would enhance patient-centred integrated care in ICUs

The researcher used the objectives to establish to what extent the current visiting policy met with satisfaction levels of the patients, family members/friends and nursing staff in the three adult intensive care units (medical, surgical and coronary/neuro-surgical), in a private hospital in KwaZulu-Natal, in the city of Durban. Patients nursed in ICU and especially in coronary and neuro-surgical units require very little stimuli. Visitors are allowed between 15:00 and 16:00 and again between 19:15 and 20:00. Visiting times are restricted to immediate family and only two members per time. Visiting duration totals 1 hour and 45 minutes in 24 hours.

#### **5.2 FINDINGS**

##### **5.2.1 Respondents' profile (demographic information)**

The demographic profile of all the respondents is discussed simultaneously. The respondents' age, gender and religious affiliation were indicated. The majority of the respondents were females aged between 50 and 59 years. The majority were Indians, followed by Whites then Blacks. With regard to religion, the majority were Christians,

followed by Hindus then Muslims. It was important for these variables to be measured as they play a significant role in understanding the respondents' background and the possible significant role of others in their lives, including the source of their support system. The age of the respondents is congruent with the fact that coronary heart conditions are more prevalent in individuals above 40 and mostly females. The knowledge of religious affiliation enables the carer to provide care without transgressing religious norms and values. The family members' age corresponded with that of the patients.

The nurses' age was slightly different from the patients and family members. This was congruent with the fact that ICU is a highly demanding, stressful and technologically chaotic environment.

### **5.2.2 Respondents' preferences and perceptions regarding visiting time in ICU**

- **Patients**

The study found that the majority of the respondents (48,84%) were happy with the opportunity given to them to be visited, for the following reasons: the visit helped to provide a familiar environment, helped to reduce their stress levels and helped to reduce anxiety. The visitors' role during visiting time included support (spiritual, emotional, psychological), providing comfort, and bringing in personal items for the respondents. These findings concur with those of Marfell and Garcia (1995:87), Hupcey (1999:180) and Roland et al (2001:18).

Although the majority of the patients indicated that they were happy with the current visiting time, some also indicated a preference for longer visiting time or more frequent visits for the following reasons:

- Family members travelled far to visit.
- Family members/friends provided comfort and support.
- The patients preferred that their visitors stay longer.

Peterson (2005:72) advocates the implementation of an open visitation policy in ICUs. In this study, the majority of the respondents indicated a preference for extended visiting

time in ICU. Gonzalez et al (2004:194) found that patients were satisfied with a guideline that is flexible enough to meet the needs of patients and their families.

- **Family members/friends**

The respondents were of the opinion that their visit was important to the patients. The majority of the respondents believed that their visit was important for the following reasons: providing support (psychological, emotional, moral and spiritual), physical comfort, and for patient reassurance that the visitor was kept informed of the patient's progress.

The respondents also believe that they were of assistance to the nursing staff by assisting with communication, helping to provide comfort, providing emotional/spiritual support, and allowing the nurse to perform other duties. These findings concur with those of Ramsey et al (2000:42), Carlson et al (1998:40) and Berwick and Kotagal (2004:736).

While the respondents believed that family members should be allowed to spend more time with their critically ill loved ones, they recognised the need for restricted visiting time in ICU. At the same time, however, they disagreed that imposing restricted visiting time on family members of critically ill loved ones is acceptable. The respondents believed that open/expanded visiting time in ICU would lead to greater family/patient satisfaction. This would appear to indicate that family members recognise and respect the need for policy.

- **Nurses**

The respondents were of the opinion that visitors help provide history, physical comfort, emotional support, visitor control and translation. Carlson et al (1998:40) and Ramsey et al (2000:42) indicate similar results.

The majority of the nurses were dissatisfied with the current visiting practice for the following reasons: lack of control, insufficient visiting time for family, visiting times scheduled too closely, the number of people visiting, patients became distressed and tired, emotional, and exhausted. Kirchhoff et al (1993:238) found that critical care

nurses did not perceive liberal visitation as important to the patient's recovery, while other nurses believed that the liberalisation of visiting policies would interfere with the ability of the nurse to provide nursing care (Ramsey et al 1999:42).

The majority of the respondents preferred scheduled visiting time, while some preferred extended visiting time and only a few advocated open flexible visiting time. This finding supports Farrell et al's (2005:18) statement that nurses "tend to be the primary gatekeepers in the ICU; the nurse ultimately decides who is allowed to visit and for how long visitors may stay". Moreover, this finding indicates that the nurses in this study do not appear to be ready yet to embrace the concept of patient-centred care.

In summary, the majority of the patients and family members/friends preferred extended ICU visiting time and perceived this as beneficial to them, while the majority of the nurses, however, preferred scheduled visiting time.

### **5.2.3 Recommended mechanism and measure with regard to a visiting schedule which will enhance patient integrated care in ICU**

In this study the patients and family members expressed the need to be able to provide physical comfort and emotional support, help alleviate anxiety, and be kept informed of the patient's progress. These are some of the basic tenets of patient-centred care. The National Research Corporation and Picker Institute Brochure (2005:4) identify the following basic principles of patient-centred care:

- physical comfort
- respect for patients' values, preferences and expressed needs
- access to care
- coordination and integration of care
- transition and continuity
- emotional support and alleviation of fear and anxiety
- involvement of friends and family
- information and education

The findings of this study support a more "patient-centred approach" and the review of the current policy and practice is therefore recommended.

### 5.3 LIMITATIONS

The following were identified as limitations:

- This study was conducted in one private hospital setting in KwaZulu-Natal. Due to the small sample size, findings of this study cannot be generalised. Research done in other areas therefore may yield different results.
- Although the study included respondents from different racial groups, it was not representative of the demographic population of the region of KwaZulu-Natal.
- The researcher found no national literature on the subject and therefore focused on international studies and literature.
- The statistical information from the data obtained is limited due to the small sample size. Correlations could therefore not be done.

### 5.4 RECOMMENDATIONS

Based on the findings of this study, the researcher makes the following recommendations:

- **Management strategies**

The following mechanisms and strategies should be employed: adopt a multi-team approach (assessing the transferability of the findings, feasibility, cost/benefit ratio of the intervention), establish guidelines, provide education, training and adequate resources to facilitate the transition, conduct surveys to establish customer and staff satisfaction, and facilitate communication.

- **Nursing education**

Introduce and improve in-service training programmes to include topics on flexible visiting, patient-centred care, and family-centred care. Encourage nurses to involve family members in caring for their loved ones during visiting time, and improve their communication skills. Involve/include nurses in all phases of the implementation of new policy and practice, and obtain their input.

- **Nursing practice**

Encourage nurses to facilitate and solicit patient and family participation in patient care. Encourage nurses to assist patients by helping them to identify their needs, and providing them with adequate information to enable them to make informed decisions. Nurses should encourage family members to participate in making decisions and the care provided.

- **Future research**

It is recommended that further research be conducted on the following topics:

- A wider study on patients, family members/friends and nurses' preferences and perceptions regarding visiting time in ICU in other hospitals in other provinces and other clinical settings
- Patient-centred care and its perceived benefits
- Comparative studies on the physiological effects, if any, associated with different visiting schedules.

## **5.5 CONCLUSION**

This chapter presented the findings, discussed its limitations, and made recommendations for practice and further research.



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## PATIENT QUESTIONNAIRE

**THEME: Preferences and Perceptions of Visiting Hours in the Intensive care Unit**

<b>1. Surgical</b>	
<b>2. Medical</b>	
<b>3. Cardiac/Neuro</b>	

<b>Questionnaire number</b>			
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<b>Date completed</b>					
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**PLEASE MAKE A  IN THE BLOCK APPLICABLE TO YOUR ANSWER**

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### SECTION A: DEMOGRAPHIC INFORMATION

**Q1. Please indicate your gender**

<b>Male</b>	
<b>Female</b>	

**Q2. To which race group do you belong?**

<b>1. White</b>	
<b>2. Coloured</b>	
<b>3. Indian</b>	
<b>4. Black</b>	
<b>5. Other</b>	

**Q3. Age**

<b>1. Less than 30 years</b>	
<b>2. 30 -39 years</b>	
<b>3. 40 - 49 years</b>	
<b>4. 50 – 59 years</b>	
<b>5. 60 years or older</b>	

**Q4. Your religious denomination is**

<b>1. Christian</b>	
<b>2. Buddhism</b>	
<b>3. Jewish</b>	
<b>4. Moslem</b>	
<b>5. Hindu</b>	
<b>6. Other</b>	

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**SECTION: B ALL OF THE FOLLOWING QUESTIONS RELATE TO YOUR STAY  
IN ICU**

**Q5. Were you visited by your family or a friend while you were in ICU?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q6. If Yes, in Q5 how did you feel about the visit? Please elaborate.**

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**Q7. If Yes, would you have preferred your visitor(s)**

<b>1. stay longer</b>	
<b>2. visit more often</b>	
<b>3. Neither</b>	

**Q8. Please could you give reasons for your response in Q7**

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**Q9. Would you have preferred your visitor(s) to leave?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q10. If Yes, in Q9 which of the following would be the reason?**

<b>1. Needed to rest</b>	
<b>2. Increased stress levels</b>	
<b>3. Increased anxiety</b>	
<b>4. Did not want family to observe therapy/treatment</b>	
<b>5. family dynamics not conducive</b>	
<b>6. other reasons</b>	

**Q11. If your response is 6 in Q10, please elaborate**

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**Q12. Is there anything in particular that your visitor(s) could do for you that the nursing staff could not do?**

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**Q13. How did you experience the nursing staff's attitude towards your visitor(s)?**

<b>1. Friendly</b>	
<b>2. Unfriendly</b>	
<b>3. Flexible</b>	
<b>4. Inflexible</b>	
<b>5. Other attitudes</b>	

**Q14. If your response is 5 in Q13 please elaborate \_\_\_\_\_**

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**Q15. In ICU would you have preferred?**

<b>1. Scheduled visiting hours</b>	
<b>2. Extended visiting hours</b>	
<b>3. Open/unrestricted/flexible visiting hours.</b>	

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**THANK YOU FOR PARTICIPATING IN THIS STUDY**

**If you have any questions or encounter any problems by contact details are**

**Are as follows: Researcher**

**- Ronica Surajbally**

**Contact no.**

**-031- 4632005**

**QUESTIONNAIRE FOR FAMILY MEMBER / FRIEND****THEME: Preferences and Perceptions of Visiting Time in the Intensive Care Unit**

<b>1. Surgical</b>	
<b>2. Medical</b>	
<b>3. Cardiac/Neuro</b>	

<b>Questionnaire number</b>			
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<b>Date completed</b>					
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PLEASE MAKE A  IN THE BLOCK APPLICABLE TO YOUR ANSWER

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**SECTION A: DEMOGRAPHIC INFORMATION****Q1. Are you a**

<b>Family</b>	
<b>Friend</b>	

**Q2. Please indicate your gender**

<b>Male</b>	
<b>Female</b>	

**Q3. To which race group do you belong?**

<b>1. White</b>	
<b>2. Coloured</b>	
<b>3. Indian</b>	
<b>4. Black</b>	
<b>5. Other</b>	

**Q4. Age**

<b>1. Less than 30 years</b>	
<b>2. 30 -39 years</b>	
<b>3. 40 - 49 years</b>	
<b>4. 50 – 59 years</b>	
<b>5. 60 years or older</b>	

**Q5. Your religious denomination is**

<b>1. Christian</b>	
<b>2. Buddhism</b>	
<b>3. Jewish</b>	
<b>4. Moslem</b>	
<b>5. Hindu</b>	
<b>6. Other</b>	

**SECTION B: EXPERIENCE OF YOUR VISIT TO THE PATIENT**

**Q6. Were you informed about the visiting time in ICU?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q7. Were you given the opportunity to visit the patient?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q8. If yes in question 6, how did you experience your visit?**

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**Q9. Were you asked to leave?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q10. If yes in question 8, how did you feel about leaving**

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**Q11. If yes to question 8, was a reason given to you as to why you should leave?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q12. If yes to question 10, was the reason acceptable?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q13. Are you of the opinion that your visit was of importance to the patient the patient?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q14. If Yes, please indicate which way do you think, that your visit was of importance to the patient.**

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**Q15. Did the patient appreciate your visit?**

<b>1. Yes</b>	
<b>2. No</b>	

**Q16. If Yes in question 15, did the patient want you to**

<b>1. stay longer</b>	
<b>2. visit more often</b>	

**Q17. Are you of the opinion that your visiting could be of assistance to the nursing staff?**

<b>1. Yes</b>	
<b>2. No</b>	



**Q18. If Yes in question 17, as a visitor, in which way could your visit be of assistance to the nursing staff?**

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**Q19. Did you get the feeling that the nursing staff would have preferred that you leave?**

<b>1. Yes</b>	
<b>2. No</b>	

**SECTION: C Perceptions of Visiting Hour Practises****Q20. Visiting hour in the ICU should not be restricted**

<b>1. agree</b>	
<b>2. Strongly agree</b>	
<b>3. disagree</b>	
<b>4. Strongly disagree</b>	
<b>5. uncertain</b>	

**Q21. Imposing restricted visiting hour on family members of critically ill loved ones is acceptable**

<b>1. agree</b>	
<b>2. Strongly agree</b>	
<b>3. disagree</b>	
<b>4. Strongly disagree</b>	
<b>5.uncertian</b>	

**Q22. Family need to be allowed to spend more time with their critically ill loved ones**

<b>1. agree</b>	
<b>2. Strongly agree</b>	
<b>3. disagree</b>	
<b>4. Strongly disagree</b>	
<b>5. uncertain</b>	

**Q23. Open visiting hour will not disrupt routine care**

<b>1. agree</b>	
<b>2. Strongly agree</b>	
<b>3. disagree</b>	
<b>4. Strongly disagree</b>	
<b>5. uncertain</b>	

**Q24. Expanded visiting hours will lead to greater patient/staff/family satisfaction**

<b>1. agree</b>	
<b>2. Strongly agree</b>	
<b>3. disagree</b>	
<b>4. Strongly disagree</b>	
<b>5. uncertain</b>	

**Q25. Open visiting hours will lead to greater patient/family and staff satisfaction**

<b>1. agree</b>	
<b>2. Strongly agree</b>	
<b>3. disagree</b>	
<b>4. Strongly disagree</b>	
<b>5. uncertain</b>	

**Q26. You are satisfied with the current visiting hour practises**

<b>1. satisfied</b>	
<b>2. Strongly satisfied</b>	
<b>3. dissatisfied</b>	
<b>4. Strongly dissatisfied</b>	
<b>5. uncertain</b>	

**Q27. Family member's visiting when one is critically ill helps reduce anxiety**

<b>1. agree</b>	
<b>2. Strongly agree</b>	
<b>3. disagree</b>	
<b>4. Strongly disagree</b>	
<b>5. uncertain</b>	

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**THANK YOU FOR PARTICIPATING IN THIS STUDY**

**If you have any questions or encounter any problems by contact details are**

**Are as follows: Researcher**

**- Ronica Surajbally**

**Contact no.**

**-031- 4632005**

## ICU NURSING STAFF QUESTIONNAIRE

**THEME: Preferences and Perceptions Visiting Time in the Intensive Care Unit**

1. Surgical ICU	
2. Medical ICU	
3. Cardiac/ Neuro ICU	

<b>Questionnaire number</b>			
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<b>Date completed</b>					
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**PLEASE MAKE A  IN THE BLOCK APPLICABLE TO YOUR ANSWER**

### SECTION A: DEMOGRAPHIC INFORMATION

**Q1. Please indicate your rank**

<b>1. Registered nurse</b>	
<b>2. Enrolled nurse</b>	
<b>3. Auxiliary nurse</b>	

**Q2. Please indicate your age**

<b>1. Less than 30 years</b>	
<b>2. 30 -39 years</b>	
<b>3. 40 - 49 years</b>	
<b>4. 50 – 59 years</b>	
<b>5. 60 years or older</b>	

**Q3. Your religious denomination is**

<b>1. Christian</b>	
<b>2. Buddhism</b>	
<b>3. Jewish</b>	
<b>4. Moslem</b>	
<b>5. Hindu</b>	
<b>6. Other</b>	

**Q4. How long have you been working in ICU?**

<b>1. &lt; 1 year</b>	
<b>2. 2 -5 years</b>	
<b>3. 6- 10 years</b>	
<b>4. 11-15 years</b>	
<b>5. &gt;15 years</b>	

**Q5. If you are a registered nurse, are you?**

<b>1. ICU trained</b>	
<b>2. ICU experienced</b>	
<b>3. neither of the above</b>	

**SECTION: B THE FOLLOWING QUESTIONS RELATE TO YOUR PERCEPTIONS OF THE CURRENT VISITING HOUR PRACTICES**

**Q6. What is your perception of the current visiting hour practise in this hospital?**

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**Q7. In ICU would you prefer?**

<b>1. Scheduled visiting hours</b>	
<b>2. Extended visiting hours</b>	
<b>3. Open/unrestricted/flexible Visiting hours.</b>	

**Q8. Please substantiate your answer in Q7.**

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**Q9. How would you describe the patients response to the visits from their family /friends in the ICU ?**

<b>1. calming</b>	
<b>2. exhausting</b>	
<b>3. other responses</b>	

**Q10. If your answer is 3 in Q9 please state the other responses**

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**Q11. Were patients' visitors able to support you in any way? Please elaborate.**

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**Q12. Are there any contributions that you would like to make towards visiting time in the ICU?**

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**THANK YOU FOR PARTICIPATING IN THIS STUDY**

**If you have any questions or encounter any problems by contact details are**

**Are as follows: Researcher**

**- Ronica Surajbally**

**Contact no.**

**-031- 4632005**

**UNIVERSITY OF SOUTH AFRICA**  
**Health Studies Research & Ethics Committee**  
**(HSREC)**  
**Faculty of Human Sciences**  
**CLEARANCE CERTIFICATE**

Date of meeting: 29 August 2005 Project No: 834-966-5  
Project Title: PERCEPTIONS AND PREFERENCES OF PATIENTS,  
FAMILY/FRIENDS AND NURSES ON VISITING TIME IN ICU  
Researcher: R Ramnath  
Supervisor/Promoter: Mrs MM Moleki  
Joint Supervisor/Joint Promoter: -  
Department: Health Studies  
Degree: Master of Arts

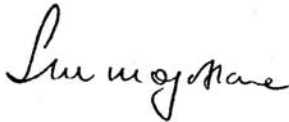
**DECISION OF COMMITTEE**

**Approved**  **Conditionally Approved**

Date: 31 March 2006



**Prof TR Mavundla**  
**RESEARCH COORDINATOR**



**Prof SM Mogotlane**  
**ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

**PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES**

## Participant Information and Informed Consent

Title: Perceptions and preferences of Patient,Family/Friends and Nurses on visiting time in Intensive Care Units

Researcher's Name: Sr. R. Surajbally

Contact No: 031- 4632005

### PARTICIPANT INFORMATION

**This document may contain words that you do not understand. Please ask the researcher to explain any words or information that you may want clarified.**

You are being asked to take part in an independent research study, a curriculum requirement for the completion of a Master's Degree. The purpose of this study is to establish the effectiveness of current practice.

**Participation in the study is entirely voluntary. You may leave the study at any time. Your decision to withdraw participation will not affect the medical care or affect any benefit to which you are entitled.**

This is what will happen if you decide to participate in the study:

If you are eligible and have filled out a consent form to participate in the study, you will be given a questionnaire.

The questionnaire will be marked with numbers to ensure anonymity.

**Only the researcher and her assistants will have access to the information on the questionnaires. This information will be destroyed on completion of the study. This study will not endanger lives.**

Your participation is entirely voluntary and there will be no remuneration for your participation.

### VOLUNTEER'S STATEMENT

**I voluntarily agree to participate in this study.**

I understand that I may withdraw my participation at any time during the study without prejudice.

**I have read and understood this statement of informed consent.**

I have had a chance to ask questions and understand the answers given to all of my questions.

**I hereby consent to participate in this study.**

\_\_\_\_\_  
Signature of Study Volunteer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Study Volunteer





**Network Healthcare Holdings Limited  
(Netcare)**

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Ms R Ramnath  
12 Cotton Hollow Village  
32 Stella Crescent  
**ESCOMBE**  
4093

**February 2006**

**Cc: St Augustine's Hospital**  
**Hospital Manager:** Mr. Rory Passmore  
**Nursing Manager:** Ms Colette Longworth

Dear Ms Ramnath

**RESEARCH ON OPEN/EXPANDED VISITING HOURS IN THE INTENSIVE CARE UNITS  
WITHIN THE CONTEXT OF PATIENT CENTERED INTEGRATED CARE**

It is with pleasure that we inform you that your application to conduct research on Open/expanded visiting hours in the intensive care units within the context of patient centred integrated care at St Augustine's Hospital has been successful, subject to the following:

- i) All information with regards to Netcare will be treated as confidential.
- ii) Netcare's name will not be mentioned without written consent from the Academic Board of Netcare.
- iii) Where Netcare's name is mentioned, the research will not be published without written consent from the Academic Board of Netcare.
- iv) A copy of the research will be provided to Netcare once it is finally approved by the tertiary institution, or once complete.

**Executive Directors:**

R H Friedland BVSc (Pret), MBBCh (Wits), Dip Fin Man, MBA, MRCVS (CEO); P G Nelson CA(SA) (Chief Financial Officer);  
I M Davis Dip Pharm (MPS); V L J Lithakanyane MBChB, M Med (Radiotherapy), MBA; N Weltman CA(SA)

**Non-Executive Directors:**

M I Sacks CA(SA), AICPA(ISA) (Chairman); A P H Jammie BSc (Hons), BA (Hons (Wits)), MSC London (LSE), PhD London (LBS);  
J M Kahn BA (Law), MBA Dcom (hc), SOE; M B Kistnasamy MBChB (Natal), M Med (Community Health) (Natal);  
H R Levin BCom, LLB, LLM, H Dip Tax, H Dip Co Law (Wits); J Shevel MBBCh (Wits); J A Van Rooyen MBBCh (Pretoria), M Med (Clin Path)  
(Stellenbosch)

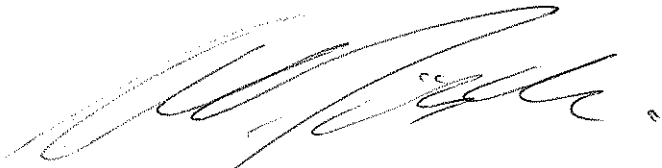
**Company Secretary:** J Wolpert CA(SA) FCMA FCIS

Reg. No. 1996/008242/06

- v) All legal requirements with regards to patient rights and confidentiality will be complied with.

We wish you success in your research.

Yours faithfully



**DR CW FÖLSCHER**  
**Duly Authorised**  
**Research Administrator**  
**NETCARE**



Tel: (012) 667-1265  
Cell/Mobile: 073-782-3923

53 Glover Avenue  
Doringkloof  
0157

30 October 2007

TO WHOM IT MAY CONCERN

I hereby certify that I have edited Ronica Ramnath's Master's dissertation,  
**Perceptions and preferences of patients, family/friends and nurses on  
visiting time in ICU**, for language and content.

IM Cooper  
192-290-4