



## POINT OF VIEW

# For an open-door, more comfortable and humane intensive care unit. It is time for change<sup>☆</sup>



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### KEYWORDS

Intensive Care Unit;  
Comfort;  
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**Abstract** The Intensive Care Unit is a wonderful place where lives are saved, but it is also a very harsh and unpleasant place where critically ill patients face terrible diseases in very adverse environmental conditions. We must change the design of the ICU and its organization; we must improve privacy, welfare and comfort of patients and families, following their personal and emotional demands. To free up the visiting hours and to improve family care are among our most urging matters, which we should delay no further. We must equip the ICUs with modern monitors and respirators but we must also invest in organization, design, environmental comfort and humanization. We need to redesign clinical practice so that ICU care becomes more agreeable and humane. We should put off this change no longer, since it is an imperative social and professional demand.

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### PALABRAS CLAVE

Unidad de cuidados intensivos;  
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Opiniones

**Por una UCI de puertas abiertas, más confortable y humana. Es tiempo de cambio**

**Resumen** La Unidad de Cuidados Intensivos (UCI) es un lugar hermoso donde se regala vida, pero también es un lugar hostil donde los pacientes se enfrentan a una enfermedad terrible en condiciones ambientales muy adversas. Es necesario adaptar tanto el diseño como la organización de la UCI para mejorar la privacidad, el bienestar y la confortabilidad de pacientes y familias, cuidando especialmente sus demandas personales y emocionales. Abrir las puertas de la UCI liberalizando el horario de visitas y mejorar los cuidados dirigidos a la familia es una de las asignaturas pendientes que no debemos retrasar más. Debemos dotar a las UCI de modernos respiradores y equipos de monitorización, pero también debemos invertir en organización,

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diseño, bienestar ambiental y humanización. Necesitamos rediseñar la práctica clínica para que la atención en la UCI sea más confortable y humana. No se debe aplazar más el cambio ya que es una demanda social y profesional ineludible.

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*Restricting visits in the ICU is not kind, compassionate or necessary.*

Berwick D., Kotagal M.

## Introduction

Scientific and technological advances have clearly improved medical practice, but such advances have not been accompanied by parallel progress in its *humane* aspects. Teamwork in hospitals eliminates the role of the single supervising physician and contributes to make medical care more impersonal. Patients are rendered naked physically and metaphorically, and although they are perfectly identified by means of a wristband, they are depersonalized by the system, which forgets about their emotional needs and transforms them into a *medical study object*. Hospitals are hostile places, and the patients and their families experience admission with anguish and concern. In the Intensive Care Unit (ICU) these emotions are intensified in the face of extreme life or death situations. Critical patients need especially humane and comfortable care, since they are very vulnerable and must face terrible illness with great discomfort associated both with the disease process and the structure/organization of the ICU.<sup>1-3</sup> The ICU is a wonderful place where lives are saved, but it is also a hostile place, with too much light and permanent noise caused by respirators, monitor alarms and frequent (and often inadequate) conversations among healthcare professionals. All these cause discomfort, distorted by the administered medication, and lead to greater confusion. The patients moreover suffer pain and fear, with sleeping difficulties and disorientation, and are separated from their families by a restrictive visiting policy.

As early as 1979, Molter<sup>4</sup> drew attention to the fact that professional effort was mainly focused on patient care, with scant attention to family care, and underscored the need to also extend care to the *family unit*—the latter being understood as patient family and friends. In line with this more integrating philosophy, nursing care in the ICU has changed, and is now also being extended to the family unit. Many studies underscore the importance of such change,<sup>5-11</sup> since the family members experience a high prevalence of post-traumatic stress, anxiety and depression.<sup>11</sup> The family needs are *cognitive* (the need to receive clear information on the diagnosis and prognosis), *emotional* (a consequence of sadness caused by the illness), *social* (the need to maintain ties with friends as a source of emotional support) and *practical* (environmental aspects that can improve wellbeing during the stay in the ICU).

Consolation and emotional support of the patient/family should be seen as a fundamental part of our work. We need to provide relief from suffering while encouraging

confidence in being able to cope with the disease and with hospital stay, and must improve aspects of our organization with a view to creating a more comfortable and humane ICU.

## The open-door Intensive Care unit. Expanding visiting hours

Visiting policy in Spain is very restricted, with a *closed ICU* culture despite the fact that many studies recommend an open-door approach with incorporation of the family to patient care.<sup>12-19</sup> Families demand more time and flexibility in visiting. There is no reason for being restrictive in this regard, and it has been demonstrated that visits improve patient wellbeing, lessen family anxiety and increased perceived quality of care—thereby improving the image and humane dimension of the organization. A freer, expanded and more flexible visiting regimen allows families to adapt patient care to their working obligations and the care of other family members, such as children or the elderly. Closeness to the patient in critical situations or when death is imminent is even more necessary, and is of help in the mourning process. In cases of particularly vulnerable patients such as those with Down syndrome, mental disorders, very young patients or subjects with intense stress, permanent accompaniment by the family should be allowed.

## Pediatric visits

Considering the risk of infections and potential psychological trauma, the visiting policy referred to children has been even more restrictive. However, in the pediatric and neonatology ICUs, where visiting is allowed, no increase in infections has been reported.<sup>20</sup> Some studies have found that patients see visits by their small children as a potent stimulus for recovery, and it has been demonstrated that children who have been able to visit their ill relative have been able to better understand the situation and the disease.<sup>20-22</sup> If the patient/family so wishes, visiting by children should be allowed, adopting an individualized approach. This requires organizing the visit, providing information in simple language, offering all professional support for the child, and following a scheme or protocol established according to different age groups.

Different international recommendations consider that family visits should have no restrictions, although logically visiting must be adjusted to the patient desires and clinical conditions.<sup>15,23</sup> Our patients have the right to receive the affection and care of their relatives, and so an open-door policy should be a priority issue in the organization of the ICU.

## Family implication in patient care

We know that families wish to participate in patient care. If feasible from the perspective of the patient clinical condition, families could collaborate in some aspects of care, such as personal hygiene, the administration of meals, or the stimulation of physiotherapeutic exercises—in all cases under due nursing supervision. Offering the family the opportunity to contribute to recovery of the patient may have a positive effect for both the patient and the caregiver, reinforcing closeness and communication with the healthcare professionals. Some nursing societies have drafted recommendations on how to integrate family participation in patient care, based on the philosophy of centering care also on the family<sup>10</sup>.

### Information. The importance of communication in the Intensive Care Unit

People increasingly demand more information and more active participation in relation to health decisions. Studies in different cultural and geographical settings indicate that one of the most important aspects referred to patient and family satisfaction is communication with the healthcare professionals.<sup>24,25</sup> Working in an ICU requires communication skills, since incorrect information can adversely affect the relationship with the medical team. In general, training in communication has been lacking, and conveying information is a difficult art that is learned through practice, mistakes and common sense. If we want to do things correctly, we must learn and use the specific methodology referred to communication in situations of crisis. We must be able to transmit very technical and complex information in simple and easily understandable terms; explain the diagnosis and prognosis; modulate the high emotional content of the message; and control the stress it produces. We also must remember that physicians are exposed to their own worries and concerns, and that the task of having to give bad news produces anxiety in the healthcare professional. Bad news must be explained clearly and with empathy, adapting ourselves to the rhythm of comprehension which the patient/family needs, and detecting situations of emotional block and denial of reality. The family suffers anxiety and depression, which complicate the understanding of information and the decision making process. The professional must understand, cope with and redirect inadequate emotional reactions with assertiveness, and at the same time must show understanding and empathy. The family typically has greater confidence with the nursing personnel, and lets them know their doubts and concerns. In this context it is necessary to divide the information given: the nursing professionals must talk to the family about general patient care and the use of apparatuses (respirators, monitors, alarm systems), and the physicians must address matters related to diagnosis, prognosis and treatment. It is important for the professionals working in the ICU to improve their training in communication skills with a view to achieving greater levels of satisfaction, a better physician–patient relationship, and less personal stress.

## Communication with the intubated patient

Some studies have found that critical patients remember intubation and the incapacity to speak as one of the most bothersome and stressing experiences. Communication between the intubated patient and the healthcare personnel is generally insufficient and ineffective, and this proves frustrating for everyone. It is despairing to watch the efforts of intubated patients to express something, and to see how professionals try to explain different options without success—until they stop trying and simply say: “I don’t understand you, but don’t worry, everything is fine”.<sup>26</sup> Communication with intubated patients requires personal effort, time, interest, and a clear understanding of how important it is for the patient to be understood. Intensive Care Units should work to design and develop new non-verbal communication systems that can allow us to communicate with intubated patients, since the classical systems (involving written words or images) are limited and insufficient.

### Design of the Intensive Care Unit. Environmental wellbeing

A recent study in France has found that only 72% of the ICUs have individual rooms, 66% have natural light, 26% have telephone access, 38% have radio access, 68% have a clock within view, and only 11% inform of the date.<sup>27</sup> The lack of natural light and a visible clock causes a loss of time reference and alterations in circadian rhythm. Too much light during the night in turn prevents melatonin secretion, which is essential for inducing sleep. One of the most frequent patient complaints is the impossibility of sleeping because of too much light and noise.<sup>27</sup> Some studies have even found noise to exceed the maximum levels recommended by the World Health Organization.<sup>28</sup> It has been described that poor sleep quality and delirium may be associated<sup>29</sup>—the latter in turn having important short- and long-term repercussions. In this respect, some studies have reported a decrease in the appearance of delirium when nighttime rest is facilitated by improving the environmental conditions (e.g., by turning off lights or making use of ear plugs and sleep masks).<sup>30</sup> If we want to improve patient sleep, one of the pending issues is lowering light intensity and noise levels. Strategies should be adopted, such as good alarm management, adequate illumination systems, and increased awareness among all healthcare professionals of the importance of caring for patient quality of sleep.

In open-door ICUs, personal hygiene and clinical exploration are sometimes performed without taking patient embarrassment or the presence of other non-ICU professionals into account—this constituting a lack of respect for patient privacy. In general, patients in the ICU are naked—this being absolutely unnecessary provided they are clinically stable. Such a situation can go against patient dignity. In this regard, patient clothing should be considered, with the adoption of additional efforts to protect individual privacy. We also should ensure a more friendly environment and improve patient wellbeing (e.g., music, television), and facilitate communication and the right to maintain social ties, with access to mobile phones and electronics.

One of the most common complaints among families is the fact that waiting rooms are uncomfortable and unpleasant. These rooms should be made more comfortable both in practical terms (with nearby toilets/bathrooms and cafeterias) and as regards their appearance—avoiding the typical dull institutional image and creating a more pleasant and relaxing environment. With a view to improving the comfort of patients in the ICU, some scientific societies have developed a series of recommendations<sup>15,23,31</sup> that can help make the ICU a much more pleasant place.

## Conclusions

The Intensive Care Unit is a wonderful place where lives are saved, but it is also a very harsh and unpleasant place where critically ill patients face terrible diseases under very adverse environmental conditions. We must change the design of the ICU and its organization; we must improve privacy, welfare and comfort of patients and families, paying attention to their personal and emotional demands. Opening the doors to the ICU, with more flexible visiting hours, and improving family care are among our most urging concerns, and should be delayed no further. We must equip ICUs with modern monitors and respirators (without becoming *humanoid repair shops* that incur in infinite expenses), but we must also invest in organization, design, environmental comfort and humanization. We need to redesign clinical practice so that intensive care becomes more agreeable and humane. We should not put off this change any longer, since it is an imperative social and professional necessity.

## Conflicts of interest

The authors declare that they have no conflicts of interest.

## References

1. Stayt LC. Death, empathy and self preservation: the emotional labour of caring for families of the critically ill in adult intensive care. *J Clin Nurs*. 2009;18:1267–75.
2. Davidson JE. Family-centered care meeting the needs of patients' families and helping families adapt to critical illness. *Crit Care Nurse*. 2009;29:28–34.
3. Ayllón N, Álvarez M, González M. Factores ambientales estresantes percibidos por los pacientes de una Unidad de Cuidados Intensivos. *Enferm Intensiva*. 2007;18:159–67.
4. Molter NC. Needs of relatives of critically ill patients: a descriptive study. *Heart Lung*. 1979;8:332–9.
5. Pardavila Belio MI, Vivar CG. Necesidades de la familia en las unidades de cuidados intensivos. Revisión de la literatura. *Enferm Intensiva*. 2012;23:51–67.
6. Hidalgo Fabrellas I, Vélez Pérez Y, Pueyo Ribas E. Qué es importante para los familiares de los pacientes de una Unidad de Cuidados Intensivos? *Enferm Intensiva*. 2007;18:106–14.
7. De la Cueva Ariza L. La realidad de los cuidados a la familia del paciente crítico en España: la necesidad de actuar ya. *Enferm Intensiva*. 2012;23:153–4.
8. Llamas-Sánchez F, Flores-Cordón J, Acosta-Mosquera ME, González-Vázquez J, Albar-Marín MJ, Macías-Rodríguez C. Necesidades de los familiares en una Unidad de Cuidados Críticos. *Enferm Intensiva*. 2009;20:50–7.
9. Rodríguez MC, Rodríguez F, Roncero A, Morgado MI, Theodor J, Flores JT, et al. Implicación familiar en los cuidados del paciente crítico. *Enferm Intensiva*. 2003;14:96–108.
10. Torres Pérez L, Morales Asencio JM. Participación familiar en el cuidado del paciente crítico: recomendaciones de la Sociedad Andaluza de Enfermería de Cuidados Críticos. *Tempus Vitales*. 2004;4:18–25.
11. McAdam JL, Kathleen A, Dracup KA, White DB, Fontaine DK, Puntillo KA. Symptom experiences of family members of intensive care unit patients at high risk for dying. *Crit Care Med*. 2010;38:1078–85.
12. Velasco Bueno JM, Prieto de Paula JF, Castillo Morales J, Merino Nogales N, Perea-Milla López E. Organización de las visitas en las unidades de cuidados intensivos en España. *Enferm Intensiva*. 2005;16:73–83.
13. Errasti-Ibarrondo B, Tricas-Sauras S. La visita flexible en las unidades de cuidados intensivos: beneficios para los familiares del paciente crítico. *Enferm Intensiva*. 2012;23:179–88.
14. Berwick DM, Kotagal M. Restricted visiting hours in ICUs. Time to change. *JAMA*. 2004;292:736–7.
15. Davidson JE, Powers K, Hedayat KM, Tieszen M, Kon A, Shepard E, et al. Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004–2005. *Crit Care Med*. 2007;35:605–22.
16. Kleinpell RM. Visiting hours in the intensive care unit: more evidence that open visitation is beneficial. *Crit Care Med*. 2008;36:334–5.
17. Spreen AE, Schuurmans MJ. Visiting policies in the adult intensive care units: a complete survey of Dutch ICUs. *Intens Crit Care Nurs*. 2011;27:27–30.
18. Lee MD, Friedenberg AS, Mukpo DH, Conray K, Palmisciano A, Levy MM. Visiting hour's policies in New England intensive care units: strategies for improvement. *Crit Care Med*. 2007;35:497–501.
19. Vandijck DM, Labeau SO, Geerinckx CE, De Puydt E, Bolders AC, Claes B, et al. An evaluation of family-centered care services and organization of visiting policies in Belgian intensive care units: a multicenter survey. *Heart Lung*. 2010;39:137–46.
20. Clarke C, Harrison D. The needs of children visiting on adult intensive care units: a review of the literature and recommendations for practice. *J Adv Nurs*. 2001;34:61–8.
21. Johnstone M. Children visiting members of their family receiving treatment in ICUs: a literature review. *Intens Crit Care Nurs*. 1994;10:289–92.
22. Knutsson SE, Bergbom IL. Custodians' viewpoints and experiences from their child's visit to an ill or injured nearest being cared for at an adult intensive care unit. *J Clin Nurs*. 2007;16:362–71.
23. Fourrier F. Mieux vivre la réanimation. *Reanimation*. 2010;19:191–203.
24. Boulding W, Glickman SW, Manary MP, Schulman KA, Staelin R. Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. *Am J Manag Care*. 2011;17:41–8.
25. Damghi N, Khoudri I, Oualili L, Abidi K, Madani N, Zeggwagh AA, et al. Measuring the satisfaction of intensive care unit patient families in Morocco: a regression tree analysis. *Crit Care Med*. 2008;36:2084–91.
26. Ricart A. La comunicación en Medicina Intensiva. REMI Libro Electrónico de Medicina Intensiva; 2014. Available from <http://www.medicina-intensiva-libro.com/2011/05/306-la-omunicacion-en-medicina.html> [accessed September 2013].
27. Lombardo V, Vinatier I, Baillot ML, Franja V, Bourgeon-Ghittori I, Dray S, et al. Sociétés de Réanimation de Langue Française (SRLF) How caregivers view patient comfort and what they do to improve it: a French survey. *Ann Intens Care*. 2013;3:19–26.

28. Christensen M. Noise levels in a general intensive care unit: a descriptive study. *Nurs Crit Care*. 2007;12:188–97.
29. Kamdar BB, King LM, Collop NA, Sakamuri S, Colantuoni E, Neufeld KJ, et al. The effect of a quality improvement intervention on perceived sleep quality and cognition in a medical ICU. *Crit Care Med*. 2013;41:800–9.
30. Weinhouse GL, Schwab RJ, Watson PL, Patil N, Vaccaro B, Pandharipande P, et al. Bench-to-bedside review: Delirium in ICU patients – importance of sleep deprivation. *Crit Care*. 2009;13:234–41.
31. Fourrier F, Boiteau R, Charbonneau P, Drault J, Dray S, Farkas J, et al. Structures et organisation des Unités de Réanimation: 300 recommandations. *Reanimation*. 2013;21:523–39.