EXPLORING PATIENT, VISITOR AND STAFF VIEWS ON OPEN VISITING

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Background: There is a debate within nursing on whether open visiting promotes or hinders patient care.

Aim: This study aimed to add to the evidence base on which visiting times best suit patients, visitors and staff.

Method: The study used a naturalistic research design. Three questionnaires were carried out with patients, visitors and staff in an oncology setting.

Results and discussion: The three groups favoured set visiting times and protected mealtimes. Participants also favoured a limit to the number of visitors per patient at any one time and thought a quiet time should be introduced.

Conclusion: Patients, visitors and staff preferred set visiting times. They also felt some flexibility needed to be built around these set times.

BACKGROUND

This study was conducted at Clatterbridge Centre for Oncology NHS Foundation Trust, a regional oncology centre. A literature search revealed that most of the evidence on hospital visiting supported open visiting. Within the nursing community, there is an ongoing debate about its advantages and disadvantages. Much of the research investigating these arguments has been on a small scale or even anecdotal.

AIM

This study aimed to add to the evidence base for hospital visiting times that best suit patient, visitor and ward staff needs. Its purpose was to gather opinions about current visiting times and preferences for future options in an oncology setting. It aimed to analyse responses to highlight similarities and differences between the groups, seeking possible explanations.

LITERATURE REVIEW

The issue of visiting times to hospital wards has historically divided and polarised nurses (Hader, 2004). The debate within nursing on whether open visiting promotes or hinders patient care continues.

Since the 1950s, ward visiting has changed from a strict, nurse-controlled regime to a more flexible, patient-centred approach. New open visiting policies have been slowly introduced over the past 20 years. Despite government encouragement to improve patient choice, most wards in the UK do not have a truly open visiting policy (Plowright, 2005).

Little research into general ward visiting has been conducted in recent years. Much of the work is either anecdotal or focuses on specialist areas such as ICUs and coronary care units. ICUs often have very strict policies, while patients’ families are among the most anxious visitors. Studies into ICU visiting undertaken by Solovy (2004), Clarke and Harrison (2001) and Clarke (2000) supported flexible or open visiting policies, with guidelines and training for nurses to help manage conflict or ask visitors to leave when necessary.

Solovy (2004) conducted a pilot study of open visiting in ICU and found it provided a patient-centred, high-quality and safe service. This author concluded that guidelines on when visitors may be asked to leave would have to be developed to help nurses provide patient-centred care and promote privacy and dignity.

Farrell et al (2005) conducted a qualitative study using semi-structured interviews with ICU nurse managers about their relationships with visitors. The study concluded that arguments against open visiting cannot be founded, supporting Solovy’s (2004) findings.

Some studies have supported a move towards flexible visiting rather than open visiting (Tanner, 2005). Flexible visiting includes guidelines for staff to outline to visitors about when they may be asked to leave in patients’ best interests. Soltani et al (2004) advocated open visiting that can be flexible to suit patients’ and families’ individual needs.

Hoban (2004) discussed open visiting in an article summarising an NHS trust’s work on visiting hours on general wards. She described open visiting as detrimental to patients because it led to a lack of rest time.

<table>
<thead>
<tr>
<th>TABLE 1. PATIENT, VISITOR AND STAFF VIEWS ON VISITING</th>
<th>Percentage of patients who agreed</th>
<th>Percentage of visitors who agreed</th>
<th>Percentage of staff who agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting makes patients tired</td>
<td>38%</td>
<td>22%</td>
<td>100%</td>
</tr>
<tr>
<td>No visitors should be allowed at mealtimes</td>
<td>88%</td>
<td>78%</td>
<td>100%</td>
</tr>
<tr>
<td>There should be a quiet time on the ward</td>
<td>70%</td>
<td>22%</td>
<td>91%</td>
</tr>
<tr>
<td>Children should be allowed to visit the ward</td>
<td>84%</td>
<td>80%</td>
<td>82%</td>
</tr>
<tr>
<td>Visiting to the ward should be at set times</td>
<td>40%</td>
<td>40%</td>
<td>93%</td>
</tr>
<tr>
<td>Visiting to the ward should be open</td>
<td>26%</td>
<td>36%</td>
<td>7%</td>
</tr>
<tr>
<td>Visitors need more education on infection control</td>
<td>78%</td>
<td>78%</td>
<td>92%</td>
</tr>
</tbody>
</table>
which in turn decreased recovery time. She suggested patients need a quiet hour with no visitors.

Hoban (2004) also raised issues around infection control problems associated with increased ward visitors. She concluded that user involvement in developing visiting time policies is extremely important. While much of this article is based on opinion and anecdotal evidence, it does appear to reflect ward nurses’ attitudes.

However, Plowright (2005) argued against Hoban’s views on visitors and infection control problems. She argued restrictions imposed on visitors do not extend to doctors and other multidisciplinary team members. She also argued that restricting visiting hours decreases communication between visitors and staff, as fewer staff are on duty during evenings and weekends. This makes it more difficult for visitors to speak to staff.

The introduction of protected mealtimes has affected open visiting hours. The Hospital Caterers Association (HCA) (2004) advocated that hospital mealtimes should be protected from visitors and any other interruptions, including those caused by staff. Protected mealtimes require all staff to be present on the ward during mealtimes but only to be involved in providing meals rather than doing any other work. The HCA (2004) suggested this encourages patients to eat more and gives nurses greater awareness of what patients are eating.

Davidson and Schofield (2005) investigated the benefits of protected mealtimes. They found the system improved patients’ nutritional intake and was beneficial to them. This is supported by Tanner (2005) and Soltani et al (2004) but conflicts with the ideal of truly open visiting practices and the cultural norm of mealtimes being a social activity.

It appears that no research has been conducted to investigate visiting in the oncology setting, where visiting times may need to be adapted to suit patients’ individual needs. However, Thomas (2001) conducted a phenomenological study examining palliative care patients’ perceptions of visiting.

The main themes highlighted were coping and control. Participants suggested visiting provided a link to the outside world and the anticipation of visitors was something they enjoyed. Negative comments included visitors often staying their welcome and therefore patients’ pain or symptoms appeared worse.

Participants also said that when visitors turned up without making arrangements in advance, it made them feel powerless and they felt a loss of control. Patients also mentioned feeling awkward and embarrassed if they needed care and that visitors could be too noisy and occasionally too many came at once.

Thomas (2001) was the first to show visiting from a patient perspective. This study highlights some real issues for patients and illustrates that visiting is not always a positive experience.

Tanner (2005) conducted a questionnaire with patients, visitors and nurses on general wards. The results did not support much of the previous evidence for open visiting. The study showed that none of the patients, visitors or nurses preferred completely open visiting and they all also wanted a quiet rest hour. Nursing staff preferred set visiting times. However, the rationale for any of these opinions are not presented.

Tanner (2005) also highlighted the need to consult with service users when developing any service. As the study was carried out on general wards, it cannot necessarily be generalised to an oncology setting. Despite the study having been carried out on a large scale and analysed both quantitatively and qualitatively, the qualitative analysis is not discussed in depth, and is mainly from a nursing perspective.

The literature review revealed the following gaps in the evidence:

- An up-to-date study is required to reflect the current situation regarding ward visiting;
- Most of the evidence relates to specific specialist areas such as ICU. Little work has been done on general wards, and no work has been done in the oncology setting, where patients’ needs may be very different from those in other settings;
- Most studies investigated visiting hours from a nursing or nurse manager perspective. Little work has been undertaken to explore patients’ and visitors’ opinions and experiences;
- Much of the recent literature on the subject is not research-based but outlines the opinion or experience of the authors of the articles concerned;
- As Tanner (2005) highlighted, no research study has used patient and public involvement (PPI) to help design the study. To truly understand service users’ opinions of visiting times, patients and visitors should be included in designing the questions for the study.

The findings of the literature review demonstrate the need for an up-to-date study to be undertaken on visiting times. This should be carried out in a new setting (such as oncology), and should seek the opinions of patients, visitors and staff.

**METHOD**

The literature review revealed that no study had involved patients in designing the research tool. It was felt this was an important area for improvement.

Three PPI forums in the Merseyside Cancer Network were invited to give their input to the study at all stages from questionnaire design to validity of results.

For each participant group – patients, visitors and staff – a different questionnaire...
was developed. The PPI groups formulated topics for questions, and also assessed their appropriateness and wording within the questionnaires. The PPI-generated questionnaires contained a mixture of open and closed questions along with Likert scales to help describe, quantify and explain participants’ opinions.

After ethics committee approval had been granted I distributed the questionnaires to patients, visitors and staff. This gave me a good opportunity to explain the study and answer any questions participants may have. Due to the variety of types of questions included, data analysis was both quantitative and qualitative.

A naturalistic research design was chosen to explore the three groups of participants’ opinions and experiences regarding visiting times. It used a cross-paradigm survey approach to provide in-depth data to help clarify understanding of which visiting option is preferred and why. The survey would also examine whether the different groups have different opinions and experiences and if so, explore the basis for these.

Study participants were current inpatients, their visitors and ward staff including nurses, HCAs, cleaners and the ward clerk. Patients, visitors and staff from both radiotherapy and chemotherapy wards were invited to participate by completing a questionnaire until a quota sample was achieved. I personally invited participants to take part. It was hoped that a sample of 25 participants from each group would be achieved.

After discussions with patients and carers, final drafts of the questionnaires were developed. These were used to conduct a pilot study once ethical permission had been granted. The pilot was conducted with two participants from each group, after which issues identified were addressed to produce the final version of the questionnaire.

A covering invitation letter and information sheet explaining the research and its aims in detail accompanied the questionnaire, along with a return envelope. Sealed boxes were placed on the wards so that participants could either return their completed questionnaires to the box or give sealed envelopes to a staff member to do so. The sample consisted of 50 patients, 50 visitors and 45 members of staff. Data was analysed both qualitatively and quantitatively to help provide a deeper understanding of the information.

RESULTS

Results showed that overall opinions from the three groups favoured set visiting times and protected mealtimes. They also provided evidence to suggest participants favoured a limit to the number of visitors per patient at any one time and that a quiet time should be introduced on the wards. The main negative theme related to the lack of flexibility with the current visiting system.

The main findings from each group are shown in Table 1 (p30).

Questions on number of visitors produced the following results:

- Patients felt there should be 3–4 visitors allowed at any one time (3=26%, 4=52%);
- Visitors felt there should be 2–4 visitors allowed at any one time (2=18%, 3=24%, 4=40%);
- 71% of staff felt two visitors should be allowed at any one time.

Fig 1 shows the results on whether the number of visitors per patient at a time should be capped.

The results from this study have provided a better understanding of the opinions and experiences of patients, visitors and staff at a regional oncology centre regarding visiting times. They have enabled me to provide the hospital with recommendations for change that may improve experiences of visiting times for all three groups.

Details of aspects of visiting that the three groups liked or disliked, are shown in Table 2 (p31).

DISCUSSION

The results of the study demonstrated that all three groups preferred two visiting periods, one starting between 1pm and 2pm and the second starting at 6pm.

There were differences between groups, with chemotherapy patients feeling 1pm was a suitable start time, and radiotherapy patients opting for 2pm. This may suggest that radiotherapy patients prefer a long
lunch period or like a period after lunch to rest before visitors arrive.

Staff also felt visiting should start at 2pm. Other data suggested that staff feel visitors tire patients, who need rest periods.

There is limited evidence to support set visiting times. McMillan (1999) felt open visiting was detrimental to patient well-being. Tanner (2005) supported set times but with early start times of 10am and 11am.

This study suggests that oncology patients receiving chemotherapy and radiotherapy prefer not to have visitors during the morning. In Tanner’s (2005) study staff thought visitors should not be allowed during the morning as the ward was busier, and it helped protect patients’ privacy, dignity and confidentiality.

All groups of participants in this study felt visiting should finish between 4pm and 5pm and again between 8pm and 9pm. The majority of participants stated 8pm as a suitable finish time. Again, there were slight differences between chemotherapy and radiotherapy patients.

Chemotherapy patients were more in favour of later finish times than radiotherapy patients. This may be because radiotherapy makes patients tired and they may be more tired than those receiving chemotherapy. Also it may be because radiotherapy patients are in hospital for longer periods than those having chemotherapy.

All groups favoured giving patients some quiet time to rest.

There were, however, conflicting opinions from the groups on whether visiting/visitors made patients tired, and also whether visitors tire during long visits. Staff and visitors felt patients needed rest and that visiting made patients tired, whereas patients said this did not happen but felt it made visitors tired.

The main themes in the positive aspects of current practice were set visiting times and protected mealtimes. Other positive aspects were that visiting has a beneficial effect on patients; that it helps break up the day; and patients look forward to visits from relatives and friends. This supports much of the work patients look forward to visits from relatives and friends. This supports much of the work of Farrell et al (2005) favouring flexible visiting.

All groups recognised the need for flexibility, especially because of the nature of illness and treatment. It was also recognised that, because the unit was a regional treatment centre, many visitors travel long distances so flexibility may be required.

While all participants wanted flexibility, there were still strong opinions in favour of set visiting times.

Tanner (2005) found that all three groups felt the need for some flexibility in visiting times, depending on the individual situation. Farrell et al (2005) favoured flexible visiting and found nurses felt this was in patients’ best interests.

CONCLUSION

This study has shown that patients, visitors and staff preferred set visiting times. Overall, accounts demonstrated that some flexibility needs to be built into set visiting times, to allow visitors onto the ward outside the set times in certain circumstances. All groups emphasised this need due to the nature of treatment provided in an oncology setting.

The results also revealed that all groups favoured protected mealtimes for patients.

This study has shown the changes required to visiting times at Clatterbridge Centre for Oncology to meet the needs of patients, visitors and staff.

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REFERENCES


