Pharmacophore

ISSN-2229-5402

Journal home page: http://www.pharmacophorejournal.com

Pharmacophore
an International Journal
ISSN 2229-5402

CHALLENGES OF VISITING PATIENTS IN CORONARY CARE UNIT FROM THE PERSPECTIVE OF NURSES: A QUALITATIVE STUDY

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ARTICLE INFO

Received:
14th Jan 2017
Received in revised form:
23th Jun 2017
Accepted:
24th Jun 2017
Available online:
14th Aug 2017

Keywords: *Visiting, Challenges, Coronary Care Unit, Nurse, Qualitative study*

ABSTRACT

Introduction: Visiting patients in intensive care units is always a challenging issue for the medical staff, patients and visitors. For appropriate planning and decision about visiting program in an acceptable way and based on requirements of nurses, patients and their families, it is necessary to analyze the nurses' perspective about visiting patients.
Objectives: This study aimed to explore the challenges of visiting program of patients' admitted to CCU from the perspective of nurses.
Methods: This study was conducted in 2016 with qualitative research approach and content analysis of Granihime and Lundman (2004) to analyze the data. Nine CCU nurses were selected in three focus groups based on a purposive sampling method and data were collected using semi-structured, and face-to-face interviews, with audio recordings.
Results: Data analysis resulted in extraction of four themes, including: "Management and human resource empowerment", "effective education", "physical factors of intensive care unit", and "quality of visiting policy".
Conclusion: These findings could help hospitals' managers and planners to focus and plan to improve the quality of visiting programs of CCU.

To Cite This Article: Mina Rezaei, Marziyeh Asadizaker*, Simin Jahani, Zohreh Shamohammadi, (2017), "Challenges of visiting patients in Coronary Care Unit from the perspective of nurses: A qualitative study", ***Pharmacophore, 8(4),*** *35-41.*

Introduction

Today, critically ill patients are admitted to the cardiac intensive care unit (CCU) [1]. Hospitalization in intensive care units impose an enormous mental and physical stress to the patient [2]. Identifying stressors is important for health care and nursing communities and they need to protect patients from unnecessary stress to enhance compliance patterns of patient, so the patient can prevent further stress [3]. One of the psychological stressors for patients hospitalized in intensive care unit is being parted from family members and short visiting time [4]. Today, environment of intensive care unit includes not only patients but also their families. Accordingly, it is necessary to take care of the patient's family as well [5]. In the first 24 hours of hospitalization in the intensive care unit, family members experience a sudden and severe stress [6]. Stressful factors experienced by family members increase various special needs [7], including visiting patients [8]. Kamrani, quoted from safdari et al (2004) states that despite scientific progress and accelerating development in medical and nursing profession, visiting, an important need of patients and their families is neglect and this has not been reviewed for nearly forty years in Iran while visiting restriction has being applied for many years in intensive care units [9]. Visiting patients is customary in Iran due to religious and cultural beliefs [10] and family members are directly affected and always have special commitment to each other in difficult situations or crises [11]. In addition, visiting patients is considered a rewarded human

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task in Iran [12]. Patients in intensive care units tend to be visited by close family members [13]. On the other hand, families of patients in intensive care unit want to visit their patient and require flexible policies of visiting [14]. Nurses, as a therapist member of health must consider patients' needs for visiting and be aware of their positive and negative impacts [15]. Open visiting has led nurses and doctors to be face with three major concerns: increasing patients' physiological stress, interfering with nursing care, and physical and mental fatigue of families [16]. Visiting in ICU has been an ever-challenging issue for the medical staff, patients and visitors [17]. For appropriate planning and decision making about visiting program in an acceptable way and based on requirements of nurses, patients, and their families, it is necessary to analyze the nurses' perspective about visiting patients [18]. With regard to the fact that the visiting program in CCU has not been revised in Iran, the researchers of this study believe that the nurses' views about the challenges can be helpful in revising the visiting program. So, this study aimed to achieve deeper information using qualitative approach to determine the challenges of visiting program of patients' admitted to CCU from the perspective of nurses.

Materials and Methods

In this study, to assess the challenges of visiting program of patients admitted to CCU, from the perspective of nurses, a qualitative approach using content analysis was used. Qualitative content analysis is defined as a research method that is used as mental interpretation of text data content. In this method, codes and themes are identified through the process of systematic classification. Content analysis is beyond the actual content extraction from text data. In this method, hidden themes and patterns can be revealed from data content of the participants [19]. This study was conducted in 2016 by purposive sampling method on 9 nurses, including three focus groups of 2, 3 and 4 participants with a bachelor's degree in nursing and at least 6 months experience working in CCU who were currently working there as well. After visiting nurses and explaining the objectives of the study, time and place of interview was agreed. The informed consent form was provided to all participants that mentioned the purpose of the study, recording the interviews, preserving anonymity and ensuring the confidentiality of information, the right to retire during the study and knowing the results, if desired.

To collect data, semi-structured face-to-face interviews with audio recording were used. In this interview, nurses were encouraged to share their experiences of visits and were asked "What is your experience of visiting at CCU? How do you see the situation?" And the next questions were exploratory, like "What do you mean? Please explain and give an example in this case" based on experience of the participants and in order to achieve deeper information and clarify the concept of the study. The duration of the interview lasted 45-90 minutes. Data collection and analysis were conducted on the objectives of the study and based on participants' description. Content analysis as developed by Granihime and Lundman (2004) was used to analyze the data, which included writing down the interviews word-by-word and several reviews to get the general sense, dividing the whole text into summarized semantic units, abstraction of summarized semantic units by code labeling, separation of codes in the sub-themes by comparing them based on similarities and differences, and regulating themes as the marker of hidden text content [20]. In this study, all interviews were recorded and then written word-by-word. To get an overview, the handwritten text was read several times. In the next step, parts of the text were extracted and analyzed (semantic unit). These units were then compressed into semantic units and more summarized and were given abstract compact units and encoded tag. The whole text was taken into consideration, pressed and labeled. Different codes were compared based on differences and similarities and categorized into classes in such a way that represented the handwritten text. The findings were consistently compared with handwritten text frequently. Lincoln and GABA criteria [21] was used to check the integrity of the data. Coded interviews were returned to participants to consider whether the research has shown their view. Also, the interview text with the corresponding codes and classes were sent to two observers (faculty members with PhD of qualitative analysis) to evaluate the validity of analysis and express their opinion. This research has the Ethics code IRAJUMS.REC.1395.236.

Results

In this study, given that all nurses of CCU were women, every nine people selected were female. The youngest was 27 years old and the oldest was 50 years old. Participants had a clinical experience between 10 months and 15 years of working in the CCU.

Data analysis resulted in extraction of four themes, including: "Management and human resource empowerment", "effective education", "physical factors of intensive care unit", and "quality of visiting policy".

Themes	Categories
Management and human resource empowerment	• Limitations caused by doctors • Communication Failure of Nurses • Failure of the controlling staff • Shortage of staff controlling visits
Effective education	• Inadequate employee's education • Weakness in visiting culture

Physical factors of intensive care unit	• Inappropriate architecture • Improper equipment
Quality of Visiting Policy	• Inefficiency of visiting program • Low satisfaction of nurses, patients, and families from the Visiting Program • Unpleasant experiences for patients and families

1. Management and human resource empowerment

1-1. Limitations caused by doctors: One of the limitations of the visiting program, from the nurses' view, is limitations caused by doctors. They believe that doctors do not spend enough time for the patient's family and do not give sufficient authority to nurses to decide about visiting patients and families, nor have they the necessary coordination with nurses about visiting patients and families.

"More than 60-70% of families come to see the doctor, not the patient."(Nurse # 1)

"Some doctors also had the problem in that they themselves help the family to come inside, although we had told them not to come inside. Then, suddenly others would also expect that their doctor let them inside." (Nurse # 2)

"They do not listen to nurses, telling them that the visits should be limited, as they say that the doctor told us to be by the patient." (Nurse #3)

1-2. Communication failure of nurses: Inappropriate reflection of nurses to the visiting request is another constraints and limitations of visiting program, expressed by nurses. They consider occupational factors such as high workload, lack of fun and travel, lack of financial support or appropriate comfort in the workplace as effective factors for inappropriate relationship of nurses.

"You put your whole life for a job when they give you as much as you deserve, right? But when you see that this was not just. Why did they reduce my salary? Many say that this was unjust. I worked my shifts the whole month. These dissatisfactions remain and affects your spirit in any job you are, when accumulated, especially nurses who should have high communication ability" (Nurse #4)

"When they financially degrade you, you are bored with families as well as the patient." (Nurse # 2)

"Another thing is that the nurses sometimes have no fun. Most of them cannot take one week's vacation in a year. So, no fun, no vacation, you become depressed and aggressive. When the patient is admitted, I cannot kindly talk to the families and tell them that these days are the visiting days and I say instead: Get out after you put your patient on the bed, ring the bell if you had any requirements, and do not come to the door." (Nurse # 1)

1-3. Failure of the controlling staff: A committed and loyal staff is required to control and restore the essential order. Negligence and carelessness of security staff, and disloyalty of the service personnel indicate the failure of the controller, according to the participants' views.

"We do not have a strong security staff in the main corridor of the hospital to guide the visitors to their patients when someone comes. The security staff just sits at the main door and opens the door in the visiting time and sits inside his room" (Nurse #5)

"On the contrary, when no one should come inside, like 11-12 midnight, they let the door open and have no control." (Nurse # 6)

"Another problem is the hospital security. They have no control on the patient's family. When a patient is getting admitted to CCU, one family member is enough, and there is no need for entrance of 5-6 people. An urgent patient who wants to come to CCU must also be controlled by the security so we do not have to become involved with families the whole time. Just because the security has not told them to stay outside and one person is enough to do the patient's stud. This is also an issue that the security does not involve himself and the nurse should do his job" (Nurse # 2)

1-4. Shortage of staff controlling visits: Nurses stated that in addition to negligence and irresponsibility of the controller, time of the nurses is dedicated to non-medical interventions due to shortage of controllers.

"In visits, we need the serving staff. We may need an emergency; we cannot put a chair by the door and justify that to the families." (Nurse #1)

"Our serving staff should be doubled that is now one. There is a shortage in Services section. We do not have proper serving staff or help; the whole load is on nurses." (Nurse # 2)

2. Effective education

2-1. insufficient employee training: An integrated implementation of visiting program requires educating patients and their families. Lack of awareness of the patient's conditions and visit instructions indicate lack of effective education.

"For example, the patient is just being admitted to the ward; after one hour he calls the nurse, then after another hour, so what? We want to know what is wrong with our patient. You have just taken your patient from the clinic; go ask your doctor so you do not frequently disturb us and your patient. But the doctor does not explain the situation to them." (Nurse # 1)

2-2. Weakness in visit culture: Another challenges posed by participants was weakness in visit culture. Nurses said that factors such as ignoring time of sleep and relax of patients, ignoring patient's comfort, imposing stress on patient,

dysfunction in treatment with frequent requests, ignoring the law of visiting, long visits, large numbers of visitors, governing relations instead of rules indicates weakness in visiting culture.

"They come any hour they have time. We should settle our visiting time with them. At midnight after having their fun, they come and ring the CCU's door bell and say that they have to visit the patient. Did you come for midnight party? At midnight! What have you thought? You will go home after party at this time, now you came for visiting your patient in winter!" (Nurse # 7)

"Most of the cases who come to visit at midnight are not the first degree relatives. They just want to say hello and go away. The first degree family members mostly know the visit time." (Nurse # 8)

"The first degree family members mostly know the visit time. Those who come to visit at ironic hours are not the first degree relatives." (Nurse # 7)

"While we are in the patient's native town; they do not think of the patient, they just want to prove that they have come for visit when the patient was at hospital. By 12 AM, as my colleague says, they wake the patient up to visit him! For example, we had a visitor at midnight that said to wake the patient up to see that he came to the hospital. They do not care for the patient's comfort and just want to say that they were here. I came to visit you when you were sick at hospital. We have visitors that care about themselves more than the patient and do not understand whatever we try." (Nurse # 2)

3. Physical factors in the intensive care unit

3-1. inappropriate architecture: Another challenging factor, raised by nurses, was inappropriate architecture of CCU. The explanation of participants indicated inappropriate architecture of the ward, including: defect of construction sector, the inappropriate location of paraclinical sectors, and limitations of isolated rooms.

"We have 15 beds, including 2 isolate beds. These two isolated beds have no window to outside or corridor. The patient in the isolated bed cannot talk to his visitor; we often face this problem during our shifts. It causes chaos, and dissatisfaction of visitors and patients. They cannot see their patient, so they ask to come in and visit him." (Nurse #9)

"Type of CCU building is also very strange. It is located in the ward in central hall. The visitors' door is at the garden and the visitor should go 4-5 corridors to reach there. From the other side, there are no signs to guide them. When you enter the garden, you see a small door that does not seem to be the CCU door, which is in the hall. There are no signs." (Nurse #5)

3-2. Undesirable equipment: Another physical factor, raised by the participants, was the failure of equipment and its layout, as well as incompetence in the FAQ section that influence the visits.

"One other problem we have are doorbells that are mostly out of order. They have been repaired several times, but the problem seems to be the equipment and they are not working." (Nurse #9)

4. Quality of Visiting Policy

4-1. Inefficiency of visiting program: According to nurses, interference of visits with treatment, lack of fitness of visiting program with the needs of the patient, aggression and physical fights of visitors to visit their patient represent the low quality of visiting policy.

"At visiting time, one patient may have 20 visitors; if he meets them all, it takes one hour for the patient to talk on the door since 4-5 PM." (Nurse # 1)

"In the patient's situation, he should talk with this number of visitors!" (Nurse # 2)

"Face-to-face visits are better for the patient than by the window. In face-to-face visits, the patient can also nod, but by phone, he must talk to every visitor." (Nurse # 1)

"The patient would not be agitated, when he meets his first degree relative. There were many cases that the patient caused us trouble for this reason. The agitated patient fell off his bed and hurt himself and increased nurse's workload. The nurse was questioned by superiors and told off. So, if we do something to reduce the patient's agitation, for example, through visiting his family, these problems would also resolve. Also, families would become aggressive and create problems for us, if they do not meet their patient. For example, they threatened the nurses to sue and threats of physical confrontation or break the door." (Nurse # 6)

4-2. Low satisfaction of nurses, patients, and visitors of the visiting program: According to nurses, negative impacts of visiting on physical condition, the reluctance of some patients to visiting, disagreement between nurses on visiting, and the patient's and visitor's desire to face-to-face meeting shows low satisfaction of visiting program.

"A group of people come at a small window with curtains; nothing can be seen from there. There is only the phones, which are always out of order. What's the use? The patient gets more agitated, especially ones who cannot talk. So the patient gets nothing" (Nurse #7).

"With 20 visitors at the window, at the end of the visits, they expect that 3-4 of them come inside. They don't get satisfied by the window." (Nurse #3).

4-3. Unpleasant experience for patients and their relatives: Nurses stated that the visiting program caused an unpleasant experience for patients and their relatives and no fun in wards increased the patients' request for visiting.

"The difference between CCU and ICU is that patients are awake, are all recovering, and quite oriented. They have no problems and can even get out of bed and walk, but we put them in a situation worse than ICU, where there is rigid care, principally." (Nurse # 2)

"One of the patients interpreted it's like a prison. They get tired; no TV, no radio, not even a magazine." (Nurse #1)

"They do not let us see our families." (Nurse #3)

Discussion

Due to the fact that the challenges raised include "management and human resource empowerment", "effective education", "physical factors of intensive care unit", and "quality of visiting policy"., in order to manage and organize visits in CCU, it is important to pay attention to these challenges.

The results of this study shows the necessity of management and empowerment of human resources, including doctors, nurses, service, and security personnel in the field of patient's visiting to provide an appropriate visit by proper coordination of these sectors. This study showed restrictions applied by physicians. They do not give sufficient power of decisions to nurses regarding visits and do not take enough time for patients' families, on the other hand. Doctors and nurses have different understanding of patient's needs due to different professional role which causes each plan a different care goal for the patient while proper communication between doctors and nurses improves the planning based on common goals [22]. Proper communication between nurses and doctors is effective on the quality of nursing care as well [23]. In addition, the patient's relatives should be given accurate and encouraging information. But they must be informed about the possible dangers of patient's family [24].

Another challenge posed is the communicational problems of nurses. Nurses of intensive care units do not take the communication with families serious or are not aware of the effect of communication of patients with their family members [25]. The family of the patient admitted to intensive care unit have stress and are in a hard situation, because of lack of sufficient information about the disease and unfamiliarity with the environment, so they need support and sympathy of staff [26]. The more the patients' family are understood by the staff, the more they will be satisfied [27] However, the results of this study showed that heavy workload, long working shifts, lack of recreation and travel, lack of financial support and lack of peace in the workplace of nurses cause communication problems. The study by Lesley E Long also found that increasing the level of urgency, high workload and shortage of nurses affect the quality of nursing care, especially in communication [28] and nursing managers and planners of care system should pay more attention to eliminating or modifying clinical communicational barriers [29]. Based on the findings of this study, the ineffectiveness of the controllers and the shortage of controlling staff affect the visiting program. Human resources are considered the most basic part of health care [30]. Insufficient human resources and lack of professional development reduce the quality of patient care [31]. The present study shows the ineffective education and culture failure in visiting, necessitates effective education that all health staff of medical centers should receive to be able to educate patients and their families. Based on the researchers' experience, working in CCU may be a reason for no educational programs for the staff on educating patients and their families. Providing planned education to visitors can increase patient's satisfaction in various dimensions and guide the visitor to improve patient's situation [32]. Another finding of this study showed unfavorable physical factors of the CCU as a factor affecting visiting at CCU. Failure to anticipate cases, such as pleasant physical environment, presence of family bedside the patient, and offering complementary therapies, have made intensive care units far from optimal environment to improve patient's situation [33]. A century ago, Florence Nightingale emphasized that the environment plays an important role in improving patients. Today, the designers and managers of the hospital building administration make great effort to provide a proper environment for the patients [34]. The present study also emphasized creation of an appropriate environment, necessity of cooperation of nurses, based on their knowledge and experiences, beside architects to improve physical environment to improve the quality of visits.

This study showed low quality of visiting policy that necessitates revising the visiting policy. The method and content of the policy should be considered based on users' needs and information needed by the users. Each policy should be revised and updated at least every four years [35].

Conclusion

Nurses have a fundamental role in management of visits, thus improving quality of visits in CCU to improve psycho-emotional needs of patients and their families require identification of challenges in visiting programs, from the perspective of nurses. This study showed that challenges from the perspective of nurses include management and human resource empowerment, effective education, physical factors of intensive care unit, and quality of visiting policy. These results could help managers and planners to know the field of focus and plan for improving quality of visiting program.

Acknowledgements

This study is part of the master's thesis of Intensive Care Nursing by the number NCRCCD_9509. The authors thank all the partners who have helped in this study.

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