Family and Pet Visitation in the Critical Care Unit

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Visitation in critical care units is based on practices initiated with the first intensive care units in the 1960s. Visitation was restricted because little was understood about the impact on the patient or the family, including children. Family-focused care is a challenging concept to implement into practice. A focus on family needs should drive a critical review of current visitation practices in every critical care unit. Research has demonstrated that rigid and restrictive visitation should be abolished, and may actually be harmful to the patient, family members, and family dynamics.1

Family-focused care is ideally based on the identified needs of the family. What constitutes “family” is defined in the broadest terms, to include whomever the patient has identified as a significant relation. The traditional nuclear family is no longer an inclusive description of every patients “family.” Research has identified 5 categories of family needs: receiving assurance, remaining near the patient (proximity), receiving information, being comfortable, and having support available.2 Family and pet visitation are nursing interventions to meet support, proximity, information, and comfort needs.

Q: How do patients respond to interactions with family members?

Nurses are often concerned that family and patient interactions will lead to deterioration in hemodynamic or intracranial pressure indices. Nurses, as patient advocates, desire to limit potentially detrimental stimuli. Studies have found a decrease or no significant change in heart rate, blood pressure, or intracranial pressure during family visitation. Monitoring the patient’s physiological response to the presence of family members is important.3-9

Beneficial affects of family interactions with critically ill patients include improved family understanding of the patients condition,3,10 reduced family and patient anxiety,11-14 improved control, and better rest between visits.15 Families have the opportunity to have more of their needs met using an open visitation intervention.16 Opening visitation also improves family satisfaction with the critical care experience.10,13 It would appear that the positive impact of less restrictive family visitation outweighs potentially negative consequences.

Nurses’ perceptions of patient preferences are not always accurate and their attitudes are not always positive.17,18 Patients and families have positive perceptions of family visits.19 Positive beliefs and attitudes of nurses are essential in promoting family visitation. For many nurses, a turning point from excluding to including families in critical care practice is the personal experience of having a relative or loved one hospitalized in a critical care unit.19

Q: How is the family affected by the ICU experience and how can I intervene?
Structured, inclusive and open visitation. Each offers the opportunity for greater support and education of the family by the nurse. Planning visitation should be based on the patient preferences for visitors and when they would like visitors. Preparation of the family and children before visiting is very helpful. Once the family is at the bedside, the nurse has the opportunity to review/update the illness or injury that led to the critical care unit admission, what interventions are being done and how the equipment is used to monitor the patient. The nurse can role-model interactions with the patient. Additionally, these interactions provide the opportunity to identify needs that can be referred to other team members (social worker, chaplain, clinical nurse specialist, etc). Providing a means for families to feel connected with the patient is also beneficial (eg, beepers and exchanging phone numbers).

Nurses competent in meeting the physiologic needs of patients may find new challenges when attempting to meet their psychosocial needs. One third of critical care nurses studied said they did not have the skills needed to meet the psychosocial and emotional needs of families. Nurses report that open visitation takes time, causes delays and makes it difficult to provide patient care. Nurses typically receive very little education regarding meeting family needs. Nurses must know crisis management, provision of empathy, and referral options.

Therapeutic communication with families is needed to promote

Having a critically ill family member is a very stressful experience. Family responses to a critical illness may include anxiety, anger, and feelings of helplessness. The stress of the critical illness on families has been found to lead to sleep loss, poorer nutrition, increased use of cigarettes, alcohol, and medications. Families have described feelings of vulnerability, uncertainty, intense emotions, and physical illness in children. Research has found extensive family disruption during the critical illness.

Nursing interventions that support the patient and family are based on assessment of each patient and family’s strengths, preferences, coping styles, and the ability to learn and adapt. Alternatives to restrictive visitation include: flexible, contract, patient-controlled,

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understanding of what the patient and family know, clarify misconceptions, and reflecting back what has been voiced. Evaluation of the family’s response to the visit will allow for planning for subsequent visits. Daily interaction with the wide variety of emotions of patients and families is a challenge and may necessitate use of support services by staff. More frequent interactions between family and staff may also be one of the most rewarding components of providing care for the critically ill patient.

Q: Should children be allowed to visit a critically ill sibling or parent?

Children are integral parts of the family unit and are not exempt from the stress of a critical illness of a family member. Children are often shielded from information about the critically ill family member, but are still able to describe what is happening with some accuracy.21,24 Children’s responses to the critical illness of a family member include emotional turmoil, family disruption, need for support, minor illnesses, eating less, and increased difficulty sleeping, among others.25-27 Parents were unable to identify many of these changes.26,28 Child visitation brought no adverse effects and children’s negative behavioral and emotional responses to the family member’s illness were reduced with facilitated child visitation.29,30

Sibling contact with newborns has not been associated with bacterial infections, but screening for communicable diseases is warranted.21,22 Some institutions recommend using a health screening form and health screening guideline when facilitating child visitation in the critical care unit. Contact your hospital epidemiologist for your institution’s guidelines.

Parents have reported that visitation is helpful for siblings during the crisis of a critical illness in the family.24 Parents are in the best position to decide the appropriateness of visitation by each child. Often the child’s imagination creates more distressing images than the accurate information shared during a visit. Age-appropriate interventions are beneficial in helping to prepare children for what they might see, feel and hear.27,29,30,33,34 Use of supplemental material can be useful (eg, photos, illustrations, coloring or story books, and videotapes) in preparing a child to anticipate the visit.

Preparing the child and environment are critical elements to successful child visitation. After the visit, exploration of the child’s interpretation of the visit, along with their feelings and questions, allows for positive reinforcement and correction of misinterpretations. The visit offers opportunities for the parent and child to continue discussions about the visit and the ill family member. Thus child visitation is not harmful and may be helpful for the child and family.

Q: Won’t pet visitation increase risk of infections to patients?

Most of the empirical evidence for animal visitation and infections comes from tracking infection rates in animal visiting programs. Anecdotal evidence is plentiful from programs across the country that have never had any situations of zoonotic infections (infection passed from pet to human) or diseases. Sandra Wallace, MD, infectious disease director at Huntington Memorial Hospital in Pasadena, Calif, is the medical consultant for a successful Animal Assisted Therapy (AAT) program. After thousands of AAT visits, they have never had an episode of a zoonotic infection or evidence of pet transmission of infection from patient to patient (S L Wallace, personal communication, April 17, 1996). Also, the Centers for Disease Control and Prevention (personal communication) has never had a reported
case of infection from pet visitation. Hospitals have been wise, though, and most have stringent protocols to ensure the animals are clean with current vaccinations, and frequent health and behavior screens. The Delta Society30 has played a huge role in educating people and certifying AAT animals that have behaviors and personalities that work well with people in the hospital setting. Controversy still exists whether the immunosuppressed patient should receive AAT. Until more research is done in this area, many institutions opt to play it safe and not allow animals visits to the immunosuppressed.

Q: What benefits does animal or pet visitation provide to my patient?

Again, anecdotal evidence is great in this area. Stories of people getting out of bed or moving and speaking for the first time when their pet or a therapy dog visits are numerous. Many of these benefits are hard to measure and are very subjective, so research is difficult. The research done has shown benefits of decreasing heart rate and blood pressure and increasing skin temperature, indicating relaxation from petting a companion dog.32,37 Other studies suggest that people experiencing stress, either acutely or chronically, may benefit from short-term interactions with their pet that serve to focus attention away from the stressor to a more pleasurable, calming interaction.38-41

Two types of programs are commonly used: family pet visitation and visitation by certified animal-owner teams. In general, suggestions for success include careful selection of the animal, limiting exposure of animal-allergic patients, implementing an infection control program, formulating policies with broad representation, and developing plans for surveillance and response to an emergency situation.52,43 Critical care nursing is more than just meeting the physiologic needs of the patient. Promoting interaction between critically ill patients and family members and/or pets provides a basis for psychological support interventions. The beneficial effects documented in research are limited to the immediate impact. Actual benefits may be far reaching for the patient, family, child, and even the nurse.

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This article is based on the protocol “Family Visitation and Partnership in the Critical Care Unit” by Marita Titler, Ronda Drahozal, and Laura Cullen, from the *Creating a Healing Environment Series* of AACN’s *Protocols for Practice*. Protocols can be obtained from AACN, 101 Columbia, Aliso Viejo, CA 92656-1491, (800) 899-AACN, (949) 362-2000. $11, AACN members; $14, nonmembers.
Meeting family needs while a loved one is critically ill is a priority within the fast-paced intensive care environment. Research continues to clarify our understanding of family needs and has also shown some new trends; family presence during resuscitation is being discussed in the clinical literature. Evaluation of family presence during resuscitation is still incomplete and research is needed to fully understand family presence and patient preferences during resuscitation. What is clear about family presence during resuscitation is that parents of pediatric patients have been welcomed more readily than families of adult patients, screening of families may be necessary, families have information needs that must be met before attending the resuscitation, families need a facilitator for support and assistance with interpreting resuscitation efforts, and staff communication during the resuscitation may be altered when families are present.1-3 There are anecdotal reports of family presence during resuscitation helping families to feel connected with their loved one and to understand that everything possible was done.1 Families often must work through the transition from supporting recovery to forgoing life-support,4 and family presence during resuscitation may be helpful for some families to resolve otherwise lingering doubts or regrets.

Creating a healing environment in the critical care unit also involves creating an environment to meet patient, staff, and family needs. Open family visitation is just the beginning; additional strategies to consider include creative unit designs, additional intervention to promoting family involvement, and promoting sleep and other holistic therapies.5 Environments that support family visitation include comfortable seating at the bedside; family conference rooms and lounges with close proximity; access to food, laundry, and shower facilities; access to meditation and relaxation facilities; and comfortable furniture for rest and relaxation.

When designing the new medical intensive care unit at the University of Iowa Hospitals and Clinics, the planning team selected comfortable bedside furniture so that families would be able to sleep in the patient’s room during the most critical part of his or her recovery. Developing a new unit design was also an opportunity to include music therapy, noise-reduction strategies, and other innovations to meet both patient and family needs. Another new evidence-based practice intervention involves supporting families’ transition from the pediatric intensive care unit to the general pediatric unit (N. Van Waning, unpublished data, 2002). Use of pet visitation and animal therapy are expanding in many organizations; in our institution, this therapy is a result of the work of an evidence-based practice project team (R. Drahozal, unpublished data, 2002).

Research is still needed to better understand use of family and pet visitation in critical care, and clinicians can be confident that clinical practices promoting family and pet visitation are evidence based. The challenge continues to be broader implementation and evaluation of family and pet visitation protocols across critical care settings. Current trends are positive and offer an opportunity to continually reevaluate assumptions in how to better meet families’ needs.

References
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