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# The Elixir of Visiting: A Qualitative Study on the Experiences of Conscious Mechanically Ventilated Patients in Intensive Care Units Regarding Visiting Family Members

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## Abstract

**Background:** Visiting family members is one of the basic human needs; however, there is contradictory evidence about the advantages and disadvantages of the existing visiting systems. Therefore, the investigation of patients' preferences for the visiting strategies, and achievement of their authentic experiences can significantly contribute to decision-making about the type of acceptable and approved policies in this domain.

**Aim:** The aim of this study was to explain the experiences of conscious patients undergoing mechanical ventilation in Intensive Care Units regarding their visits with their family members.

**Method:** This qualitative study was conducted on 15 conscious mechanically ventilated patients admitted to the Intensive Care Unit in Iran in 2017. The data were collected using semi-structured interviews and observations. The sampling was performed through purposive sampling technique, which was continued until data saturation to select the individuals with rich experiences about the subject under investigation. The data were analyzed through the conventional type of qualitative content analysis.

**Results:** Out of the initial 385 codes, 11 subthemes and 5 main themes were extracted during the analysis process, all of which were placed under the general concept of "the elixir of visiting". The five main themes included visiting as a healing agent, visiting as an agent for the enhancement of perceived support, visiting as an agent for gaining hope, visiting as the patient's urgent need, and preference for planned visiting.

**Implications for Practice:** The results of the present study showed that visiting was like an elixir for the conscious patients undergoing mechanical ventilation in the Intensive Care Units. This practice could allay lots of their pains and lead to numerous valuable effects, such as elimination of loneliness and sadness, increased hope for survival and recovery, and enhancement of a sense of support. Therefore, nursing authorities and managers are required to take steps in terms of redefining visiting rules and regulations in line with patients' preferences, and thereby move towards the promotion of patient care.

**Keywords:** Intensive Care Unit, Conscious patients undergoing mechanical ventilation, Visiting family members

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## Introduction

The structure of the Intensive Care Unit (ICU) and the physical conditions of the patients in need of admission to this unit are considered as highly stressful events for patients and their families (1, 2). Moreover, this admission is accompanied by considerable pains and grief for those who are deeply concerned about patient prognosis or the occurrence of critical conditions and even sudden death (3). The severity of these unpleasant experiences is to the extent that they affect the quality of life in the patients and their families, and also result in post-traumatic stress disorder (2, 4).

Studies in this domain have suggested that one of the most difficult and stressful events associated with the ICU admission is to keep the patients away from their families in an isolated state, which leads to the emergence of sense of loneliness and stress in such patients (5). In addition, the structure and the philosophy of the ICU have been designed in such a way that the presence of family members in this unit entails strict restrictions and prohibitions (6).

Investigations have also demonstrated that despite the implementation of major changes in visiting policies and the growing evidence of the active role of family in the care process, there are still restrictions on visiting hours within hospitals (2, 7). For example, in a survey conducted on 171 hospitals in New England, it was revealed that only one-third of the hospitals were following an open visiting policy (7). In spite of the emphasis on the subject of visiting as a religious and humanitarian duty, which is accompanied by spiritual rewards, no specific changes have been made in the visiting process and policies in Iran, especially visiting the ICU patients (8, 9).

According to the literature, such beliefs as augmented risk of infection owing to increased presence of family members in this unit, interruptions in patients' rest times, as well as incidence of physiological changes (e.g., tachycardia, arrhythmia, hypertension, and anxiety) in patients can have a significant role in imposing the given restrictions by the nurses and nursing managers (8-10). Moreover, the majority of the doctors and nurses consider ICU visitations as stressful events and believe that increased visiting may result in the elevation of cardiovascular disorders, disrupted rhythms, and high blood pressure (8, 11).

There are numerous positive and negative comments raised by the nurses about open visiting (2); therefore, it seems that weighing up these two types of attitudes can be helpful in adopting the effective type of visiting policy. For example, in a study conducted by Marco (2006), all the nurses agreed on and stressed the point that family visits could facilitate the patients with emotional support and increase their desire to live. However, the majority of these nurses believed that the presence of family members could cause interruptions and delays in treatment delivery, which were unpleasant for the patients and would make them suffer from pains (11).

The negative impacts of open visiting are reported to be inability to properly plan for nursing care, time waste by nurses to give information to patients' families rather than care provision, a sense of being controlled by families, nervousness and inability to have a normal behavior, and also increased mental and physical demands on nurses (2, 12-14). On the other hand, the positive aspects of this type of visiting policy include reduced patient anxiety, hormonal changes in favor of desired hormones, increased sense of comfort, patient safety, boosted satisfaction among families with no changes in hemodynamic state of patients (2, 14-17), and the possibility of providing such care as massages by family members (18).

This contradictory evidence has created confusion and uncertainty in families and also brought about challenges among nurses and medical teams regarding the type of acceptable and approved policies in this domain (19). According to the American Association of Critical-Care Nurses, 78% of adult ICU nurses preferred no-restriction policies; nonetheless, more than 70% of the hospitals were following the policies of placing restriction on family visits (19, 20).

Moreover, the issue of restricted visitations has long been taken into account as a necessity for recovery and treatment. Nevertheless, there is no reliable scientific basis for the accuracy of the beliefs raised by the nurses and medical teams about the disadvantages of open visiting and the need to restrict visits to the ICU, which can add to these challenges and misperceptions (19).

Visiting family members is considered as one of the basic human needs. According to Lee et al., visiting is one of the ten important and exceptional requirements for the ICU patients (20). Regarding this and given the contradictory evidence listed on the advantages and disadvantages of available visiting systems, it is of utmost importance to conduct further studies in this domain. The individuals

affected by such policies are not only families and nurses, but also patients who need more special attention due to being in critical conditions.

Consequently, the investigation of patients' authentic experiences regarding the existing visiting systems can highly contribute to making decisions about acceptable and approved policies in this regard. A qualitative approach is the best method to examine patients' experiences (21, 22). However, there are limited qualitative investigations in this domain, conducted abroad, such as the study carried out by Gonzalez (23) examining some aspects of this issue, including views and preferences of the patients, family members, and nurses about visiting policies out of Iran.

Furthermore, to the extent of the researchers' knowledge, there is no qualitative study shedding light on patients' actual experiences about visiting at the time of ICU stay. With this background in mind, the present study was conducted to investigate the experiences of the conscious patients undergoing mechanical ventilation regarding visits in the ICU.

## Methods

This qualitative study was conducted on 15 conscious ICU patients undergoing mechanical ventilation in Mashhad, Iran, in 2017. To obtain rich and in-depth data, the conventional type of qualitative content analysis was utilized (21, 22). The study population was selected through purposive sampling technique. The inclusion criteria were: 1) the ability to remember and recount experiences, 2) lack of psychological disorders or dementia, 3) minimum use of mechanical ventilation for 24 h, 4) Persian language proficiency, 5) physical and spiritual ability, and 6) consent to interview.

After referring to the ICUs of the government hospitals in Mashhad, the researcher informed the nurses about the study objectives and asked them to introduce the current or previous patients in the given unit, who were eligible for the present study. The data collection was performed using in-depth semi-structured interviews. To this end, at the onset of the interviews, the researcher introduced oneself, explained the purpose of the study, and then asked the participants to explain their current health status and the cause of their ICU admission in order to establish a friendly relationship with the patients and fulfill the warm-up stage of the interviews.

Subsequently, the formal interview was conducted using questions, including "How were the visits in the ICU?", "Please, explain about your own memories and experiences of visiting family members in the ICU.", "What feelings and perceptions did you have when someone came to visit you?", and "What were the effects of visits on your recovery and morale?". As the study progressed, the questions were directed toward the main established categories. For example, regarding the participants' statements on their experiences about the inconveniences of visiting family members and specific people, the rest of the participants were also asked to talk about the same experience.

Finally, a total of 19 interviews were conducted with 15 participants, 4 cases of which were complementary interviews. The time of the given interviews varied within 25-156 min (mean=60.31 min) in both initial and complementary interviews. The place of interviews was selected based on the participants' choices. In this regard, if the patient was hospitalized in the ICU and was able to participate in the interview, it was performed in the ICU; however, this occurred in only one case.

Since the patients admitted to the ICU had been recently extubated and were not in good physical and mental conditions, the rest of the interviews were preferred to be conducted at the time of discharge from the ICU, when they had physical and mental preparation. Complementary interviews were also performed in the aforementioned patients' houses. Therefore, four cases of the interviews were conducted in the post-ICU divisions of the government hospitals, and four of them, including an initial interview and three repeated interviews, were performed in the researcher's office at the Faculty of Nursing and Midwifery, Mashhad, Iran. The other ten interviews were also conducted at patients' homes in their city of residence based on patients' requests to avoid putting them into trouble.

To validate the data, the technique of observation was utilized to monitor the conscious patients undergoing mechanical ventilation in the ICU. Accordingly, the researcher attended in the unit wherein the patient was hospitalized with the coordination of the ICU authorities and was located in a place where the patient was in his sight. Then, the researcher observed the patient's moods and reactions before, during, and after visiting while simultaneously writing down all the events. The time of these observations varied from 2-5 h for each patient. The data collection was continued until data

saturation; in other words, it was ended when no new codes were obtained in the three final interviews and observations.

The conventional type of content analysis was employed to analyze the data. Based on the steps of this method (24), first, all the recorded interviews were transcribed. Then, the interview transcriptions and the observation manuscripts were studied for several times. To immerse in the data, the researcher also repeatedly listened to the interviews and reread the results of the interviews and observations. Subsequently, the data were broken into semantic units (codes) in form of statements and paragraphs associated with their original meanings.

After reviewing the semantic units for several times, an appropriate code was allocated to each semantic unit. The codes were then categorized based on conceptual and semantic similarities and abridged as much as possible. The process of decline in data reduction was evident in all units of analysis as well as main categories and subcategories. The obtained data were assigned into main categories that were more general and conceptual, and then the themes were abstracted.

With the addition of each interview, the analysis process was repeated, and the categories were reviewed and revised. Moreover, to confirm the validity of the data, we employed such methods as peer debriefing, external checking, and member checking (21, 25-27). Following the coding of some interviews, the participants' comments on the codes were also obtained in order to confirm the accuracy of the codes and ensure the interpretations. For external checking, the obtained codes and categories were submitted to a number of professors at the School of Nursing and Midwifery in Mashhad, Iran, and their comments were considered (21, 26, 27).

In accordance with the ethical principles, we obtained the permission from the Research Ethics Committee of Mashhad University of Medical Sciences (code number: 922379, date: April 04, 2014). In addition, informed consent was obtained from the participants, and they were informed about recording the interviews and keeping the recorded voices.

## Results

The participants included 15 conscious patients undergoing mechanical ventilation with the age range of 22-52 years. In terms of gender, 10 participants were female. Other characteristics of the participants are illustrated in Table 1. Within the analysis process, out of a total of 385 initial codes, 11 subcategories and 5 main themes were extracted all of which were placed under the general concept of "the elixir of visiting" (Table 2). The five main themes included visiting as the patient's urgent need, preference for planned visiting, visiting as a healing agent, visiting as an agent for the enhancement of perceived support, and visiting as an agent for gaining hope.

**Table 1. Characteristics of the study participants**

Characteristics	Number (%)	
Gender	Male	5 (33.4)
	Female	10 (66.6)
Age (year)	18-30	5 (33.4)
	31-40	3 (20)
	41-50	7 (46.6)
Education level	Illiterate	1 (6.6)
	Primary school	2 (13.4)
	High school	7 (46.6)
	Academic education	5 (33.4)
Type of disease	Internal	4 (26.6)
	Psychiatric	4 (26.6)
	Surgical	3 (20)
	Traumatic	4 (26.6)
Duration of undergoing mechanical ventilation (day)	3-10	5 (33.4)
	10-20	6 (40)
	>20	4 (26.6)



**Table 2. An example of extracting codes, categories, and subcategories from the raw data**

Categories	Subcategories	Codes	Semantic unit
Visiting as a patient's urgent need	Waiting and longing for visits	Counting the seconds to visit the support people	"I was waiting for the visiting time at 2 p.m. from noon onward. I used to check the clock every 5 min until it hit 2 p.m."
	Restricted visiting as an unfavorable criterion	Sense of depression and grief	"As you know, it was peculiar. For example, I would get depressed if they were not able to attend ... that sounded like I was dead."
Preference for planned visiting	Willingness to meet specific people	Discomfort due to visits with distant relatives	"The only thing I did not like at the visiting time was the presence of people rather than my beloved ones who came there, such as relatives. I did not like them to see me under those critical conditions. I was upset."
	Need for visitations at specific times	Need for visits in times of distress	"The point that whether they permitted my husband to come in for a few minutes to see me late at night had made me worried. I needed to see my husband late at night ... because I was desperately homesick."
The elixir of visitations	Relieving loneliness and grief after visiting	Ending grief	"When somebody came to see me ... I felt relieved. I mean, I was delightful that someone opened the door and came to see me ... the moment they were beside me, I was fine. When one came to visit me, I could forget all about my sorrows."
	Visiting as a contributing agent to tolerate extreme conditions	Visiting as a cause for tolerating the heavy atmosphere of the ICU	"I could not tolerate staying at the ICU for one minute. It was very hard. When they came to visit ... it helped me to handle those tough conditions."
visiting as an agent for the enhancement of perceived support	Sense of being valued during visiting	Feeling of being important	"My sister wrote that some people called and asked about my health condition. She said that Mrs. so-and-so asked about my well-being or someone avowed for having offerings for me ... I found that they were missing me a lot. I acknowledged that lots of people were worried about me."
	Sense of self-confidence during visitations	Sense of being supported	"In the hospital and at the visiting time when they opened the curtains and you knew some people were waiting behind the door, it could give you the confidence ... I was not in contact with them, but it made me confident."
	Sense of being more cared with the presence of support people	Better care in the presence of the support person A sense of lower incidence of wrong actions in the presence of the support person	"I felt that everything was clean, tidy, and right when my wife was on the bedside. She was watching for wrong and missed activities. I did not feel well when she was not beside me, and I had a fear that things did not go well. The personnel, who were really busy, were likely to forget something."

**Continuous of Table 1.**

The elixir of visitations	Visiting as an agent for gaining hope	Hope for survival and recovery after visiting	Being hopeful to life Hope for improvement after visitations	“The presence of the family members could give me hope. When they came to see me, I felt that I was better according to the doctor’s viewpoint ... I also felt much better when my children and my husband came there ... I thought that I was good that my doctor had let my kids come and visit me. I became hopeful.”
		Recalling positive side of life after visiting	Remembering good memories of life Remembering kids and family	“I had forgotten my whole life, my children, and even my husband. When they came there, I found that I had my own home, my husband, and my kids. It was very good, and it gave me a lot of hope.”

**Theme 1: Visiting as the Patient’s Urgent Need**

The given theme consisted of two subcategories, namely “waiting and longing for visiting” and “visiting restrictions as unfavorable criteria”.

**Waiting and Longing for Visiting**

Based on the participants’ experiences, their enthusiasm to visit the family members was to the extent that they counted the seconds to reach to the time of visiting the family members, and they were also constantly watching the door and waiting to meet these individuals. This eagerness for visiting was clearly indicated in the statements of a participants as he expressed:

*“I was concerned about visiting. I was waiting for the visiting time at 2 p.m. from noon onward. I used to check the clock every 5 min until it hit 2 p.m. When I sometimes could not see the clock due to the closed curtains, I asked the nurses to tell me the time every 5 min, and they always told me just 5 min passed.”*

(A male participant aged 22 years with a history of undergoing mechanical ventilation for 20 days) This was also evident in the observation of a conscious patient undergoing mechanical ventilation in the ICU, which was as follows:

*“It was about 3 p.m., and the 26-year-old female patient was undergoing mechanical ventilation lying on the bed No.5. She was restless and constantly looking at the clock. Definitely, she was waiting for something. Once the big hand of the clock reached to 12 and it hit 3 p.m., she pointed to the clock and the visiting door using fast hand and eye gestures to make the nurse understand that she felt like it was the visiting time, and that the nurse should open the door.”*

**Visiting Restrictions as Unfavorable Criteria**

The participants stated that restrictions on visiting and being away from family members had caused unpleasant feelings, such as extreme sadness and a sense of death. They also argued that the restricted visiting policy changed the ICU into a prison for them, and that they felt like they were in jail, which could aggravate their homesickness and depression. Since the patients felt that they had no control over themselves due to fluctuations between conscious and unconscious states after receiving sedatives as well as extreme weakness and lethargy, they feared that their care process would be neglected in the absence of their family members, which could fuel sufferings and sense of anxiety in them.

In this regard, a 33-year-old male participant undergoing mechanical ventilation for 32 days remarked:

*“As you know, it was peculiar. For example, I would get depressed if my family members were not able to attend. My wife’s presence was very effective. When they came in, they could give massages to my legs, and it was very helpful. It was also very different when we could talk with each other. The day they could not come to visit me, I did feel differently. That sounded like I was dead.”*

Furthermore, another male participant aged 47 years with 5 days of undergoing mechanical ventilation stated:

*"I would have preferred to go somewhere that was not like there. It was like a prison wherein I could not communicate with anyone. I liked to have my support person close to me to get help in eating and other chores."*

### **Theme 2: Preference for planned Visiting**

This theme was also comprised of two subcategories, including "willingness to visit specific people" and "need for visiting at certain times".

#### **Willingness to Visit Specific People**

The participants expressed their urgent need to only visit close family members and loved ones. In this regard, visits by others, such as relatives and friends, not only failed to please the patients but also added to their sufferings and discomfort. Accordingly, some participants stated that they did not at all want their distant family or acquaintances to see them under such critical conditions while they had tubes in their mouths and lying weak and disabled on the bed. Moreover, the participants reported that they sometimes liked to visit only a specific person, such as their spouses or their mothers, and that nobody's presence in those conditions was as effective as the companion of these particular people. In this respect, one of the participants expressed:

*"One of my relatives was a specialist doctor, who had come from Germany. He had asked to see me, but he was not allowed to do so. His presence in the unit was important to me. I wanted him to come because I thought he could boost my morale. His presence was good for my treatment process. If the doctor was beside me, he could have a greater focus on my therapeutic procedure, and it was important."*

(A male participant aged 47 years undergoing mechanical ventilation for 15 days)

The statement of another participant in this regard was as follows:

*"The only thing I did not like at the time of visiting was the meeting of others, including relatives. I did not like them to meet me in that state. I was upset. But I loved the ones that used to come and see me."*

(A 28-year-old female participant with a history of 19 days undergoing mechanical ventilation)

#### **Need for Visiting at Certain Times**

The participants complained about the restriction of the visiting hours to specific times without considering the patients' needs. They reiterated that, in many cases, they felt desperate at unexpected times, especially late at night, and they needed one of the family members to be alongside. This time was not predictable due to the unstable conditions of the patients, and it was likely to show up at any time of day and night. Therefore, the restriction of visiting to a specific time would deprive the patients of benefiting from the presence of their close families at the time they needed someone alongside. In this regard, a subject noted:

*"The point that whether they permitted my husband to come in for a few minutes to see me late at night had made me worried. I needed to see my husband late at night. Some nurses hardly ever let him come in although I was in dire need, and I was desperately homesick."*

(A female participant aged 28 years with a history of undergoing mechanical ventilation for 19 days)

### **Theme 3: Visiting as a Healing Agent**

This theme included two subcategories of "visiting as a relieving agent for loneliness and sadness" and "visiting as a contributing agent to tolerate difficult conditions".

#### **Visiting as a Relieving Agent for Loneliness and Sadness**

The ICU admission is accompanied by overwhelming with sufferings and discomfort in patients. The ill-conditioned person, physical and emotional environment of the ICU, and highly aggressive therapeutic measures taken to preserve the patient's life are among the causes of these pains and inconveniences that are often inevitable. The participants stated that the most important factor soothing them under these difficult conditions was visiting family members.

They also added that these visitations could relieve their sense of loneliness and create an opportunity to spill their guts, end their grief, and get out of the ocean of sufferings and discomfort. Considering



the effect of the presence of others on reducing inconveniences, one of the participants said:

*“Visitations could help me get rid of my sense of loneliness. I could feel for a few minutes that others were beside me. I was really alone in the ICU. When I was completely disabled, the only good feeling I had was the visitations. I felt like others were close to me.”*

(A 28-year-old female participant with a history of 19-day use of mechanical ventilation)

The statement of another participant about tackling the grief following the visitations was as follows:

*“When somebody came to see me, such as my relatives or my support person, I could feel relieved. I mean, I was delightful when someone opened the door and came to see me. I felt really happy when my relatives or my colleagues came to visit me. The moment they were beside me, I was fine. When one came to visit me, I could forget all about my sorrows.”*

(A female participant aged 36 years with a history of undergoing mechanical ventilation for 35 days)

#### **Visiting as a Contributing Agent to Tolerate Difficult Conditions**

Given the inevitability of the numerous causes for distress and sufferings in the ICU, there were no resorts except resilience for patients, and they had to endure the difficult conditions. According to the participants, visiting with the family members reinforced their patience helping them to tolerate these difficult conditions. This was evidently expressed by a participant:

*“I could not stay in the ICU even for one minute, and it was very hard for me. When visitors came once a day just for half an hour, it could help me to bear such difficult conditions.”*

(A 22-year-old participant with a history of undergoing mechanical ventilation for 20 days)

#### **Theme 4: visiting as an agent for the enhancement of perceived support**

This theme was comprised of three subcategories, including “sense of being valued by visiting”, “sense of self-confidence during visits”, and “sense of being cared with the presence of support person”.

##### **Sense of Being Valued by Visiting**

Given the restricted visiting policy in the ICU where patients are isolated and have no access to family members, the patients are overwhelmed by a sense of being abandoned by family. The participants expressed that the presence of family members during the visiting times reflected that they were valuable to their families, and that they had not been forgotten. A 36-year-old female participant with a history of 35 days of using mechanical ventilation recounted her experience about this feeling as follows:

*“For example, my sister wrote that so-and-so came from other cities or that some people called and asked about my health condition. I liked to know who called me and asked about my well-being. They said that Mrs. So-and-so asked about my well-being or someone avowed to have offerings for me. These events made me happy, and I found that they were missing me a lot. I acknowledged that lots of people were worried about me.”*

##### **Sense of Self-Confidence during Visits**

Visitations for patients meant having a supporter who could help them, or someone on whom they could rely in their conditions of weakness. This could by itself boost self-confidence in patients. One of the participants in this regard expressed:

*“In the hospital and at the visiting time when they opened the curtains and you knew some people were waiting behind the door, it could give you self-confidence that you were still valuable for them; you were still important to them. They had tolerated heat and cold to come and stand behind the window to see you and to let you know that they were beside you. I was really self-confident that my family was giving value to me, and it could confirm that I was still important to them even in such conditions. It made me sure that they had not forgotten me, and that they could do anything for me. I was not in contact with them, but it made me confident.”*

(An unmarried female participant aged 22 years with a history of 17 days of undergoing mechanical ventilation)

##### **Sense of Being Cared with the Presence of Support Person**

Occasionally, the patients admitted to the ICU are even unable to express their slightest needs due to

the use of the endotracheal tubes, which is accompanied by a sense of helplessness and frustration. Therefore, the presence of a support person, as a confirmed and reliable individual observing and monitoring the care provision and treatment, can ensure the patients that they are cared, and that everything is completely implemented. Considering this assurance, one of the participants marked:

*“I felt that everything was clean, tidy, and right when my wife was on the bedside. She was watching for the wrong and missed activities. I did not feel well when she was not beside me, and I had a fear that things did not go well. The personnel, who were really busy, were likely to forget something.”*

(A 47-year-old male participant with 15-day use of mechanical ventilation)

#### **Theme 5: Visiting as an Agent for Gaining Hope**

The given theme consisted of two subcategories, namely “hope for survival and recovery by visits” and “recalling the positive side of life after visiting”.

##### **Hope for Survival and Recovery by Visits**

The critical conditions of the mechanically ventilated patients and the certain conditions of the ICU can stimulate a sense of extreme despair in the patients concerning survival and improvement. According to the participants, permission to have visitations meant that they were improving and getting better, which made them hopeful to survive. More details in this regard were provided by one of the participants as follows:

*“The presence of support people could give me hope. I was really encouraged. When they came to see me, I felt that I was better according to the doctor’s viewpoint and that was the reason the family members were allowed to visit me. I did not feel well until my brother came in, that time I felt better. I also felt much better when my children, and my husband came there. I thought that I was good, so my doctor had let my kids come and visit me. I became hopeful.”*

(A female participant aged 35 years with a history of undergoing mechanical ventilation for 9 days)

##### **Recalling Positive Side of Life after Visiting**

The participants argued that visiting close family could result in the renewal of memories and remembrance of good things of life in the conditions of despair and frustration of ICU stay. Furthermore, it could enliven a sense of hope to the world outside the stressful ICU environment in patients. In this respect, a 40-year-old female participant undergoing mechanical ventilation for 6 days pointed out:

*“I became so happy when the family came along. That really gave me high spirits. When a person loses one’s memory, they may forget others. I had forgotten my whole life, my children, and even my husband. When they came there, I found that I had my own home, my husband, and my kids. It was very good and gave me a lot of hope.”*

Therefore, based on the data analysis, visiting as an urgent need for the ICU patients was considered as a healing agent ending loneliness and grief, which inspired a sense of being supported, and enlivened the patients with a ray of hope. Since all the subcategories reflected the healing effect of visitations on patients, the obtained themes were placed under a general concept entitled as “the elixir of visiting”.

## **Discussion**

The analysis of the participants’ experiences about visiting led to the extraction of five main themes, which were placed under the general concept of “the elixir of visiting”. These five themes included visiting as a healing agent, visiting as an agent for support perception, visiting as an agent for gaining hope, visiting as the patient’s urgent need, and preference for scheduled visiting.

According to the results, the participants’ experiences suggested that visitations could contribute the ICU patients in terms of healing, tolerating difficult conditions, and ending loneliness and grief. The findings of this study were consistent with those obtained by Gonzales et al. (2004) (23). Gonzales et al. derived three concepts of dependability, convenience, and comfort from the participants’ experiences concerning family visits in the ICU. Furthermore, the majority of the mentioned participants were satisfied with the flexible visiting policy since it could meet both the needs of the patients and those of the visitors.

It is worth mentioning that the interpersonal interactions in Iran are more visible and there are deeper emotional dependencies between people and family members like other eastern nations; however, such relationships are poor in the western and industrial countries. Regarding this, the agreement between our findings and those of the mentioned study despite the very different cultural backgrounds of the two studies was probably derived from the issue that the needs for visits are among the human basic needs (20), which are not dependent on a particular culture.

Even the advanced medical centers of the world, such as the Massachusetts Hospital that was the research context in the study of Gonzales et al., emphasized the importance of family visitations along with the provision of high-quality nursing care in patients' assurance and peacefulness (23). In another study conducted by Michelle and Aitken, the concept of "the big benefit" was extracted from the ICU patients' experiences regarding open visits with family members, which was in line with the findings of the present study (28).

The mentioned concept represented the participants' positive feelings towards adopting open visiting policies in the ICUs. According to the American Association of Critical-Care Nurses, the unrestricted presence and participation of a supporter, such as a family member or any person requested by patients, could promote care security and also increase satisfaction levels in patients and families. This was helpful especially in the ICU wherein the patients were usually intubated and unable to speak (19).

The unrestrained visiting of the support people can improve the nurse-patient relationships, facilitate patients' better perceptions, affect progress in patient care and family-oriented care, as well as enhance personnel's satisfaction (19). Furthermore, the results of a study performed by Fumagalli et al. shed light on the positive effect of visits on ICU patients' relief and relaxation. These researchers reported that increased visiting hours could reduce anxiety and hormonal changes in favor of good hormones, and consequently lower the incidence of cardiovascular complications (15).

A sense of being supported following visits was one of the other concepts extracted from the participants' experiences in the present study. This theme consisted of three main concepts, namely a sense of being valued, acquiring self-confidence, and a sense of being cared. The participants also expressed that visits had heartened them and were like a support. Likewise, in the study of Gonzales et al., the participants stated that visitations meant that "other people loved and took care of them". Additionally, they expressed that visiting people made them feel like they were loved and cared for (27). Patients' urgent needs for visiting were among the other findings of the present study. In this regard, the patients reported to count the moments and eagerly wait for the visiting hours during the ICU stay. They were also greatly annoyed by restricted and prohibited visitations. A sense of homesickness and imprisonment, as well as fear of receiving incomplete care were cited among the causes of sufferings accompanied by restrictions on visiting. Numerous studies have also confirmed this issue and emphasized the need for visitations among the ICU patients.

In the studies carried out by Kareshki et al. and Kalfon et al., sense of loneliness and restricted visiting hours were mentioned as the most important causes of discomfort among the ICU patients (1, 4). Moreover, Lee et al. reported that the adoption of restricted visiting policies increased anxiety and dissatisfaction in patients and their families. They also proposed the need for open visiting as one of the 10 basic needs of the ICU patients and their families, which could promote the quality of care for these patients.

The findings of the present study and those of the similar investigations can be considered as valid documents highlighting the positive effect of open visiting, which are in struggle with the contradictory evidence associated with the type of acceptable visiting policy. As previously mentioned, there are no valid documents regarding the accuracy of nurses' claims about the disadvantages of open visiting (19). One of the most important findings of this study was preference for scheduled visiting. In other words, although the patients suffered from restricted visiting policy, they did not accept the completely open visiting policies without any restrictions.

Among the results of the present study, willingness to meet specific people confirmed the issue that while the patients tended to visit their favorite individuals, they were annoyed by visiting some people, such as distant families. Furthermore, the participants highlighted the need for visiting at certain times. They expressed that they sometimes felt an urgent need to have some support people or visitors, especially spouses or parents, alongside. Nonetheless, restricted visiting policy inhibited them to visit these loved ones, which resulted in a lot of sufferings for patients.

Scheduled visiting as an alternative and adjusted policy along with open and restricted visiting policies has also attracted the attention of many researchers. For example, Tanner conducted a study entitled "Visiting time preferences among patients, visitors, and personnel". The findings of the mentioned study indicated that none of these three groups had the desire to have open visitations. In addition, the given patients and visitors preferred visiting in a quiet hour away from busy working time in the unit. The nursing personnel also wished to schedule visiting hours. Moreover, in the mentioned study, a third of the patients were embarrassed regarding receiving nursing care in the presence of their support people (29).

The application of the scheduled visiting instead of open visiting without any restrictions was also highlighted by Silva Ramos et al. They noted that most of the patients could not accept unrestricted visits and considered them bothersome in terms of relaxation and care. Despite the multiple benefits of open visiting policy for patients, the participants of the mentioned study preferred visits with shorter duration and lower frequency. In other words, their emphasis was on flexible visiting hours instead of increasing the duration of visiting hours (2).

The positive impact of scheduled visits was also endorsed in a study carried out by Rahmani et al. revealing that scheduled visiting could contribute to improved quality of treatment (30). Moreover, Salvati et al. showed that unlike the common belief that the presence of support people could cause unstable hemodynamic states in patients, programmed visitations had no negative impacts on physiological parameters of the patients. Accordingly, they concluded that there was no reason for restricted visiting in the ICUs (6).

The limitation of this study was that even though a high percentage of the ICU patients were able to remember and recount the events in this unit, they were prone to forgetting the events due to taking sedatives. However, to resolve this limitation, the researcher made use of observation technique within data collection process, and therefore validated the data in this regard.

### **Implications for Practice**

The results of the present study showed that visiting as an urgent need for the conscious patients undergoing mechanical ventilation in the ICU was like an elixir that could allay lots of their pains. Moreover, this practice could lead to very valuable effects, such as relieving loneliness and grief, giving hope for survival and recovery, and raising a sense of being supported. Moreover, the findings suggested that visiting was an urgent need for the patients, who felt longing for visitations, and that restricted visits were accompanied by lots of sufferings and great distress.

However, the patients raised the need for scheduled visiting and visitation with specific individuals at particular times. In addition, the patient were unwilling to meet some people due to their conditions. Based on these findings, the healthcare authorities and policy-makers, especially the nursing managers, are required to take steps and redefine the rules and regulations of visiting in accordance with patients' preferences, and thereby move towards the promotion of patient care.

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### **Conflicts of Interest**

The results of the present study did not have any conflicts of interest with an individual or an organization.



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