PATIENT AND FAMILY OPINIONS AND PREFERENCES OF VISITING PRACTICES IN A BURNS INTENSIVE CARE UNIT

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DECLARATION

I, Lauren Bridget Webber, declare this research report is my own work. It is being submitted for the degree of Master of Science (in Nursing) at the University of the Witwatersrand, Johannesburg. It has not previously been submitted for any degree or examination at this or any other university.

Signature BWebber

This 22nd day of September 2021

Protocol number: M190638

DEDICATION

I dedicate this research to all nurses who go above and beyond the call of duty and give so much of themselves to the care of their patients and patient families.

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ABSTRACT

Purpose: The purpose of this study was to describe the opinions and preferences of family members and patients on visiting practices in the Burns ICU setting of a level 1 private sector hospital in Gauteng, South Africa.

Background: Many visiting practices have been implemented throughout the years within Intensive Care Units. Although there are numerous benefits to patients, family members and healthcare workers within the ICU, especially specialised units as burns, regarding family and patient-centered visitation, controversy still surrounds this issue, thus it is important to explore the opinions and preferences about visitation practices.

Methods: A quantitative, non-experimental, descriptive and cross-sectional survey design was used to describe the patient and family members' opinions and preferences of visiting in a Burns ICU. The final sample consisted of N= 51 respondents, thus giving a response rate of 96.2% for the study. Data was collected from the patients and family members using a validated questionnaire developed by Ramnath (2007). Data was analysed using descriptive and inferential statistical tests using t-tests and Chi-square analysis. Testing was done at the 0.05 level of significance.

Results: The majority of the respondents preferred a longer visiting time compared to shorter and more frequent visits. Thirty nine point two percent (39.2%) of the participants reported wanting to stay longer and 29.4% of the respondents would have preferred the visits to be more frequent. Fifty nine point three percent, (59.3%) of the family respondents strongly agreed that visiting hours in the Burns ICU should not be restricted and 14.8% strongly disagreed and felt that it should be restricted. Fifty one point nine percent (51.9%) disagreed that imposing restricted visiting hours on a family member of a critically ill loved one is acceptable.

Conclusion: Open visiting hours was found most beneficial to both the patients and their family member's ion this study. It was largely reported in this study that both the family members and the patients had reduced anxiety levels during these open visits. It was also identified that patients found their recovery easier as their visitors helped to distract them from their predicament as well as support them through their recovery. Although it was reported that the staff were friendly, not all the patients and family members felt sufficiently supported or that they were provided enough information and education on the patients' condition.

Keywords: Patient, Family, Opinions, Preferences, Visiting practices, Burns, Intensive Care Unit

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.0 INTRODUCTION

This chapter provides an overview of the study and the research process. The background of the study, problem statement, purpose, objectives, and significance of the study will be explained. The research methodology will be explained briefly including the following: the research design, data collection process, data analysis and the ethical considerations of the study.

1.1 BACKGROUND OF THE STUDY

Policies that have been formed regarding visitation within ICUs, have predominantly been based on the views of the health practitioners within the medical field, and in only a few has the family and patient opinions and preferences been incorporated (Monroe & Wofford, 2017). Worldwide there is a growing interest in changing from provider-centred care to a patient-family centred environment whereby the patient and their family are treated as a unit.

The Institute for patient and family centered care (2010), identifies the key elements of patient and family centered care are respect for family preferences, flexibility and customization of care, honest information sharing to promote participatory decision-making, collaboration on all levels of health care delivery systems and a strength-based approach to working with patients and families. Within the Burns ICUs not only does the patient feel overwhelmed due to the extent of their injuries but the families are also devastated and unsure on how to care or be there for the patient (Bishop, Walker & Spivak, 2013).

In most hospitals' visitation can also vary from one ICU to another. Family members are often not always allowed to be present at times that may suit them because doctors may be doing patients' rounds, invasive procedures are being carried out or a patient is requiring resuscitation. This leads to the needs of the patient, family and healthcare professionals being inadequately met (Owens, Huynh & Netzer. 2017).

According to Van Mol et al. (2016) the family has a greater understanding of the patients’ needs and a more comprehensive understanding of their condition including the options for best care, and thus the family needs to be an integral part of the patient’s journey to recovery.

As families know the patients coping mechanisms and what they are like personally, they can share this information with the nurses in order for the nurses to help plan the patients individual care. This is especially important for the patient that is unconscious or sedated and cannot speak for themselves (Khaleghparast et al., 2015).

According to Khaleghparast et al. (2015) the nurse as well as the other health providers can observe and identify specific needs that a patient and their family may have, by spending more time together through open visitation, which would thus lead to a more holistic approach to care.

In the literature it does suggest that if the family members are not allowed to be a part of the patients care, they can experience negative effects, such as sleep deprivation and additional stress. The negative effects are because the family members feel that they need to be constantly present but are excluded from the care and treatment of their critically ill family member (Owens, Huynh & Netzer, 2017).

Open visiting hours often cause concerns or annoyance among nurses as it can increase the patients’ physiological stress if there is tension within the family dynamics and boarders the line of the patients right to privacy (Khaleghparast et al., 2015). According to Monroe & Wofford (2017), nurses feel that open visitation obstructs in their planning for their shift. The same nurses also felt that open visiting directly interferes with their nursing care. The rationale for this was that due to interruptions and increased workload they are not able to manage their care for the critically ill patient as well as the family.This results in restricted visitation being the preferred type of visitation for the staff (Monroe & Wofford, 2017).

According to Choi, Curlin & Cox (2018), family members are able to provide information about the patients religious beliefs which can be incorporated into the critically ill patients holistic care. When religious and spiritual concerns are focused on not only by the multidisciplinary team but also the family, all parties are pleased with the outcome of care. However, this applies to non-intensive care units, as there is little knowledge on how the ICU multidisciplinary team addresses the religious aspect of care (Choi, Curlin & Cox, 2018).

It has been identified that within ICUs a spiritual care leader such as a priest; rabbi; cleric are the main providers in the religious care of the patients and family in ICU. These leaders provide the most satisfaction to family members and patients in their time of need (Johnson et al., 2014).

If implemented correctly open visitation can be of benefit to patients and their families as there is a decrease in patient anxiety. The healthcare professionals work with the family as they can be present and included in treatment options therefore improving the patient, nurse and family experience and providing complete holistic care (Shulkin et al. 2014).

In compiling and reviewing visitation policies cultural beliefs, space availability within the ICU and accessibility to the units should also be considered to create the most beneficial setting for all parties involved such as the nurse, patient, family and multidisciplinary team (Khaleghparast et al., 2015).

It has been found that ICU nurses across all ICUs have mixed beliefs and attitudes toward visitation. Nurses believe that visiting has a positive effect on the patient however they do not believe that visiting is important in the patients’ recovery (Monroe & Wofford, 2017).

According to Bishop, Walker & Spivak (2013) because of the severity burn injuries and the instability of the patients it has been said that restricted or closed visitation protects the family from possible infections and other factors such as the trauma of dressing changes. Through this restriction though it has been found that there is frustration and dissatisfaction from the patient and family as there is a limit to their knowledge and lack of education on how to care for their patient post discharge and they feel information is withheld regarding the treatment needed. It has been found that not all families wish to be present during such invasive procedures but having the knowledge that they have the option to be part of the procedures allowed for the feeling of involvement regarding treatment without being judged for not wanting to be part of the procedure (Bishop, Walker & Spivak, 2013).

Burns injuries can and most often are overwhelming for the patients that have been victim to the injuries but also their family. Individuals who have burn injuries are at high risk for psychological impairments such as post-traumatic stress disorder and depression, not only due to the trauma they incurred but also due to their prolonged hospital stay and during rehabilitation and the coming to terms with their change of body image. The patients therefore rely on their family for support during their recovery and rehabilitation (Bayuo, Agbenorku & Amankwa, 2016).

1.2 PROBLEM STATEMENT

There is a worldwide debate on what the best policy is to implement in the ICU setting regarding visitation practices. The types of visitation include open/unrestricted/flexible and scheduled/restricted hours. The open/unrestricted/flexible visitation allows for visitation during anytime of the day. Scheduled/restricted is where times are set, and visitation can only occur within that time limit. Most of the visitation policies that are being used have been formed by healthcare professionals with little or no consideration of patients or their family opinions and preferences, especially within specialised units such as a Burns ICU. The role of family centred care is important in such a unit due to the newly developed needs that the family and patient must adjust to as well as change in body image of most of the patients. The goal of a specialist burns unit is rehabilitation, starting from the patient’s day of admission which impacts directly on them and their family. Only one study was found, in the South African setting, with the title, “The Perceptions and Preferences of Patients, Family/Friends and Nurses on Visiting Time in ICU” by Ramnath (2007). Limited research has been carried out regarding the opinions and preferences of patients and family members of visiting practices in the ICUs, especially in the South African setting. With such limited opinions of visitation from non-healthcare professionals, it is important to explore what the patients and family views are on visitation practices. This exploration will lead to suggestions on how the current visiting practice can be altered if need be, therefore enhancing patient - family centered care.

Therefore, this study intends to identify the opinions and preferences of patients and family members in the Burns ICU with regards to visiting practices.

The research question was:

- What are the opinions and preferences of patients and their families regarding visiting practices in Burns ICU?

1.3 PURPOSE OF THE STUDY

The purpose of this study was to describe the opinions and preferences of family members and patients on visiting practices in the Burns ICU setting of a level 1 private sector hospital in Gauteng, South Africa.

1.4 OBJECTIVES

The objectives of the study were:

- To describe the opinions and preferences of family members and patients with regards to visiting practices in the Burns ICU.
- To identify the differences in the opinions and preferences of patients and their family members regarding visiting practices in the Burns ICU of a level 1 trauma private sector hospital in Gauteng, South Africa.

1.5 SIGNIFICANCE OF THE STUDY

In the Regulations Relating to the Scope of Practice of Persons who are Registered or Enrolled under the Nursing Act (No. 50 of 1978), it states that the nurse is to maintain optimum health for the patient and the family (Sanc.co.za, 1984). Having a family member admitted to the ICU induces immense stress on the family and the patient as their condition can or may change unexpectedly and there is an uncertainty of how long the patient will remain in ICU. This leads to the family adjusting their daily living around the restricted practices. With rehabilitation being an important factor in a patient's recovery especially in a specialist Burns ICU, family and patient centred care is often not a main priority. Limited knowledge surrounds the preferences of visiting practices of the family and patient, as the current visitation practices have been developed by the opinions of only the healthcare professionals. This study is significant as it intends to determine what the opinions and preferences are of the family members and patients are regarding visitation practices in the Burns ICU. It is also hoped that in the future, any suggestions made by the family and patients in this study will be used when reviewing visitation practices for the Burns ICU.

1.6 OPERATIONAL DEFINITIONS

Definitions for the purpose of the study are as follows:

- **Family**

Family is a legal, biological or emotional relationship that a patient identifies with (Bishop, Walker & Spivak, 2013). In this study, family refers to immediate family members such as parents, spouses, siblings, children of the patient and close friends in the case that the patient does not have any family.

- **Intensive Care Unit (ICU)**

A section of a hospital where special medical equipment and services are provided for patients who are critically injured or ill (Merriam-webster.com, 2019). This study intends to use the specialized Burns ICU.

- **Level 1 Trauma Hospital**

A comprehensive tertiary care facility that is able to deliver complete care for all injuries form prevention to rehabilitation. (Braintrauma.org, 2019).

- **Open Visitation**

A non-specified visiting time and duration (Ismail and Mulley, 2007).

- **Opinion**

A personal view not necessarily based on fact or knowledge (South African Pocket Oxford Dictionary, 2002).

- **Patient**

A person receiving or registered to receive medical treatment (South African Pocket Oxford Dictionary, 2002). For the purpose of this study patient refers to all patients that are admitted or have been admitted to the Burns ICU.

- **Preference**

A greater liking for one alternative over another or others (South African Pocket Oxford Dictionary, 2002).

- **Private Sector**

The part of a country's economic system that is run by individuals and companies, rather than the government (WhatIs.com, 2019). In this study private sector refers to a non-operated government hospital.

- **Restricted Visitation**

Visiting time and duration is already specified (Ismail and Mulley, 2007).

- **Visiting**

To go to see or stay at (a place) for a particular purpose (such as business or sight-seeing). (Merriam-Webster.com Dictionary*,* Merriam-Webster, 2021). Visiting relating to this study is a practice where friends and family can see and spend time with the patient in the ICU.

1.7 OVERVIEW OF THE RESEARCH METHODOLOGY

This study used a quantitative, non-experimental, descriptive, and cross-sectional design. An already developed questionnaire by Ramnath (2007), titled “Preferences and Perceptions of Patients, Family/Friends and Nurses on Visiting Time in ICU” was used for data collection, to describe the opinions and preferences around visiting practices of family members and patients of the burn’s ICU. Non-probability sampling was the choice of sampling for this study.

Ethical clearance and permission to conduct the study were obtained from the university’s relevant committees, the private sector hospitals research operations committee and from the hospital manager as well as the Burns ICU unit manager. Participation was completely voluntary, and participants could withdraw at any point in time. Once permission was achieved from the hospital and unit manager the questionnaires were provided to patients and family members once they had read through the information letter and informed written consent was obtained.

The setting was in a burns ICU of a level 1 trauma private sector hospital which has a total of eight beds. Six to eight patients per month are admitted to the unit, as counted in the admissions book. Descriptive and inferential statistics was used, with the help of a biomedical statistician who was consulted to assist with the analysis and interpretation of the data collected.

Reliability of the study was maintained by ensuring that the data collection is consistent. This was be achieved by complying with the data collection questionnaire. The researcher was the sole data collector throughout the study. Only the researcher and supervisor viewed the raw data collected. Validity was ensured by selecting a large sample for the study. It was also be ensured through established validity as the questionnaire has been used before.

1.8 OUTLINE OF THE STUDY

The outline of the study will be presented as follows:

Chapter One:	Outline of the study
Chapter Two:	Literature Review
Chapter Three:	Research design and methods
Chapter Four:	Results of the study
Chapter Five:	Discussion of findings, conclusions, and recommendations

1.9 SUMMARY

This chapter supplied an outline of the research study. The problem statement, purpose of the study, the research objectives and significance of the study were described. Operational terms were also provided. A brief outline of the study and its research methodology, validity and reliability and ethical procedures were given.

The next chapter will provide a detailed review of the literature.

CHAPTER TWO
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews different studies carried out on visitation policies, types of visiting, patient and family involvement, barriers and benefits to visiting, the history of visitation and visiting in the Burns ICU.

2.2 THE HISTORY OF VISITATION

During the 1700s and 1800s the majority of hospitals had very little restrictions when it came to visiting a patient (Ismail & Mulley, 2007). By the 19th century, the regulation of visiting was more apparent (Mooney & Reinarz, 2020). The restrictions on visitation were most apparent during the 1980s and 1990s (Ismail & Mulley, 2007). The regulations were implemented as the hospital staff thought that visiting carried a large risk of infection and therefore could hinder the patients' recovery (Mooney & Reinarz, 2020). They also felt the requests and disruptions made by the visitors could affect the smooth running of the wards and impose on the privacy and confidentiality of the patients (Ismail & Mulley, 2007). The regulations were also enforced to maintain the hospitals well-ordered identities and minimize disruptions in the wards. These visiting hours varied from one hour during the day to one visitation a week or sometimes not at all, to limiting the number of visitors at the patient's bedside and to prevent unwanted goods such as illegal items entering into the healing hospital environment. During 1944 the UK Medical Research council advised all visitors to children's and isolation hospitals to wear face masks and protective gowns to prevent cross infections (Mooney & Reinarz, 2020).

In the critical care units of today, the visiting policies have originated from practices implemented in the 1960s, where the first intensive care settings were developed. Due to the lack of information about the effects of visiting on the patients and their families, strict restrictions on visiting were implemented as a reflection of this concern. Although the studies carried out in the 1980s and 1990s showed large positive outcomes towards open or less restricted visiting in the adult ICU setting, most of the intensive care units still implemented restrictions on the frequency of visits, the duration of the visits as well as the number of visitors allowed and their ages (IPFCC, 2021).

2.3 DEFINITIONS AND CLASSIFICATIONS OF VISITING

Ismail and Mulley (2007) have what seem to be the closest descriptions for open, restricted and flexible visiting hours. Open visiting is the ability to visit the patient at any time of the day and with the visit being of any duration. Normally ICUs have a limit on the number of visitors but open visiting moves away from this concept (Ning & Cope, 2020). Restricted visiting is defined by the rules set on the time visiting starts and ends, the duration of the visit, the number of visitors who are allowed to visit and who is able to visit during those set rules. Visiting hours that have some restrictions but that can be easily altered according to the patient and family circumstances, needs and choice is known as flexible visiting (Ismail & Mulley, 2007). Years of research have been carried out and is still being performed, yet there still remains a discontinuity across the world with regards to which is the best visiting practice is best and most favoured (Ning & Cope, 2020).

2.4 PATIENT AND PATIENT-FAMILY CENTERED CARE

In recent years the ICU advocates are moving away from only patient-centered care and making it known that patient-family centered care is the best practice (SCCM | ICU Liberation Bundle (A-F), 2021).

Patient-centered care is the focus of only the individual patient preferences and thus means providing care to those patients that meets all their needs. Within this patient-centered care, the patient’s values are taken into consideration to assist in all clinical decisions as well as maintain and provide respectful care to their individual wants (SCCM | ICU Liberation Bundle (A-F), 2021).

According to the Society of Critical Care Medicine’s ICU Liberation Bundle (2021) patient-family centered care is a combination of many characteristics. Some of these characteristics include the following:

- Actively involving the patients and their family members in decision making of the treatments or care needed
- Constantly keeping the patients and their family members informed and up to date
- Continuously involving both the patients and their families in their own self-management, where possible
- Providing emotional support and comfort to not only the patient but their family members too as they are treated as unit and not separate entities
- The cultural and religious beliefs of the patient as well as their wishes and concepts towards their condition need to be maintained with a clear understanding at all times.

In order to be able to meet all these characteristics identified, open or flexible visitations need to be implemented and maintained to prevent social isolation of patients and their family. Efforts in improving family comfort, having daily family meetings with the multidisciplinary team, with discussions of current treatment and future care as well as encouraging shared decision making, has a positive effect on all the parties involved (SCCM | ICU Liberation Bundle (A-F), 2021).

By allowing the patient to have their family around them during their time of need, this made possible by flexible visitation, the patients and their family members gain great benefit and the patients' recoveries are often quicker, smoother and easier. A few of these benefits that lead to better patient and family outcomes include decreased anxiety, depression, confusion and restlessness. The patients ICU stays are drastically decreased and cardiovascular complications are reduced due to decreased stressful factors (SCCM | ICU Liberation Bundle (A-F), 2021).

Through the involvement of the patients and their families and focusing on patient-family centered care, during both the ICU stay and the recovery, there is increased satisfaction due to the support and the sense of safety and security provided (SCCM | ICU Liberation Bundle (A-F), 2021).

Through the years of visitation there have been many objections that have prevented open/unrestricted visiting. Some of these objections included infection risks, disruption of patient care, imposing of confidentiality as well as increased stress, for not only the patient but also the family members. In recent years it has been found that there is no conclusive evidence for limiting family visiting in the ICU setting (Giannini, Garrouste-Orgeas & Latour, 2014).

The Italian National Committee for Bioethics has acknowledged and made a point of raising the importance of liberalising visiting policies, as they are consistent in keeping and adhering to the principles of autonomy, respect, beneficence and non-maleficence of the patient and their family (Giannini, Garrouste-Orgeas & Latour, 2014).

2.5 THE IMPORTANCE OF FAMILY INVOLVEMENT

It has been found that because families have not been a focus during a patients ICU stay, some of the patients' relatives frequently develop depression, increased anxiety and even post-traumatic stress symptoms (Giannini, Garrouste-Orgeas & Latour, 2014).

A study carried out by Fumis, Ranzani, Martins & Schettino (2015), in a tertiary private teaching hospital in Brazil, found that more family members tend to suffer from emotional disorders such as anxiety, post-traumatic stress symptoms and depression, compared to the patient. The study also found that religious beliefs had an important protective role in preventing or lessening the severity of the development of these disorders. It was identified, and in line with other studies, that people with strong religious beliefs were better able to cope and had a greater acceptance of the stressful environment, rather than succumbing to and suffering from anxiety and other disorders (Fumis, Ranzani, Martins & Schettino, 2015).

A study conducted in a Neuroscience ICU in Atlanta, America, focused on the needs of patients' family members in an intensive care unit with continuous visitation (Jacob, Horton, Rance-Ashley, Field, Patterson, Johnson, Saunders, Shelton, Miller & Frobos, 2016). The main needs that were highlighted by the family members were being able to talk with a doctor every day and being assured that the best course of care was being given to the patient, through continuous information being continuously provided and discussed. This lead to the necessary information, support and comfort given to family members involved (Jacob et al., 2016).

The continuous visitation policy has been allowed in this Neuroscience ICU since 2007. The setup of this ICU differs to almost all ICUs worldwide as this visitation policy allows family members to be at the patient's bedside 24 hours a day. It also provides these family members with a family suite close to the patient's room. The room is equipped with chairs that are able to change into beds, a table, sink, a telephone and television as well as internet access. The policy also allows for four family members to be at the patient's bedside during the day. The slightest and only restriction is that only two family members are allowed to remain at the bedside throughout the night (Jacob et al., 2016).

The family members are given the choice to remain at or leave the patient’s bedside while any procedure, including invasive procedures, are being performed. If the family members wish to stay for the procedure, they are encouraged to be present and participate where applicable. They are also encouraged to participate during shift change and medical team rounds. This allows them to be continuously updated on the patient's condition. During emergency situations, such as resuscitations, a member of the nursing staff and/or a hospital chaplain remain with the family continuously providing them with updates and explanations of the procedures performed (Jacob et al., 2016).

To assist with the participation in the patient's care throughout their stay, as well as the adjustment of hospital routine, the family members are provided with a family coordinator who is trained to provide information and support (Jacob et al., 2016).

Through this study, the continuous visitation policy practiced in the hospital and the examples explained, met the needs identified by family members more frequently than compared to other studies. These needs were interactions with a doctor at least once a day, having a place for some alone time in the hospital as well as chaplain services and assisting in financial services (Jacob et al., 2016).

It was however noted that even though the family participated or were present during rounds, some members felt they needed one on one time with the doctor, therefore indicating that rounds may not always be the best way for doctors to communicate with family members and vice versa (Jacob et al., 2016).

When a patient is admitted with a severe burn injury it is not only the patient that has suffered but their family members tend to suffer as well. With this in mind Bayuo & Wong (2020) have said that burns needs to move from patient centered care and include family centered care as the family play a major role as informal carers for the injured burn victim.

The family members often experience strong emotions of guilt, anxiety, stress and fear, with these emotions and more persisting throughout the patient's hospitalisation. While the family members are trying to deal with their own emotions they may also be needed to participate in the patient's care throughout their burn injury management. This adds even more pressure and stress to the family members than they are able to cope with (Bayuo & Wong, 2020).

In the study conducted by Bayuo & Wong (2020) it focused on identifying the issues and concerns of family members of patients who have suffered burn injuries. The most forthcoming issue found was the visiting policies of the healthcare institutions. As the visiting policies appeared inflexible, the family members found it difficult to make it to the institution on time due to them having to drive far distances, as well as them having the feeling of limited communication. The relatives felt that the staff focused more on the patient and during visiting time the staff gave the relatives space to spend time with the patient rather than supporting and thoroughly updating them on the patients’ condition. In the case of the awake patients, the patients were expected to pass their information onto their relatives. The relatives also felt that they needed to be with the patient more often to provide more hands-on care to the patient but due to visiting hours, this kind of care was limited (Bayuo & Wong, 2020).

The other issue raised was the lack of support the relatives experienced during the patients admission for their burn injuries. They found it was difficult to adjust to the new body image of the patient but at the same time needing to re-establish their emotional connections. They were unsure how to understand and express their emotions while at the same time having to support their admitted relative throughout their care. As the healthcare staffs' main focus was on the patient the family members were often unable to convey their thoughts and distress (Bayuo & Wong, 2020).

As burn injuries occur so suddenly and without warning, family support is just as big a need as the care of the patient. Just as the needs of the injured patient differ throughout their care so does the needs and concerns of the family. Therefore as Bayuo & Wong (2020) have identified that if family members of burn victims are provided support and supported through most, if not all of their psychosocial, psychological, role change and financial roles, burn survivors may in turn also receive better support and care from their relatives.

During their often tedious recovery, patients with burn injuries consider support from their relatives vital to their recovery and even consider their psychosocial needs greater than their physiological needs (Bäckström, Willebrand, Sjöberg & Haglund, 2018).

Family centered care is where the patient admitted has a family unit who also need support and care from healthcare workers in order to positively contribute to and are included in the recovery plan (Bäckström, Willebrand, Sjöberg & Haglund, 2018).

ICUs should be the frontline of developing ways to identify and meet the family members' needs. It has been found, in prior research, that nurses are prone to misjudge the importance of their role towards assisting the needs of the family as well as underestimating the needs of the family of the critically ill patient (Bäckström, Willebrand, Sjöberg & Haglund, 2018).

Healthcare workers for the most part tend to focus on the injured burn victim and rely on or expect the patient to discuss important information of their care with their relatives, rather than interacting with the family directly. In this sense family members felt their time in the specialized care unit was impersonal and they experienced a lack of information and a feeling of rejection from the staff. These feelings brought forward by family members also contributed towards experiences of inflexibility towards visiting hours, a lack of acknowledgement from the staff of their difficult situation and feeling like a burden when spending time with the patient (Bäckström, Willebrand, Sjöberg & Haglund, 2018).

The feelings of neglect were worsened as the support provided by the social workers was primarily directed towards the patient and family were often advised to seek support elsewhere (Bäckström, Willebrand, Sjöberg & Haglund, 2018).

In the study done by Bäckström, Willebrand, Sjöberg & Haglund (2018) all the family hoped for from the healthcare workers was proactive and individualized support instead of inflexibility and negative attitudes towards visiting hours. The family members did occasionally feel supported was when a staff member went above and beyond in the care towards the family and not only the patient. The examples where the latter was supported was when health care workers validated with how the family were feeling or when the healthcare member and family were of the same or similar religious beliefs (Bäckström, Willebrand, Sjöberg & Haglund, 2018).

Allowing the family to be part of the patients care allows the relatives not only to be supported during the vulnerability and involvement of care, but also allows the family to be close to the patient and observe the patient's care and therefore placing confidence in the care the patient receives. The support and participation in care that the critical care staff provides is important for the family members' well-being and their ability to contribute effectively to the patients care (Blom, Gustavsson & Sundler, 2013).

Patients who have suffered from burn injuries require a complex plan for recovery and rehabilitation. As the plan is so complex all factors need to be included, balanced and integrated to provide the best care possible and achieve the nearest to normal quality of life for all involved. These factors are physical, emotional, psychological and societal influences (Bishop, Walker & Spivak, 2013).

If a family member is present during a burn victims dressing change, in the intensive care unit, a great opportunity is provided to educate them on how to carry out the procedure for post discharge, if needed, and it allows them to be included in the care delivery of the patient. By including the family member in the patients care, part of the anxiety that they feel is alleviated (Bishop, Walker & Spivak, 2013).

One of the biggest factors contributing to not only the families but also the patients anxiety, is the fear that healthcare providers withhold important information when it comes to their care. Patients and their relatives feel it is their right to be given the option to be able to have a relative present during procedures the patient will be subjected to. Allowing relatives to be present during a procedure, especially dressing changes of the burn wounds, helped to greatly reduce the patients pain and anxiety compared to those patients that did not have a relative present (Bishop, Walker & Spivak, 2013).

Families that consist of members that provide support as well as those who have important bonds are a fundamental and an extremely important part of society (Netzer & Iwashyna, 2017).

A study carried out in Ghana on the beliefs and attitudes of visiting in the ICU found that most of the family members believed that open visiting was valuable and had a positive effect for the patient, but identified that it could also alter the patients recovery. The negative outcomes identified by the family members included that the privacy of the patients would be affected but also that the patients needed rest in order to prevent psychological distress. The positive aspects identified showed that the relatives knew that visits were helpful for the staff as well as contributing to the improvement of patient-centered care as more opportunities arose for education and more family involvement in care (Yakubu, Esmaeili & Navab, 2019).

These opinions appear to be affected by Ghanaian cultural tradition, where families of multiple generations live together in the same compound. This includes grandparents, parents and children all sharing in personal and private, good and difficult times. This could be a factor contributing to the patients rest and recovery as there would be more than one family member coming to visit. In continuing with cultural beliefs, the family members indicated that in line with spiritual and superstitious beliefs not all relatives had the patient's best interests at heart. They further went on to say that although they wanted opening visitation, there should be a limit on the number of people allowed to visit as well as a set start time for visitation should be set but no end time, therefore adjusting to the needs of the patient and relatives (Yakubu, Esmaeili & Navab, 2019).

A new law passed in Switzerland grants family members of patients, without the capability to make decisions, a central role in the decision making towards the patients care. Therefore opening visitations would allow the relatives of the patients to be actively involved in their care and treatment, as well as providing better interactions between healthcare providers, the patient and family members (Di Bernardo, Grignoli, Marazia, Andreotti, Perren & Malacrida, 2015).

2.6 NURSES PERCEPTIONS TOWARDS VISITING

It has been identified that healthcare professionals often feel uncomfortable examining a patient in front of a family member and felt that they were under extra pressure and afraid to make an error with the family present. The staff also felt that they had extra responsibilities on top of their already tightly planned routine by carrying out the many more requests made by the family members, therefore identifying it as more as a burden. This raises the issue that staff require communication training in order to be better equipped to communicate with family members who are present in the ICU for long periods of time (da Silva Ramos, Fumis, Azevedo & Schettino, 2013).

Nurses are taught the importance of the family aspect of patient centered care but although the knowledge is there, it is rarely practiced in todays' health care (Blom, Gustavsson & Sundler, 2013).

The nurses and doctors working in a Burns ICUs were asked how they felt about the presence of a family member during the burn wound dressing changes and other procedures. They both voiced concerns about being judged during the dressing changed and also about the family members ability to tolerate seeing the raw wounds. With these concerns raised, the staff were also able to acknowledge that the integration of patient and family education during such procedures, as well as the rest of the patients' care was imperative to improving the patients recovery outcomes (Bishop, Walker & Spivak, 2013).

A study conducted by Athanasiou, Papathanassoglou, Patiraki, McCarthy & Giannakopoulou (2014), on the nurses perspective of family visitations in Greek

ICUs, found that nurses felt open visiting does not give the family members any more information or support with regards to the patients' condition compared with restricted visitation. The nurses did however acknowledge that the patients were emotionally supported, their boredom reduced and their will to live was increased by their family visiting. It was also found that the nurses felt the outcomes of the visits depended on the personalities and relationships of the patients and their families. Most of the nurses who partook in the study said that visiting, especially open visiting, obstructed the planning of nursing care as they spent more time talking to the family than looking after the patient. The nurses did recognize that flexible visitation was of benefit to the patient and the family but they were in favour of restricted visiting for the benefit of the nurses. On this note, nurses who worked more than their 15 allocated shifts had more negative beliefs and attitudes towards visitation. However, if the ICU as adequately staffed, the more open they were towards open visitation. The nurses further went on to say that they felt they were not adequately qualified to interact with the families. They also said that this placed a large burden on them and that only in the event where the patient was deteriorating in condition did they make exceptions to the visit (Athanasiou et al., 2014).

2.7 BENEFITS AND BARRIERS TO VISITING

As more studies are being conducted with regards to open visiting practices, more evidence is suggesting that open visiting has been found to be very beneficial. These benefits include increased patient and family satisfaction, reduced anxiety and depression as well as decreased frequency and duration of ICU delirium (Ning & Cope, 2020.).

Restrictive visiting makes many family members feel as if they are being excluded from their loved ones during their time of need. The families that suffer and feel the most affected by restricted visiting hours include those that cannot get time off from work, due to lack of job flexibility, for the scheduled visiting session as well as those with few economic resources or means to finance or find additional daycare and caregiving (Netzer & Iwashyna, 2017).

If visiting hours are kept unrestricted, a major benefit is that the family are able to contribute towards the therapies and other important matters that the patient may be unable to contribute towards. They will also be able to be the voice for the patient and a constant advocate of the patients' values and wishes, even in their end-of-life decisions (Jordan, 2014).

A barrier towards open visiting practices is that the healthcare professionals may have an increased workload as now they are not only caring for the critically ill patient but are also caring for the family members and their needs during such a stressful and possibly life changing time. As a result of the increase in the healthcare workers workload there may be delays and suboptimal performances in their duties (Jordan, 2014).

Family members visiting ICU patients find their presence fundamental in improving the safety and comfort of their loved one by contributing in a large way to the patients care. The patients reported feeling less vulnerable as their relatives provided adequate amounts of reassurance as well as having a calming effect on their current stressful situation (Di Bernardo et al., 2015).

Health care providers on the other hand tend to underestimate the positive effect family members have and the help that they are able to supply. Health care staff have identified that at times talking to the family about the patient is an intrusion, whereas the family and patients disagree, saying that it is beneficial to the care of the patient (Di Bernardo et al., 2015).

2.8 SUMMARY

This chapter presented a summary on the literature on the topic of this study. Previous research studies were looked at and the results and recommendations were highlighted.

An overview of the history of visiting, patient and family centered care, the importance of family involvement, the nurses view points on visitation and the barriers and benefits of visiting were discussed.

The next chapter will outline the research methods and design used in this study.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter will discuss, in detail, the research design and methods used to carry out this study, and how the objectives are reached. The research objectives, study setting, population and sample will be discussed as well as the data collection process, data analysis and ethical considerations used in this study.

3.2 AIM AND OBJECTIVES OF THE STUDY

The purpose of this study was to describe the opinions and preferences of family members and patients on visiting practices in the Burns ICU setting of a level 1 private sector hospital in Gauteng, South Africa.

The objectives of the study were:

- To describe the opinions and preferences of family members and patients with regards to visiting practices in the Burns ICU.
- To identify the differences in the opinions and preferences of patients and their family regarding visiting practices in the Burns ICU of a level 1 trauma private sector hospital in Gauteng, South Africa.

3.3 RESEARCH DESIGN

Research design can be explained as the steps taken during the research process to reach the results and expected outcomes of the conducted study (de Vos, Strydom, Fouchè & Delport, 2011). Therefore the steps chosen for the research design and methods need to be selected sensibly in order to achieve the purpose of the study and the research questions with the available resources. This study used a quantitative, non-experimental, descriptive and cross-sectional design. This method allows the researcher to represent a larger population by describing the themes presented, by the anonymous respondents, and drawing conclusions from the sample data collected (Brink, van der Walt & van Rensburg 2018).

3.3.1 Quantitative

Quantitative research examines and uses measurable variables to identify relationships between the variables and provide sufficient evidence regarding the research problem in a controlled manner (Brink, van der Walt & van Rensburg, 2018). The researcher identifies a research problem based on the trends in the field or the need to explain why something occurs. Objective theories are tested through determining the relationship between variables and these relationships are provided in a numeric representation of trends and opinions. These numerical representations of data, collected and measured using instruments, can be analysed statistically (Creswell, 2012). This study used graphs and tables to illustrate and show the trends in the data collected.

3.3.2 Non-experimental

In a non-experimental design no manipulation of any variables is made (de Vos, Strydom, Fouchè & Delport, 2011). Therefore the researcher is able to collect data without controlling the action of the variables being studied (Brink, van der Walt & van Rensburg, 2018). This study used a quantitative non-experimental design. Data was collected by the researcher without any manipulation of independent variables or interventions being introduced.

3.3.3 Descriptive Design

Descriptive design gathers information from the chosen sample, in the form of a questionnaire or survey, without identifying any causes or effects (Brink, van der Walt & van Rensburg, 2018). Therefore this is a descriptive design, using a data collection survey instrument, to describe the opinions and preferences of patient and family members in the Burns ICU. According to Polit & Beck (2012) also describes the relationship between variables within which the phenomena may have previously been studied. The data was collected between December 2019 and August 2020.

3.3.4 Cross-sectional Survey Design

Cross-sectional survey design examines current attitudes, beliefs, opinions, or practices to acquire information (Creswell, 2012) on one occasion or point in time with different participants (de Vos, Strydom, Fouchè & Delport, 2011). This study used a randomised cross-sectional design to identify and analyse the preferences and opinions of visiting hours of the patients and family members in the Burns ICU.

In this study the respondents, patient and family members, were given a self-administrated questionnaire. Questions were asked in typed or written form and thus the answers needed a written response as well.

3.4 RESEARCH SETTING

The research setting is the specific area where the data is collected (Brink, van der Walt & van Rensburg, 2018). The study was conducted in the Burns ICU of a level 1 trauma private hospital in Gauteng, South Africa. The ICU is an eight bedded specialty unit and has its own operating theatre within the unit. The beds are separated and isolated and each bed is in its own room, with each room containing its own glass doors, ventilator, infusion pumps, heater, patient monitoring device, scaled bed, a hand basin and shower hose. All equipment is the most modern and up to date with regards to technology. It is an adult unit admitting mostly those over the age of 18 years but occasionally children over 12 years are admitted as they are

treated as adults. Depending on the severity, depth, size and location of the burn injuries as well as the discretion of the admitting trauma doctor, patients with a total body surface area above 10% are admitted to the unit. All burn injuries from chemical; veld fires; hot water; petrol; gas explosions; domestic abuse, building fires, aircraft and electrical are treated in this unit. Not all patients admitted to the Burns ICU require mechanical ventilation but the non-ventilated patients need close monitoring, provided by the ICU, due to their high risk of infection. On average the unit admits six to eight patients per month as counted in the admissions book. Although there are many private paying patients that are admitted to this unit as many, if not more, are admitted under workman's compensation. The average length of stay varied, depending on the severity of the burn wounds. It varied between two weeks to two or more months. A multidisciplinary team approach is used in the care and recovery of the patients. The team consists of a dietitian, physiotherapist, occupational therapist, psychologist, relevant doctors and nurses.
The nurse patient ratio in the Burns ICU is 1:1. This ICU is the only one of its kind within the private sector in Gauteng, South Africa.

3.5 RESEARCH METHODS

Research methods can be explained as the systematic steps taken by the researcher to collect data relevant to the research study (Brink, van der Walt, & van Rensburg, 2018). These steps include identifying the population, sample, sampling methods, data collection and data analysis. The mentioned steps will be discussed comprehensively.

3.5.1 Population

Population is a group of individuals that are relevant to the research study (Burns, Grove & Gray, 2014). The total population for this study were the patients admitted to the burns ICU and their family members. The population for this study consisted of all the family members and patients in the only private sector Burns ICU in South Africa.

3.5.2 Sample and Sampling Methods

Sample method is used to define a small percentage, known as the sample size, which represent the total population without bias (Brink, van der Walt & van Rensburg, 2018). The study used non-probability convenience sampling in order to select the willing participants for the study. Non-probability convenience sampling indicates that not every component of the population will have an opportunity to be selected in the sample but the readily available participants are asked to participate (Brink *et al,* 2018). Convenience sampling was used in order to select the willing participants for the study. Not all patients received visitors during the time of data collection and others were heavily sedated and ventilated. For this study a total sample of N=51 participants were available for recruitment and used in this setting.

The study's inclusion criteria were as follows:

- All family members that visited with a relative in the Burns ICU for more than 48 hours.
- Patients that were admitted in the Burns ICU for more than 48 hours, who must have had visitors, were fully conscious and well orientated.
- Provided consent was obtained.
- Participants were over the age of 18 years.

3.6 DATA COLLECTION

Data collection depends on the research design and methods aimed at achieving the study objectives. Therefore it is the process used to collect the data needed in a research study (Burns, Grove & Gray, 2014). This study used a self-administered questionnaire to collect data which was handed to the consenting participants by the researcher only. The instruments, validity and reliability and the procedure used to collect data will all be elaborated on in the next paragraphs.

3.6.1 Instrument

The instrument used for data collection was a questionnaire developed by Ramnath (2007) titled *"Preferences and Perceptions of Patients, Family/Friends and Nurses* *on Visiting Time in ICU".* Permission to use the tool was obtained from the developer (Appendix G).

The instrument consisted of three questionnaires, each individualized for the patients, the family and the nurses respectively. All questionnaires contain closed and open-ended questions. In this study only the patient and family members were given their individualized questionnaires. Nursing staff were not included in this study.

The patient questionnaire (Appendix A) consisted of a section A containing three demographic questions. These questions included age, gender and religious denominations. Section B containing eleven questions relating to the patients stay in ICU. Section B asked about the patients stay in the Burns ICU. It consisted of multiple choice questions of:

- What they would have preferred from their visitors regarding length and duration of visit
- If they wanted their visitor to leave and the reason
- How they experienced the nursing staff attitudes towards their visitor
- Which type of visitation hours they would have preferred

The follow-up open-ended questions asked how the patients felt about their visits, to elaborate on their answers, providing reasons as to why they wanted their visitors to leave, why they had the preference to the length and duration of the visit as well as asking what their visitors could do form them that the nursing staff couldn't.

The family member questionnaire (Appendix B) consisted of a section A containing four demographic questions. These demographics included, age, gender and religious denomination and whether the visitor was a family member or friend. Section B containing fourteen questions related to their experience of their visit to the patient. Section B consisted of multiple choice questions including:

- If they were allowed to visit the patien
- If they felt their visit important to the patient
- What the patient required or preferred from them
- If they were informed of the visiting time in the Burns ICU
- Were they asked to leave

- Was a reason given as to why
- If the reason was appropriate
- If they assisted the nursing staff or if the nurses wanted them to leave.

The follow-up open-ended questions asked the family members to elaborate on some of their reason for choice in the multiple choice questions. Section C contained eight questions around their perceptions of visiting hour practices. Section C contained a five-point Likert scale of strongly disagree to strongly agree.

The questionnaire aimed at understanding the perceptions, experiences and feelings around visiting practices (Ramnath, 2007). The questionnaires used were appropriate for this study as it had already been used in South Africa, but had not been used in a specialised Burns ICU.

Once permission from the authors had been granted the questionnaires were given to the respective participants in the Burns ICU to determine their opinions and preferences towards visitation practices.

3.6.2 Validity and reliability of the instrument

Reliability is the uniformity and stability in results that are produced when an instrument has been used (Creswell, 2012). Validity is the evidence identified that shows that the interpretations from the tests used complement its suggested use (Creswell, 2012). Reliability and validity of the “Preferences and Perceptions of Patients, Family/Friends and Nurses on Visiting Time in ICU” questionnaires were developed in South Africa and assessed by the developers in the sample of the original study. The sample size used for the patients was 39 and 46 for the family members (Ramnath, 2007).The developers tested for content validity by performing a pre-test on the instrument by using two subjects for each category. There were two experts from each of the critical care units who assessed the tool for content and face validity. The final tool was compiled based on the experts’ recommendations. There were no modifications made on the original questionnaire. Content validity was used as the questionnaires had been tested and used in a previous study by Ramnath (2007), *Perceptions and Preferences of Patients, Family/Friends and Nurses on visiting time in ICU.* Face validity was determined by the participating family members and patients being asked if all questions were clearly worded and understandable so as not to be misinterpreted.

3.6.3 Procedure

Approval and permission to use the questionnaires (Appendix A and B) in this study was obtained from the original author (Appendix G). Permission was sought from the university post graduate and ethics committee as well as the necessary hospital management (CEO, the private hospitals Ethics Committee, Nursing Services Manager, Medical Director and Nursing Unit manager of the respective ICU).

Once approval and permission had been granted from the above mentioned, the researcher presented an information letter (Appendix C) to the willing participants to read through. Both the university's post graduate and ethics committees indicated that a written consent was not needed for this study because the act of the participants completing the questionnaires was an indication of given consent. Although a written consent form (Appendix D) was not required, one was provided to those willing participants who requested it once having read through the information letter. On obtaining consent the questionnaire was then given to the participants in the Burns ICU.

The researcher collected data outside of working hours, after visitation and not in her nurses' uniform. While the questionnaires were being completed the researcher remained in close contact with the participants to assist in answering any questions that arose at the time of completion of the questionnaires. The researcher was contactable, via telephone at all times during data collection should the participants have had any queries relating to the questionnaires. All data collected was handled confidentially as only the researcher and the researchers' supervisor had access to it. This was stated in the information letter. All participants were assured of confidentiality and anonymity. Anonymity was ensured as each questionnaire had a number and no personal information from the participant was needed for completion of the questionnaires.

The completed questionnaires were posted into a sealed box in the unit manager's office for safekeeping and to protect the identity of the participants. Once all the questionnaires had been completed the sealed box was collected by the researcher and taken to the supervisors' office and placed in a locked cupboard for further safekeeping. The researcher only opened the box once all the questionnaires had been completed.

3.6.4 Data Analysis

This study used descriptive and inferential statistics. These statistics were used to analyse the demographic data and to identify the opinions and preferences of visiting hours of patients and family members.

- Excel was used in the data management. Data was checked for errors, missing values and duplicates.
- The program used in the data analysis was STATA version 15.0.
- The correlation coefficient test was used to determine similarities found in the data
- The chi squared test was used to determine any differences that occurred in the data.
- The demographic variables and the opinions and preferences were described in percentages and numbers.
- The descriptive statistics were represented as percentages and frequency and these were illustrated in graphs and tables.
- A statistician was consulted to assist with the analysis of the data collected.

3.7 ETHICAL CONSIDERATIONS

The following ethical considerations will be discussed under the headings of:

- informed consent;
- permission to conduct research,
- anonymity and confidentiality, as well as
- data security and management.

3.7.1 Informed Consent

An information letter (Appendix C) was provided to all willing participants. Once having read through the letter and agreeing to participate freely a written consent form (Appendix D) was provided for those participants who requested to sign. As per the post graduate and ethics committees of the university consent was given through the completion of the questionnaire for those who did not wish to sign the written consent form. The information letter explained the study in detail and emphasised that participation was completely voluntary, confidentiality and anonymity would be kept throughout and the ability to withdraw at any point without penalisation was clearly stipulated. Participants were informed of their rights to informed decision making, honesty, dignity, justice and safety and none of the above mentioned were disrespected during the study.

3.7.2 Permission to Conduct Research

The research protocol was presented to the Department of Nursing Education for peer review and to determine if the study would be practical to conduct. After being presented to the Department of Nursing Education, approval and permission to conduct this study was granted from the Faculty of Health Sciences Postgraduate Committee (Appendix H), the Human Research Ethical Committee (Medical) of the University of the Witwatersrand (Appendix F) as well as the Ethics Committee of the private hospital (Appendix I) were the study was conducted. In addition permission to conduct field work research was acquired and granted from the Hospital Manager as well as the respective Nursing Managers (Appendix J). Approval to use the research instrument was requested and granted from the developer of the questionnaires, Ramnath 2007 (Appendix G).

3.7.3 Anonymity

Anonymity was maintained by numbering the questionnaires ensuring no form of identification of the participants appeared. No names or information relating to the participants appeared on the questionnaires. Participants were informed that their identity and confidentiality would be protected throughout the study.

3.7.4 Confidentiality

The completed questionnaires were placed in a sealed box. To ensure confidentiality this box was placed in the unit managers' office. The researcher did not collect the questionnaires individually. Only the researcher and her supervisor had access to the completed questionnaires. The data will also be stored in the supervisors locked office cupboard for five years.

3.7.5 Data Security and Management

The researcher and supervisor were the sole viewers and managers of the data and kept the completed questionnaires in a locked cupboard in her office once collected from the participants and during data analysis.

3.8 VALIDITY AND RELIABILITY OF THE STUDY

3.8.1 Validity

Validity is the extent an instrument used in a research study performed, measured or evaluated that which it was intended to do (Burns, Grove & Gray, 2014). Validity was ensured by selecting a large sample for the study. It was also ensured through established validity as the questionnaire had been used before. No modification to the original study's methodology or instrument was made in this study.

3.8.2 Reliability

Reliability is the degree in which a research instrument can be relied upon to provide consistent results when used on comparable populations at different times (Brink, van der Walt & van Rensburg, 2018). Reliability was maintained in this study by making sure that the data collection was consistent. This was achieved ensuring the researcher was the sole data collector throughout the study and only the researcher and supervisor viewed the raw data collected.

3.9 SUMMARY

This chapter discussed the research design and methods used by the researcher to reach the study objectives. The research objectives, study setting, population and sample were discussed as well as the data collection procedure, data analysis and ethical considerations considered during this study.

The next chapter will present the results of the study.

CHAPTER FOUR

DATA ANALYSIS AND RESULTS

4.1 INTRODUCTION

This chapter describes the patient and family opinions and preferences of visiting in a Burns Intensive Care Unit, with the intention of identifying differences in the opinions and preferences of patients and their family. Recommendations for policy changes and education of staff members will also be made. This was achieved by a non-experimental, quantitative, descriptive and cross-sectional design. The population included all patients and their family members admitted to the Burns ICU setting of a level 1 private sector hospital in Gauteng, South Africa. Data was collected from a population sample of n=53 respondents with non-probability sampling used. Data was collected using a data collection tool (see Appendix A and B). Data was analysed using descriptive and inferential statistics, as described in chapter three. The statistical tests used in this study, included independent sample t-tests and Chi-Square analysis. Testing was done at the 5% level of significance ($p<0.05$). The findings on the scale, construct, study group and item analysis will be discussed in this chapter.

4.2 RESULTS AND FINDINGS

4.2.1 Descriptive Results

4.2.1.1 *Response Rate*

By the end of the data collection period of nine months (December 2019 to August 2020), 53 questionnaires were handed out and returned. Only n=51 of the questionnaires returned were used in the data analysis, for the study findings, as two of the questionnaires were defective as they were incomplete. This made for a good response rate of 96.2% (n=53). The study obtained responses from both the patients and the patients' families to investigate their opinions and preferences on Burns ICU visiting hours. From the population of n=51, n=24 were patients (47.1%) and n=27 (52.9%) were family.

4.2.1.2 *Nominal Data and Biographical Data*

This section of the patient (Appendix A) and family (Appendix B) questionnaires, describes the biographical data of the participants. This comprised of three questions for the patients and four questions for the family members.

As this study aimed to obtain the opinions and preferences of patients and family members regarding the visiting hours in the Burns ICU.

Question 1 (Appendix A) and Question 2 (Appendix B) were completed to identify the gender of the respondents ensuring fairness and accuracy in the research findings of both sexes.

Table 4.1 shows the number and percentage of patients and family members sex/gender in the Burns ICU.

Table 4.1 Sex / gender of the respondents

SEX	NUMBER OF PARTICIPANTS (n)	PERCENTAGE (%)
Male	25	51%
Female	26	49%
TOTAL	**n = 51**	

Figure 4.1 presents the results for **Table 4.1**

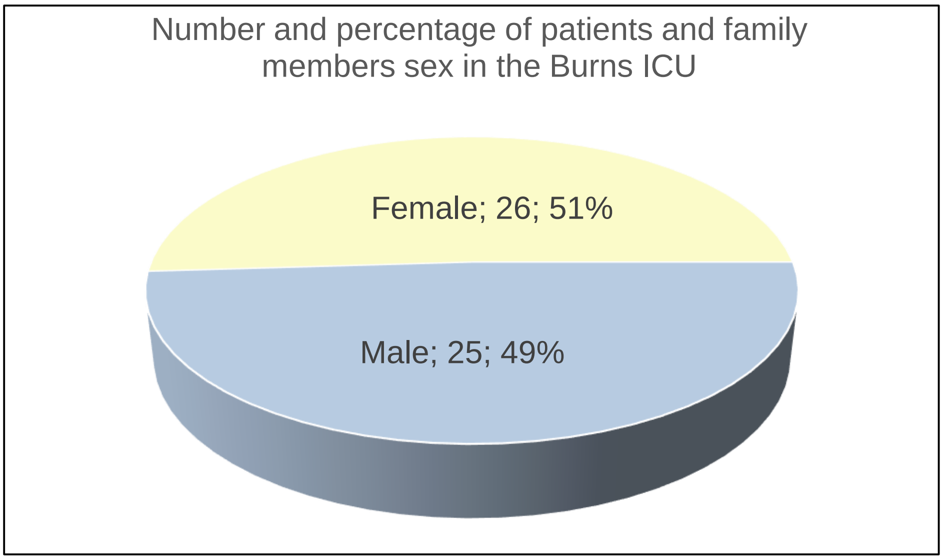


Table 4.2 shows the demographic data of the patient respondents.

Table 4.2 Demographic data of the patient respondents.

APPENDIX A	**PATIENTS**		
Q2	**Category: Age**	**Number Of Participants (N)**	**Percentage (%)**
	20-40	14	58.33%
	41-60	8	33.33%
	61-80	2	8.33%
	80+	0	0%
	N	**24**	
Q3	**Category: Religious Denomination**	**Number Of Participants (n)**	**Percentage (%)**
	Christian	21	87.5%
	Buddhism	0	0%
	Jewish	0	0%
	Muslim	0	0%
	Hindu	0	0%
	Other	3	12.5%
	N	**24**	

The results in **Table 4.2** show the age ranges and religious denominations of the 24 patient respondents:

- 58.3% were between the ages of 20-40 years,
- 33.3% of the respondents were between 41-60 years, and
- 8.3% of the respondents were between 61-80 years.
- There were no patient participants over the age of 80years.

The majority, 87.5% of the respondents, were Christians and 12.5% indicated they belonged to other denominations but chose not to disclose in the space provided.

Table 4.3 provides a summary of the demographic data of the family respondents.

Table 4.3 Summarises the demographic data of the family respondents.

APPENDIX B	**FAMILIES**		
Q3	**Category: Age**	**Number Of Participants (n)**	**Percentage (%)**
	20-40	10	37.0%
	41-60	9	33.3%
	61-80	6	22.2%
	80+	2	7.4%
	N	**27**	
Q4	**Category: Religious Denomination**	**Number Of Participants (n)**	**Percentage Frequency (%)**
	Christian	23	85.2%
	Buddhism	0	0%
	Jewish	1	14.8%
	Muslim	0	0%
	Hindu	0	0%
	Other	2	7.4%
	N	**27**	

The results in **Table 4.3** show the age ranges and religious denominations of the 27 family member respondents:

- 37.0% were between the ages of 20-40 years,
- 33.3% of the respondents were between 41-60 years,
- 22.2% of the respondents were between 61-80 years and
- 7.4% of the respondents were above 80 years.

The majority, 85.25% of the respondents were Christians, 14.8% were Jewish and 7.4% indicated they belonged to other denominations but chose not to disclose in the space provided.

The joint results of both the patient and family members' respondent ages are outlined in **Figure 4.2** in a histogram. This histogram shows that most of the respondents were aged between the age of 20 years and 40 years.

Figure 4.2

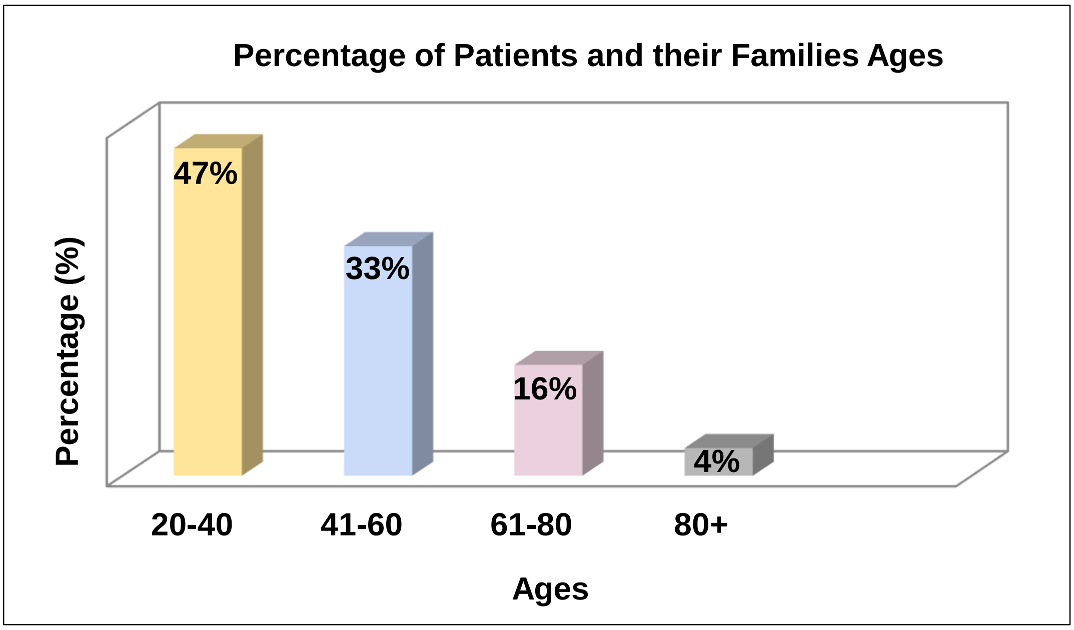
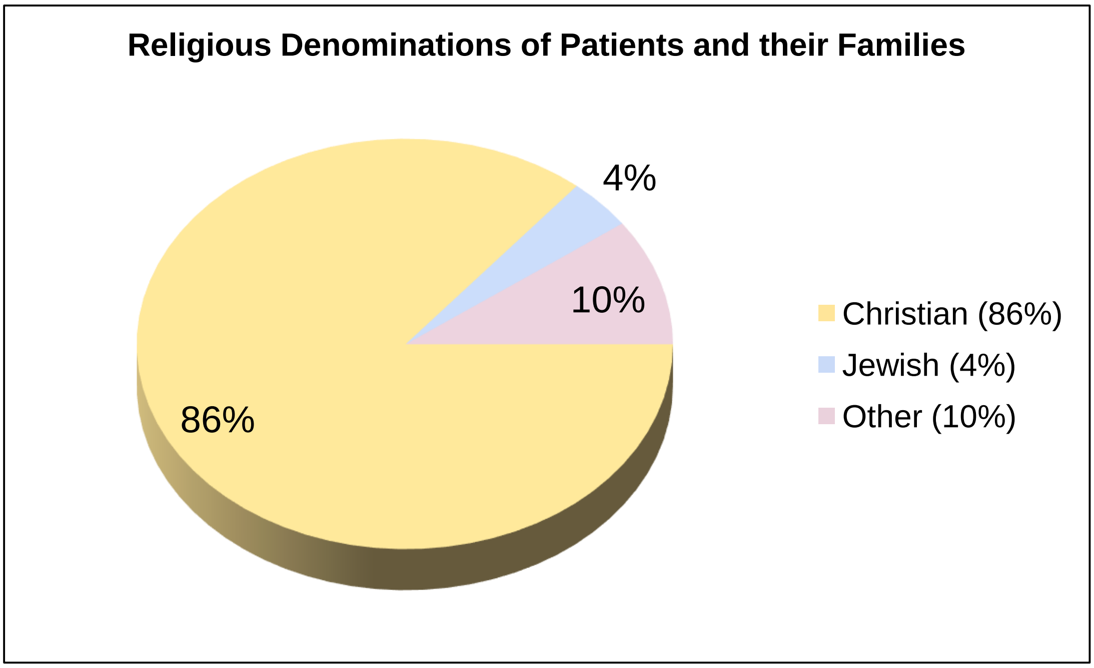


Figure 4.3 pie chart shows the combined results of the patient and family member respondents' religious denominations. The pie chart shows that the majority of the respondents were of the Christian denomination.

Figure 4.3



4.2.1.3 *Burns ICU Visits*

All the family member respondents had visited their relatives and all patient respondents had been visited by their family members, in the Burns ICU, prior to participating in the study and completing the questionnaire. This was evaluated in Question 4: “Were you visited by your family while you were in ICU?” of the patients questionnaire (Appendix A) and in Question 6: “Were you given the opportunity to visit the patient?” of the Family questionnaire (Appendix B). This made the response rate very high and accurate in order to continue with the results.

The participants were asked how they feel about the visit. This was on Question 5 of the Patients questionnaire (Appendix A) and the family members were in Question 7 (Appendix B). **Table 4.4** shows how the patients and family members felt about the visit. Due to the identical responses from both groups the results were summarised together.

Table 4.4 provides an outline on how the participants felt about their visits.

Table 4.4: Shows how the participants felt about their visits

APPENDIX A: Q5 **APPENDIX B: Q7**	**Statement:** **How did you feel about the visit**	**Number of Participants (n)**	**Percentage (%)**
	Good Feeling and experience about the visit	46	90,1%
	Bad feeling and experience about the visit	5	9.9%
	N	**51**	

Table 4.4 Shows that in the results:

- 90,1% of the respondents (patients and family) had a good feeling and experience about their visit at the Burns ICU.
- Only 9.9% of the sample had a bad experience.

The participants were then asked how the patient felt about the visit, Question 15 (APPENDIX B), and what preference the patient had regarding their visit, Question 6 (APPENDIX A). **Table 4.5** shows the patients preference to the visit. Due to the similarities in responses from both respondent groups the results were summarised together.

Table 4.5 shows which preferences that patients had regarding their visits.

Table 4.5 Patients preference for their visit

APPENDIX A: Q6 APPENDIX B: Q15	**Statement:** **Which of the below did you prefer:**	**Number of Participants (n)**	**Percentage (%)**
	Stay longer	20	39.2%
	Visit more often	15	29.4%
	Neither	7	13.7%
	Both	9	17.7%
	N	**51**	

Table 4.5 shows that of the 51 respondents:

- 39.2% (n=20) have confirmed that the patients preferred the visitors to stay longer.
- 29.4% (n=15) of the respondents said that the patients preferred the visitors to visit more often,
- 13.7 % (n=7) of the respondents said the patient would prefer neither the visits to be longer or to visit more often.
- 17.7% (n=9) of the respondents said the patients preferred the visit to be longer and more often

4.2.1.4 *Patient and Family Opinions about Visitors Leaving Burns ICU*

Table 4.6 shows the patients preference of whether they wanted their family member to leave and their reasoning as to why they wanted them to leave.

Table 4.6: Shows the patients preference to their family member leaving and their reasoning as to why they wanted them to leave

APPENDIX A			
Q8	**Statement: Did you prefer your visitors to leave?**	**Number of Participants (n)**	**Percentage (%)**
	Yes	4	16.7%
	No	20	83.3%
	N	**24**	
Q9	**Statement: Patient's reason for visitor to leave**	**Number of Participants (n)**	**Percentage (%)**
	Needed a rest	3	12.5%
	Increased stress level	0	0%
	Increased anxiety	0	0%
	Did not want family to observe therapy/treatment	0	0%
	Family dynamics	1	4.1%
	Other	0	0%
	N	**24**	

Table 4.6 results show that:

- 16.7% of the patients preferred their visitors to leave
- 83.3% of the patients indicated that they did not want their visitors to leave.
- 12.5% of the patients needed a rest and
- 4.1% had family dynamic reasons and therefore wanted their family members to leave the visit.

Table 4.7 shows how many family respondents were asked to leave.

Table 4.7: Shows how many family respondents were asked to leave

APPENDIX B			
Q8	**Statement: Were you asked to leave?**	**Number of Participants (n)**	**Percentage (%)**
	Yes	10	37.0%
	No	17	62.96%
	N	**27**	
Q9	**Statement: How did you feel about leaving?**	**Number of Participants (n)**	**Percentage (%)**
	Good	6	60%
	Bad	4	40%
	N	**10**	
Q10	**Statement: Were you given reason on why you should leave?**	**Number of Participants (n)**	**Percentage (%)**
	Yes	10	100%
	No	0	
	N	**10**	

Table 4.7 results show that of all the n=27 family member respondents only

- 37% (n=10) were asked to leave.
- From those n=10 family members, six (60%) of them felt good about leaving and
- Four (40%) of them did not want to leave.
- All 10 of the respondents indicated that they were provided with a reason as to why they had to leave. They also indicated that they understood that daily routines had to take place.
- The remaining 40% (n=4) was unhappy to leave and mentioned that they wanted to spend more time with the patient.

4.2.1.5 *Perceptions of Visiting Hours by Family Members*

Table 4.8 shows the perceptions the family members had about the visiting hour practices in the Burns ICU.

Table 4.8: Family member perceptions about the Burns ICU visiting hour practices.

APPENDIX B	Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
		N	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Q19	**Visiting hours in the Burns ICU should not be restricted**	16	59.3%	4	14.8%	3	11.1%	0	0%	4	14.8%
Q20	**Imposing restricted visiting hours on a family member of critically ill loved one is acceptable**	4	14.8%	3	11.1%	1	3.7%	14	51.9%	5	18.5%
Q21	**Family need to be allowed to spend time with their critically ill loved ones**	8	29.6%	13	48.1%	4	14.8%	1	3.7%	1	3.7%
Q22	**Open visiting hours will disrupt routine care**	7	25.9%	9	33.3%	7	25.9%	4	14.8%	0	0%
Q23	**Expanded visiting hours will lead to greater patient/staff/family satisfaction**	10	37.04%	10	37.04%	5	18.52%	2	7.41%	0	0.00%
Q24	**Open visiting hours will lead to greater patient/staff/family satisfaction**	10	37.0%	6	22.2%	6	22.2%	3	11.1%	2	7.4%
Q26	**Family members visiting when one is critically ill helps reduce anxiety**	17	62.9%	9	33.3%	1	3.7%	0	0%	0	0%
		n = 27									

Table 4.8 above shows that:

- 59.2% (n=16) of the visitors strongly agreed that visiting ours should not be restricted but with regards to the statement of open visiting hours will disrupt routine care, n=9 (33.3%) agreed and n=4 (14.8%) disagreed with this response. Not one participant strongly disagreed.

- 51.8% (n=14) disagreed that it is acceptable to restrict visiting hours on a family member of a critically ill loved one and only n=4 (14.8%) agreed with this response. 37.0% (n=10) of the respondents both agreed and strongly agreed that expanded visiting hours lead to greater staff/patient and family satisfaction with only n=2 (7.4%) disagreeing with this statement.

In response to family members needing to spend time with their critically ill loved one:

- 48.1% (n=13) agreed.
- Only one (3.7%) of the participants strongly disagreed.

Majority of the family respondents (62.9%) strongly agreed that visiting their critically ill loved one helps reduce anxiety. Not one of the respondents disagreed with this statement.

4.2.1.6 *Preferred Types of Visiting Hours*

Table 4.9 shows which type of visiting hours the patients would have preferred in the Burns ICU.

Table 4.9: Type of visiting hours the patient would have preferred while in Burns ICU

APPENDIX A	**Statement**	**Scheduled Visiting Hours**		**Extended Visiting Hours**		**Open/ Unrestricted/ Flexible Visiting Hours**	
		n	**%**	**n**	**%**	**n**	**%**
Q14	**In Burns ICU would you have preferred?**	3	12.5%	1	4.2%	20	83.3%
							n = 24

Table 4.9 above show that:

- 83.3% (n=20) of the patient respondents indicated that they would prefer Open/Unrestricted /Flexible visiting hours.

- 12.5% (n=3) of them would prefer Scheduled visiting hours and
- only 4.2% (n=1) of the patient respondents would prefer Extended visiting hours.
-

4.2.2 Comparative Results

4.2.2.1 *Test Chi-Squared*

Chi-Squared test was used to test if the visitors in Burns ICU were satisfied with the current visiting hour practices. A random sample of 27 visitors participated in the study and they were asked in Question 25 of the Family questionnaire APPENDIX B if they were satisfied with the current visiting hours. A 5% level of significance was used to test the null hypothesis.

Table 4.10 shows whether the family members were satisfied with the current visiting practices.

Table 4.10: Visitors satisfaction about the current visiting hour practices.

Category: Type of Visiting hours	**Observed values (Oi)**	**Expected value (Ei)**	**Residuals**	**Observed value Expected value**	$\chi2$
Strongly satisfied	11	5.4	5.6	31.36	5.80740740 7
Satisfied	11	5.4	5.6	31.36	5.80740740 7
Uncertain	1	5.4	-4.4	-19.36	-3.5851851 85
Dissatisfied	3	5.4	-2.4	-5.76	-1.0666666 67
Strongly Dissatisfied	1	5.4	-4.4	-19.36	-3.5851851 85
					Σ3.377777 778

Based on the above findings in the table we can conclude to say we reject the null hypothesis of 5%. There is a satisfaction with the current visiting hour practices.

4.2.2.2 *Correlation Coefficient Test*

To test the inferential statistics the correlation coefficient test was used. A random sample of 24 Burns ICU patients and family was taken and four of them preferred scheduled visiting hours while 17 stated that they prefer the open unstructured visiting hours. A 99% confidence interval for proportion was conducted for the patients and family members that preferred scheduled visiting hours and open unstructured visiting hours.

$$\text{CI} = \hat{p} \pm z^{*}\sqrt{\frac{\hat{p}(1-\hat{p})}{n}}$$

^p = 4/24 = 0.17 p^= 17/24 = 0.71
CI (p) = 0.36743; -0.027439 CI (p) = 0.475055; 0.948496

At a 99% confidence interval the population proportion of patients and family members who preferred scheduled visiting hours is between 0. 36743 and -0.027439. At 99 % confidence interval the population proportion of patients and family members who preferred open visiting hours is between 0.475055 and 0.948496. These results show that the respondents preferred different visiting hours as there is a negative relationship on the respondents who prefer the scheduled visiting hours compared to the positive relationship on the respondents who prefer the open visiting hours.

A correlation coefficient test was conducted to test if the respondents' age has an impact on the type of visiting hours that the respondents preferred. A random sample of seven respondents was taken from the 50 respondents who participated in the study. Three of the respondents where aged between 20- 30 years and four of the respondents were aged between 30- 45 years.

Table 4.11 shows which variables were used in the correlation coefficient test.

Table 4.11: Shows the variables used in the correlation coefficient test

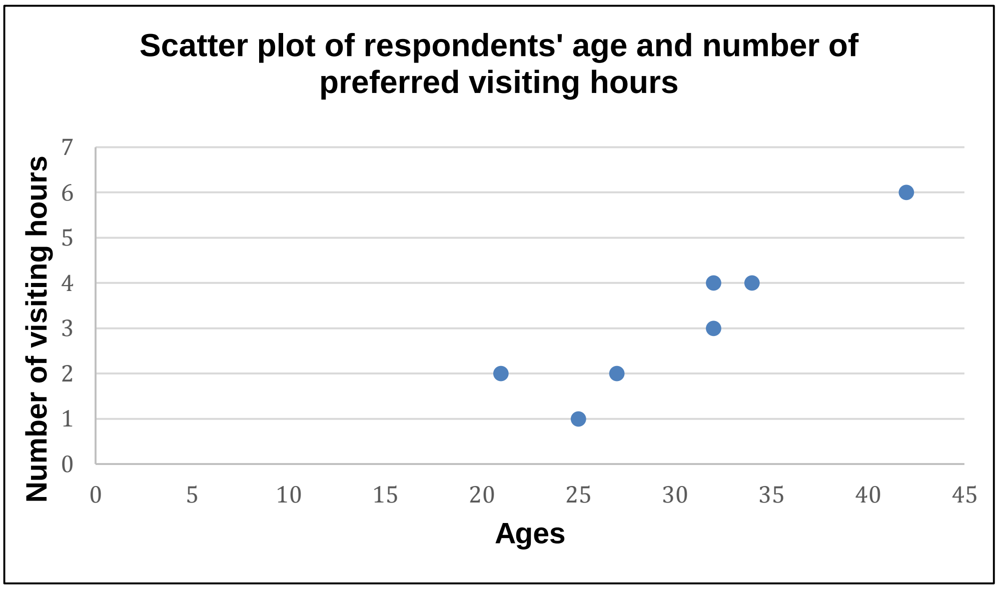
Age (x)	21	25	27	32	32	34	42	**213**
Number of visiting hours (y)	2	1	2	3	4	4	6	**22**
XY	23	26	29	35	36	38	48	**733**
X ^2	42	50	54	64	64	68	84	**426**
Y ^2	4	2	4	6	8	8	12	**44**

$$r = \frac{n(\sum xy) - (\sum x)(\sum y)}{\sqrt{[n\sum x^2 - (\sum x)^2][n\sum y^2 - (\sum y)^2]}}$$

r= 0.1629

There above results show that there is a positive relationship between the age and the number of hours that the respondents preferred. The older respondents prefer longer visiting hours compared to the younger respondents. This means that the age of the respondents has an impact on the preferred number of visiting hours. Below find a scatter plot to show the regression between the age and the number of visiting hours.

Figure 4.4



4.3 OPEN-ENDED RESPONSES/ADDITIONAL NOTES/OBSERVATIONS

It was noted in Question 5 of the patient questionnaire (APPENDIX A), "How did you feel about the visit?" majority of the patients reported positive feelings. Some of these positive feelings included:

- "Very happy as it made me feel special"
- "I feel fortunate"
- "I was so excited"

The patients that reported negative feelings wrote responses such as:

- "I felt very sad to see my family member in pain"
- "I found it extremely tiring/exhausting when they stayed longer than 30 minutes"
- "A bit uncomfortable if the nurse is there the whole time"

Most of the family members reported in their questionnaires that the nursing staff were generally accommodating, friendly and supportive but it was noted that the family often required more information with regards to their loved ones condition.

Those family members who were asked to leave indicated in their questionnaire that they were only asked to leave when "the patient required assistance" and "for treatment by medical staff". Although the majority of the family members accepted they had to leave, some were unhappy as their "visit was cut short" and they "wanted to spend more time" with their loved one.

4.5 SUMMARY

This chapter discussed descriptive and comparative statistical tests that were used. These tests were used to analyse and describe the collected data. The above chapter provided the results to the data collected by using the relevant and classified descriptive (to interpret the ordinal and nominal data). Comparative results were used to show and explain the relationship and preferences about patients and the visitors in the Burns ICU.

The following chapter will discuss the main findings of the study, limitations, recommendations and conclusions.

CHAPTER FIVE

SUMMARY OF STUDY, MAIN FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This chapter, the final chapter, provides a complete summary of the study and its main findings. Following the summary a detailed discussion of the limitations of the study and recommendations for clinical practice, nursing education and further research will be given. Finally this chapter includes the conclusion from the main findings.

5.2 SUMMARY OF THE STUDY

5.2.1 Purpose of the Study

The purpose of this study was to describe the opinions and preferences of family members and patients on visiting practices in the Burns ICU setting of a level 1 private sector hospital in Gauteng, South Africa.

5.2.2 Objectives of the Study

The objectives of the study were:

- To describe the opinions and preferences of family members and patients with regard to visiting practices in Burns ICU.

- To identify the differences in the opinions and preferences of patients and their family regarding visiting practices in the Burns ICU of a level 1 trauma private sector hospital in Gauteng, South Africa.

5.2.3 Methodology

Before starting with the study, an ethical clearance certificate was obtained from the Human Research Ethics Committee of the University of Witwatersrand (Appendix F). After ethical clearance was received, permission to use the questionnaire was granted from the original author (Appendix G). Approval to carry out the study was received from the Post Graduate Committee of the School of Therapeutic Sciences (Appendix H). Approval was also granted from the Private Hospitals Ethics Committee (Appendix I) and a letter of acknowledgement was received from the institutional management of the level one private sector hospital, where the study took place (Appendix J).

A Burns ICU of a level 1 trauma private sector hospital was used for this study. The population target was all patients and family members of the patients admitted to the ICU in question. A total sample of n=51 was obtained through non-probability convenience sampling.

A developed questionnaire by Ramnath (2007) titled “Preferences and Perceptions of Patients, Family/Friends and Nurses on Visiting Time in ICU” was used in this study.

The patient questionnaire (Appendix A) consisted of 14 questions and the family questionnaire (Appendix B) consisted of 26 questions. Section A of both questionnaires collected the demographic data of the respondents. Section B of the patient tool related to their stay in the burns ICU and consisted of both multiple choice and open-ended questions. Section B of the family tool related to their experience of the visit and contained both multiple choice and open-ended questions. Section C of the family tool was only multiple choice and questioned the perceptions of visiting hour practices.

This study’s objectives were achieved by using a quantitative, non-experimental, descriptive and cross-sectional design. Data was analysed using descriptive and inferential statistics with the assistance of a statistician.

5.3 SUMMARY OF MAIN RESEARCH FINDINGS

From this study, the demographic data showed that 58.3% of the patient respondents and 37% of the family respondents were both part of the largest age group which was between the ages of 20-40 years. The majority of the patient respondents were of the Christian denomination (87.5%) with the remaining 12.5% of undisclosed other denominations. Within the family respondents 85.2% were Christian, 14.8% were Jewish and 7.4% were of other denominations.

These variables provided important information as they have a large part in understanding the support system and the participant background.

The *first objective* was to describe the opinions and preferences of family members and patients with regard to visiting practices in Burns ICU.

Of the combined 51, patient and family, respondents it was identified that 39.2% of the participants reported wanting to stay longer for their visit. Twenty nine point four percent (29.4%) of the respondents would have preferred the visits to be more frequent and 17.5% of the respondents said they preferred the visit to be both longer and more often. Thirteen point seven percent (13.7 %) of the participants were indifferent to the length or frequency of the visits.

In this study it shows that the majority of the respondents preferred a longer visiting time compared to shorter and more frequent visits. This is similar to the study done by Ramnath (2007) where the patients also indicated that they had a preference (48.57%) for longer visiting time (Ramnath, 2007).

When the patients were asked about whether they would have preferred the visitor to leave 20 (83.3%) of the patient respondents indicated no. Extra notes added by a patient included, “They should have stayed with me”. This was a note written beside the multiple choice question and not part of an open-ended question. The remaining four (16.7%) of the patients preferred their visitors to leave. The reasons chosen by three (12.5%) of the respondents for preferring their visitors to leave was because they, the patient, needed to rest and one (4.1%) patient indicated that family dynamics were not conductive.

Sixty-nine point two three percent (69.23%) of Ramnath’s (2007) patient respondents preferred their visitors to stay (Ramnath, 2007). These results were similar in this study, having 83,3% patient respondents preferring their visitors to stay.

When asked to leave 40% of family members who did not want to leave their loved one, when asked to leave, stated in their responses that they would have preferred to stay with the patient. The visitors wrote that they were “a little unhappy as the visit was cut short” and “I was heartbroken to leave my family member alone”. Of the 10 participants asked to leave 100% indicated that they were given a reason as why they were asked to leave and that they understood the reasoning provided. The reasons given as to why they needed to leave was to carry out “treatment of the patient by medical staff” and “only asked to leave when patient required assistance”.

Majority of both the patient and family respondents throughout this study indicated that they wanted to stay longer and that it was beneficial for both the patient and family member. This is also the sentiment in a study conducted by the Neuroscience ICU in Atlanta, America. The family stated that continuous or longer visiting did allow family members to get support and their comfort needs were met. Therefore both family and patients benefited from longer visiting hours (Jacob et al., 2016).

The patient respondents showed that 83.3% of them would prefer Open/Unrestricted /Flexible visiting hours, with only 12.5% preferring Scheduled visiting hours and 4.2% of the patient participants indicated wanting Extended visiting hours. In the study conducted in Atlanta, in America, continuous visitation policy has been allowed in this ICU since 2007 (Jacob et al., 2016), which is similar to this study whereby the patients also would prefer Open/Unrestricted /Flexible visiting hours.

The *second objective* was to identify the differences in the opinions and preferences of patients and their family regarding visiting practices in the Burns ICU of a level 1 trauma private sector hospital in Gauteng, South Africa.

The largest difference noted from this study was how the ages of the participants affected their preference for the type of visiting they preferred. It was found that the older respondents, of ages above 30 years, preferred longer visiting hours compared to the younger respondents. It was also noted that not all the respondents preferred open visitation but that between 0.36743 and -0.027439, of the 99% confidence interval, patients and family members of population proportion preferred scheduled visiting hours.

Other differences noted were that of the respondents, both patient and family combined, reported that 90.1% experienced a good visit, while only a 9.9% difference reported having an unpleasant experience.

This large positive outcome was mainly due to the written responses summarised as the immense relief felt in seeing their loved one as well as the feeling of support, love and comfort that majority of the respondents reported or elaborated on in their questionnaires.

The negative experiences or differences that emerged were that the patient respondents reported that they tired easily and the family respondents indicated that they felt overwhelmed at seeing their loved one so injured. Fifty nine point three percent (59.3%) of the family respondents strongly agreed that visiting hours in the Burns ICU should not be restricted and 14.8% strongly disagreed. Fifty one point nine percent (51.9%) disagreed that imposing restricted visiting hours on a family member of a critically ill loved one is acceptable, only 11.1% agreed that restricted visiting hours are acceptable and only 3.7% of the family respondents indicated that they disagree with the statement that family need to be allowed to spend time with their critically ill loved ones whereas 48.1% agreed.
Comparing the above with Ramnath (2007) it was found that of the family members, only 26.09% disagreed that imposing restricted visiting was acceptable compared to the 43,48% of the family respondents that agreed that the visiting time in ICU should be restricted (Ramnath, 2007).

There was a similar response to: “open visiting hours will disrupt routine care”, with 25.9% of the respondents uncertain and strongly agreeing to this statement. But despite the response that routine will be disrupted in open visiting, 37.0% strongly agreed that pen visiting hours will lead to greater patient/staff/family satisfaction and only 11.1% disagreeing. In comparison 37.04% of respondents indicated that expanded visiting hours will lead to greater patient/staff/family satisfaction. Comparing the study done by Jacob et al., (2016) family members are not asked to leave during any procedure being performed on the patient, including invasive procedures, but are allowed to stay and observe if they so wish. This allows them to be continuously updated on the patient's condition (Jacob et al., 2016).

The respondents in Ramnath's 2007 study felt that open/expanded visiting time in ICU leads to greater family and patient satisfaction (Ramnath, 2007).

As it can be seen, the majority of the respondents indicated that the family of the critically ill loved persons deserve to be with them throughout their recovery. Sixty two point nine percent (62.9%) of the participants all strongly agreed that there is a reduction in anxiety when family members visit their critically ill loved one. A few identified factors contributing towards the decreased anxiety included being able to see the patients recovery as well as provide a welcome distraction to the patient. According to the findings in Bayuo and Wong (2020), the relatives, in their study, felt that they needed to be with the patient more often to provide more hands-on care to the patient but due to visiting hours, this kind of care was limited and adding to increased anxiety (Bayuo and Wong, 2020).

5.4 LIMITATIONS OF THE STUDY

The following limitations were identified in this study:

- The global Covid-19 pandemic
- The use of a small sample and inconveniencing sampling
- The use of only one Burns ICU in the private sector

Due to the Covid-19 global pandemic, data collection time was prolonged as all hospital visitations were suspended. This was implemented by hospital management for patient and staff safety during the pandemic. In doing so, during this time no questionnaires could be completed in the Burns ICU. Once fixed 30 minute visitations were allowed data collection was able to continue.

The small sample can lead to restricted generalised findings, but redoing the study in other Burns ICUs in the public and private sectors a larger sample can be used to oppose or support these findings.

There is insufficient literature in the South African context with regards to visitation practices in general and especially within the Burns ICU setting.

5.5 RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made.

5.5.1 *Recommendations for Clinical Nursing Practice*

Family members and the patients should be encouraged by the nursing staff and all other health professionals to actively participate in the recovery of the patient. The other health care professionals include the ddietitian to ensure patient reaches their adequate nutritional intake and therefore assisting in quicker wound healing. The physiotherapist to assist in recovery of gross motor movements, the occupational therapist to aid in the recovery of fine motor skills and adjusting to daily living functions and the psychologist aiding in debriefing of traumatic event and providing mental coping mechanisms. The nurses should be encouraged to follow evidenced based practice and actively practice family and patient-centered care.

5.5.2 *Recommendations for Nursing Education*

It is recommended that nurses receive in-service training on patient and family centered care as well as the need for flexible visiting hours. Encouragement and education on how to involve family members to participate in the care of their loved ones during their visiting time is needed. This could include, assisting in dressing changes, feeding, bathing, etc. When forming and implementing new policies and practices, the inclusion of nurses input in all aspects should be taken into account.

5.5.3 *Recommendations for Further Nursing Research*

That study was only conducted in one Burns ICU, and therefore the generalised findings only applied to that one unit. It is recommended that a further replication of this study be performed, with a larger population in other Burn ICUs. The replication study would be done to support the findings of this current study. A qualitative study exploring the patients, families and nurses' opinions and perceptions should be conducted. It is also recommended that nurses' perceptions and opinions be included in the next study as they play a big role in the education and patient as well as family centered care.

5.6 CONCLUSION

The purpose of this study was to investigate the opinions and preferences of family members and patients on visiting practices in the Burns ICU setting of a level 1 private sector hospital in Gauteng, South Africa.

Open visiting hours was found most beneficial to both the patients and their family member’s ion this study. It was largely reported in this study that both the family members and the patients had reduced anxiety levels during these open visits. It was also identified that patients found their recovery easier as their visitors helped to distract them from their predicament as well as support them through their recovery. Although it was reported that the staff were friendly, not all the patients and family members felt sufficiently supported or that they were provided enough information and education on the patients’ condition.

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APPENDIX A

PREFERENCES AND PERCEPTIONS OF PATIENTS, FAMILY/FRIENDS AND NURSES ON VISITING TIME IN ICU

PATIENT QUESTIONNAIRE

Questionnaire number:

PLEASE PUT AN X IN THE BLOCK APPLICABLE TO YOUR ANSWER

SECTION A: DEMOGRAPHIC INFORMATION

Q1. Gender:

Male	
Female	

Q2. Age:

Q3. Religious Denomination:

Christian	
Buddhism	
Jewish	
Muslim	
Hindu	
Other	

SECTION B: THE FOLLOWING QUESTIONS RELATE TO YOUR STAY IN BURNS ICU

Q4. Were you visited by your family while you were in ICU?

Yes	
No	

Q5. If yes in Q5, how did you feel about the visit? Please elaborate.

____

____

____

____

____

Q6. If yes in Q5, would you have preferred your visitor(s) to:

Stay longer	
Visit more often	
Neither	

Q7. Please give a reason for your response in Q6.

____

____

____

____

____

Q8. Would you have preferred your visitors to leave?

Yes	
No	

Q9. If yes in Q8, which of the following would be the reason?

Needed a rest	
Increased stress levels	
Increased anxiety	
Did not want family to observe therapy/treatment	
Family dynamics not conductive	
Other reasons	

Q10. If your response in Q9 was “other’, please elaborate.

____

____

____

____

____

Q11. Is there anything in particular that our visitor(s) could do for you that the nursing staff could not do?

____

____

____

____

____

Q12. How did you experience the nursing staff’s attitude towards your visitor(s)?

Friendly	
Unfriendly	
Flexible	
Inflexible	
Other attitudes	

Q13. If your response in Q12 was “other attitudes”, please elaborate.

____

____

____

____

____

Q14. In Burns ICU would you have preferred?

Scheduled visiting hours	
Extended visiting hours	
Open/ unrestricted/ flexible visiting hours	

THANK YOU FOR PARTICIPATING IN THIS STUDY

If you have any questions or encounter any problems please don’t hesitate to contact.

Lauren Webber (Researcher) **Cell: 076 537 0604**

APPENDIX B

PREFERENCES AND PERCEPTIONS OF PATIENTS, FAMILY/FRIENDS AND NURSES ON VISITING TIME IN ICU

FAMILY MEMBER QUESTIONNAIRE

Questionnaire number:

PLEASE PUT AN X IN THE BLOCK APPLICABLE TO YOUR ANSWER

SECTION A: DEMOGRAPHIC INFORMATION

Q1. Are you a:

Family member	
Friend	

Q2. Gender:

Male	
Female	

Q3. Age:

Q4. Religious Denomination:

Christian	
Buddhism	
Jewish	
Muslim	
Hindu	
Other	

SECTION B: EXPERIENCE OF YOUR VISIT TO THE PATIENT

Q5. Were you informed about the visiting time in ICU?

Yes	
No	

Q6. Were you given the opportunity to visit the patient?

Yes	
No	

Q7. If your response in Q5 was “yes”, how did you experience your visit?

____

____

____

____

____

Q8. Were you asked to leave?

Yes	
No	

Q9. If your response in Q8 was “yes”, how did you feel about leaving?

____

____

____

____

Q10. If your response in Q8 was “yes”, was a reason given to you as to why you should leave?

Yes	
No	

Q11. If your response in Q10 was “yes”, was the reason acceptable?

Yes	
No	

Q12. Are you of the opinion that your visit was of importance to the patient?

Yes	
No	

Q13. If your response in Q12 was “yes”, please indicate why your visit was of importance to the patient.

____

____

____

____

____

Q14. Did the patient appreciate your visit?

Yes	
No	

Q15. Did the patient want you to?

Stay longer	
Visit more often	

Q16. Are you of the opinion that your visiting could be of assistance to the nursing staff?

Yes	
No	

Q17. If your response in Q16 was “yes”, as a visitor, in which way could your visit be of assistance to the nursing staff?

____

____

____

____

____

Q18. Did you get the feeling that the nursing staff would have preferred that you leave?

Yes	
No	

SECTION C: PERCEPTIONS OF VISITING HOUR PRACTICES

Q19. Visiting hours in the Burns ICU should not be restricted.

Strongly agree	
Agree	
Uncertain	
Disagree	
Strongly disagree	

Q20. Imposing restricted visiting hours on a family member of critically ill loved ones is acceptable.

Strongly agree	
Agree	
Uncertain	
Disagree	
Strongly disagree	

Q21. Family need to be allowed to spend more time with their critically ill loved ones.

Strongly agree	
Agree	
Uncertain	
Disagree	
Strongly disagree	

Q22. Open visiting hours will disrupt routine care.

Strongly agree	
Agree	
Uncertain	
Disagree	
Strongly disagree	

Q23. Expanded visiting hours will lead to greater patient/staff/family satisfaction.

Strongly agree	
Agree	
Uncertain	
Disagree	
Strongly disagree	

Q24. Open visiting hours will lead to greater patient/family/staff satisfaction.

Strongly agree	
Agree	
Uncertain	
Disagree	
Strongly disagree	

Q25. Are you satisfied with the current visiting hour practices?

Strongly satisfied	
Satisfied	
Uncertain	
Dissatisfied	
Strongly dissatisfied	

Q26. Family members visiting when one is critically ill helps reduce anxiety.

Strongly agree	
Agree	
Uncertain	
Disagree	
Strongly disagree	

THANK YOU FOR PARTICIPATING IN THIS STUDY

If you have any questions or encounter any problems please don’t hesitate to contact.

Lauren Webber (Researcher)	**Cell: 076 537 0604**

APPENDIX C

PATIENT AND FAMILY OPINIONS AND PREFERENCES OF VISITING PRACTICES IN AN INTENSIVE CARE UNIT

Information Letter

Dear Sir/Madam,

My name is Lauren Webber, a Master of Science (Nursing) candidate in the Department of Nursing Science at the University of the Witwatersrand, Johannesburg, South Africa. I hope to conduct a research project and would therefore like to invite you to consent to being included in my study as research is a process used in seeking new knowledge. The aim of this study is to investigate the opinions and preferences of family members and patients on visiting practices in the burns ICU.

I am inviting you to take part in a research study. A questionnaire will be provided consisting of closed and open-end questions relating to visitation in the Burns ICU. The questionnaire will take approximately 15minutes to complete. If you agree to participate the questionnaire will be completed after one of your visits to the burns unit. I will be available during your participation should you have any queries. Participation in this study is voluntary. You can choose to withdraw from the study at any time without any consequences for you or your relative. Your refusal or withdrawal will not affect your or their relationship or care with the staff in any way. Your anonymity and confidentiality will be assured in this study by using a research code number instead of your real name. The questionnaire once filled out will be placed in a sealed box and transported to the Wits Nursing Department. From there it will be kept in a locked cupboard in the supervisor's office. Only the researcher and supervisor will have access to this cupboard. The completed questionnaires will be retained for a period of five years. The result of this study will be available to you should you so wish.

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

The appropriate people and research committees of the University of the Witwatersrand, Gauteng Department of Health and the selected level 1 trauma private hospital have approved the study and its procedures.

Thank you for taking time to read this information letter. Should you wish to contact me or require further information, please do not hesitate to contact me in the nursing education department or on the following cell phone 076 537 0604.

Yours sincerely

Lauren Webber
(MSC Nursing Student and Researcher)

Supervisor: Vivien Herbert
Contact: 011 488 4273

APPENDIX D

PATIENT AND FAMILY OPINIONS AND PREFERENCES OF VISITING PRACTICES IN A BURNS INTENSIVE CARE UNIT

Participant Consent Form

I ………………………………………………… (Full name) give permission to be included in the research study. I have read the information letter and understand the content of the research; and I have been given the opportunity to ask questions I might have regarding the procedure and my consents to being included in the study.

Therefore, I give the consent of participating in the research.

…………………………
……………….…………………………..……..

Date
Signature

APPENDIX E

University of the Witwatersrand
Department of Nursing Education
Faculty of Health Sciences
7 York Road
Parktown
Johannesburg
2193

The Chief Executive Officer
PO Box 91155
Auckland Park
Johannesburg
2006

To whom it may concern

RE: REQUEST TO CONDUCT RESEARCH AT A LEVEL 1 TRAUMA PRIVATE HOSPITAL

I am currently a registered postgraduate student at the University of the Witwatersrand, in the Department of Nursing Education. I hereby request your permission to undertake research at the level 1 trauma private hospital in Johannesburg. The title of my research is: *Patient and Family Opinions and Preferences of Visiting Practices in an Intensive Care Unit.*

The purpose of this study is to investigate the opinions and preferences of family members and patients on visiting practices.

I want to assure you that the institution’s name and patients involved in the study will not be divulged in the research report. Informed consent will be obtained from all the participants and a copy of the research report will be made available to you if so requested.

I hope to conduct my research study in the Burns Intensive Care Unit once my proposed study has been approved by the Committee for Research on Human Subjects of the University of the Witwatersrand as well as the selected private hospitals Research committee.

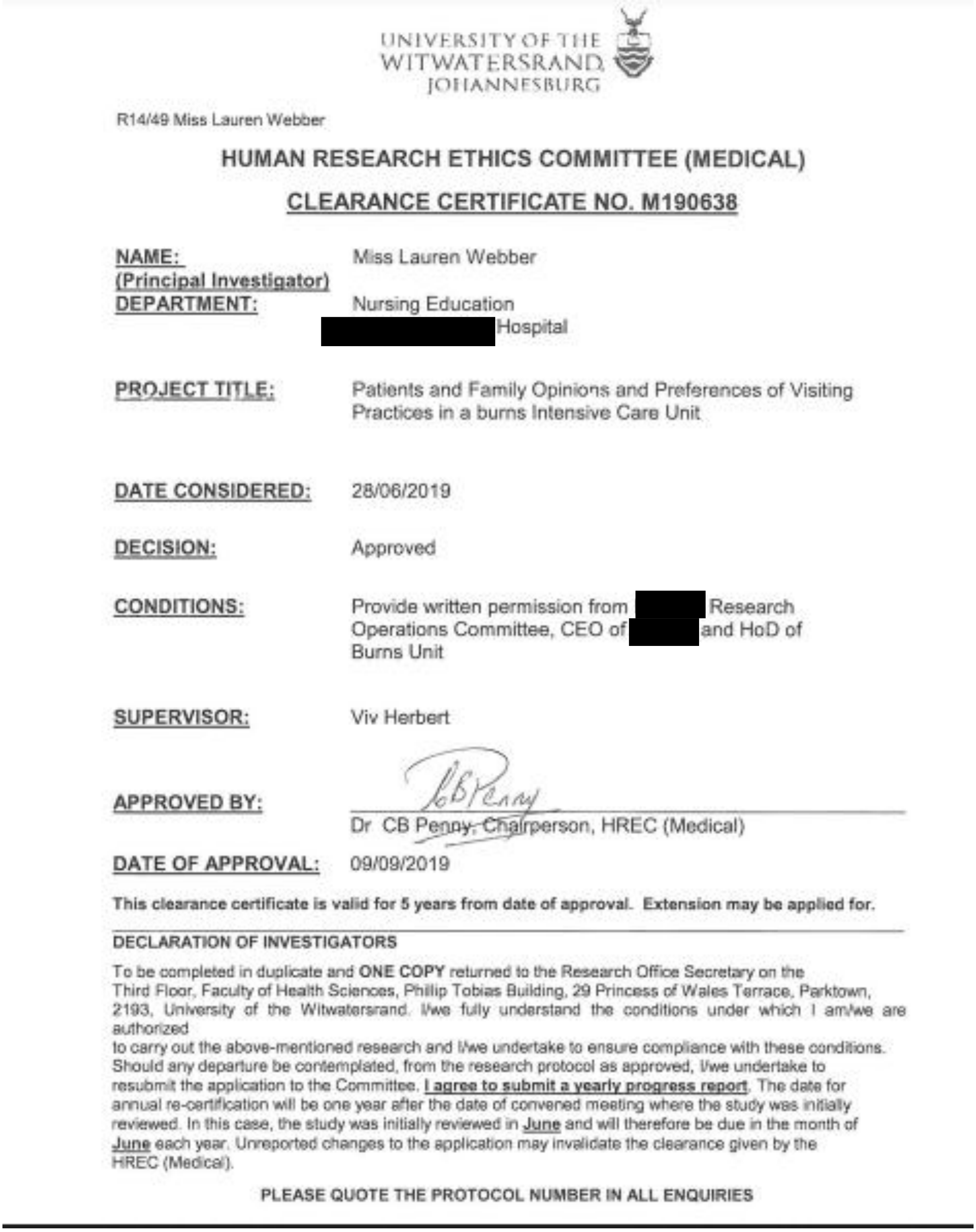
Yours sincerely,

Lauren Webber

MSc Nursing Postgraduate Student

APPENDIX F

Ethical Clearance Certificate



UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

R14/49 Miss Lauren Webber

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M190638

NAME:
(Principal Investigator) Miss Lauren Webber

DEPARTMENT: Nursing Education
[redacted] Hospital

PROJECT TITLE: Patients and Family Opinions and Preferences of Visiting Practices in a burns Intensive Care Unit

DATE CONSIDERED: 28/06/2019

DECISION: Approved

CONDITIONS: Provide written permission from [redacted] Research Operations Committee, CEO of [redacted] and HoD of Burns Unit

SUPERVISOR: Viv Herbert

APPROVED BY: CB Penny
Dr CB Penny, Chairperson, HREC (Medical)

DATE OF APPROVAL: 09/09/2019

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

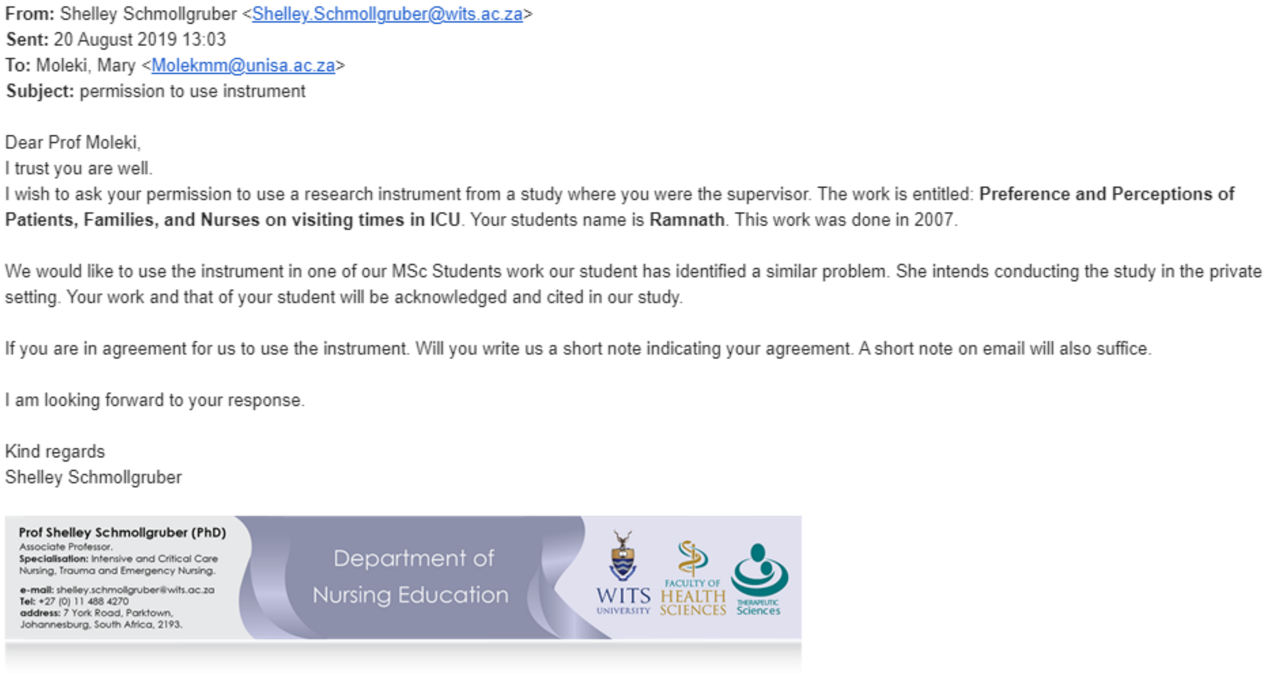
DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in June and will therefore be due in the month of June each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX G

Permission to Use Instrument



From: Shelley Schmollgruber <Shelley.Schmollgruber@wits.ac.za>
Sent: 20 August 2019 13:03
To: Moleki, Mary <Molekmm@unisa.ac.za>
Subject: permission to use instrument

Dear Prof Moleki,
I trust you are well.
I wish to ask your permission to use a research instrument from a study where you were the supervisor. The work is entitled: **Preference and Perceptions of Patients, Families, and Nurses on visiting times in ICU**. Your students name is **Ramnath**. This work was done in 2007.

We would like to use the instrument in one of our MSc Students work our student has identified a similar problem. She intends conducting the study in the private setting. Your work and that of your student will be acknowledged and cited in our study.

If you are in agreement for us to use the instrument. Will you write us a short note indicating your agreement. A short note on email will also suffice.

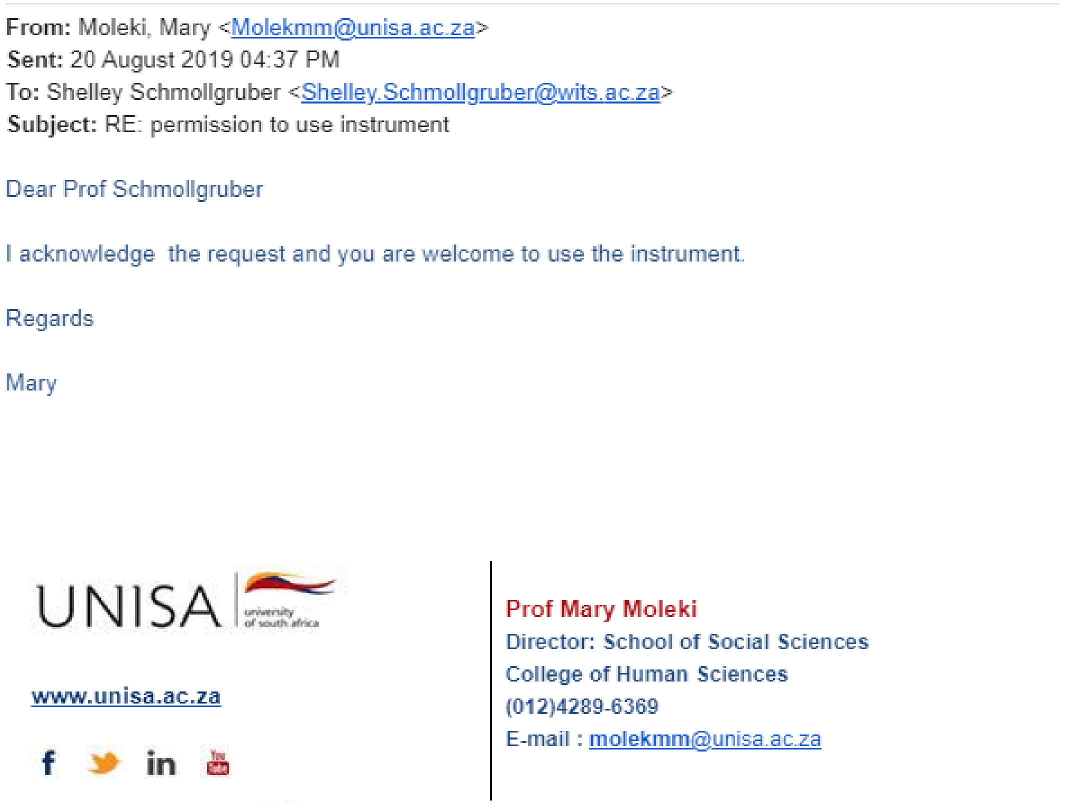
I am looking forward to your response.

Kind regards
Shelley Schmollgruber

Prof Shelley Schmollgruber (PhD)
Associate Professor.
Specialisation: Intensive and Critical Care Nursing, Trauma and Emergency Nursing.
e-mail: shelley.schmollgruber@wits.ac.za
Tel: +27 (0) 11 488 4270
address: 7 York Road, Parktown, Johannesburg, South Africa, 2193.

Department of Nursing Education

WITS UNIVERSITY
FACULTY OF HEALTH SCIENCES
THERAPEUTIC Sciences



From: Moleki, Mary <Molekmm@unisa.ac.za>
Sent: 20 August 2019 04:37 PM
To: Shelley Schmollgruber <Shelley.Schmollgruber@wits.ac.za>
Subject: RE: permission to use instrument

Dear Prof Schmollgruber

I acknowledge the request and you are welcome to use the instrument.

Regards

Mary

UNISA university of south africa

www.unisa.ac.za

Prof Mary Moleki
Director: School of Social Sciences
College of Human Sciences
(012)4289-6369
E-mail : molekmm@unisa.ac.za

APPENDIX H

Postgraduate Approval Letter

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

23 April 2021
Person No: 602217
PAG

Miss LB Webber
P O Box 44672
Linden
2104
South Africa

Dear Miss Lauren Webber

Master of Science in Nursing: Approval of Title

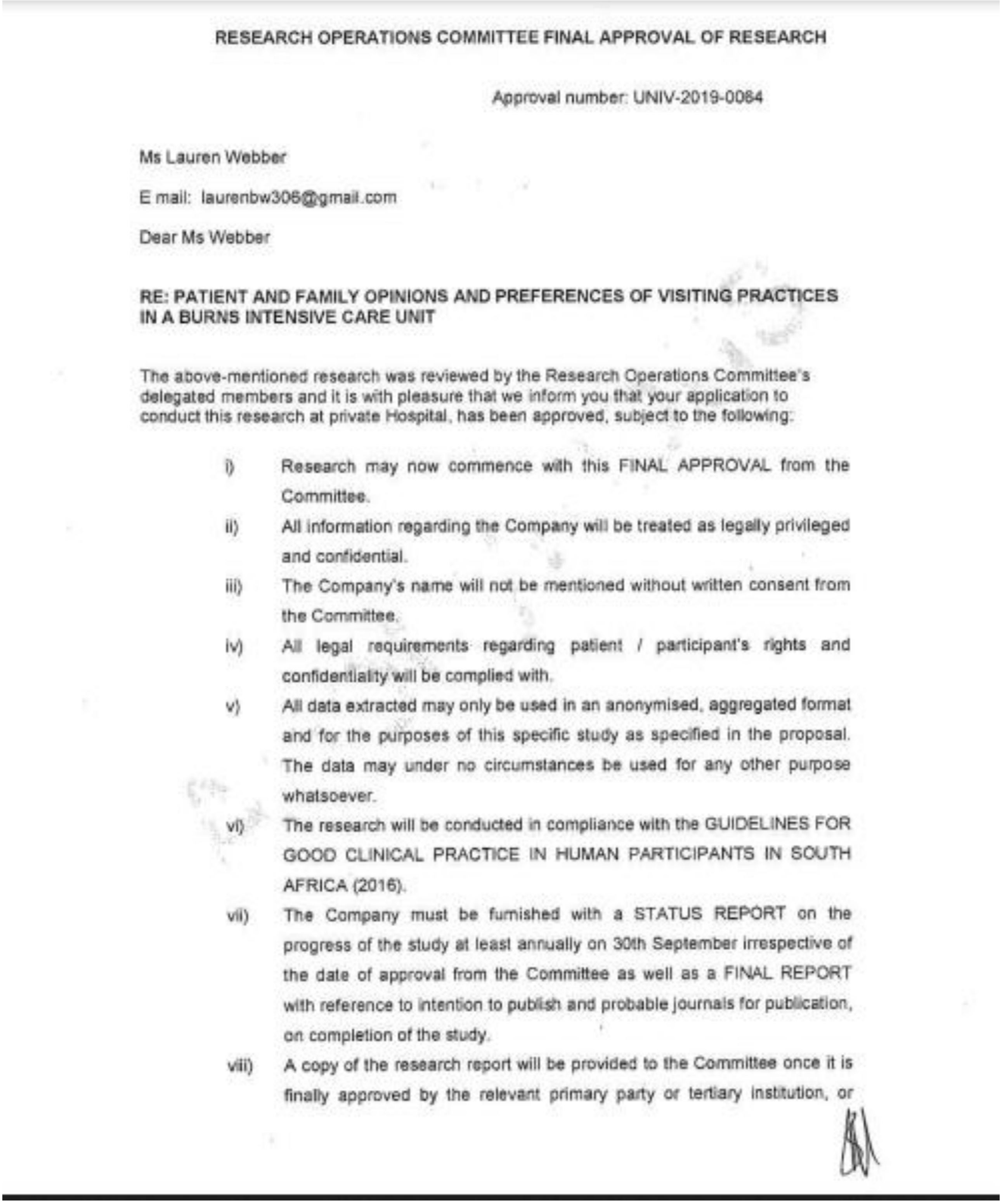
We have pleasure in advising that your proposal entitled *Patients and family opinions and preferences of visiting practices in a burns intensive care unit* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

APPENDIX I

Approval Letter from Hospital



RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2019-0084

Ms Lauren Webber

E mail: laurenbw306@gmail.com

Dear Ms Webber

RE: PATIENT AND FAMILY OPINIONS AND PREFERENCES OF VISITING PRACTICES IN A BURNS INTENSIVE CARE UNIT

The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at private Hospital, has been approved, subject to the following:

i) Research may now commence with this FINAL APPROVAL from the Committee.

ii) All information regarding the Company will be treated as legally privileged and confidential.

iii) The Company's name will not be mentioned without written consent from the Committee.

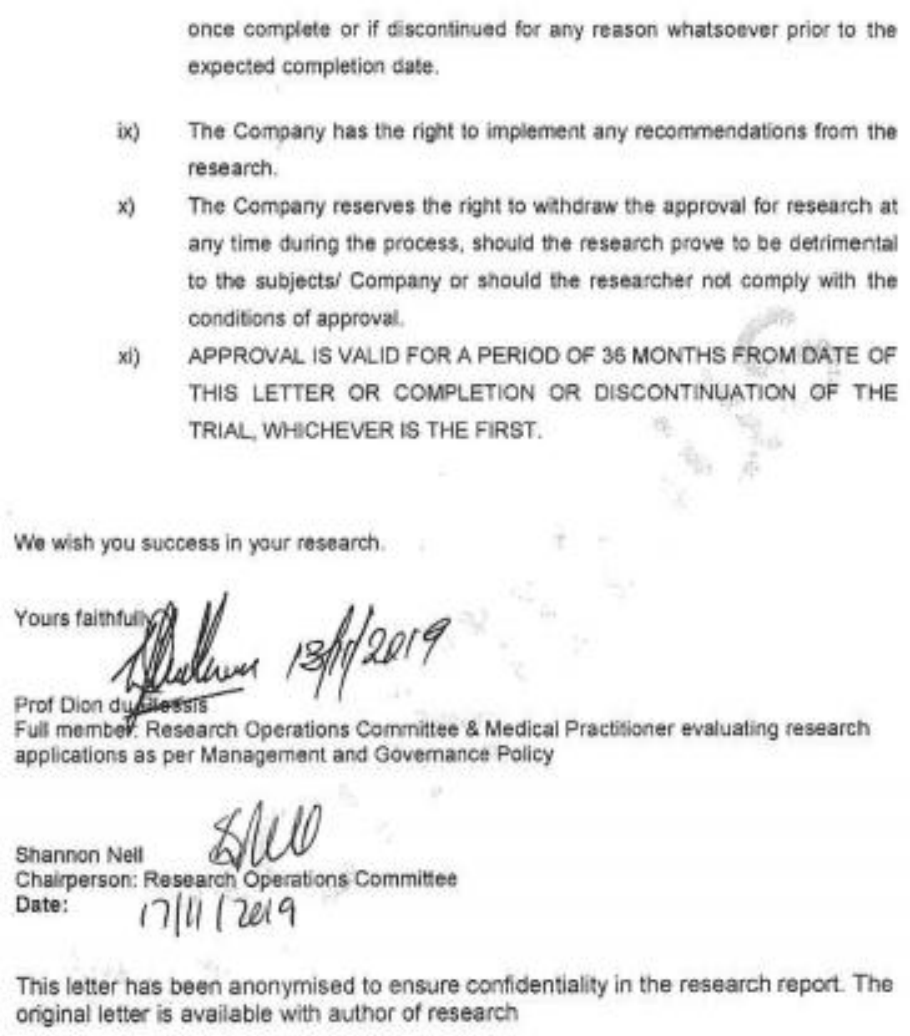
iv) All legal requirements regarding patient / participant's rights and confidentiality will be complied with.

v) All data extracted may only be used in an anonymised, aggregated format and for the purposes of this specific study as specified in the proposal. The data may under no circumstances be used for any other purpose whatsoever.

vi) The research will be conducted in compliance with the GUIDELINES FOR GOOD CLINICAL PRACTICE IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2016).

vii) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

viii) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or



once complete or if discontinued for any reason whatsoever prior to the expected completion date.

ix) The Company has the right to implement any recommendations from the research.

x) The Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/ Company or should the researcher not comply with the conditions of approval.

xi) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE TRIAL, WHICHEVER IS THE FIRST.

We wish you success in your research.

Yours faithfully 13/11/2019

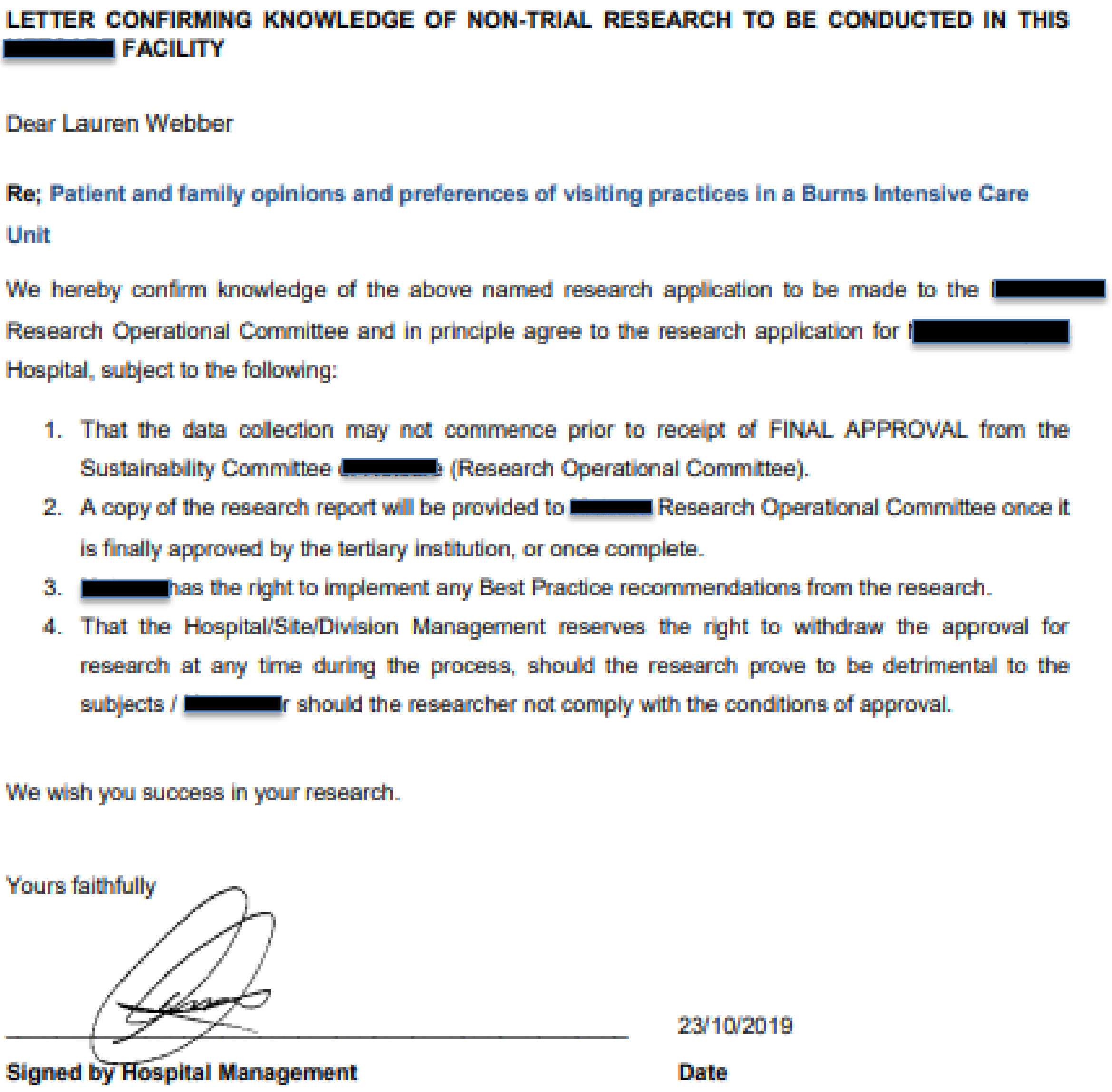
Prof Dion du Plessis
Full member: Research Operations Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Shannon Neil
Chairperson: Research Operations Committee
Date: 17/11/2019

This letter has been anonymised to ensure confidentiality in the research report. The original letter is available with author of research

APPENDIX J

Letters of Acknowledgement from Hospital and Unit Manager



LETTER CONFIRMING KNOWLEDGE OF NON-TRIAL RESEARCH TO BE CONDUCTED IN THIS [redacted] FACILITY

Dear Lauren Webber

Re; Patient and family opinions and preferences of visiting practices in a Burns Intensive Care Unit

We hereby confirm knowledge of the above named research application to be made to the [redacted] Research Operational Committee and in principle agree to the research application for [redacted] Hospital, subject to the following:

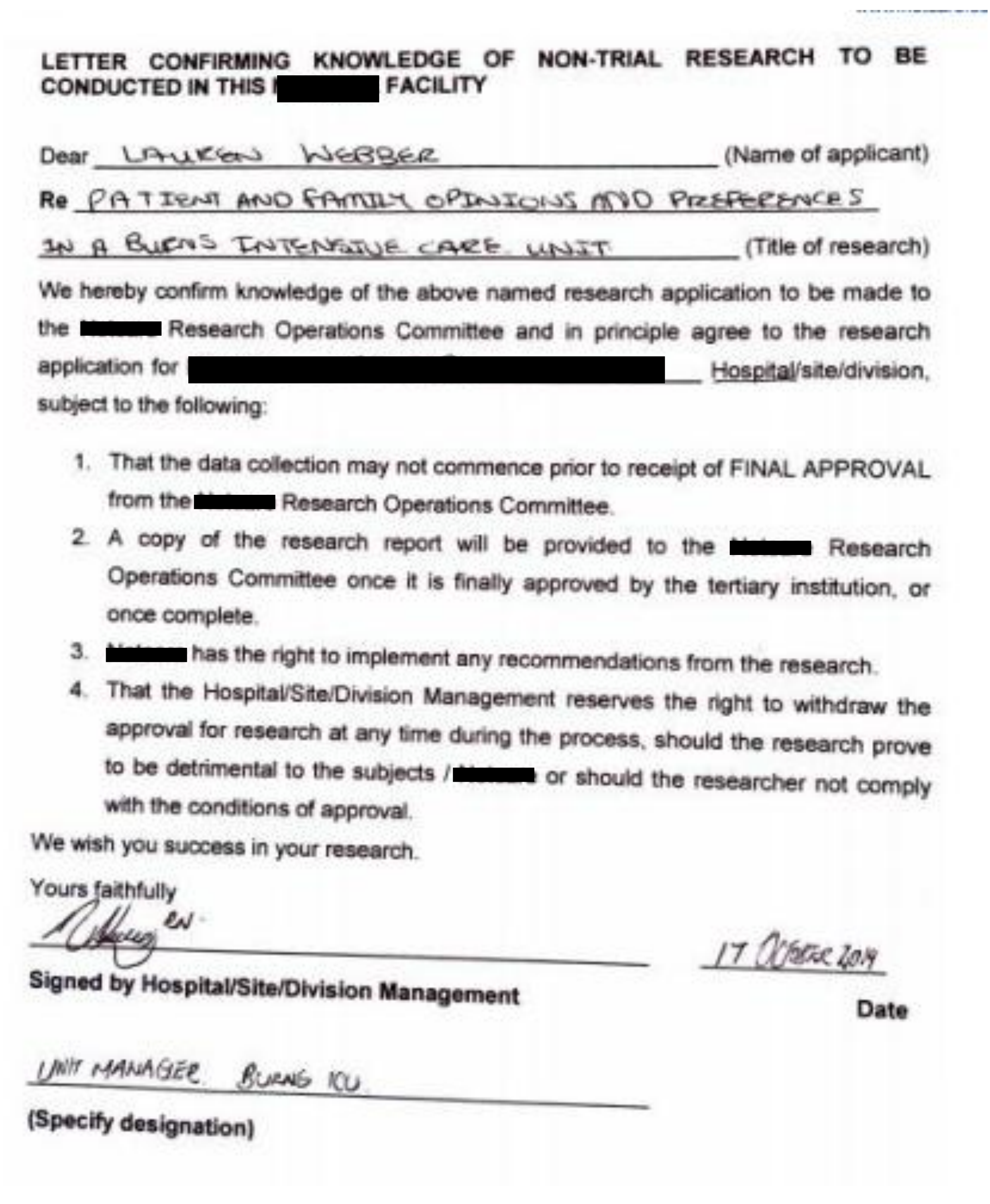
1. That the data collection may not commence prior to receipt of FINAL APPROVAL from the Sustainability Committee [redacted] (Research Operational Committee).
2. A copy of the research report will be provided to [redacted] Research Operational Committee once it is finally approved by the tertiary institution, or once complete.
3. [redacted] has the right to implement any Best Practice recommendations from the research.
4. That the Hospital/Site/Division Management reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects / [redacted] should the researcher not comply with the conditions of approval.

We wish you success in your research.

Yours faithfully

Signed by Hospital Management 23/10/2019

Date



LETTER CONFIRMING KNOWLEDGE OF NON-TRIAL RESEARCH TO BE CONDUCTED IN THIS [redacted] FACILITY

Dear LAUREN WEBBER (Name of applicant)

Re PATIENT AND FAMILY OPINIONS AND PREFERENCES IN A BURNS INTENSIVE CARE UNIT (Title of research)

We hereby confirm knowledge of the above named research application to be made to the [redacted] Research Operations Committee and in principle agree to the research application for [redacted] Hospital/site/division, subject to the following:

1. That the data collection may not commence prior to receipt of FINAL APPROVAL from the [redacted] Research Operations Committee.
2. A copy of the research report will be provided to the [redacted] Research Operations Committee once it is finally approved by the tertiary institution, or once complete.
3. [redacted] has the right to implement any recommendations from the research.
4. That the Hospital/Site/Division Management reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects / [redacted] or should the researcher not comply with the conditions of approval.

We wish you success in your research.

Yours faithfully

Signed by Hospital/Site/Division Management

17 October 2019

Date

UNIT MANAGER BURNS ICU

(Specify designation)