“Intelligent use of open visiting would aid patient recovery”

Many nurses look back with horror at the separation of children from their parents when admitted to hospital in years gone by. They weren’t allowed to see each other until discharge. Thankfully, we now have a more enlightened approach, with parents welcome at the bedside. Unfortunately, the same does not apply to adults, as restricted visiting is enforced in many areas, despite many trusts advertising person-centred care in their mission statements.

New nurses arrive on adult wards and they quickly soak up the organisational culture, use existing esoteric language, such as “obs”, which gives a feeling of importance, of belonging. As a student nurse, I remember having the honour of ringing the visitors’ bell. How powerful to ring a bell and crowds of people suddenly disperse. It is, of course, more subtle now with discreet signs displaying visiting times. The power lies with the nurse, it’s our patch, we call the shots and the uniforms, routines, and general busy working environment add to the power base.

In my experience, open visiting does happen but it appears to be something one has to “qualify” for. Sometimes an overworked nurse under pressure will allow a relative at the patient’s bedside outside of visiting hours to provide essential care, feeding, washing and offering support. Another instance is for the terminally ill who are quite rightly allowed open visiting.

But what about patients? Where is their voice in all this? A useful approach is to put yourself in your patients’ shoes, for example, what would you want if you were a visitor who lived miles away and couldn’t make prescribed visiting times?

The Francis report has put patient and public involvement into the spotlight with recommendations for more focus on patient experience and involvement. As nurses, we must ask questions within our profession and enter into a dialogue with patients and families to improve care.

With open visiting there are issues to consider, such as the difficulties associated with “communal living”; some may not wish to see visitors at all whereas others may want their family there all the time. The ward infrastructure may not be able to support open visiting due to a lack of suitable areas for families to be together. However, I believe the sensitive and intelligent use of open visiting would be a positive contribution to the recovery of patients in our care. We need to take a holistic approach by looking at ways of making adult wards truly “family friendly” with a focus on hospitality and comfort.

So, should we ring the visitors’ bell for the last time? Will we look back in years to come and see that restricting visitors to old, frail and vulnerable people in hospitals was detrimental? Or will we carry on? I advocate that we deepen our understanding of the working relationship we have with people we care for. We need to release the shackles of control and facilitate a shift in power dynamics, by joining hand in hand with families to become part of the patient and public involvement experience.

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It’s 30 years since Patricia Benner published her seminal work From Novice to Expert, suggesting nurses move through different stages of learning and skill acquisition. Benner believed a characteristic of reaching expert practitioner status was the ability to rely on intuition.

Our research report (page 19) supports her theory with an analysis of nurse documentation. It revealed a link between staff noting more optional comments and vital signs, and patient death and cardiac arrest. In other words, nurses’ concerns about deteriorating patients were reflected in the amount of entries on those patients. The authors say greater awareness of documentation patterns may help staff to spot deterioration earlier. If future research confirms these findings, expert nurses’ instincts may become a tool to recognise deterioration before it is reflected in vital signs.

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www.nursingtimes.net / Vol 110 No 22 / Nursing Times 28.05.14 11