A thematic analysis of nurses' experiences with open visiting hours on medical units

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Abstract

Aim: To describe medical nurses' experiences caring for patients and families within an environment with open visiting hours (OVH).

Background: OVH is an approach where families and friends can visit patients without restrictions. OVH is a strategy used by hospitals to promote patient-and-family-centered care (PFCC). In an OVH environment, the increased presence of family can alter nurses' working environments. However, research examining nurses' perspectives on OVH is limited. As OVH becomes more widely implemented, it is essential to understand the influence of OVH on the nurse.

Design: A qualitative descriptive approach was used.

Methods: Semi-structured interviews were conducted with 10 registered nurses on two medical units in a large urban Canadian hospital. Thematic analysis was used to analyze the data inductively. Strategies were used to enhance rigour.

Results: Four main themes resulted which described participants' experiences with OVH as they related to the processes and philosophy of OVH, the care of patients and family, and the influence families had on patient care and nurses working environments. An overarching theme of *Reliance and Resistance* reflected participants' mixed feelings toward OVH. While OVH facilitated PFCC and alleviated nurses' work, at times it also hindered opportunities for nurses to get to know patients and added to their work. Further, increased family presence created challenges related to space, overcrowding, increased noise levels, and created concerns about safety.

Conclusion: The findings add to an understanding of the clinical realities of OVH from the perspectives of medical nurses, and the potential implications for PFCC and nurses' working environment.

Relevance to clinical practice: OVH creates an environment to foster PFCC. However, nurses may benefit from training to facilitate communication and engagement with families. Organizations who wish to implement OVH should consider how contextual factors may influence nurses' environments and their practice.

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Chapter One: Introduction

1.1 Statement of the Problem

Open visiting hours (OVH) is an approach that allows in-patients' families and friends (hereafter referred to as family) to visit them 24-hours a day without restrictions on the duration of the visit, time of visitation, and on the number of visitors (Canadian Foundation for Health Care Improvement [CFHI], 2015; Monroe & Wofford, 2017). OVH is most common within critical care settings to allow greater flexibility for patients and families to be together (Da Silva et al., 2013; Roland et al., 2001). It is also common in paediatric in-patient settings where OVH facilitates the presence of parents who are considered integral in the provision of care to their children (Mastro, Flynn, & Preuster, 2014; Soury-Lavergne et al., 2012). However, outside of these settings, OVH is a relatively new strategy used by hospitals to improve the experiences of patients and families while in hospital, and to embrace patient-and-family-centered care (PFCC) (CFHI, 2015; Institute for Patient and Family Centered Care [IPFCC], 2010, 2017). Research indicates that eliminating restrictions on hospital visiting hours is viewed as favorable by patients and families (Hardin et al., 2011; Jacob et al., 2016; Mitchell & Aitken, 2017). The increased presence of families, facilitated by OVH, creates opportunities for health care providers, patients and families to develop therapeutic relationships, participate in care, information sharing and shared decision-making, and to collaborate with each other (Ciufo et al., 2011; IPFCC, 2017; Mastro, Flynn, & Preuster, 2014).

Research examining nurses' perspectives on OVH, however, is more mixed (Kozub et al., 2016; Nuss et al., 2014; Monroe & Wofford, 2017). Nurses acknowledge that OVH offers additional emotional support for patients, opportunities for information sharing with families, and facilitates families' assistance with activities of daily living (Ciufo et al., 2011; Riley et al., 2014). However, nurses also identify some challenges working within an OVH context (Monroe

& Wofford, 2017). For example, the increased and unrestricted presence of families can limit space, lead to interruptions and disorganization of patient care and add to nurses' workload (Da Silva et al., 2014; Monroe & Wofford, 2017; Nuss et al., 2014; Shulkin et al., 2013). Since it is known that OVH alters nurses' working environment, it is important to examine how and in what ways. Unfortunately, research exploring nurses' perspectives on OVH comes mainly from nurses in critical care and paediatric settings where OVH is common (Ciufo et al., 2011; Smith et al., 2009). As OVH becomes more widely implemented, it is important to understand the influence of OVH on nurses in non-specialized settings, such as medical units. Although research in adult critical care settings can add to an understanding of nurses' experiences and their views on OVH, the findings may not translate to nurses working in medical settings. Contextual factors such as workload, patient acuity, and nurse-to-patient ratio contribute to variability in the working environments of nurses (The Canadian Federation of Nurses Unions [TCFNU], 2012; Schenk et al., 2017). For example, medical units have the highest nurse-to-patient ratios with five to 10 patients per nurse, compared to 1 to 2 patients per critical care nurse (Rothberg et al., 2005; Schenk et al., 2017). Although both medical and critical care nurses care for patients with multiple medical conditions, patients in critical care units require nurses to frequently monitor and provide interventions, whereas patients in medical units are found to be more stable which contributes to the higher nurse-to-patient (Schenk et al., 2017). The increased presence of families facilitated by OVH policies and practices may be a particular issue for nurses on medical units given the number of patients and families they care for. With this in mind, research within critical care settings may not necessarily translate or be generalizable to nurses' experiences on medical units. These notable differences highlight the importance of exploring OVH from the perspectives of medical nurses in an effort to gain a better understanding of their experiences working in the context of a medical unit with OVH.

1.2 Standard Hospital Visiting Hours

The standard visiting hours within hospitals are restricted visiting hours (IPFCC, 2010). Restrictions may include the number of visitors allowed for each patient and the time in which visitors are allowed to visit (e.g., visiting hours from 3 pm to 8 pm); (Shulkin et al., 2013; Smith et al., 2009). In some settings, there are also restrictions regarding who can visit, (i.e., where only immediate family such as a partner or a parent are allowed at the bedside; Farell, Joseph, & Schwartz-Barcott, 2005). Most institutions stipulate that visitation occur during regular business hours (i.e., 9 am to 5 pm) when patient care units are less likely to be busy since most patient care such as medication administration, personal care, diagnostic tests, and nursing/interdisciplinary rounds are performed in the mornings (Hendrich et al., 2008). However, visiting hours set around these times are not always feasible for visitors due to conflicting personal and work schedules, or the need to arrange for transportation (Sims & Miracle, 2006).

Similarly, institutions may refer to their hospital visiting hours as *flexible* rather than *restricted*. Flexible visiting hours signifies a visitation policy that is less restrictive and is based on the discretion of the nurse (Agard & Lomborg, 2011; Smith et al., 2009). Flexible visitation can be categorized into *structural* or *contractual* visitation (Smith et al., 2009). Structural visitation refers to the length of time visitors may stay and places the same limits on all visits (Hardin et al., 2011; Smith et al., 2009). For example, an institution may allow visitation to occur for a maximum duration of thirty minutes each time. In contrast, contractual visitation is specific. A visiting contract is developed through the collaboration between nurses, patients and family members with the aim of meeting the individualized needs of everyone (Slota et al., 2003; Smith et al., 2009). In reality, structural and contractual visiting are almost never fully actualized as nurses tend to use their judgment and discretion as to whether or not visitors should be present (Smith et al., 2009). This process of nurses recreating the boundaries for visitation to permit flexible visitation is known as *gate-keeping* (Agard & Lomborg, 2011; Farrell, Joseph, &

Schwartz-Barcott, 2005). Flexible visitation permits patients and families to be together under circumstances where patients' conditions are unstable or life-limiting (Sims & Miracle, 2006). Thus, flexible visiting is often used in critical care settings (Farrell, Joseph, & Schwartz-Barcott, 2005).

1.3 Open Visiting Hours

Although OVH is meant to eliminate restrictions on when family and friends can visit patients, the duration of their visit, and the number of visitors, there is variability in how it is defined and implemented in practice (Mitchell & Aitken, 2017). In a report of medical and surgical units in Canadian hospitals, it was found that only 35% of the hospital units that had OVH permitted 24-hour visitation without any restrictions (CFHI, 2015). Several units that claimed to have OVH had certain restrictions in place such as the number of visitors (CFHI, 2015). It was also found in the CFHI (2015) report, that some hospitals defined OVH as *extended* visiting hours; indicating that there were restrictions, however, visiting hours extended beyond standard (restricted) visiting hours. McAdam and Puntillo (2013) point to inconsistency in the vocabulary used to describe OVH with terms such as *24/7, anytime, accommodating, extended,* or *flexible*, which contribute not only to a lack of understanding of what OVH *is* but also how it is actualized.

Although OVH practices exist, there is considerable variability across patient care settings and within and across countries (Cappellini et al., 2014; Ciufo et al., 2011). As described above, OVH in adult care settings is predominantly within critical care or intensive care units (ICU), OVH with rates as high as 70% (Liu et al., 2013). However, information on the extent of OVH outside of critical care settings is limited. CHFI's (2015) report indicated that only 23% of acute care hospitals have OVH, which suggests that OVH is not widely used in Canadian hospitals (CFHI, 2015). Even within critical care settings, there is variability. An international review of OVH in ICUs found that the majority (70%) of Swedish ICUs had OVH, whereas, ICUs

surveyed in Belgium and Italy tend to have restricted visiting hours (Cappellini et al., 2014). Findings from Cappellini et al. 's (2014) study regarding Swedish ICUs contrasts the findings from a North American survey of 606 hospitals which found that only 25% of ICUs have OVH (Liu et al., 2013).

Despite slow progression in the implementation of OVH and the inconsistencies with how OVH is defined and implemented, countries across Europe and South America have begun to recognize the benefits of OVH and have revised their visitation policies to become less restrictive (Cappellini et al., 2014; Escudero et al., 2014). In countries such as Iran and Saudi-Arabia where culturally, the family is a central value, OVH has to some degree been acknowledged by hospitals and their staff (Baharoon et al., 2014; Tayebi et al., 2014). That is not to suggest that countries such as in Europe and North America do not value family as central to a patient's healthcare experience, but instead, it raises the question as to why they have lagged in their adoption of OVH.

O'Reilly et al., (2015) acknowledges that Canada has yet to adopt and implement OVH fully. According to O'Reilly et al., (2015), despite the increasing popularity of OVH, there are concerns about it in practice. Organizations and healthcare providers, namely, nurses believe unrestricted visiting will lead to a rise in the number of visitors; create additional noise, disruption, and increased infection risks (O'Reilly et al., 2015). The literature indicates that while nurses appreciate the value of OVH for patients and families (Chapman et al., 2014; Monroe & Wofford, 2017), there are concerns that OVH will negatively impede patient care, patient privacy, the well-being of patients and families, and lead to an increase in workload (Athanasiou et al., 2014; Ciufo et al., 2011; Da Silva et al., 2014; Monroe & Wofford, 2017; Nuss et al., 2014). As OVH gains greater acceptance outside of the critical care context, it is essential to understand the challenges and opportunities that OVH brings from the perspectives of nurses working within OVH environments. At this time, the experiences and perspectives of

nurses in non-specialized adult inpatients environments such as medical units are missing from the literature.

1.4 Research Aim and Objective

The study aimed to describe medical nurses' experiences of OVH in relation to the provision of care to patients and families. The objective was to provide an understanding of how medical nurses engaged with OVH and what the likely increased presence of family had on nurses and their practice. The study will add to the literature on nurses' experiences with OVH outside of critical care settings. Findings from the study increase understanding of nurses' experiences in the medical context and inform OVH policies and practice.

1.5 Researcher's Reflection, Assumptions, and Epistemic Stance

As the primary researcher, it is important to acknowledge my position and values in relation to the phenomenon of interest. The inspiration for this study is rooted in my own experience working as a registered nurse on a medical unit that transitioned from restricted to OVH. My career as a registered nurse started in a medical unit and is where I learned the foundational skills to my practice. Working in a medical unit shaped my practice as I was exposed to patients with various medical conditions and challenges. My unit was one that was patient-and-family-centered; nurses seemed to truly value patients' experiences. Before the implementation of OVH, nurses on the medical unit, including myself, were quite flexible and lenient with visitors and visiting times. Therefore, when OVH was implemented on our unit, it was a subtle change. However, I remember feeling surprised to learn that the hospital allowed families to visit 24-hours a day. I envisioned OVH would create chaos on the unit. However, I empathized with patients. My patients were oftentimes overwhelmed with the plethora of healthcare professionals involved in their care, the number of tests they were scheduled for, and the challenges they faced. I realized how comforting it was for patients to have their loved ones present whenever they wanted. I found that OVH helped both patients and their families who

were in a vulnerable state feel as though they could be together and function as a family while in hospital.

At the same time, OVH was time-consuming as I spent more time with patients and their families; leaving me little time to complete other interventions and tasks. While the presence of families through OVH made it challenging to balance my time, I also felt that OVH enhanced my practice as it required me to strengthen my communication and time management skills. Over time, it was easier for me to develop a rapport with patients and their families which made me feel complacent within my practice. I found that the presence of families facilitated opportunities for me to get to know patients on a more personal level, beyond context of illness. Overall, despite the challenges I faced, I had a positive view of OVH and felt that OVH supported the philosophy of care on my unit. However, my views on OVH were not shared by several of my colleagues. Many disagreed with OVH as it was now permissible for families to stay overnight. My colleagues felt families were an inconvenience as they were often times in the way of them providing care. Moreover, several nurses expected that if families chose to visit, that they should be providing some level of care to patients. I recognized that nurses' views and experiences concerning OVH were wide-ranged and that it is essential to be open to these differing perspectives to gain insight and build knowledge regarding OVH.

Taking into consideration my own experiences in relation to the limited research on nurses' perspectives on OVH outside of critical care settings, I felt that it was necessary to capture the experiences of medical nurses. As a result, I chose a qualitative descriptive approach using thematic analyses (Braun & Clarke, 2006; Sandelowski, 1995). I felt that an explicit conceptual or theoretical framework, such as one related to PFCC would restrict the study and limit the aim of *broadly* understanding nurses' experiences with OVH. While I recognize the context in which medical nurses' work, medical nursing, and PFCC, my study is purposefully open to understanding participants' perspectives on OVH.

Qualitative description aligns with my ontological and epistemic values of a constructivist worldview (Sandelowski, 1995). Constructivism supports relativism, which is a concept where beliefs and principles have no absolute truth or validity (Appleton & King, 1997). Constructivists assume that knowledge is understood as subjective rather than objective where the researcher must interact with study participants throughout the research process (Guba & Lincoln, 1989). The purpose of collaborating is to expose the multiple views of reality and to co-create knowledge (Appleton & King, 1997). Ultimately, the goal is to gain some level of understanding, while remaining open to new interpretations as information and experiences change (Creswell, 2009).

1.6 Organization of the Thesis

In this chapter, I identify the research problem. I also elaborate on why I chose to focus my study on medical units and provide an overview of various hospital visiting practices, including OVH. In this section, I also identify the research aim and objective and am reflexive in discussing my experience with OVH and assumptions about OVH. Further, I identify my methodology and epistemological stance. In Chapter Two, I provide background to the study by describing the context to the focus on nursing care on medical units. I describe the concept of patient-and-family-centered care (PFCC) as it relates to OVH. In Chapter Two, I examine literature relevant to the research inquiry. That is, literature that focuses on OVH from the perspectives of nurses in adult in-patient settings. In discussing this literature, I identify where my research fits with what is known about the phenomenon of interest. In Chapter Three, I outline the methods used to describe medical nurses' experiences of OVH in relation to the provision of care to patients and families. In this chapter, I describe qualitative description and the use of thematic analysis. Chapter Four is presented as a manuscript within this thesis. In Chapter Four, I discuss the results of my study, and the implications of the findings for clinical practice, as well as the limitations of the study. I conclude the thesis with Chapter Five, where I

offer an integrated discussion on medical nurses' perspectives regarding OVH. In Chapter Five, I elaborate on the discussion in Chapter Four, as they relate to the impact of OVH on nurses' working environments and relate the findings to the impetus of OVH as a strategy to foster an environment that cultivates the delivery of PFCC. Also, I relate the findings to advanced practice nursing roles and the implications for clinical practice, leadership, research, and consultation and collaboration.

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Chapter Two: Background and Literature Review

In order to provide context to the study, I begin by describing the milieu of nursing care on medical units. Then, I introduce the concept of patient-and-family-centered care (PFCC) in relation to OVH. Although the purpose of this inquiry is not focused on PFCC, OVH is adopted as a means to facilitate PFCC. Therefore, it is necessary to discuss OVH as it relates to PFCC. In the section on PFCC, I draw on literature examining patients', families', and organizations' perspectives on OVH. Next, I discuss literature relevant to my inquiry from the perspectives of nurses in adult in-patient settings. Based on the extant literature, I identify gaps in the literature to provide support for the study aims to describe medical nurses' experiences of caring for patients and families in an OVH environment.

2.1 Nursing Care on Adult Medical Units

Adult medical units are designed to treat patients with sudden, unexpected, and urgent episodes of injury and illness that require rapid interventions (World Health Organization [WHO], 2013). Patients admitted to medical units present with a range of acute and chronic illnesses such as cancer, diabetes, dementia, heart disease, infection, and kidney disease (Bell et al., 2013; Canadian Association of Medical and Surgical Nurses [CAMSN], 2008). An aging population has meant that clinicians (including medical nurses) on medical units are increasingly caring for older adults whose care can be complex due to multiple-morbidities and conditions such fragility, dementia, and mobility issues (e.g., bed-ridden) (CAMSN, 2008; Lewis et al., 2010). Furthermore, the acuity of patients on medical units has increased with the addition of acute monitoring or step-down areas on some medical units to monitor patients who would have previously been admitted to critical care units (Bell et al., 2013; Hurst, 2011). While patients are admitted to medical units with physiological conditions (acute and chronic), they also present with unique combinations of physical, functional, psychological, emotional, social, cultural, and

spiritual needs, which adds to the complexity of their care (Beatrice, 2007; CAMSN, 2008; RNAO, 2015).

Medical nurses work to meet the multifaceted needs of patients with a wide range of medical conditions, increasing acuity, and multiple-morbidities makes medical nursing both complex and challenging (Canadian Nurses Association [CNA], 2015). For this reason, medical nurses require a broad range of knowledge in order to provide and prioritize the care needs of patients and their families (CAMSN, 2008). As part of their practice, medical nurses assist patients with personal care activities (e.g., feeding, bathing, toileting), and provide educational and emotional support to patients and their families (CNA, 2015; Schenk et al., 2017). Further, they conduct timely physical assessments, continuous patient monitoring, and assist with interventions (e.g., thoracentesis, pain-block). As part of their job, medical nurses also assume the role of a coordinator, educator, and advocate for patients and their families (CAMSN, 2008).

Caring for patients with multiple, individualized health care needs requires a health care team (e.g., physicians, unregulated health care providers, social work, physiotherapy and other allied health). Medical nurses often act as liaisons between health care providers, patients and families to ensure clear communication regarding the goals of care (CAMSN, 2008; Schenk, 2017). With a high turnover of patients on medical units, nurses are often responsible for coordinating admissions and discharges in an effort to maintain an efficient flow of patients (CAMSN, 2008). Furthermore, medical nurses are responsible for coordinating and managing the care of multiple patients. Since patients admitted to medical units tend to have conditions that require tests and investigations medical nurses are often responsible for coordinating these procedures (CNA, 2015).

As educators, medical nurses spend a significant portion their time providing patient and family teaching. Patient and family teaching may include instructions on medical conditions, laboratory values, medications, plans of care, and procedures (Schenk et al., 2017). Patient and

family teaching are an opportunity for nurses to identify whether patients or families have any knowledge gaps regarding their plan of care, and to ensure they are informed, prepared, and supported (Arnold & Boggs, 2007; CAMSA, 2008). Education empowers patients and families to participate in their care through shared-decision making and self-management (CAMSA, 2008). Through patient and family teaching/education, nurses coach patients in how to self-manage their care, and mentor family caregivers involved in their loved one's care.

Nurses on medical units advocate for patients across the continuum of care. Nurses' close proximity to patients means they have an opportunity to develop therapeutic relationships that can facilitate "getting to know" patients and families in their care (Arnold & Boggs, 2007; IPFCC, 2010; RNAO, 2015). This knowledge is important for identifying patients' and families' needs and preferences (e.g. cultural and spiritual considerations), for which nurses can advocate to the rest of the health care team (RNAO, 2015). Advocacy is an important role for medical nurses as patients may be rendered vulnerable because of their condition and/or lack of understanding of it, in addition to how it is managed (Arnold & Boggs, 2007). For example, there is increasing representation of older patients on medical units with cognitive impairments (CNA, 2015). Also, patients admitted to medical units who are alone with no family or support. Nurses can advocate on behalf of patients to ensure that they are receiving quality care that is appropriate and is in the best interest of the patient (Arnold & Boggs, 2007).

Nurses on medical units are not only challenged by the diverse and multi-faceted needs of patients in their care but by their working environment. Much of nursing work and the environment are influenced by the economics and efficiencies with the Canadian health care system (Rothberg et al., 2005; Thomson, 2007). With shortened hospital stays, bed shortages, lack of resources (e.g. medical equipment), and hospital budget constraints, medical nurses are faced with increased workloads and an ethos of busyness on their units as they attempt to provide the same quality care to patients and families with limited resources (Thomson, 2007).

Currently, nurse to patient ratios on medical units range from one nurse to five patients (1:5), with ratios as high as 10 patients (1:10) during night shifts (Berry & Curry, 2012; CAMSN, 2008; Rothberg et al., 2005; Singer et al., 2014). Consequently, medical nurses must prioritize the varying needs of several patients and families in their care. This involves managing multiple responsibilities at the same time. For instance, a medical nurse may need to assess an older patient who is newly admitted to the unit after having a fall, implement immediate interventions to another patient who is in respiratory distress, provide teaching to a patient and their family newly diagnosed with congestive heart failure, while coordinating a discharge from the medical unit for a patient who requires community resources. Considering the patient population and the number of patients medical nurses care for, medical units can be described as being in a constant state of fluctuation as nurses try to meet the increasing health care needs of patients in their care (Canadian Medical Association [CMA], 2013). Adding to nurses' workloads, is the responsibility of teaching and mentoring students (i.e. nursing students, medical students, new graduates, and other health care providers). Medical units are commonly used for student placements because they are considered an ideal environment for students to gain diverse and foundational knowledge; however, clinical placements require nurses to mentor students while simultaneously balancing their patient care responsibilities (CAMSN, 2008; Oliveria, 2014).

In summary, medical nurses work in a highly complex and demanding working environment. Caring for several patients with diverse needs and varying acuity is challenging. Adding to the challenges faced by medical nurses are increased workloads and a lack of resources, which puts pressure on nurses as they strive to enact their roles and provide care centered on the needs of patients and families (Beatrice, 2007; Thomson, 2007).

2.2 Patient-and-Family-Centered Care and Open Visiting Hours

Patient-and-family-centered care (PFCC) is a philosophy and approach to care that is respectful of, and responsive to, the preferences, needs, and values of patients and their families

(IPFCC, 2017; RNAO, 2015). Open visiting hours (OVH) is one of the many strategies to promote PFCC through family presence. In this section, I will discuss how the increased presence of family, facilitated through OVH, relates to attributes underlying the concept of PFCC. It is important to note that there is variation in how PFCC is conceptualized in the literature (Mastro, Flynn, & Preuster, 2014; Park et al., 2018). Despite varying conceptualizations of PFCC, they all include the following four attributes: dignity and respect, information sharing, participation, and collaboration (IPFCC, 2017; Mastro, Flynn, & Preuster, 2014; RNAO, 2015).

2.2.1 Respect and dignity.

Maintaining patients' respect and diginity is a central focus of providing care that is patient and family centered (RNAO, 2015). Respect and dignity go beyond preserving the privacy of patients and families; it also includes acknowledging patients as experts on their life and, listening and honouring patients' and families' perspectives and decisions (Ciufo et al., 2011). Patients and families may hold certain knowledge, values, and cultural and spiritual beliefs that health care providers should consider during planning, delivery and evaluation of safe and quality and care (CFHI, 2015; IPFCC, 2017; Park et al., 2018). When patients and families are respected and treated with dignity by health care providers, they feel more inclined to share their knowledge, needs, and decisions regarding care (Ciufo et al., 2011). Through openness, families are welcomed and respected partners in care rather than merely visitors (Ciufo et al., 2011). Acknowledging families as more than just visitors reminds health care providers that families are an essential aspect of the provision of care and that they are an extension of the patient (IPFCC, 2010). The attribute of respect and dignity facilities a partnership where patients and families feel comfortable communicating with health care providers. It also encourages health care providers to be receptive to opinions and decisions that are voiced by patients and

families. This contributes to a partnership that is *mutual*, which is central to PFCC (Ciufo et al., 2011; IPFCC, 2017).

In many ways, OVH helps to preserve patients' dignity. Hospitalization can be very difficult for patents and their families. Being in an unfamiliar setting, in addition to suffering from an illness, can make patients feel vulnerable, leading to feelings of powerlessness, fear, pain, and isolation, (otherwise known as the phenomena of alien equipment) (Ciufo et al., 2011; Farrell, Joseph, & Schwartz-Barcott, 2005). When a patient feels vulnerable, their dignity, sense of self-respect and self-worth may be compromised (Farrell, Joseph, & Schwartz-Barcott, 2005). Family presence facilitated by OVH allows patients to feel a sense of security rather than vulnerability during their time in the hospital (Cappellini et al., 2014). For example, hearing a familiar voice and feeling a family member's touch can comfort patients and help to eliminate feelings associated with alien phenomenon (Chapman et al., 2016; Hunter et al., 2010; Farrell et al., 2009; Vandijck et al., 2010). The presence of family is particularly significant for the older population because unfamiliar environments may evoke psychological changes such as confusion and hallucinations (Agard & Lomborg, 2011). Therefore, the presence of family offers patients a sense of familiarity and, in some cases, prevents psychological changes from occurring (Agard & Lomborg, 2011; Chapman et al., 2016; Hunter et al., 2010; Vandijck et al., 2010). Ultimately, increasing family presence through OVH creates opportunities for patients to maintain a sense of normalcy while in the hospital and helps preserve their dignity.

While family presence facilitated by OVH is helpful in preserving the dignity of patients during their hospitalization and for maintaining a sense of normality, OVH and the increased presence of family also creates challenges regarding patients' privacy and confidentiality (Carroll & Gonzalez, 2009; Ciufo et al., 2011; Nuss et al., 2014; Whitton & Pittiglio, 2011). In a 2009 descriptive exploratory study examining visitation preferences of patients in cardiac and surgical ICUs, it was revealed that patients were fearful that others would easily overhear their personal

health information in their room (Carroll & Gonzalez, 2009). In circumstances where patients are in shared rooms (e.g., semi-private or ward rooms), privacy breaches may occur more easily because patients and families are merely separated by a curtain, limiting privacy (Hardin et al., 2011; Kirchoff, 1985). Furthermore, OVH may lead to overcrowding of visitors in patient rooms contributing to potential privacy breaches. Although patients favour OVH and an increase in the presence of family during their hospitalization, patients may not necessarily want to share their health information with their family members (Carroll & Gonzalez, 2009). Since OVH permits 24-hour visiting, patients may use their discretion to limit visitation to preserve their privacy or simply because of personal preference. A patient's desire to limit visitation may place the patient and possibly health care providers in an uncomfortable situation with family members (Carroll & Gonzalez, 2009; Whitton & Pittiglio, 2011).

OVH precipitates challenges that compromise the respect and dignity of patients. While PFCC should be organized in a way that is respectful and reflective of the changing health care needs and preferences of patients (RNAO, 2015), the presence of family may create challenges as families may interfere with patient care and negatively influence the feelings and experiences of patients while they are in the hospital. In a study by Carroll and Gonzalez (2009), patients perceived rest as a crucial part of their recovery, while also describing a lack of rest due to frequent or long visits from families. Although OVH is an approach that respects families' wishes to be near patients, families are, at times, overbearing and anxious (South & Adair, 2014). Carroll and Gonzalez (2009) found that family members had a tendency to frequently assess patients' comfort and pain levels, which also interrupted the patients' rest. In some cases, family monitoring intensified patients' perception of pain even though their pain was under control (Carroll & Gonzalez, 2009). To date, most of the discussions on OVH in the literature focus on the positive consequences of OVH from patients' perspectives. While Carroll and Gonzalez's (2009) study provides insight on potential concerns patients may have with OVH, there is little

research that addresses the negative consequences of OVH and what this may mean for patients and families receiving care.

2.2.2 Information sharing.

When health care providers communicate patient's clinical status, progress, and prognosis to patients and families in a timely and unbiased manner, this is known as information sharing and is an essential attribute of PFCC (Park et al., 2018). Information may relate to the planning and delivery of care, the patient's clinical status, progress, and prognosis (IPFCC, 2017; Park et al., 2018). OVH promotes family presence, which creates more opportunities and time for communication between health care providers and families, thereby facilitating information sharing. A benefit of having families more present is that the family can act as a patient advocate and proxy; (if this is the patient's preference), communicating pertinent information to the health care team about the patient's medical history, and personal preferences. This information sharing is not only useful during times of decision-making, but it also allows the health care team to come to know the patient as a person with individualized preferences and needs as part of a comprehensive patient assessment (da Silva Ramos et al., 2013; Livesay et al., 2005; Riley at al., 2014). It is also important to have families present when caring for patients with language or cognitive limitations as families can facilitate communication between patients and health care providers and share information about the patient with health care providers (RNAO, 2015).

Families play an important role in supporting patients' informational needs (Cappellini et al., 2014; Mitchell & Aitken et al., 2017). Hospitalization disrupts daily routine as patients are bombarded with several tests, procedures, and interventions. As a consequence, patients often feel overwhelmed or may not comprehend the information given to them by their health care providers (Cappellini et al., 2014). When families are informed, they can reiterate information in a way they know the patient will understand to support patients' informational needs (Cappellini et al., 2014; Mitchell & Aitken et al., 2017). By reinforcing information to the patient, the

patient can regain a sense of control over their lives, which can help them to feel motivated and empowered to participate in their care (Hardin et al., 2011; Whitton & Pittiglio, 2011).

Information sharing allows patients and families to be well-informed when participating in care and shared-decision making (IPFCC, 2017). When informed, families become empowered and more inclined to participate in their loved ones' care (Ciufo et al., 2011; Mastro, Flynn, & Preuster, 2014; Park et al., 2018). Furthermore, having the flexibility to speak to health care providers daily and on multiple occasions facilitates communication of information regarding the patient's condition and care. In a study conducted by Jacob et al. (2016) in an ICU with continuous visitation, family members stated that receiving information regarding patients provided families with the reassurance that their loved ones were in good hands and receiving the best care possible.

2.2.3 Participation.

Participation is an attribute of PFCC that involves encouraging patients and their families to partake in part or all aspects of patient care (IPFCC, 2017). OVH is an approach that increases family presence, providing more opportunities for families to engage with patients and health care providers in order to facilitate participation. Participation may include providing physical, practical, and emotional care, but also extends to include shared-decision making regarding care (Mastro, Flynn, & Preuster, 2014). OVH grants patients the option to invite their loved ones to be a part of their care at any point during their hospitalization (Ciufo et al., 2011). Although a PFCC approach focuses on patients and families become active partners in care, the level of participation depends on the patient's and family member's wishes, as well as the patient's ability to participate in their care (RNAO, 2015). Family participation in patient care also depends on the family's readiness to participate to the extent they want to be involved (Ciufo et al., 2011; IPFCC, 2017). When participating in self-care, patients cultivate self-determination as they gain confidence and knowledge about addressing and meeting their own

health care needs. Self-determination allows patients to make decisions regarding their care with the support of health care providers and their families (Hardin et al., 2011; RNAO, 2015; Whitton & Pittiglio, 2011). OVH allows patients to have open access to those they need for support. With the presence of family by their side, patients may feel more empowered to make decisions regarding their care (South and Adair, 2014).

Family participation in patient care is known to enhance continuity of care for patients (Gasparini et al., 2015). Research has shown that family involvement in care increases patient and family satisfaction, as well as their overall hospital experience (Ciufo et al., 2011). In a quality improvement study that assessed families' level of satisfaction and views regarding visitation policies in ICUs, families indicated the highest level of satisfaction with OVH as it allowed them to participate in their loved one's care (Roland et al., 2001). Furthermore, research examining the needs of families during patient hospitalization indicates that families value proximity to patients (Ciufo et al., 2011; Jacob et al., 2016). OVH offers families the closeness they desire with patients as it allows families the flexibility to organize planned visits that are convenient for them and which facilitates participation in care (Hart et al., 2013). Furthermore, participation in care is also associated with improved rapport between patients, families and health care providers; OVH supports an environment where therapeutic relationships have the potential to grow stronger as OVH offers opportunities for more interactions between partners in care (Hunter et al., 2010).

2.2.4 Collaboration.

Collaboration involves health care providers partnering with patients and families to identify priorities and goals to mutually meet the health care needs of the patient (RNAO, 2015). In order for collaboration to occur, a therapeutic relationship built on trust and respect is required (Arnold & Boggs, 2007). A therapeutic relationship fosters a partnership between patients, families, and health care providers in which power imbalances are eliminated. In other words,

patients and families are viewed as equal and valuable collaborators alongside health care providers. The elimination of power differences facilitates interactions that are holistic and authentic and allows patients and families to feel more inclined to collaborate with health care providers (Hamrick et al., 2014; Mastro, Flynn, & Preuster, 2014).

A successful collaborative relationship is based on communication, availability, and accessibility. Open communication between patient, families, and health care providers is needed to ensure mutual understanding of goals of care, assess personal preferences, and negotiate and find common ground on treatment goals (Sidani et al., 2014). For open communication to occur, patients, families and health care providers need to be available. OVH facilities accessibility to patient care areas and increases families' availability as their time to visit is no longer confined to specific visiting hours, resulting in more communication with patients and health care providers (Ciufo et al., 2011). With OVH, health care providers can invite families to participate in bedside shift reporting and multidisciplinary rounds, which gives families the chance to share their opinions and collaborate with members of the health care team (Mastro, Flynn, & Preuster, 2014). In a study conducted by Hart et al., (2013), the authors indicated that OVH provides families with the opportunity to collaborate with patients and health care providers in activities such as discharge planning. Family participation in discharge planning allows for consideration of their own needs and the needs of the patient (Hart et al., 2013).

Patients prefer to make individual decisions regarding their care by collaborating with their families and health care providers (South & Adair, 2014). For example, in a study examining patients' perspectives on visiting hours in the ICU, Hardin et al. (2011) found that patients preferred to make decisions regarding when visitation is appropriate. Patients voiced that visitation should depend on how they feel, what tests or interventions are scheduled to occur that day, and ultimately, when it is convenient for them (Hardin et al., 2011). In this study, patients

were comfortable consulting and collaborating with both their families and health care providers when making decisions about visitation times (Hardin et al., 2011). Patients also collaborate with health care providers and families to coordinate other aspects of care such as meals times and when they will receive personal care (RNAO, 2015). Collaboration facilitates PFCC by ensuring that decisions are not driven solely by health care providers, but instead, are guided by patients and those who are included in their circle of care (IPFCC, 2017; RNAO, 2015).

At an organizational level, studies indicate that with the increased presence of family through OVH, promotes a faster recovery for patients (Escudero, Vina, & Calleja, 2014; Hunter et al., 2010). Increased opportunity for collaboration between patients, families, and health care providers allows for the needs of patients to be met faster which facilitates discharge (Hart et al., 2013; Riley et al., 2014). Earlier discharge from the hospital means that patients return to their usual daily activities and routines and there is a reduction in expenditure because of the decrease in length of hospital stay (Gasparini et al., 2015; South & Adair, 2014).

In summary, it is evident that OVH is an approach that increases family presence and facilitates PFCC. OVH creates conditions which contribute toward respect and dignity, information sharing, participation, and collaboration between patients, families, and health care providers. Patients and families generally have a favorable view of OVH as it is an approach that meets many of their needs (Ciufo et al., 2011). Increased family presence brought about by OVH creates a familiar environment for patients while in the hospital as families can be by their side at any time; offering their presence and contributing to their care. OVH provides families with the flexibility that makes it easier to interact with health care providers, and to participate in care without feeling restricted by time (Monroe & Wofford, 2017). Furthermore, the elimination of restrictions to hospital visitation means patients, families, and health care professionals have more opportunities to build a rapport with each other (Garrouste-Orgeas et al., 2008). As a result,

both patients and families may feel respected as equal partners in their care and may be more comfortable participating and collaborating with health care providers (RNAO, 2015).

2.3 Nurses' Perspectives on Open Visiting Hours

I conducted a review of the literature to obtain literature on OVH from the perspectives of nurses in adult inpatient medical units (refer to *Appendix A* for literature search strategy). The review revealed that there is limited research that has explored medical nurses' perspectives on OVH (Gasparini et al., 2015; Shulkin et al., 2013; Tanner, 2005). Much of what is understood about nurses' perspectives on OVH comes from critical care settings, and there is little research outside of this context. Therefore, I will begin by discussing the literature from critical care. I will then discuss the literature examining the perspectives of nurses to OVH on inpatient medical units.

2.3.1 Nurses' perspectives on open visiting hours in critical care settings.

Critical care nurses have mixed views regarding OVH and the influence this approach has on patients, patient's families, and to their nursing practice. The literature indicates that critical care nurses' view OVH as having a positive influence on patients' and families' well-being, and their nursing practice, (Mitchell & Aitken, 2017; South & Adair, 2014). At the same time, critical care nurses also identify several challenges created by the increased family presence as a result of OVH. Nurses are concerned that OVH interrupts patients' time to rest, leads to family exhaustion, disrupts patient care, and increases nurses' workload and stress (Athanasiou et al., 2014; Ciufo et al., 2011; Monroe & Wofford, 2017; Riley at al., 2014). In this section, I will start by discussing the positive implications of OVH and proceed to discuss the various concerns that nurses have with OVH.

Hospitalization is an event that disrupts the daily routines of patients and interrupts their family dynamic and functioning (Roland et al., 2001). Critical care nurses believe that OVH provides patients with comfort during their hospitalization as they can be in the presence of their

families at any time (Monroe & Wofford, 2017). In a qualitative study conducted in Denmark that explored nurses' decision-making around flexible visitation in an ICU, nurses felt that the presence of family gave patients the opportunity to hear familiar voices, which was comforting and helped to reduce anxiety associated with being in the hospital (Agard & Lomborg, 2011). Further, the increased presence of families was thought, by critical care nurses, to normalize patients' hospital experience and keep patients connected to the outside world (Athanasiou et al., 2014; Hart et al., 2013; Whitcomb, Roy, & Blackman, 2010). Families also provide patients with social support. For instance, Athanasiou et al.'s (2014) descriptive correlational study interviewed 143 nurses in Greek ICUs and found that over 80% of nurses felt that OVH minimizes patients' boredom as families provide companionship and entertainment. This finding is supported by another descriptive correlational study conducted in a surgical-medical ICU in Spain (Marco et al., 2006). In this study of 46 critical care nurses, not only did nurses believe that OVH reduced patients' boredom, but also enhanced patients' overall hospital experience (Marco et al., 2006).

Hospitalization in critical care settings is also a stressful time for family members as they cope with having their loved one in the hospital (Sims & Miracle, 2006). In a systematic review of visitation models in adult critical care units that explored the perspectives of nurses, patients, and family members, Ciufo et al. (2011) found that nurses believed that OVH decreased the anxiety families felt having a loved one admitted to the ICU. The authors' attributed this finding to families' access to patients and being able to remain near patients (Ciufo et al., 2011). Also, when families are less stressed, nurses find that there are less patient and family complaints (Roland et al., 2001; Sims & Miracle, 2006). When families provide positive feedback, it contributes to the development of a trusting relationship between nurses and families (Farrell, Joseph, & Schwartz-Barcott, 2005). This feedback ultimately enhances nurses' self-image and

self-confidence within their practice, improving workplace experiences and promoting job satisfaction (Kirchoff, 1985; Moseley & Jones, 1991; Sims & Miracle, 2006).

OVH benefits nurses as families provide essential information to nurses on patients' routines, preferences, likes and dislikes (Agard & Lomborg, 2011; Ciufo et al., 2011; Farrell, Joseph, & Schwartz-Barcott, 2005; Marco et al., 2006). Of the 46 critical care nurses interviewed, in Marco et al. 's (2006) study, 83% agreed that OVH provided them with valuable information about the patient because families were more present and available to answer any questions (Marco et al., 2006). Riley et al. (2014) using focus groups to examine patients, families, nurses, and physician's perceptions of traditional versus patient-centered visitation in ICUs, found that nurses (n=7) stated that their assessments and ability to advocate for patients were stronger with information regarding the patient from family members. Furthermore, this study nurses also found families helpful when caring for patients from different ethnic backgrounds (Riley et al., 2014). Families can facilitate culturally competent care as they remind nurses to be mindful of the patient's language, cultural values, beliefs, and practices (Fairburn, 1994).

OVH is an approach that welcomes families to participate as partners in patient care (IPFCC, 2010). As discussed, family participation benefits both patients and their families (CFHI, 2015). Critical care nurses identify that OVH provides families with opportunities to participate in patient care as visiting hours be no longer restricted (Ciufo et al., 2011; McAdam & Puntillo, 2013). Families are familiar with patients' typical responses and functioning. Therefore, when families participate in care, they are attuned to changes in patients' behaviours and are knowledgeable about patients' personal and emotional needs that may not be evident to nurses (Athanasiou et al., 2014; Escudero, Vina, & Calleja 2013). This is important since many patients in critical care units are unable to communicate (due to sedations and interventions like mechanical ventilations etc.); without the presence of family, it is challenging for nurses to get to

know their patients. When families identify and inform nurses of patient changes, needs, and concerns, it allows them to work mutually together to address patients' needs (Riley at al., 2014).

OVH and increased family presence also means that families can participate in patient care in other ways such as providing emotional and physical care (Ciufo et al., 2011). Nurses identify that family participation in emotional and physical care (e.g., hygiene, dressing, and feeding) is particularly important and helpful when there are nursing shortages during a shift (Slota et al., 2003). Families become crucial in these circumstances as they can fill the void left by nurses forced to prioritize the physical needs and care of other patients (Slota et al., 2003). While, nurses recognize the importance of family participation in the provision of emotional support and meeting patients' physical care needs (Ciufo et al., 2011), there is little discussion of how this benefits nurses beyond staff shortages and workload.

Although the literature indicates that nurses hold positive perspectives on OVH, it also highlights that critical care nurses have concerns with OVH and the negative impact it can have on patients, families, and their nursing practice (Monroe & Wofford, 2017). The main concerns relate to the rest and recovery of patients, exhaustion of family members, and their practice (Levy & De Backer, 2013). In particular, nurses identify that the increased presence family brought about by OVH is disruptive to the delivery of patient care, increases nurses' workloads, and adds to workplace stress (Ciufo et al., 2011; Garrouste-Orgeas et al., 2008; Monroe and Wofford, 2017).

Critical care nurses are skeptical of OVH; with more families present at the bedside, nurses' fear that patients will not be able to rest, impeding their recovery (Farrell, Joseph, & Schwartz-Barcott, 2005). Ensuring that patients receive adequate time to rest is an important goal among critical care nurses, and as such, they value time with no family present for patients to rest, heal and recover (Spreen & Schuurmans, 2011; Whitcomb, Roy, & Blackman, 2010). Spreen and Schuurmans's (2011) survey of 105 Dutch head nurses' views on OVH in ICUs

found that although none of the ICUs had OVH, nurses felt strongly about thwarting excessive family visits. Nurses in this study feared unrestricted visiting would prevent patients from resting and lead to exhaustion, which could prolong patients' healing and recovery (Spreen & Schuurmans, 2011). This same concern was identified in a study examining the implementation of a less restrictive visitation policy in the critical care department of a naval medical center (Whitcomb, Roy, & Blackman, 2010). In this post-implementation study, 47 health care providers were interviewed including nurses (n=26), physicians, residents, and a medical clerk. In general, 53% of the 47 participants in this study felt that OVH adversely affected patient healing and rest (Whitcomb, Roy, & Blackman, 2010). These findings are noteworthy as standard visiting hours (restricted) were originally in place to support the views of health care providers who believed that patients required continuous rest without any interruptions in order to heal (Lewandowski, 1994).

The research also indicates that nurses worry about the well-being of patients' family members (Berwick & Kotagal, 2004; Sims & Miracle, 2006). In Ciufo et al. 's (2011) systematic review, nurses believed that as a consequence of OVH and frequent visits, families were exhausted. There is concern from nurses that families may feel obligated to stay (Kirchhoff et al., 1993). Indeed, Kirchhoff et al. (1993) noticed that families tend to turn to nurses for permission to leave patients. Although Kirchhoff et al.'s study is 25 years old, similar findings are described in more recent literature (Berti et al., 2007; Da Silva Ramos et al., 2013; South & Adair, 2014). In a descriptive cross-sectional study in Belgium that explored beliefs and attitudes of 531 critical care nurses' towards OVH, Berti et al. (2007) found that 50% of nurses believed that OVH influenced families' decision to visit. Further, they indicated that with OVH, families felt forced to stay with patients at all times, causing them to be worn out (Berti et al., 2007). In another study of 106 ICU workers' (including 39 nurses) perceptions of OVH in Brazilian ICUs, Da Silva Ramos et al. (2013), identified that 50% of health care providers, presumed that OVH

led to families becoming stressed and anxious; while the remaining 50% believed that OVH has no influence on families. Similarly, a review of the literature regarding the transition to OVH in critical care setting conducted by South and Adair (2014) revealed were fearful that families might experience a peripheral impact of patients' hospitalization by visiting frequently. The authors' concluded that coping with a loved one's illness may be difficult and could emanate feelings of anxiety, fear, stress, and other emotional symptoms (South & Adair, 2014). While it may be equivocal as to whether OVH leads to family exhaustion, it is certainly a fear that nurses' express and is one of the reasons why many critical care nurses prefer to have restricted visitation (Ciufo et al., 2011).

A consistent finding in the literature is that nurses indicate that OVH impedes their ability to provide care to patients. An increase in family presence throughout nurses' work days and nights causes disorganization and interrupts their workflow (Monroe & Wofford, 2017). Nurses' state that family presence is burdensome to their daily practice as they have to physically navigate around patients' bedsides because families are 'in the way' (Levy & De Backer, 2013). Hart et al. (2013) with a descriptive correlation study explored patients', families', and nurses' satisfaction with visitation guidelines in critical care units in the United States. In this study, 72 nurses were a surveyed regarding their views on visitation in critical care units. Nurses in this study commented that open visitation was a source of interruption during the delivery of care and was ultimately detrimental to patients (Hart et al., 2013). Elaborating on their concerns, nurses explained that OVH meant that family members were constantly present, which made it difficult for them to physically access patients to perform care such as medication administration, bedside procedures, patient education (Hart et al., 2013). Similarly, in Marco and colleague's (2006) study of 46 critical care nurses, 84% of nurses believed that OVH led to families to interrupt the delivery of nursing care. In particular, nurses in this study were worried that families would postpone procedures that would cause pain to patients if not done promptly (e.g., tracheal

suctioning) Marco et al., 2006). Additionally, nurses also fear that too many visitors in the room during times of emergencies would be detrimental to patients (Hart et al., 2013). As a result, nurses in these studies concluded that placing restrictions on visitation would help to minimize interruptions and facilitate nursing workflow (Hart et al., 2013; Monroe & Wofford, 2017). With that said, the literature indicates due to possible hindrance of patient care and workflow, nurses suggest modifications to OVH such as closing the unit during assessments, shift change, night shifts, and restricting the number of visitor (some prefer to have two visitors at a time) (Livesay et al., 2005; Roland et al., 2001).

Critical care nurses not only justify restricting visiting hours as it interferes with patient care and disrupts their workflow, but also because it helps reduce the increase in workload that OVH creates (Ciufo et al., 2011; Monroe & Wofford, 2017; Nuss et al., 2014). According to Hart et al. (2013), since OVH promotes family visitation, the increase in family presence adds to nurses' work demands as families tend to have more questions, concerns and requests. In a recent integrative review of open visitation and nurse job satisfaction conducted by Monroe and Wofford (2017), three of the 14 studies included in the review, indicated that nurses believed that OVH was the reason why more time was spent giving information to families rather than providing patient care. In several of the studies included in the review, nurses stated that care is often times delayed because they are interrupted to answer questions and provide information to families (Athanasiou et al., 2014; Cappellini et al., 2014; Riley et al., 2014). As a consequence, nurses expressed feeling overwhelmed by the increase in workload caused by families' continuous demands for information (Cappellini et al., 2014; Hart et al., 2013). Although nurses acknowledge families need for information, Athanasiou's et al. (2014) study found that 76% nurses felt OVH did not provide families any additional information or reassurance. Moreover, in an OVH environment nurses feared that families may not recognize that the time they spend obtaining information in order to gain reassurance may mean less time for their loved ones to

receive care; putting their own needs above those of the patient (Hart et al., 2013). The literature indicates that critical care nurses expressed that do not always have the time to address family's needs (Riley et al., 2014). Despite these findings, nurses recognize value quality patient care as a top priority for their practice and believe that information sharing with families in an essential part of patients care and is vital for PFCC (Agard & Lomborg, 2011).

The literature also reveals that critical care nurses report that OVH places them in difficult situations and with unrealistic demands. Critical care nurses who work in an environment with OVH find it challenging to balance the emotional needs of families as they are more present while providing care to patients (Kozub et al., 2017). As a result of these additional demands to meet the needs of families, nurses describe experiencing an increase in physical and psychological burden (Athanasiou et al., 2014; Lee et al., 2007; Levy & De Backer, 2013). Unfortunately, when the needs of families are not met, nurses highlight that it triggers the potential for families to complain causing fear for nurses (Lee et al., 2007). Nurses' attempts to balance the needs of both patients and families and the constant presence of families may lead to stress, which could translate into burnout (Athanasiou et al., 2014; Berti et al., 2007; Ciufo et al., 2011; Lee et al., 2007).

The increased presence of family and fear of upsetting families can cause nurses to alter their behaviour while in their presence (Athanasiou et al., 2014; Garrouste-Orgeas, Diaw, & Verdavainne, 2008). In an observational study examining perceptions of 43 medical-surgical ICU nurses and physicians working in an environment with unrestricted visiting stated that they adjust their behaviours because encountering families made them feel uneasy (Garrouste-Orgeas, Diaw, & Verdavainne, 2008). Athanasiou et al. (2014), found that more than 50% of the 143 critical care nurses in their study felt family members controlled them, especially with their increased presence. This perceived loss of control was thought to generate feelings of nervousness to the point where nurses felt that they could not act as normal for fear of making an

error, upsetting families and not meeting their expectations (Athanasiou et al., 2014). Similar to Garrouste-Orgeas et al.'s (2008) study, nurses in Athanasiou et al. 's (2014) study also reported a change in their behaviour during times when families were present. In both studies, nurses stated that they communicated less with patients in order to avoid encounters with family members (Athanasiou et al., 2014; Garrouste-Orgeas et al., 2008).

2.3.2 Nurses' perspectives on open visiting hours in non-critical care settings.

Unfortunately, there is limited research that has been conducted to gain the perspectives of nurses in non-critical care settings with OVH. In this section, I will discuss the available literature on OVH from nurses working on adult wards, medical-surgical units, and a rehabilitation units (Gaspirini et al., 2015; Shulkin et al., 2013; Tanner, 2005), as it relates directly to my inquiry on medical nurses experiences providing patient and family care in an environment with OVH

Similar to studies examining the perspectives of critical care nurses, the literature indicates that nurses who work in non-critical care settings believe that OVH is an approach that benefits patients since family presence provides additional support and comfort for patients (Ciufo et a., 2011; Monroe & Wofford, 2017; Shulkin et al., 2013; Tanner, 2005). Shulkin et al. (2013), surveyed 21 nursing managers and coordinators to assess their experiences with OVH and patient satisfaction with OVH following implementation of the policy in a 690-bed tertiary acute care facility and a 78-bed rehabilitation hospital in the US. In this quantitative cross-sectional study, nurses who were involved with the implementation of OVH were asked to complete a 7-question survey about their experience with OVH using a five-point Likert scale. The findings indicate that all 21 nursing managers and coordinators believed that OVH had a very positive impact on their units and contributed to improved patient support and experience in the hospital. None of the respondents indicated any negative impact of OVH on patients, families, and nurses (Shulkin et al., 2013).

In addition to providing patients with support and comfort, other benefits to OVH have been identified by nurses in non-critical care settings. Tanner (2005) in a cross-sectional study surveyed nurses, patients, and visitors from 35 adult wards in two acute care hospitals in England about their views on visiting hour preferences. In total, 432 nurses completed the survey. Nurses identify several advantages OVH brought to their practice including information sharing and participation in patient care (Tanner, 2005). In this study, nurses were asked to provide additional information using open-ended survey questions. In response to the open-ended questions, nurses described that OVH was particularly useful for obtaining a medical history when patients were confused as families were present and able to provide information (Tanner, 2005). Nurses also stated that if patients had difficulty settling at night, families was helpful for calming patients (Tanner, 2005).

Tanner's (2005) study is one of the few studies in non-critical care settings where nurses identify benefits of OVH, however, in this same study, 84% of the 432 nurses surveyed found it challenging to provide nursing care when families were present at the bedside with an OVH context. One challenge identified by nurses was that frequent visitation led to unrealistic expectations from families, with open access to their unit creating an environment where families treated units like "hotels" (Tanner, 2005). Indeed, one participant in Tanner's (2005) study explained that OVH had triggered families to develop an expectation where nurses are responsible for catering to them (e.g., offering drinks, and cleaning up). As a result, nurses felt like they were taking on the role of a 'waitress' for families.

In Tanner's (2005) study, nurses also stated that families were in the way and prevented them from doing their job. Furthermore, the increased presence of families meant that nurses spent more time answering families' questions, which took them away from their other duties including patient care (Tanner, 2005). As a result, nurses in this study preferred restricted visiting

hours with visitation starting after 11 am to avoid any disruption to their workflow as mornings were their busiest time (Tanner, 2005).

In contrast, Gasparini et al., (2015) found that OVH had little impact on patient care and nursing workflow. In this American quality improvement study, Gasparini et al. (2015) evaluated 446 health care leaders' (e.g. nursing executives, nursing practice advisors, medical staff, patient and safety quality directors, patient and family advisors, hospital president and vice president) perceptions of OVH and its impact on patients' and families' complaints, and patients' experiences. The study took place in three hospitals with 26 inpatient adult and pediatric units. Participants were surveyed six months after implementation of OVH (Gasparini et al., 2015). They found that that 87% of the 446 health care leaders in this study were supportive of an OVH policy. Participants' stated that OVH created an environment where families have 'free range' where they were liberated to act and behave the way they wanted without any boundaries (Gasparini et al., 2015). Unlike Tanner's (2005) study where 84% of nurses found OVH create challenges with workflow, only 20% of nurses in Gasparini et al. 's (2015) indicated that OVH impeded on patient care and workflow. Differences in the findings from Tanner's (2005) and Gasparini et al.'s (2015) studies could be explained in part by the samples. Tanner's study included front-line nurses, while participants in Gasparini et al. 's study were health care leaders. The perspectives of health care leaders may not be reflective of front-line nurses' experiences with OVH as they are typically not involved in direct care to patients and families.

The literature regarding OVH in in-patient adult non-critical care settings indicates that nurses' view OVH and the increase in family presence useful when it comes to providing patient care, and obtaining information regarding patients (Gasparini et al., 2015; Shulkin et al., 2013; Tanner, 2005). That being said, the research is lacking. First, only Tanner's (2005) study focused on front-line nurses in a medical setting. Both Gasparini et al., (2015) and Shulkin et al., (2013) studies explored the views of nurse managers, coordinators, and health care leaders who were

involved in the implementation of OVH on adult inpatient units, whose views may have be biased. Second, research exploring nurses' perspectives with OVH in non-critical care settings is exclusively studied using quantitative research designs (Gaspirini et al., 2015; Shulkin et al., 2013; Tanner, 2005). The studies identified are quantitative and restricted to satisfaction and preferences with OVH (Gaspirini et al., 2015; Shulkin et al., 2013; Tanner, 2005). Furthermore, set questions and structured responses (i.e., tick boxes or Likert scales), used in the studies identified, limits nurses' expressions of their experiences (Gaspirini et al., 2015; Shulkin et al., 2013; Tanner, 2005). Although both Gasparini et al. (2015) and Tanner's (2005) study questionnaires provided participants with the option to add comments through open-ended questions, they were still limited in exploring nurses' experiences of OVH.

2.4 Summary of Findings and Gaps in the Literature

The literature on nurses' perspectives on OVH is primarily from nurses who work in critical care settings. In summary, nurses have inconsistent views of OVH and its influence on their practice (Hart et al., 2013). Generally speaking, nurses acknowledge that OVH provides comfort and reassurance as patients and families can be in each other's presence when they please (Cappellini et al., 2014). Critical care nurses also believe that OVH enhances their practice since an increase in family presence means more opportunities to learn about their patients through families. Increased family presence also facilitates families' participation in patients' care such as monitoring patients and providing hands-on physical care which benefits nurses (Ciufo et al., 2011; Monroe & Wofford, 2017; Slota et al., 2003). Furthermore, when families are more present, nurses can develop rapport with families. A professional and positive nurse-family relationship contributes to the development of a mutual partnership which has the potential to enhance nurses' job satisfaction and PFCC (RNAO, 2015; Monroe & Wofford, 2017). Despite the benefits, OVH has drawbacks for nurses' practice. With families around, nurses find it challenging to care for patients because families can disrupt their workflow and

add to their workload (Hart et al., 2013; Monroe & Wofford, 2017). Balancing the additional needs of families while providing patient care can be challenging for nurses (Kozub et al., 2017). The limited literature available reveals that non-critical care nurses have similar views to critical care nurses regarding OVH and its impact on their practice (Ciufo et al., 2011; Gasparani et al., 2015; Monroe & Wofford, 2017; Shulkin et al., 2013; Tanner, 2005). However, research that explores the experiences of nurses who work in an environment with OVH outside of critical care settings is limited. In particular, there are no studies that explore front-line medical nurses' experiences with OVH from their perspectives. Using qualitative approaches would provide in-depth descriptions of nurses' experiences with OVH and the influence it on nursing practice.

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Chapter Three: Methods

In this chapter, I discuss the research methods used in this study. I used a qualitative descriptive approach which involved thematic analysis (TA) to describe medical nurses' experiences of providing care to patients and families on medical units with OVH (Braun and Clarke, 2006; Sandelowski, 1995). In the study design, I elaborate on the philosophical underpinnings of this approach, and why it is apt to my inquiry. I go on to describe the study's sample, recruitment strategies, setting, data collection, and analyses. Following this, I outline the strategies I used to enhance the methodological rigour of my study. Lastly, I describe research ethics and the protection of participants.

3.1 Study Design

According to Braun and Clarke (2006), TA is a widely used qualitative research method that is used for identifying, analyzing, organizing, describing, and reporting themes found within a data set. TA elicits theoretical freedom in that the researcher can proceed with a flexible approach to provide a rich and detailed, yet complex account of data that requires few prescriptions and procedures (Braun & Clarke, 2006; Nowell et al., 2017). TA is based within a constructivist paradigm where individuals create their unique realities of an experience (Braun & Clarke, 2006). Qualitative methodologies such as TA embody a naturalistic or constructivist approach to research which values that individuals create their unique realities of experience. These experiences may consist of multiple realities that may be shared, shaped and constructed (Braun & Clarke, 2006). Therefore, an individual's reality is neither fixed nor objective but rather, subjective and is subjected to changes (Braun & Clarke, 2006).

As part of a qualitative research process that embodies constructivism, TA promotes researchers to acknowledge their assumptions regarding the phenomenon and inquiry (Chapter One). This process facilitates the co-creation of knowledge and encourages researchers to be

engaged with the inquiry, identify if and how their experiences may influence the study as they progress throughout the research process. With that said, TA is a useful approach for researchers to explore the experiences, meanings, and the realities of individuals (Nowell et al., 2017); thereby making TA an appropriate approach to present a rich description and comprehensive summary of nurses' experiences providing patient and family care on medical units with OVH.

3.2 Sampling and Sample

Participants were eligible for inclusion in the study if they were registered nurses (RN) or registered practical nurses (RPN) working on inpatient medical units with OVH and were English speaking. Although the aim was to recruit both RPNs and RNs, only RNs worked on medical units where recruitment occurred. Therefore it was not possible to include RPNs in the study.

To increase the likelihood of the study findings being transferable to other similar practice settings, purposefully sampling was originally proposed (Lincoln & Guba, 1985). Purposeful sampling is a sampling method that involves identifying and selecting particular participants that have varied experience of the phenomenon of interest (Polit & Beck, 2012). However, approximately three months into the recruitment process, the method of sampling changed to snowball sampling as a sufficient sample size had not been achieved. Snowball sampling is where participants are asked to identify other potential study participants (Polit & Beck, 2012). Sandelowski (1995) states that determining an adequate sample size is dependent on judgment and experience, where researchers evaluate the quality of the information collected. The sample size for this study was dependent on informational redundancy (Francis et al., 2009). Consistent with information redundancy, sampling ceased when the data collected did not add new information to the themes and subthemes generated through the TA.

In total, the sample included 10 participants. Of the participants who were recruited, eight were female, and two were male. The sample reflected cultural and ethnic diversity (not reported

to protect participants' anonymity). Participants' years of nursing work experience ranged from less than one year to 29 years. Five out of 10 participants worked full-time and all worked 12-hour day and night shifts.

3.3 Setting

Registered nurses were recruited from two inpatient medical units in a large tertiary care teaching hospital in a large urban center in Eastern Ontario, which serves people across rural and urban areas, and communities with diverse socioeconomic, and ethnic/cultural backgrounds. Both medical units, where recruitment occurred (referred to as *Unit A* and *Unit B*), are characterized as general medical units because they admit patients with various medical conditions. However, the units also specialize in the care of patients with specific medical conditions. Unit A is a 31-bed unit with an additional six beds designated to an acute monitoring area (AMA) that is allocated to the care of patients with stroke that require telemetry monitoring. Nurses on Unit A have specialized training to manage the care of patients in the AMA. Unit A comprises one wardroom, five semi-private rooms, and 17 private rooms. The nurse-to-patient ratio on Unit A is one to four and one to two in the AMA. Unit A also has one healthcare aid during the day and evening on the ward, and one in the night in AMA to assist with personal care. Unit B is a 37-bed internal medicine unit that specializes in the care of patients with respiratory illnesses. Although Unit B does not have an AMA, there are two beds dedicated to chronically ventilated patients. Unit B has one wardroom, ten semi-private rooms, and 13 private rooms. The nurse-to-patient ratio during the day on unit B is one to four, and on nights is one to six. Nurses caring for chronically ventilated patients have a nurse-to-patient ratio of one to two. There are two healthcare aids during the day, and one during the evenings. Private rooms on both units are usually designated to patients who require isolation precautions as per infection control, or for patients who are receiving palliative care to preserve their privacy and dignity and

accommodate their family and friends. There are one staff lounge and one family lounge, which is shared between Unit A and Unit B as they are on the same floor.

The model of care guiding nursing practice in the organization is one that values care that is: safe and competent, seamless and continuous, respectful of culture and beliefs, where patients are encouraged and assisted to participate in decisions affecting their care. This organization recognizes the value of family members as an essential part of the healthcare team who contribute to the care and the healing process of patients. The visiting hour policy in the organization changed in 2015 from restricted to OVH. In their official policy (available to staff on the organization's intranet), the organization outlines the rationale for OVH as a policy to reduce patients' anxiety, feelings of isolation and to improve patients' healing and recovery. The policy states that families are welcome to visit patients 24-hours a day according to the patient's preference or those of the patient's substitute decision-maker, when applicable. At the same time, the organization recognizes the potential impact that OVH might have on the hospital environment. In their OVH policy, they emphasize the need for staff to provide adequate care and a quiet and restful environment for patients, especially at night. To facilitate quiet and patients' rest, a '*Quiet Time*' policy is in place that requires visitors to reduce noise levels between the hours of 10 pm and 6 am. Also included in the policy is information on the OVH process, such as the requirement that visitors sign in and obtain a temporary form of identification.

3.4 Recruitment

Recruitment began with reviewing the purpose and nature of the study with the director of the medical program at the institution where recruitment occurred. Upon approval, clinical nurse managers were contacted from inpatient medical units in the institution. A meeting was arranged with the clinical managers to provide an overview of the study proposal and recruitment strategies. The clinical managers forwarded an official recruitment email outlining the study to

their nursing staff (refer to *Appendix B*). This e-mail also contained a recruitment poster (refer to *Appendix C*), including information on: eligibility and requirements of potential participants, length of time and location of participation, compensation, and the contact information for the student-researcher, the supervisor, and the research ethics board in the event that participants had any questions or concerns regarding the study. Recruitment posters were posted in selected areas of the medical units not visible to the public, such as staff lounges and staff washrooms. Participants contacted the researcher via email or telephone expressing their interest in the study.

After approximately three months into the of recruitment, an adequate number of participants had not been recruited. Therefore the recruitment strategy was modified. First, the researcher arranged a brief meet-and-greet session with the nurses on each of the medical units. The meet-and-greet intended to stimulate interest in the study, and for potential participants to meet with the researcher and to gain insight on the purpose of the study, and what participation involved. At these sessions, the researcher provided postcards with information regarding the study and contact information if they were interested in participating (refer to *Appendix D*). Also, the managers and nurse educators on the units were contacted and asked to share the recruitment poster. As there was no further interest following these recruitment strategies, snowball sampling was used. Snowball sampling in this study involved contacting participants via email a few weeks after their interview to ask them to share the recruitment poster and information regarding the study to their colleagues. Nurses who were interested were asked to contact the researcher directly via email to discuss the study and potential participation (refer to *Appendix E*). A total of four participants were recruited using snowball sampling. All nurses who participated in the study received a $10 gift certificate to compensate for their time.

3.5 Data Collection

Interview appointments were scheduled in-person (n=9) and by telephone (n=1), with interviews lasting approximately 45-60 minutes. In-person interviews took place in

conference/meeting rooms at the study site or the affiliated University to ensure that the setting offered sufficient privacy to prevent interruptions and to maintain confidentiality. Participants questions were addressed and then written informed consent obtained. One participant preferred to be interviewed via telephone. For the telephone interview, the participant was sent the information and consent form via email, asked to review it, and electronically sign it and return it to the researcher before the interview.

All interviews were conducted using a semi-structured interview guide that consisted of a series of open-ended questions (refer to *Appendix F*). The use of open-ended questions was to permitted participants to freely share their experiences without any constraints and to answer in a way they preferred, providing as many illustrations and explanations as they wish regarding their experiences. In order to create an environment of openness and transparency, the researcher introduced herself as a Master of Nursing student in efforts to build rapport and trust with participants. All interviews were audio recorded. Notes were taken before, during, and after the interview process. During the interview, notes were taken to help guide the interview. Note taking also ensured vital points were highlighted and explored throughout the interview and helped the researcher to keep track of new or recurrent information was shared. After the interview, notes were made of visual cues such as body language, facial expressions, and the researcher's initial impressions, which contributed to a rich description of participants' experiences, and added to the interpretation of the data.

3.6 Data Analysis

Data analysis was done using an inductive thematic approach, where themes identified were strongly linked to the data collected. Inductive analysis is a process of coding data without trying to fit it into a pre-existing coding frame or the researcher's analytic preconceptions and as a result, is data-driven (Vaismoradi, Turunen, & Bonas, 2013). Braun and Clarke (2006) suggest that TA consists of six phases: *familiarizing yourself with the data, generating initial codes,*

searching for themes, reviewing themes, defining and naming themes, and *producing the report.* It is important to note that TA is not a linear process. It requires the researcher to engage in six phases of analysis through a process of moving back and forth between phases to generate the themes (Braun & Clarke, 2006).

Familiarizing yourself with the data began by uploading audio recording onto a qualitative software (NVivo). Audio recordings were listened to carefully and transcribed verbatim. Data analysis relies on the intellectual practices associated with identifying possible relationships among the data (Polit & Beck, 2012). Transcriptions were read and then reread line by line, which immersed the researcher in the data. The researcher of began writing initial ideas as part of the process of *generating initial codes,* including the notes taken following each interview. Codes are short segments of data that are organized so that parts of the data can be assessed in a meaningful way (Braun & Clarke, 2006). Codes were organized using the NVivo software (QSR International, version 11). The process of generating codes was frequently discussed with the research supervisor to ensure that the process of coding was conducted in a precise, consistent, and exhaustive manner; contributing to the trustworthiness of the study. As the data was coded, the codes were sorted and clustered as the researcher began *searching for themes.* Themes are patterned responses or meaning within the data that reoccur throughout the analysis (Braun & Clarke, 2006). *Reviewing themes* involved continually checking if themes were a clear representation of the clustered codes and data. The process of reviewing themes facilitated the formation of overarching themes and subthemes and helped to generate a thematic map of the analysis.

Ongoing analysis consisted of re-listening to audio recordings while re-reading transcriptions was necessary to refine each theme to ensure the analysis that themes were reflective of the data collected and was part of the *defining and naming themes* phase (Braun & Clarke, 2006). During this phase, the researcher and research supervisor discussed and identified

clear and appropriate descriptions for each theme. Finally, the researcher developed a manuscript (chapter 4) as part of *producing the report.* In this, findings from the analysis were related to the research question and literature, producing a scholarly report of the analysis that goes beyond a description of the data (Braun & Clarke, 2006).

3.7 Methods to Ensure Rigour

Rigorous TA can produce trustworthy and insightful findings. Guba and Lincoln's (1985) framework for trustworthiness was used to address rigour. Their framework consists of confirmability, credibility, dependability, and transferability.

Credibility relates to the *truth value* in the data and interpretations; that is, confidence in the research process and findings (Guba & Lincoln, 1985). During interviews, the researcher clarified her understanding of the data with participants to ensure that her interpretations were grounded in participants' experiences and perceptions. The use of notes (as described in section 3.5) further facilitated this process. Credibility is also enhanced if the data is analyzed by more than one researcher (Guba & Lincoln, 1985; Nowell et al., 2017). As such, there was a continuous review of the data analyses by the thesis supervisor. Preliminary findings were presented to committee members to validate the research process and themes, and to ensure there was consensus. An audit trail of research decisions was kept. Audit trails help researchers systemize, relate and cross-reference data, as well as easing the reporting of the research process (Guba & Lincoln, 1985; Nowell et al., 2017). The research team comprised of nurse researchers with experience working in critical care and medicine units, as well as with methodological expertise in qualitative research and thematic analysis; adding credibility to the process and interpretations.

Dependability is a criterion that refers to transparency and integrity in the research process; that is, research is logical, traceable, and documented (Guba & Lincoln, 1985). The use of an audit trail with detailed information on analytic decisions such as codes, patterns, and

themes increased dependability (Nowell et al., 2017). Also, the involvement of the thesis supervisor and committee in the analytic process also helped to enhance dependability.

Transferability refers to the transferability of the study findings to other similar situations (Nowell et al., 2017). To increase the likelihood of the study findings being transferable to other similar practice settings, purposefully sampling was used (Lincoln & Guba, 1985). Beyond this, transferability of the findings requires detailed information on the context, sample, and findings so that judgments can be made on the whether the findings apply to others beyond the setting (Guba & Lincoln, 1985). A thorough description of the study context, participants, and findings are presented so that others can judge whether the findings are transferable (Guba & Lincoln, 1985).

Confirmability relates to how conclusions were reached based on the data and represent participants' voices rather than the researcher's bias (Guba & Lincoln, 1985). According to Guba and Lincoln (1989), credibility, transferability, and dependability must all be achieved for confirmability. The strategies described above as they relate to credibility, transferability, and dependability helped establish confirmability. Further, recognizing that researchers' assumptions (based on personal experiences and beliefs) can potentially bias their interpretations, a reflective journal was maintained throughout the study.

3.8 Ethical Considerations and the Protection of Human Rights

Ethical approval was granted from recruiting organization's Research Ethics Board and the academic institution's Research Ethics Board. Participants were informed of their rights as a study participant according to the Tri-Council Policy Statement 2 (2014). Information regarding the study was provided to participants through an information and consent form (refer to *Appendix G*). Written informed consent was obtained from participants before interviews. The completed consent forms were locked in a filing cabinet in the research supervisor's office at the affiliated university to protect participants' anonymity and confidentiality. Participants could

refuse consent or could choose to end their participation in the study at any time. If participants chose to terminate their participation, they were informed that the information collected would be destroyed and not used. No participants chose to terminate their participation in the study. Participants were informed that direct quotes from their interviews could be used in publications and presentations. However, a unique identification number (e.g., participant ID1) would be used to protect their anonymity.

Audio recordings of the interviews were transcribed by the primary researcher (AR) offsite. The audio files and transcriptions were kept in password-protected files on the researcher's password-protected computer during transcription. Audio recordings were then deleted from the audio recording device immediately after being transcribed. The transcripts were then transferred using an encrypted USB key on to the affiliated university's secure password-protected the server. All electronic data was de-identified before transfer, and participant ID numbers attached to each transcript. The master list linking participants' names and corresponding identification numbers was stored securely on the affiliated university's server only. Consistent with the REB's guidelines, in 10 years all paper data (i.e., signed consent forms and master list) will be shredded and electronic data deleted.

As it was difficult to obtain a sufficient sample size, the recruitment strategy changed to include snowball sampling. Therefore, an amendment was made to the Research Ethics Board, to approve this change to recruitment. Further, to minimize the potenital for participants to feel obligated to assist with snowball sampling, it was emphasized in email correspondence with them (refer to *Appendix B*) that they did not have to assist with recruitment.

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Chapter Four: Manuscript

Chapter Four is formatted as manuscript and will be submitted to the Journal of Clinical Nursing. This chapter is formatted in accordance with the guidelines of the journal and includes the results of the study and a discussion.

A thematic analysis of nurses' experiences with open visiting hours on medical units

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1.1 Introduction

Open visiting hours (OVH) allows patients' families and friends to visit them in hospital 24-hours a day without any restriction on the time of the visit, length of the visit, and the number of visitors (Monroe and Wofford, 2017). The elimination of restrictions on hospital visiting hours provides flexibility for families and friends (hereafter referred to as family) to be present with patients, creating opportunities for families to engage in care (da Silva et al., 2013; Monroe and Wofford, 2017). For this reason, OVH is often seen in pediatric settings as parents are integral in the care of their children (da Silva et al., 2013; Mastro, Flynn, and Preuster, 2014). OVH is also common in critical care settings to encourage patients and families to be together in the face of critical illness (da Silva et al., 2013; Mastro, Flynn, and Preuster, 2014). The elimination of restrictions on visiting hours is favoured by patients and their families and associated with positive outcomes (Mitchell and Aitken, 2017). Research examining OVH from the perspectives of patients and families indicates that OVH is linked to an increase in patients' emotional well-being, patients' and families' satisfaction with care, and a decrease in anxiety for patients and families (Cappellini et al., 2014; Institute for Patient and Family Centered Care [IPFCC], 2010). As OVH improves the experiences of patients and families, it is an approach that is becoming

more prevalent across patient care settings in efforts to provide patient-and-family-centered care (PFCC; Canadian Foundation for Healthcare Improvement [CFHI], 2015; IPFCC], 2010, 2017).

Research examining OVH from the perspectives of nurses indicates that the increased presence of family impacts their working environment (Monroe and Wofford, 2017). While OVH supports nurses 'getting to know' their patients and the building of rapport and collaboration between patients, families, and nurses, OVH also presents some challenges (American Association of Critical Care Nurses [AACCN], 2012; Ciufo et al., 2011; Munroe, 2017). Nurses report that OVH creates difficulties with space, interruptions, and disorganization to patient care, and increases their workload (Ciufo et al., 2011; Monroe and Wofford, 2017). Understanding OVH from nurses' perspectives comes predominantly from those working in critical care settings where OVH is common (Ciufo et al., 2011; Smith et al., 2009). As OVH is adopted across patient care settings, it is important to consider the views of nurses within their specific contexts, as critical care nurses' perspectives on OVH may not reflect their experiences. For instance, contextual factors such as workload, patient acuity, and nurse-to-patient (NTP) ratios are significantly different in adult inpatient settings (e.g., medicine and surgery) compared to critical care settings (Berry & Curry, 2012; Schenk et al., 2017). In particular, medical nurses have the highest NTP ratio, caring for five to 10 patients with a range of acute and chronic conditions (Canadian Association of Medical and Surgical Nurses [CAMSA], 2008). Critical care nurses, on the other hand, care for one to two patients who are critically ill and require frequent monitoring and interventions (Rothberg et al., 2005; Schenk et al., 2017). Thus, an increase in family presence facilitated by OVH may be a challenge for medical nurses, given the numbers of patients and families in their care. With limited research outside of critical care setting and broadening of OVH into other adult in-patient care settings, it is important to explore the perspectives of nurses to OVH. The focus of the current inquiry is medical nurses' experiences of OVH in relation to the provision of care to patients and families.

2.1 Background

The standard visiting hour policy within hospitals is restricted visiting hours (IPFCC, 2010). Institutional restrictions regarding visitation typically limit the number of visitors permitted for each patient, the time in which visitors are allowed (e.g., visiting hours from 3 pm to 8 pm), and the length of visitation (e.g., one hour). In some patient care areas, restrictions are placed on who can visit, where only 'immediate family' are allowed at the bedside (Farell et al., 2005). Hospitals implement restricted visiting hours out of interest for the patient, as it was feared that family presence interfered with patient healing and recovery (Lui et al., 2013). Furthermore, evidence also suggests that nurses support and justify restrictions as visitors disrupts their workload and impedes their ability to provide care (Ciufo et al., 2011; Monroe and Wofford, 2017). However, even with restricted visiting hours, nurses have some latitude when it comes to visitation. For instance, nurses may permit extended visits under certain circumstances such as in the provision of end of life care, for patients and families to have more time together. This eventually led to hospitals adopting *flexible* visiting hours, where visiting times were less restrictive and based on the discretion of nurses (Agard and Lomborg, 2011). As hospitals shift to PFCC models, OVH is becoming more prevalent outside of critical care and pediatric care inpatient care settings (CFHI, 2015; IPFCC, 2017).

Research exploring the perspectives of critical care nurses indicates that they have mixed views regarding OVH and the influence this approach has on patients, families, and their practice. Critical care nurses view OVH as an approach that positively impacts patients and their families and has benefits to their practice (Mitchell & Aitken, 2017). Nurses find that OVH provides patients with comfort and support during their hospitalization as families are more present to offer emotional and physical care (Ciufo et al., 2011). Having families present eliminates patients' feelings of isolation and boredom and distracts patients from the disruption to their daily routines (Athanasiou et al., 2014; Hart et al., 2013). OVH also creates more

opportunities for families to participate in patient care (e.g., bathing, repositioning, and feeding), which provides patients with additional support (Roland et al., 2001). Nurses believe that flexibility for families to be close with their loved ones helps to reduce families' anxiety (Roland et al., 2001; Sims & Miracle, 2006). When families are less stressed and permitted to be with their loved ones, there are fewer complaints and more positive feedback directed towards nursing staff, which enhances nurses' job satisfaction (Sims & Miracle, 2006). OVH also enhances nurses' practice because families are more available to share pertinent information regarding the patient (e.g., medical history, preferences, and routines), and participate in patient care (Agard & Lomborg, 2011; Ciufo et al., 2011; Marco et al., 2006). Furthermore, when caring for patients from different ethnic backgrounds, families are particularly helpful to nurses as they may translate for patients with language barriers or inform nurses of patients' specific cultural beliefs and needs (Riley at al., 2014).

At the same time, nurses also identify challenges with OVH. A common concern is that the increase in family presence can interfere with patients' rest, prolonging their recovery (Spreen & Schuurmans, 2011). Nurses also fear that families may feel obligated to visit patients, which may cause exhaustion and elicit feelings of anxiety, fear, and stress as they struggle to cope with their loved ones' hospitalization (South & Adair, 2014). Nurses identify that OVH can interfere with patient care as families may be in the way, making it a challenge to perform patient care (Hart et al., 2013). The increased presence of families also adds to nurses' workloads as families seek information regarding the patient's condition throughout the day; interrupting nurses' workflow and taking time away from patient care and other responsibilities (Levy & De Backer, 2013; Monroe and Wofford, 2017). Working around the challenges brought about by OVH, while balancing the needs of patients and families can create a physical and psychological burden for nurses (Kozub et al., 2017).

Unfortunately, research examining nurses' perspectives on OVH outside of critical care within adult inpatient medical settings is lacking. Studies within settings outside of critical care included the perspectives of managers, coordinators, and health care leaders, rather than frontline nurses (Gasparini et al., 2015; Shulkin et al., 2013). Only one study focused on frontline medical nurses' perspectives on OVH which indicated similar perspectives that critical care nurses had with OVH (Tanner, 2005). In this a cross-sectional study, Tanner (2005) interviewed 432 nurses from adult inpatient wards to explore their views on visiting hour preferences. Similar to the literature examining OVH from the perspectives of critical care nurses, participants in Tanners' (2005) study found OVH was helpful as families provided information on patients and participated in patient care (Cappellini et al., 2014; Ciufo et al., 2011; Gaspirini et al., 2015; Monroe & Wofford, 2017; Shulkin et al., 2013). Likewise, participants in Tanner's (2005) study had concerns that OVH was disruptive to patient care, increased their workloads, and created unrealistic expectations as nurses' catered to families' needs. Unfortunately, studies outside of critical care settings are restricted to quantitive research approaches with a focus on satisfaction and preferences with OVH, which provides a limited understanding of nurses' experiences with OVH in the care patients and families (Gasparini et al., 2015; Shulkin et al., 2013; Tanner, 2005).

Our study aimed to describe medical nurses' experiences of OVH in relation to the provision of care to patients and families. The objective was to provide an understanding of how medical nurses engaged with OVH and the influence that the increased presence of families had on nurses and their practice.

3.1 Methods

3.1.1 Design.

A qualitative descriptive (QD) approach was used to conduct this study. As a qualitative descriptive approach, thematic analysis (TA) is widely used in nursing and related fields to explore the experiences, meanings, and the realities of individuals (Nowell et al., 2017;

Sandelowski, 1995). TA aims to present a rich description and comprehensive summary; making it appropriate to describe medical nurses' experiences providing patient and family care on medical units with OVH.

When using a qualitative approach, researchers may either consciously or unconsciously focus on the data that supports their existing beliefs or expectations. In efforts to control this bias, it is important to acknowledge our assumptions and backgrounds. The research team comprised of nurse researchers with experience working in critical care and medical units, and expertise in the chosen qualitative method. The inspiration for the study was rooted in the first author's (AR) personal experience as a registered nurse on a medical unit that transitioned from restricted visiting hours to OVH. The first author believed OVH was a benefit to nursing practice as it provided the opportunity to build rapport with patients and their families. However, AR's perspective did not reflect all nurses within this unit as several nurses felt OVH was inconvenient. As a team, we recognize that our views may differ from those of participants. In order to gain insight and build knowledge regarding OVH, it is essential to reflect the experiences of nurses working within their specific context.

3.1.2 Setting.

Nurses were recruited from two medical units in a large urban teaching hospital in Eastern Ontario, Canada. Both medical units are designed to care for patients with various medical conditions. However, they also specialize in caring for specific patient populations. Unit (A) consists of patients with strokes and patients requiring acute monitoring. Unit (B) consists of patients primarily with respiratory illness or those who require tracheostomy care. The physical layout of the units is such that patients are most likely to occupy shared rooms (e.g., wards or semi-private). While there are private rooms on each unit, they are typically reserved to accommodate patients who require isolation for airborne or other contact precautions. The official visiting hour policy of this institution states that OVH is implemented to reduce patients'

anxiety, feelings of isolation, and to improve their healing and recovery. According to the policy, visitors are required to sign in and obtain a temporary form of identification. The policy emphasizes the need for staff to provide adequate care and states that patients are required to have a quiet and restful environment. The hospital implemented a '*Quiet Time*' policy to facilitate a restful environment where visitors are expected to reduce noise levels between the hours of 10 pm and 6 am.

3.1.3 Sampling and sample.

Participants were eligible for inclusion if they were English speaking and registered nurses (RN) working on inpatient medical (Units A or B). Purposeful sampling was used to recruit male and female nurses with various levels of nursing experience. Approximately three months into the recruitment process, the method of sampling changed to snowball sampling as a sufficient sample size had not been achieved. According to Sandelowski (1995), an adequate sample size is dependent on a matter of judgment and experience, where researchers evaluate the quality of the information collected. The sample size for this study was dependent on informational redundancy (Francis et al., 2009). Sampling ceased when the data collected did not add new information to the themes and subthemes generated through the thematic analysis.

Ten RNs participated; eight females and two males. Their ages ranged from 23 to 55 years. The sample reflected cultural and ethnic diversity (not reported to protect participants' anonymity). Participants' experience working on the inpatient medical units ranged from less than one year to 29 years of experience. Five out of ten participations worked full-time, and all worked 12-hour day and night shifts.

3.1.4 Recruitment.

Ethical approval was granted from the institution where recruitment occurred and the affiliated university. Before recruitment, approval was given by the director of the medicine program and clinical managers. Participants were recruited using advertisements posted in

selected areas on inpatient medical units (e.g., staff lounges) and through recruitment e-mails sent to nurses from their clinical managers. As the recruitment strategy changed after approximately three months to snowball sampling. Participants were contacted by the first author via email and asked to share information on the study with colleagues. A total of four participants were recruited using this method. All individuals who were interested in participating in the study contacted the researcher directly via telephone or e-mail to arrange a convenient time and place for the interview. Participants received a $10 gift certificate as compensation for their time.

3.1.5 Data collection.

Written informed consent was obtained from participants before data collection. Data collection comprised of nine in-person interviews and one telephone interview. Interviews lasted between 45 to 60 minutes. All interviews were conducted by the first author (AR) in a conference room at the study site or the affiliated University. The interviews were semi-structured with open-ended questions focusing on participants' perspectives on OVH. Open-ended questions were used to permit participants to share their views and experiences freely and to answer in a way they preferred. Interviews were audio-recorded with participants' permission to ensure information was not missed, and enhance the collection of the verbatim data. Notes were taken before and during the interview to help guide the interview and to keep track of new or recurrent information. After the interview, notes were made of visual cues such as body language, facial expressions, and the researcher's initial impressions, which contributed to the analysis of the data.

3.1.6 Data analyses.

The interview audio recordings and transcribed interviews were uploaded into a qualitative software program (QSR NVivo 10) to facilitate the organization of the data. Congruent with QD, TA was used to inductively analyze the data (Braun & Clarke, 2006). TA is an analytic approach used for identifying, analyzing, organizing, describing, and report themes

found within a data set (Nowell et al., 2017). Transcriptions were read and then re-read line by line by the first (AR) and second (CM) authors to identify possible relationships among the data in order to generate codes. Codes are short segments of data that are that are meaningfully similar (Braun & Clarke, 2006). As the data was coded, the codes were sorted and clustered in a search for themes. Themes are patterned responses or meaning within the data that reoccur throughout the analysis (Braun & Clarke, 2006). The themes were continually reviewed to ensure they were a clear representation of the clustered codes, and data. Open dialogue was maintained with the second author (CM) throughout this process, and preliminary descriptive explanations were discussed with other research team members (BV-W) and (CB) to validate the themes and ensure consensus. The process of reviewing themes facilitated the formation of a thematic map comprising of an overarching theme, themes, and subthemes.

4.1 Results

Based on a thematic analysis of the data, an overarching theme of *"Reliance and Resistance"* was developed. *"Reliance and Resistance"* was threaded throughout the themes and subthemes and reflected both the positive and negative aspects of OVH based on participants' experiences. *Reliance* related to the value placed on families, and their positive contributions to patient care, which was facilitated by OVH. While *resistance* reflected participants hesitancy in fully embracing OVH because of the perceived negative implications for patient care, nurses' workloads, and safety. Four main themes were developed: *"The Philosophy and Process of OVH"; "Family: Giving and Receiving Care"; "The Influence of Families on Nurses' Practice: Providing Patient Care";* and, "*The Influence of OVH on Nurses."* Figure 1 illustrates the thematic structure. The themes and subthemes are discussed below.

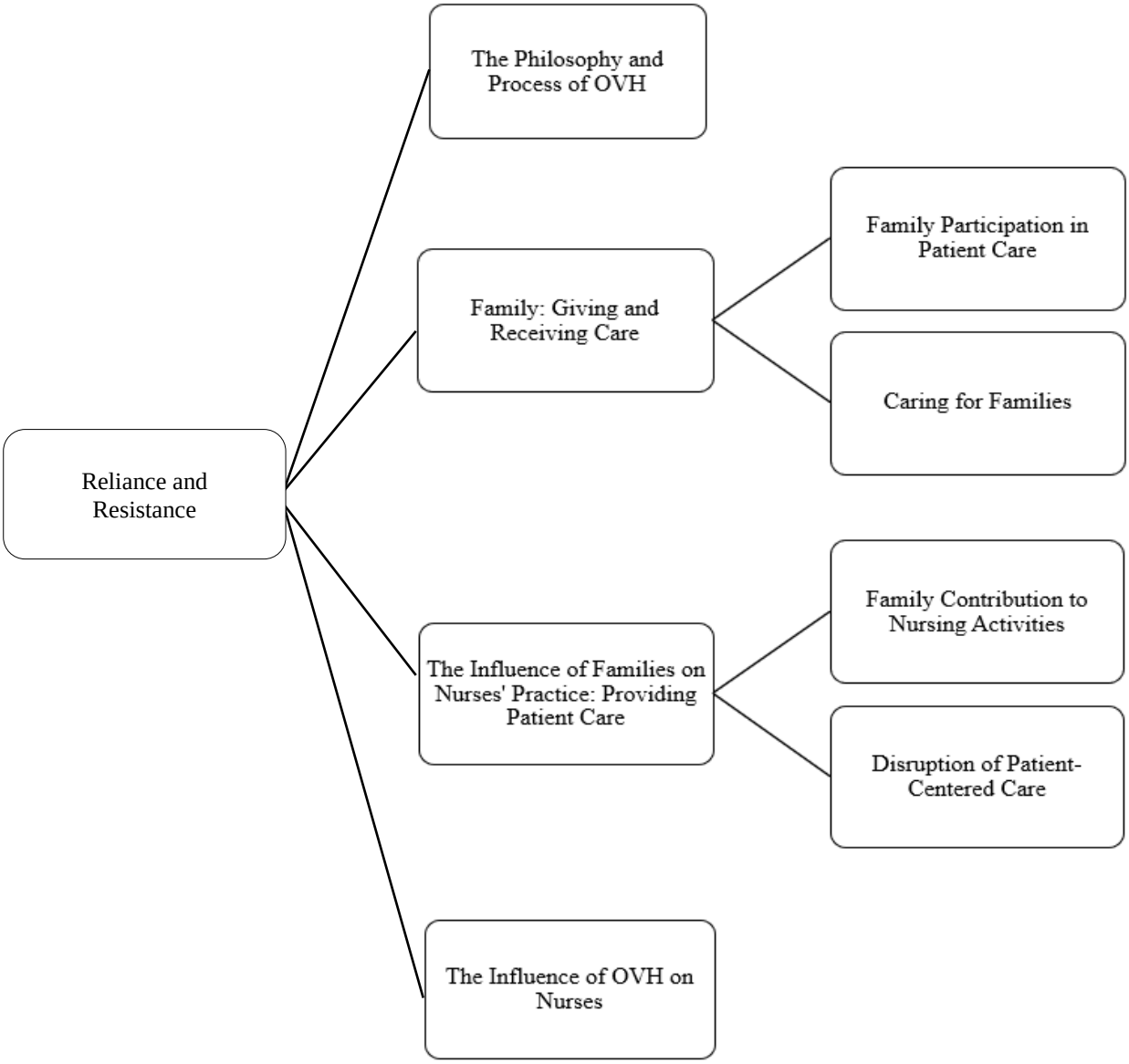

Figure 1: The thematic structure of medical nurses' perspectives of OVH and its influence on patient and family care

4.1.1 The Philosophy and Process of Open Visiting Hours.

The theme *The Philosophy and Process of OVH* reflected participants' understanding of OVH; specifically, the rationale for OVH, and how it was operationalized within their care settings. The reason for OVH was identified in the institutions' policy and in line with this, most participants indicated that OVH was implemented solely for patients and families as an approach to enact PFCC. Participants explained that patients might feel isolated, lonely, and bored while in the hospital and believed that OVH was implemented for patients to be surrounded by those

familiar to them, allowing patients to feel *"at ease"* and *"supported."* One participant explained that OVH allowed patients to have flexibility and control regarding family presence by stating, *"patients have the option to be with their family member and have their family here in hospital… they're not in prison, this is not an asylum…"* (ID3). Participants also felt families were at ease knowing there were no restrictions in place for visitation. One participant explained OVH allowed families to come in to the unit and obtain information. She went on to say that *"families feel more secure knowing and to seeing that their loved ones are there safe in hospital"* (ID5). OVH provided greater flexibility in visiting, which was more convenient for families. A participant elaborated, *"people have different work schedules…they have kids…they have things that keep them busy, and sometimes it's just not beneficial for them with restricted hours"* (ID8).

Participants' views on OVHs differed depending on their experience and familiarity with OVH. Participants who had more than ten years of nursing experience and had previously worked in settings with restricted visiting hours were less favourable toward OVH. While they understood and respected the philosophy of OVH, they preferred restricted visiting hours. These more experienced participants described that even with restricted visiting hours, there were circumstances in which they were lenient with visitation, such as when patients had life-limiting conditions and were receiving end of life care, or if a patient experienced a sudden deterioration in their condition. One participant added, "*If they said that we're going back to restricted visiting hours, I'd support that 100%. We have and believe in our hospital values of compassion and all of those things - that doesn't stop with restricted visiting hours*" (ID10). Participants who were more accustomed to OVH as their norm were more accepting of it. These participants tended to be younger and have less nursing experience. Although there were mixed feelings regarding the implementation of OVH, a key point raised by participants was the need to have some control over visitors' access to patients. Participants' highlighted the balance between flexibility in families' access to patients, against disruptions caused by families' increased presence (e.g.,

noise levels, and interruptions to patients' care). For example, participant (ID3) stated "*I like the idea, but I would like to say, let's have a limit of how many people are in the room with the patient at night … this place is loud enough as it is at night, it's almost impossible to get some sleep"* (ID3).

Processes were in place concerning OVH and how it was operationalized. Hospital staff completed a "patient admissions form," which required them to inform patients and families of the OVH policy. However, some participants were unclear about the policy and procedures and identified inconsistencies between OVH hospital-wide policy and unit-level policy. One participant stated, *"My understanding was visitors had to come to the nursing desk and get a visitor sticker and that was it. But now I ask the clerks, and they don't know what I'm talking about, so I think we don't really know what the protocol is"* (ID5). Another participant described that visitors just "*walk in"; "people just will come and go as they please"* (ID7). Consequently, some discussed the use of identifiers such as badges or stickers so that healthcare professionals could identify visitors on their unit. A benefit of the OVH process identified by one participant was that it was a way to engage with patients, "*You ask the patient, who would you like involved in your care. Is there anyone that should not be involved in your care?"* (ID10).

4.1.2 Family: Giving and Receiving Care.

The theme *'Family: Giving and Receiving Care,* exemplified the focus on families within this OVH setting. It reflected nurses' perceptions of the families' influence on patient care as well as the care and support nurses provided to families. *'Family: Giving and Receiving Care'* consists of two subthemes. *Family Participation in Patient Care* describes families' engagement in patient care; *Caring for Families* reflects nurses' focus on the care of families.

Family Participation in Patient Care. Participants identified that families contributed positively to patient care as they provided patients with emotional and personal support. OVH provided an opportunity for families to provide encouragement and motivation to patients. One

participant stated, "*I find when the family members are there, they usually eat more. It encourages them… or helps them with what they need"* (ID3). Participants remarked that when patients knew their family was coming to visit, "*it gave them a little bit of a push"* (ID9). As a result, participants noticed that patients were more willing to participate in daily activities such as mobilization with the presence of family. Participants also found families took time to reinforce pertinent information and education that was relayed by healthcare professionals to patients. One participant stated, "*sometimes family members are able to explain things in a way to them that maybe we may not be able to"* (ID8). As the units where recruitment occurred serves ethnically diverse populations, participants collaborated with families to ensure patients' cultural beliefs and values were respected. Families offered assistance with translation for patients with language barriers and ultimately *"helped patients communicate"* (ID8). Although the family was able to take on this role, there were some concerns as the same participant, added, "*sometimes we're not even sure how they're [family] translating what we're saying, are patients completely understanding what you want to tell them?*" (ID8).

Participants explained that due to the busyness of their unit and subsequent workload, it was often challenging to provide emotional care to patients, "*I wish I had more time to do the emotional stuff, to sit down, to do the hand holding, the 'let's chat'"* (ID9). Another participant elaborated, "*you can't always be there when you have four other patients that you're dealing with… you don't have time*" (ID5). Participants felt that families played a pivotal role in emotionally supporting patients as families had to time to sit with patients, to listen and offer reassurance.

Participants described that families participated in patients' personal care such as bed baths and toileting, feeding during meals times and ambulating patients with nurses. One participant stated, "*families are doing a lot of the work for us so that the patient gets better care"* (ID3). Participants noticed that families who were patients' primary caregivers at home, were ready and

willing to participate in care. They believed these family members had a better understanding of patients' needs and preferences as they were accustomed to providing their care. One participant explained*, "the family knows way better than I do how that patient is comfortable. So yes, stay, reposition them, show me how it is, show me how they like it because you're the expert, not me"* (ID9). Participants appreciated the "little things" that families did for patients, as it allowed them to do other things. Little things included, "*tucking them [*patients*] in, getting them water, or changing the TV channel*" (ID9). Participants described that families of patients from different cultural backgrounds were heavily involved in providing support to patients. Participant (ID3) explained, "*I've found that first or second-generation families are usually quite a bit more willing to get in and do a lot of the dirty work. In fact, sometimes they, insist on it"* (ID3). Also, participants noticed families offered cultural support to patients as they brought in foods that were culturally acceptable for patients. One participant said, *"I've seen patients that have not eaten all day, but as soon as the family member brings in food from their country, they'll eat the entire thing"* (ID8). Families allowed patients the freedom to enjoy their dietary preferences while in hospital.

Caring for Families. All participants described their practice as "patient-centered." One participant stated, "*We tend to focus it on the patient a lot more"* (ID3). However, in describing their care family were considered an integral part of caring for the patient; reflecting an emphasis on PFCC. Participants commonly cared for families by sharing information and providing emotional support, as the following participant stated, *"Families are worried. They just want to know what's happening to their loved ones"* (ID7). Participants explained that in situations where they felt families required emotional support (e.g., a loved one actively dying), they made time to be present with families, to sit, listen, or provide reassurance despite the busyness of their unit. One participant stated, *"emotional caring is mostly just conversational… we get talking about the person [*patient*] and listen to families talk about them [*patient*] in a positive way"*

(ID6). The time spent listening and talking was how participants showed their support to families and facilitated the process of coping. A few participants described the impact of touch (e.g., hand holding, hugs, back rubs) as part of providing care to families.

OVH permitted families to stay on the unit overnight, but space and resources to accommodate families were often limited. Participants resorted to offering what was available such as chairs, pillows, and blankets. Despite the challenges of overnight accommodations, participants also voiced concerns related to the well-being of families due to extended and overnight visits. OVH meant that access to patients was unrestricted, which participants feared would make families feel obligated to stay with patients. One participant acknowledged that *"a lot of family members become exhausted. Families don't want to miss anything, but this could be a time where they could have time to take care of themselves, visit, but also take some down time"* (ID4). In these cases, participants would encourage the family to step out, go home for a nap, a shower, or a meal, or to use the family room for a break. Some participants stated that families were often looking for a "green light" in order to take a break and were thankful for participants' concern and suggestion.

4.1.3 The Influence of Families on Nurses' Practice: Providing Patient Care.

The theme *'The Influence of Families on Nurses' Practice: Providing Patient Care'* reflects the influence of OVH on participants' nursing practice. The theme comprised two subthemes: *Family Contribution to Nursing Activities* encompasses how families' engagement in patient care benefited nurses in their work; while *'Disrupting Patient-Centered Care'* includes the negative impact of OVH and increased family presence on the delivery of nursing care.

Family Contribution to Nursing Activities. Participants' views regarding families' contribution were mixed. As described in the subtheme "*Family Participation in Patient Care,"* families were involved in various aspects of patient care offering emotional, informational, cultural, and personal support. These activities gave participants a sense of 'relief' as they had

more time within a challenging and busy work environment to complete other nursing responsibilities. The following participant explained,

> "*They [*family*] help take care of the patient… AM care, feeding the patients... I know it sounds like it's not really a big deal, but it actually helps a lot; sometimes you have to cut time out of your break or you don't get a break"* (ID5).

Another participant stated, "*We depend on them…They [*family*] become very important; if we have a very busy caseload, we can't always be there all the time"* (ID7). Participants described that the presence of families was especially helpful during certain times such as late in the morning after participants organized their day and during patients' meal times. Participants found that families assisted with feeding patients; a challenging task for nurses with competing responsibilities, and several patients to feed. The family was also an "*extra set of eyes"* monitoring the patient, which helped participants *to "feel at ease"* knowing patients were being observed. One participant explained, "*Whenever you're not in the room, you hope that something isn't wrong. I feel more at ease when somebody's in there… it's a piece of mind for me"* (ID6). This was especially important when patients presented a safety risk due to falls or cognitive deficits. Participant (ID6) added, *"If somebody is a falls risk, they [*family*] will sit and stay, and I know that my patient is not laying on the floor."* Participants expressed that "*at night it's so much harder to keep an eye on everybody*" (ID5) with limited resources, less staff, and more patients in their care. Another participant explained that sometimes families notice changes in patients that nurses do not because families are more familiar with patients. Families were the utmost help when providing care for patients with cognitive impairments, as their familiarity with the patient meant that patients were more compliant. One participant explained *"sometimes patients will refuse to take their medications, but if the daughter or husband is there, they may be more receptive to them"* (ID10).

Participants felt that the presence of family distracted patients from thinking about their hospitalization. At times, patients are confined to their bed or their room; participants' felt that families alleviated patients' sense of confinement and isolation as they provided patients with entertainment and emotional support that participants stated that they did not have the time to do. As patient assessment, organization of care, and discharge planning where a large part of nurses' work, participants found families were helpful as they were knowledgeable about patients, which made them an important source of information on the patients' medical histories, routines at home, and preferences. One participant said, "*a lot of medicine patients come from home but are not going back home. When figuring out a plan, family members are very helpful and knowing that they come in at any time it helps a lot*" (ID2).

Disruption of Patient-Centered Care. Although OVH was viewed as beneficial to patients, their families, and to participants, it also presented some challenges as OVH was disruptive. Participants identified that the increased presence of families created noise on the units; *"disturbing the peace"* (ID5) and interfering with patients' ability to rest. Most participants advocated for patients, reinforcing the 'quiet time' policy to families. Having families throughout the day and night meant there were fewer opportunities for participants to spend time with patients, separate from families. One participant elaborated, "*if I don't have family in the room it gives me time with my patient, being able to ask them questions, have them answer me, and not the four people in the room answering for that person"* (ID4). Less time to be alone with patients was problematic because it impeded participants' ability to assess and respond to patients' needs or sensitive issues such as the disclosure of personal information and concerns. In these instances, the presence of family was seen to hinder patients' ability to discuss issues fully. The increased presence of families also meant that participants spent more time providing updates to families throughout the day, which took them away from other responsibilities including patient

care. Furthermore, families' involvement in patient care sometimes created work. A participant stated,

> "*I had just spent over half an hour this lady and got her into bed Her children came and got her into the chair. When they left, I had to go and get another nurse, and we had to get the sling under her in her chair, re-change her and clean her dentures again"* (ID4).

Participants also described that multiple visitors at a time hindered their ability to provide physical care to patients. Families were sometimes in the way during *"procedures that required more space just because space in the actual rooms are kind of tight"* (ID1). Consequently, families were sometimes asked to relocate to the family room as a way to reduce overcrowding. One participant stated, *"Sometimes it becomes too crowded in the room. We can't have ten family members in the room, so we show them where the family room is" (*ID2*).* However, participants added that the "family room" was not always available as it had multiple purposes (e.g., patient room, meeting room). One participant also commented on families' cultural norms regarding visitation, "*In some cultures, some people will come in, and it will be a steady flow, all day and all night"* (ID4).

4.1.4 The Influence of Open Visiting Hours on Nurses.

The theme '*The Influence of OVH on Nurses'*, encompassed the way participants felt in the presence of families. Some participants, (particularly less experienced nurses), felt uncomfortable and that the care they provided was under scrutiny by family members. Participants also described being bombarded by family members' questions immediately after they entered a patient's room, "*It's sometimes intimidating when you walk into a room and you're getting boom, boom, boom with all these questions"* (ID4). Others talked of awkward silences. One participant stated that she used avoidance as a way to cope, *"I find you avoid the room more so when there's a lot of people in there… it's intimidating so I kind of just do my hourly check only. I find when the family is in there, I definitely I don't talk to the patient as*

much" (ID6). Another participant shared her experience with talking into rooms with patients and their significant other sleeping in bed and explained, "*I shouldn't have to see that, it's uncomfortable. It might impact my care a little bit because I'm not doing as much…literally popping my head in… I'm not there as often*" (ID9). Participants described how the presence of families sometimes created frustration; especially when families overstepped, "*some families will watch you giving care and tell you how to do it. They'll be telling you what to do and they'll be criticizing you as you're providing care."* (ID5). There was also some hesitancy to encourage families' participation in patient care. One participant explained, she was fearful of seeming as though she is passing off her nursing duties to families.

As OVH permitted families to stay with patients overnight, there was a certain level of discomfort and concern about disturbing patients and their significant others. While participants appreciated that patients and families wanted closeness, it was difficult for some. As the following participant recalls, "*I had a young couple sleeping in bed together, and it was just uncomfortable. We offered a chair, a recliner… we showed him where the family room was, but they really wanted to be in bed together."* (ID2). Some participants stated that if they knew family was in the room during the night, they would avoid the room; aside from providing necessary care.

A significant concern that related to OVH and its operationalization was the unrestricted access of visitors to patients. All participants expressed concerns about safety with the way OVH worked on their unit. Participants felt that OVH was *"unsafe"* and that they felt "*threatened"* at times. One participant explained, "*it [*OVH*] scares me because anyone can walk in. I feel very threatened…How do we protect this person [*patient*]…and how do we keep track of who's in and out"* (ID7). Moreover, female and male participants commented on safety concerns in relation to gender. Participant (ID5) stated, *"nursing is a female-dominated profession. When it's just you and five other women…it's scary. A drunken man or anyone can come in with god forbid a gun*

and start shooting up the place". During situations where they felt unsafe with visitors, female participants often tasked their male colleagues for support.

5.1 Discussion

This study aimed to describe medical nurses' experiences with OVH in the provision of care to patients and families on to medical units. Our study revealed tensions between how families enhanced *and* constrained participants' practice and revealed four main findings. First, OVH facilitated opportunities for information sharing and rapport building between families and participants, which helped participants provide PFCC. Second, the increased availability and involvement of family in patient care was seen as a benefit to nursing practice as it contributed to patient-centered care, and also reduced participants' workloads, freeing them to perform other duties. Third, OVH sometimes added to nurses' work as information sharing to families was time-consuming and took time away from their other duties including patient care. Fourth, participants were deterred from OVH as the increased presence of family created overcrowded and uneasy situations, as well as concerns regarding staff and patient safety.

Participants in our study described ways in which OVH enhanced their practice and how in some ways they relied on families to facilitate care that was patient-centered. Families were identified as an important source of information on patients, which helped participants coordinate, plan, and implement patient care. Families provided information on patients' daily routines and cultural and individual preferences, which aided the provision of patient-centered care. Information sharing was reciprocal, as participants described how the provision of information to families was a way to support and meet their needs. Research indicates that information is as an important need for families (Jacob et al., 2016; Monroe & Wofford, 2017). The flexibility that OVH offered means that families have greater access to nurses. This access means families can obtain up-to-date information regarding patient's conditions and care;

subsequently alleviating families' worries of "not knowing" and reassuring them that their loved ones are cared for.

Participants valued and relied on families as a way to ensure that care was familiar to patients and that their values and preferences were met. OVH allowed families to visit during mealtimes to help with feeding and to bring in foods that were preferred by patients and culturally-appropriate. Participants described caring for patients from diverse ethnicities, who sometimes had specific cultural requirements, and language barriers. Families were able to support culturally safe care. Our findings are consistent with Fairburn's (1994) study of nurses' attitudes and behaviours towards flexible visiting hours in coronary care units. In this study, they found that flexible visiting hours allowed nurses to collaborate with families to best support the cultural needs of patients (Fairburn, 1994). The findings illustrate how OVH has the potential to be a catalyst for nurses to engage and deliver care to patients and families that is sensitive to their individual needs.

Medical units can be described as being in a constant state of fluctuation as nurses try to meet the increasing health care needs of patients in their care (Canadian Medical Association [CMA], 2013). The context of the medical units was described by participants as busy and time-constraining. We found that the availability of families throughout the day and night alleviated nurses' workload as families provided emotional and physical care to patients. Busy assignments made it challenging for participants to emotionally support patients. The increased presence of family meant that participants to some extent "relied" on families to take on this role, as it allowed them to complete other duties. In a discussion paper debating visitation practices in critical care, Slota et al. (2003) contends that nurses rely on the participation of families in patient care during times of nursing shortages. Our study indicated the reliance on families was not necessarily because of nursing shortages, but because of busy workloads.

With increased workload and fewer staff during the night, OVH meant families were more available to monitor patients to ensure safety throughout the night. Medical nurses tend to have a higher nurse-to-patient ratio during the night wherein some institutions, one nurse may be responsible for caring up to 10 patients (Berry & Curry, 2012; CAMSN, 2008). Others identify nurses' reliance on families for monitoring (Escudero, Vina, & Calleja, 2013). Escudero et al. (2013) found that critical care nurses depended on families to monitor patients' movements and behaviours as patients were typically unable to speak. However, on medical units, the challenge of monitoring patients is complex as is not uncommon for nurses to care for older adults with cognitive impairments and frailty (CNA, 2015). These patients may pose additional safety risks, require frequent monitoring and additional care which may be difficult to balance with the needs of other patients (CAMSN, 2008). Similar to the views of nurses in acute care wards with OVH in Tanner's (2005), participants found that families' knowledge of patients facilitated monitoring and felt that it was important to have families present when caring for patients with cognitive impairments. Families helped to settle patients during the night and were able to facilitate communication between patients and nurses, and as some participants explained, encouraged patient's engagement with care.

Although families involvement was pivotal in some aspects of patient care and associated with reduced nurses' workload, OVH also created work. Medical and surgical nurses spend significant time providing counselling to patients and families as part of their practice (Schenk et al., 2017). However, the increased presence of family meant participants spent additional time addressing questions, concerns and providing frequent updates throughout the day. In an integrative review of OVH and nurse job satisfaction, nurses were often interrupted to answer questions and felt overwhelmed by the continuous demands of families (Monroe & Wofford, 2017). While participants in our study acknowledged that providing families with informational support was an essential part of their role, consistent with other research, extra time spent

providing family care added to their workload and left less time for patient care and other tasks (Cappellini et al., 2014; Hart et al., 2013).

OVH permits open access throughout the day and night. In their interactions with families, participants' encountered situations which they felt created difficulties for the provision of patient care, their comfort, and for safety. Participants explained OVH led to increased visitors and overcrowded rooms. Despite the use of the family room and reinforcement of the *Quiet Time* policy, overcrowded rooms led to increased noise levels, which made it challenging for participants to maintain an environment that did not impede on patient rest. The presence of more families throughout the day and night led to uncomfortable situations. As a result, participants avoided patient rooms unless patient care was necessary. Similarly, in critical care settings with OVH, nurses have described using avoidance tactics because they are fearful of making mistakes in front of families or not meeting families' expectations (Athanasiou et al., 2014; Garrouste-Orgeas et al., 2008). These findings are a concern as avoidance may limit nurses' engagement with patients and families, which could hinder PFCC and thwart the overall purpose of OVH.

A significant concern for participants in our study was safety; particularly at night when nurse to patient ratios was high. The uncertainty of procedures in place made it difficult for participants s to monitor who was in their unit, which created a sense of uneasiness. Interestingly, literature exploring OVH from nurses' perspectives has not identified this concern for staff and patient safety. We found that although participants faced challenges with OVH and increased family presence, almost all participants stated that concerns regarding safety were one of the main reasons for limiting family access to their units. Reflecting the tension between reliance and resistance toward OVH, participants instead, indicated a preference for a visitation policy that offered a balance in access (akin to flexible visiting).

5.1.2 Limitations.

We acknowledge limitations to our study. Participants' experiences and perspectives on OVH likely reflect the culture and operationalization of OVH within this hospital and on the medical units where recruitment occurred. Therefore, the findings may not translate to some other medical settings with different OVH policies and procedures. Another limitation relates to the sampling technique. We changed from purposeful to snowball sampling in efforts to recruit more participants. It is possible that earlier participants could have discussed their responses with potential participants they identified. Also, we discussed patients' and families' care from only the perspectives of nurses. Future research would benefit from exploring patients and families' perspectives on OVH in medical units to examine whether OVH facilitates PFCC.

6.1 Conclusion

In this study, we explored medical nurses' experiences with OVH in relation to patient and family care. Participants expressed both positive and negative experiences with regards to OVH and its implications for nursing care. OVH and increased family presence provided opportunities for participants to work in collaboration with families to provide PFCC. However, families constant request for information and support took time away from patients and added to their work. Ironically, OVH also led to a lack of family interaction and discouraged opportunities for PFCC. Lastly, given the open access of units at all times, and the uncertainty of processes in place, we learned that OVH evoked contextual concerns with space, overcrowding, noise levels, and safety. The findings from this study not only adds to the understanding of OVH but also provides insight regarding the perspectives of nurses outside of the critical care context.

7.1 Relevance to clinical practice

OVH was seen to foster an environment where families are valued as more than just a visitor, but as an equal partner where they can engage with nurses and participate in care to mutually meet the needs of patients (IPFCC, 2017). However, increased workload, lack of time,

and uncomfortable interactions prompted by OVH have the potential to hinder communication and engagement with patients and families. Given these findings, we suggest that hospitals revisit staffing levels in efforts to accommodate nurses for the extra time required to provide family care and to provide nurses with the flexibility where they can effectively engage with patients and families in a way that supports PFCC. As OVH increases family presence, it is important for hospitals to think about space and accommodations, and how contextual factors influence nurses' environments and their practice. Hospitals must also ensure that patients, families, and staff have a clear understanding of the OVH policies and procedures and to ensure they an enforced appropriately. We feel that given OVH created potential impedances to communication and engagement with families, nurses may benefit from training tailored specifically at the aims of OVH and PFCC. Perhaps nurses may require concrete examples of how to best engage with patients and families and may benefit from guidance and support as they integrate an increase in family presence within their practice.

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Chapter 5: Discussion

The aim of this inquiry was to describe medical nurses' experiences of OVH in relation to the provision of care to patients and families. The study sought to provide an understanding of how medical nurses engaged with OVH and what influences OVH had on nurses and their practice. In this chapter, I will begin by briefly describing the study findings in relation to the attributes of PFCC. Following this, I will expand on key findings (identified in Chapter Four) as they relate to the impact of OVH on nurses' working environments. Specifically, I will discuss OVH processes and safety, the concern of accommodating families, space and overcrowding, and the issue of "uncomfortable situations" prompted by the increase in family presence. Building on the clinical implications identified in Chapter Four, I will elaborate on the implications of the findings to the competencies of advanced nursing practice: clinical, research, leadership, and consultation and collaborations (CNA, 2008).

5.1 Open Visiting Hours and Patient-and-Family-Centered Care

Patient-and-family-centered care (PFCC) is both a philosophy and an approach to care that is respectful and responsive to the preferences, needs, and values of patients and their families (RNAO, 2015). As identified in Chapter Two, dignity and respect, information sharing, as well as participation and collaboration are attributes that underpin the concept of PFCC (IPFCC, 2017; RNAO, 2015). In the following sections I discuss each of these concepts as they relate to the findings presented in Chapter Four.

5.1.1 Dignity and respect.

Honouring patients and families' values, beliefs, and perspectives are essential in fostering PFCC and maintaining patients' and families' dignity (Ciufo et al., 2011; RNAO, 2015). According to the United Kingdom's Royal College of Nurses (RCN; 2008), dignity may be promoted or diminished by the physical environment, organizational culture, the attitudes, and behaviours of health care providers, and in how care is delivered. In our study, OVH and

families' increased availability enabled nurses and families to ensure that patient's values, preferences, and individualized needs were honoured. As participants recognized families as an extension of the patient and as partners in care it provided evidence to suggest that they valued families and that they were considered as more than just visitors. This is noteworthy because dignity is present when families' thoughts and opinions are valued (RCN, 2008). Dignity and respect facilitate a partnership where patients and families feel comfortable to communicate and collaborate with health care providers in patient care and decision-making and offer patients and families a sense of control (RCN, 2008; RNAO, 2015).

While participants believed that OVH was beneficial for patients and families, they also felt that the increase in family presence impeded on "one-on-one" time with patients, and in some instances caused them to avoid families. Several participants explained that they preferred to spend time with patients separately from their families. This time with patients was important for participants to become knowledgeable about patients' needs and preferences and gave patients the opportunity to disclose personal information that they may not want to share in front of others. Time alone with patients is important for establishing and maintaining therapeutic relationships nurse-patient relationships (CNO, 2002).

While families increased presence helps safeguard patients, OVH poses a risk to the preservation of patients' and families' privacy and confidentiality. Although participants in our study did not raise the issue of privacy and confidentiality, the limited space and overcrowded rooms, and greater access and family involvement in patient care, described by participants, increases the possibility of confidentiality breaches. Whitton and Pittiglio (2011) argues that patients' and families' confidentiality is already compromised due to due to lack of space and overcrowded rooms. Concerns regarding privacy and confidentiality have been raised in several studies by patients, families, and nurses as a barrier and challenge to OVH (Carroll & Gonzalez, 2009; Hardin et al., 2011; Whitton & Pittiglio, 2011). Nurses have an ethical and legal

responsibility to maintain the privacy and confidentiality of patients' health and personal information (CNO, 2017). Therefore, it is important for health care providers to take these concerns into account in an OVH context. As such, we recommend that organizations with OVH policies guide health care staff on and how to maneuver potential issues that could compromise patient's privacy and confidentiality.

5.1.2 Information sharing.

Participants in our study indicated that the increased presence of families facilitated information sharing. OVH fostered an environment where nurses had more opportunities to learn about patients through information sharing with families, which aided the delivery of individualized care to patients. The availability of families also facilitated communication between patients and nurses and created more opportunities for families to obtain up-to-date information on patients. They used the information provided by families to organize care that was centered on patients' individual needs and wishes, which as previously suggested, is important for preserving patients' dignity and respecting their values. The literature on PFCC indicates that families play an integral role in the care of patients as they communicate pertinent information about patients (RNAO, 2015). In this current study, families were considered "experts" by participants. Their insights regarding patients' preferences were an important source of knowledge on patients' medical history and personal preferences. Similar to other studies in the PFCC literature, the increase in families' presence meant nurses had more instances to communicate and "get to know" patients and their families on a more personalized level, which informed and guided a holistic practice and the delivery of PFCC (IPFCC, 2017; Riley et al., 2014).

Additionally, information sharing was facilitated through OVH, particularly when family were available to help participants navigate barriers to communication including language barriers and in instances where a patient was cognitively impaired. Language barriers can depersonalize encounters with patients; having the ability to communicate with non-English speaking patients strengthens communication and trust between patients and nurses (Lundgren, 2018; Squires, 2018). The availability of family and their input as a proxy for the patient is particularly important for patients with cognitive impairments who are unable to understand or express their wishes effectively. Mackie, Marshall, and Mitchell (2017) in an Australian study to understand acute care nurses' views on family participation and collaboration, found that family members of patients with cognitive limitations helped nurses to obtain clinically important information such as patients' baseline status and changes in patients' behaviour. Similarly, participants in our study stated that the families of patients with cognitive limitations were an important source of information on patients' needs and preferences. These findings are noteworthy, as the increased presence and accessibility of families through OVH, can help nurses to engage with patients and families to ensure that care is PFCC.

Further, it was also evident in our study that OVH creates an environment that fosters communication. Similar to the literature on OVH, participants in our study felt that OVH provided families with the flexibility and accessibility to communicate with health care providers, which helped keep them informed (Ciufo et al., 2011; Jacob et al., 2016). According to Ciufo et al., (2011), requests for information is often an unmet need for families. However, in our study, participants were receptive to families' need to receive up-to-date information and felt that sharing information had a positive influence as it alleviated families' stress and worries. This finding is consistent with Jacob et al.'s (2016) study examining the needs of families in an ICU with continuous visitation. They found that receiving information on patients provided families with the reassurance that their loved ones were in "good hands" (Jacob et al., 2016). Providing

information regarding the health and status of patients was one way of providing care to the family.

5.1.3 Participation and collaboration.

In our study, participants valued the need of patients and families to be close. OVH and the increased presence of families fostered a physical environment for patients that was familiar and provided them with comfort. Families' involvement in patient care is a way to enhance the continuity of care and can provide patients with a sense of normality. As families are familiar with patients, they are more attuned to patients' personal and emotional needs and daily routines and can inform nurses; contributing to an enhanced patient experience (Athanasiou et al., 2014; Gasparini et al., 2015; Marco et al., 2006). Our findings add support to the literature, as participants respected that families had an integral role in normalizing the hospital experience (Cappellini et al., 2014; Chapman et al., 2016). Studies have shown that families' involvement in patient care can help patients' overcome fear, anxiety, stress, and depression associated with hospitalization (Alshahrani, Magarey, & Kitson, 2018; Cappellini et al., 2014).

It is also important to note that the setting where our study took place was described by participants as complex and challenging. The heavy work demands made it difficult for participants to meet the emotional needs of patients. This finding is not unusual as acute care environments such as medical units can be highly complex and chaotic, leaving nurses with little time to perform basic nursing care and emotional support (Beatrice, 2007; Schenk et al., 2017). Thus, participants stated that the flexibility of OVH improved access for families and enabled them to actively participate in providing physical care, emotional support, and companionship to patients at any time. The American Association of Critical Care Nurses identifies that families are an important source of emotional support for patients and their input is associated with positive patient outcomes (AACN, 2012). Given the reality of acute care environments, the reliance on families to provide patients with emotional support may be in the best interest of the

patient. In some ways, families are in a better position to provide patients with emotional support as they are more aware of patients' emotional needs (Athanasiou et al., 2014). However, nurses should also be mindful that families have their own emotional needs. According to Jacob et al., (2016), some family members may experience a certain level of stress when their loved one is in the hospital; therefore, supporting patients emotional needs while managing their own could be a challenge for families.

Participants recognized that OVH offered families the flexibility to be present with their loved ones at any time during the day and night and therefore enabled families more opportunities to participate in patients' care in a more flexible manner. Participants respected that in some cultures, families may be more heavily involved in the care of patients at home and in hospital. In Alshahrani et al.'s (2018) study, although outside an OVH context, families of patients in a Saudi Arabian medical unit assisted in patients physical care because it appeared to make them feel closer to their loved ones. Participants in our study understood that being with patients was a fundamental need for many families and that in meeting this need, families are provided with a sense of ease and reassurance (Ciufo et al., 2011; Jacob et al., 2016).

It is necessary to note that the extent of families' involvement in care is likely to be variable depending on patients' wishes, and the level at which families feel comfortable (IPFCC, 2017). We found that although participants acknowledged and accepted families' participation in the care of patients, there was no discussion concerning families' willingness and ability to engage. As OVH increases opportunities for the family to participate in care, nurses need to assess, communicate and seek appropriate opportunities to encourage and support families' level of participation.

Participants in our study indicated that families increased availability and presence played a collaborative role in ensuring patients' safety and providing patient care. Although medical nurses care for adults across the life span, the aging population means that they are

increasingly caring for older adults who may present with cognitive impairments and frailty (CNA, 2015). These patients are at increased risk for falls and need to be closely monitored to prevent injuries (RNAO, 2017). Participants in our study explained that close monitoring of patients at increased risk of falls was difficult at night when staffing levels were lower. Having family around the patient meant they were able to monitor patients' safety and could alert nurses to any problems that arose. These collaborative efforts helped maintain patients' safety. This finding relates to those of DuPree, Fritz-Campiz, and Musheno (2014). In their study of falls prevention strategies in the ICU, DuPree et al., (2014) found that the 62% incidence in injuries resulting from falls were reduced by 35% when visiting hours changed from restricted to open. The authors attributed the reduction in injuries due to falls to the increased presence of family and their participation in monitoring patients (DuPree et al., 2014).

On the contrary, OVH was found to hinder the nurse-family relationship as the increased presence of families created "uncomfortable situations" at times that resulted in participants avoiding families (refer to chapter four). Consequently, communication and engagement with both patients and families were potentially compromised. In critical care settings with OVH, similar findings have been reported (Athanasiou et al., 2014; Garrouste-Orgeas, Diaw, and Verdavainne, 2008). Athanasiou et al. (2014), for example, found that critical care nurses avoided families because they feared making an error, or not meeting families' expectations in care. Together these findings indicate that in an OVH setting with the increased presence of families developing a therapeutic relationship and collaborating with families may, at times, be challenging. This finding is noteworthy as developing a therapeutic relationship enhances nurses' ability to partner with families to improve the health and wellness of patients (RNAO, 2015). Based on these findings, we recommend that there be strategies in place such as workshops to improve nurses' communication and engagement with families to support the delivery of PFCC and help nurses to cope with the challenges of increased family presence.

In summary, we found OVH facilitated opportunities for nurses to deliver PFCC. The increased presence of families facilitated communication and information sharing between nurses and families which helped nurses to personalize the care given to patients, facilitated communication with patients, and was a way to provide care to the family. OVH promoted dignity and respect by fostering an environment that was conducive to information sharing as well as family members' participation and collaboration in patient care. However, it is also important to note that at times, families' presence was problematic. OVH practices also prompted participants to consider issues around safety as well as challenges they faced in upholding patient privacy and confidentiality. The following section elaborates on these concerns.

5.2 Open Visiting Hours Processes and Safety

Although the OVH policy was available to participants in our study, there was a lack of clarity regarding procedures. For example, visitors were expected to wear an identification badge before entering patient care areas, but it was unclear where these were issued. Furthermore, participants stated the OVH procedures were not always followed as some visitors entered the medical units without any identification. Findings from our study indicate that there was a disconnect between policy and practice. Importantly, the lack of clarity and adherence to OVH policies contributed to participants' concerns regarding safety; an issue that was especially worrying when staffing levels were lower (i.e., during the night). Participants indicated that nurse-to-patient ratios were 1:7 at night. This is not unusual as medical nurses can have nurse-to-patient ratios as high as one nurse for 10 patients during the night (Beatrice, 2007; Berry & Curry, 2012; Schenck et al., 2017). With less staff and limited resources, it was difficult for participants to keep track and monitor who was on their unit, which caused them to feel that they had lost control over their environment and created fear. Female participants, in particular,

expressed concerns about feeling unsafe and unprepared to handle situations that compromised safety.

According to the CNA (2014), a workplace culture that values the well-being of patients, families, and staff is a prerequisite for positive practice and improving patient, nurse, and organizational outcomes. A working environment that is unsafe may demotivate nurses and lead to absenteeism, high staff turnover rates and difficulties with retention, which could negatively impact patient care (International Council of Nurses [ICN], 2012). Relevant to our findings is the Registered Nurses Association of Ontario (RNAO) Healthy Work Place Environment guideline. This guideline is designed to support healthcare organizations in their efforts to create and maintain positive work environments. Concerns regarding workplace safety relate directly to the physical, structural and procedural components of the Healthy Working Environment Model (RNAO, 2008). In this model threats to personal safety are identified as a *physical work demand factor* along with staffing and access to appropriate equipment and resources (RNAO, 2008). As organizations have a fundamental duty to promote the safety of *all persons* in practice settings, the RNAO guideline (2008) recommends that organizations examine nurses' physical environments and put structures and processes in place to best support and respond to nurses' concerns as they relate to the work environment (RNAO, 2008). Structures and processes in an OVH context could include clear OVH policies and procedures, and access to supports such as security personnel. Specifically, increasing the number of security personnel and revisiting their roles with OVH. Since nursing staffing levels added to participants' concerns about safety, we recommend examining staffing levels to ensure that nurses have realistic workloads that support a safe practice environment.

Nurses also have a responsibility for safety. The CNA (2014) states that nurses have a responsibility to advocate for a safe working environment, question what safeguards are in place, and make efforts to promote safety in the practice setting. Participants in our study felt strongly

about maintaining patients' safety, and their own. Given their safety concerns, participants preferred some restriction over visiting; with limits on the number of visitors, and restrictions on visiting during the night unless under exceptional circumstances such as a patient whose condition is unstable or who is dying. While few studies identify safety as a reason to restrict visiting hours, research does indicate that nurses favour more control over their environment and prefer to make decisions regarding visitation based on what they feel is in the best interests of patients (Agard & Lomborg, 2011; Farrell, Joseph, & Schwartz-Barcott, 2005). Tayebi et al. (2014) in an examination of rationales for restricting visiting hours, found that safety was one of the main reasons to restrict visitation in Iranian ICUs. As OVH impacts nurses' working environments, we recommend that front-line nurses and other stakeholders be involved in the development of visiting policies and procedures. Nurses are well-positioned to provide insights into policies and the operationalization of OVH in their contexts, including potential risks, and ways to mitigate safety concerns.

5.3 Accommodating Visitor Space, and Overcrowding

Findings from our study indicate that the increase in family presence from OVH led to challenges with accommodating families with limited resources and space, and overcrowding. Participants explained that the lack of space created difficulties when there were multiple visitors and overnight visits. Patient rooms were small, and equipment (e.g., vitals machines, intravenous pumps, commodes) restricted the available space. Given the lack of space, patient rooms were overcrowded, which made it challenging for participants to maintain a quiet environment for patients to rest. Moreover, participants sometimes had limited resources such as cots and linen to offer families for overnight visits. Despite this, participants tried their best to accommodate family visits. Participants were particularly challenged in accommodating large families that extended to include close friends and members of the patient's community. In some cultures, "steady" visitation from various extended family members and friends is not uncommon (Tayebi

et al., 2014). Similar to our study, (Tayebi et al., 2014) found that patient rooms just could not accommodate an OVH environment with multiple and large extended families. As families are an integral part of patients' recovery and experience, it is important that they have access to amenities (da Silva et al., 2014). These environmental constraints are beyond the control of nurses. Organizational-level changes are, therefore, necessary to address these issues. As organizations seek to develop environments that foster PFCC such as OVH, consideration must be given to the physical and structural environment and resources to accommodate families (RNAO, 2008). Specifically, the impact of OVH on practice environments to ensure appropriate supportive measures are in place (RNAO, 2008). Specific measures could include a large family meeting room, and a sleeping area for families (Lee et al., 2007). Concern regarding space and potential for overcrowding have been identified in by others (Da Silva Ramos et al., 2014; Gasparini et al., 2015; Lee et al., 2007). It is noteworthy that Gasparini et al., (2015) is one of the few studies conducted on adult inpatient units where the concern of space was discussed; however, only from the perspectives of health care leaders. They anticipated that OVH would lead to inadequate space, including limited family space. Except for Gasparini et al.'s (2015) study, our findings did not reflect the OVH literature. Instead, the issue with space from critical care nurse's perspective was the concern for lack of patient privacy, compromising patient confidentiality, and visitors creating a physical barrier to patients (Lee et al., 2007).

Although participants in our study did not raise the issue of privacy and confidentiality, the limited space and overcrowded rooms, and greater access and family involvement in patient care, described by participants, increases the possibility of confidentiality breaches. Whitton and Pittiglio (2011) argue that patients' and families' confidentiality is already compromised due to due to lack of space and overcrowded rooms. Concerns regarding privacy and confidentiality have been raised in several studies by patients, families, and nurses as a barrier and challenge to OVH (Carroll & Gonzalez, 2009; Hardin et al., 2011; Whitton & Pittiglio, 2011).

However, similar to others, we found that too many visitors and overcrowded rooms contributed to increased noise levels (Farrell, Joseph, & Schwartz-Barcott, 2005; Spreen & Schuurmans, 2011; Whitcomb, Roy, & Blackman, 2010). Consistent with the literature, participants felt that late night or overnight visits should be restricted to remove ambient stressors such as noise to optimize an environment that promoted sleep for patients (Hunter et al., 2010). According to the CNA (2017) nurses have a responsibility to promote patients' health and well-being by supporting environmental preservation and restoration and advocating for initiatives that reduce environmentally harmful practices. Participants' in our study reinforced the *Quiet Time* policy (refer to chapter three) and redirected families into the family room to reduce overcrowding and noise levels. Their beliefs regarding the importance was a reason given for limiting family visitation. This finding is compelling given that restricted visiting hours was justified for decades because it was thought to impede on patient's rest, healing and recovery (Fairburn, 1994; Farrell, Joseph, & Schwartz-Barcott, 2005). Perhaps future research on OVH should be aimed at exploring the reasons why nurses prefer limiting family presence. Moreover, the perspectives of nurses from various settings may be of particular interest to see if there are differences in contextual factors that influence their opinion. Further, given that nurses have an ethical and legal responsibility to maintain the privacy and confidentiality of patients' health and personal information (CNO, 2017), it is important for health care providers to take these concerns into account in an OVH context. We recommend that organizations with OVH policies guide health care staff on and how to maneuver potential issues that could compromise patient's privacy and confidentiality. Moreover, future research on OVH should focus on patient's perspectives on noise and overcrowding to explore if and how these factors influence their hospital experience and care.

5.4 Uncomfortable Situations and Avoidance

Another key finding was that OVH created several circumstances that resonated as potential stressors for nurses. Participants' stated that increased family presence created several "uncomfortable situations" where participants felt "uneasy," "awkward," or "intimidated." Examples of these situations are: being bombarded with questions from several families at once, walking into patient rooms with families sleeping in bed with patients, or feeling that they are being monitored or criticized. As a result of these encounters with families, participants avoided interacting with families as a way to cope. It is noteworthy that while "uncomfortable situations" can occur in a restricted visiting context, all participants attributed their experiences to OVH. Similar findings have been reported in the OVH literature in critical care settings (Athanasiou et al., 2014; Da Silva Ramos et al., 2013; Garrouste-Orgeas et al., 2008). These findings indicate that dealing with the demands of OVH and coping with increased family presence places an emotional demand on nurses.

According to the RNAO's Healthy Work Place Environment model (2008), cognitive, psychological and social components of a nurses' workplace such as emotional demands (e.g., increased workloads) and role strain can influence a healthy work environment. This is important as nurses' working environment is an important aspect of determining job satisfaction (Monroe & Wofford, 2017). As OVH facilitates a change in families' presence and their roles, through participation in patient care, it is important that nurses are supported. In the RNAO's Healthy Work Place Environment guideline it is recommended that healthcare systems and organizations should be accountable for implementing appropriate supportive measures (RNAO, 2008). Although our sample was small, we noticed that participants who felt intimidated or overwhelmed by family members were novice nurses, with less than five years of nursing experience. Similar findings have been reported by da Silva Ramos et al. (2013). In an observational and descriptive study that aimed to explore ICU workers' perceptions of OVH, da

Silva Ramos et al (2013) found that 84% of nurses, physicians, respiratory therapists with five years of experience indicated the need to receive communication training to better interact with family members who were present in the ICU 24-hours a day. Lee et al. (2007) suggests that formal communication skills training is necessary for the implementation of OVH as it can improve the dynamics between staff and visitors. Therefore, we recommend that organizations offer guidance to nurses, novice or experienced who are uncomfortable interacting with families and may need to offer training programs aimed to facilitate better communication with families on a unit and/or organizational level. Implementing education and training at an undergraduate level may also be beneficial to prepare nurses to communicate and collaborate with families. Furthermore, future research should explore the specific issues nurses' experience with family presence. Conducting OVH research focused specifically on nurses' concerns will inform interventions aimed at enhancing nurses' practice and the delivery of care to patients and families.

In summary, the goal of OVH is to improve patient and family satisfaction and outcomes through PFCC. However, the existing literature and findings from our study indicate that OVH alters nurses' working environment. Our study highlights that OVH can negatively impact nurses' working environment. The increase in family presence led to: safety concerns when there were unclear policies and procedures in place, increases in workload as nurses attempt to balance the care and needs of patients and families, concerns regarding space, overcrowding and noise, and poor communication with families. Given our findings and limited research there is a need for greater understanding of the impact of OVH on nurses and their practice outside of the critical care context. Future research would benefit from gaining not only the perspectives of nurses but also those of patients and families. Also, the influence of OVH on non-nursing hospital staff. Very few studies take into consideration the views physicians, allied health (e.g., physiotherapist, occupational therapist, and social worker), security, and clerical staff; all of

which may have contact with patients and families. As OVH is an approach that is starting to become common in across settings, future research exploring the perspectives of stakeholders' other care settings (e.g., long term care and rehabilitation).

5.5 Implications of the Findings for Nurses' Advance Practice Role

An advanced practice nurses (APN) is a role that encompasses analyzing, synthesizing and applying nursing knowledge, theory and research evidence to foster system-wide changes and advance nursing care and the profession as a whole (CNA, 2014, 2008). The implications of our findings will be discussed in relation to the Canadian Nurses Association (2008) competencies; clinical practice, leadership, research, and consultation and collaboration.

5.5.1 Clinical practice.

This section on clinical practice will build on the implications identified in Chapter Four. Nurses in advanced practice roles have expert knowledge, skills, and abilities and are able to assess clients, develop and contribute to plans of care, and intervene in complex and unpredictable situations (CNA, 2014). Like others, meeting the informational needs of families was challenging for participants in our study as it took time away from patients (Monroe & Woodford, 2017). In critical care settings, nurses in advanced practice roles have helped to reduce nurses' burnout and increase job satisfaction as they have taken on the role of supporting staff and assisting with challenging family encounters (Monroe & Wofford, 2017; Riley et al., 2014). Indeed, some critical care units with OVH, have a designated "family caregiver specialist" who is responsible for educating and addressing families' needs; allowing nurses to focus on patient care (Monroe & Wofford, 2017). While it may not be feasible for APNs on medical units, they do have a role in supporting nurses. For example, the APN could guide and educate nurses through interventions to improve communication with families and assist in resolving conflicts and "uncomfortable situations". The presence of the advance practice nurse role, such as CNS in clinical settings with OVH would improve nursing practice as they would

be available to mentor, role model, consult and educate nurses as needed. Part of an advanced practice role is to measure indicators such as timeliness, effectiveness, efficiency, and client-centered care (CNA, 2014). Our study revealed some challenges brought on by OVH such as increased workloads. APNs could be involved in measuring how these challenges influence nurses and their work, and the implications for nursing practice.

5.5.2 Leadership.

Nurses in advanced practice roles are leaders and agents of change. As part of their role, they engage in initiatives to improve policies at an organizational level (CNA, 2014). The APN has the knowledge and ability to lead implementation strategies to promote and optimize patient and family outcomes (CNA, 2008). With their ability to critically analyze research and evidence-informed practices, the APN can influence policies such as OVH both within and across organizations. Furthermore, with their involvement in policy, APNs can evaluate gaps and operational issues from an organizational level and contribute to the development of innovative solutions (CNA, 2008). APNs contribute to nursing practice by leading and fostering the development of nurses in efforts to maximize their scope and depth of practice (CNA, 2008, 2014). The role of the APN is to identify problems and initate changes to address challenges from individual concerns in nursing practice to organizational concerns (CNA, 2008). This can include advocating for and implementing change to create a safe and healthy workplace environment for nurses. Our study revealed that nurses are impacted by OVH as it creates a change in their working environment. APNs can advocate for the necessary resources to aid the provisions of OVH, as well as support for patients, families, and staff. We found that participants were not involved in the process of transition from restricted to OVH. APNs could advocate, support, and encourage the involvement of front-line nurses in policymaking, especially when it a policy that directly influences nurses' working environments.

5.5.3 Research.

APNs can strengthen the link between research and clinical practice (CNA, 2008, 2014). Nurses in advanced practice roles could facilitate the implementation of OVH to health care professionals and on an organizational level. By providing expert opinion regarding the effectiveness of OVH and its implementation into the practice settings. As there is still much to be learned about the implications OVH has on patients, families, health care providers in various clinical settings, APNs can identify potential knowledge gaps regarding OVH. APNs could lead or be involved in quality improvement initiatives and research on the impact of OVH to better inform policy and develop implementations. For example, participants in our study found OVH created challenges for nurses. Research aimed at understanding these challenges could inform interventions to better support nurses working in an OVH context.

5.5.4 Consultation and collaboration.

Nurses in advanced practice roles consult and collaborate with colleagues and stakeholders across different levels (CNA, 2008). Our study highlighted issues with policy adherence and safety on the units. Through collaboration with staff and other health care leaders (e.g., clinical managers, security personnel, policymakers), APNs could work to ensure that OVH processes are in place, transparent, clearly understood (by staff, families, and patients), and followed. The nurse in an APN role in collaboration with nurses and the interprofessional team could also help to identify potential concerns and situations that may arise with OVH and determine the most appropriate measures to address these.

5.6 Limitations

As with all research, there are limitations with the study. In Chapter 4 I identified limitations as they related to the sample and sampling. I acknowledged that my study took place in a particular context that is reflective of OVH in that organization on the units that were the

setting for the study. Consequently, the findings from my study are likely to be transferrable to context that are similar. Relatedly, I recognize that the recommendations that I have made are based on only one study of 10 medical nurses. More evidence is required to better understand the influence of OVH, and to support evidence-based recommendations. While OVH is a strategy to facilitate PFCC, my study aimed to capture participant's experiences with OVH more broadly. However, I found that the concept of PFCC was authentically discussed by participants and the attributes were interlaced within the study findings. As I reflect on the study and my approach to the investigation, conceptually framing the study within a PFCC model would have facilitated a more in-depth investigation of OVH as it relates to PFCC.

Thesis Conclusion

In conclusion, the study offers insight into medical nurses' experiences with OVH and highlights how the provisions of OVH facilitates and hinders the delivery of PFCC. OVH fostered an environment that was viewed by participants as conducive to the delivery of PFCC. However, OVH and the increased presence of families had a negative impact on nurses working environments adding to nurses' workload and leading to lack of space and resources, increased noise, "uncomfortable situations" and concerns regarding safety. Consequently, participants had mixed views about OVH and some preferred limits on visiting. The study brings to light ways in which OVH influences nurses working environment and the delivery of patient and family care. Recommendations are made to better support nurses in an environment with OVH in the provision of PFCC, and for research to increase understanding of the influence of OVH. As organizations look for ways to improve patients' and families' experiences, such as OVH, it will be important for them to consider the impact not only on patient and family outcomes but on those providing the care.

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Appendix A

Search Strategy

Focus: A comprehensive literature review was conducted to identify literature on patients', families', nurses', and organizational perspectives on OVH within adult inpatient medical units. However as literature in this context was limited, the search was expanded to include other literature (i.e., critical care settings, rehabilitation, and surgical units) that could inform the inquiry.

Search strategy and inclusion criterion: Four scholarly databases were searched: PubMed, CINHAL, Embase, and Scopus. Keywords and mesh headings, and surrogate terms included: *open visiting hours, 24-hour visiting, unrestricted visiting hours, non-restricted visiting hours, hospital visiting hours, family visitation,' patient-centered care, person-centered care,' family-centered care, nursing, and medical units*. The following Boolean operators *AND* and *OR* were used to combine search terms. The scope of the review initially included North American studies. However, it was recognized that some international literature could translate to the Canadian context; therefore, international literature was included. No limitation was placed on the years of publication. The years searched were those covered by the databases. The years searched dated back to 1985, and up to 2017. There were no restrictions on the type of research, and limits on the evidence. For example, commentaries were included as they had reflections on OVH. Also, grey literature such as practice guidelines from websites: The Institute of Person and Family-Centered Care (IPFCC), and the Registered Nurses' Association of Ontario (RNAO). The reference lists of identified literature were scanned for relevant research (descendancy search).

Exclusions: Literature was excluded if it was not deemed relevant to the focus of the inquiry. This included OVH within outpatient settings, pediatric, and mother-baby settings. Restrictions were placed on language. Only English language literature was included.

Appendix B

Recruitment E-mail

Good morning/afternoon,

My name is Angelina Raghubir. I am a Master of Nursing Student from the University of Ottawa. I am reaching out to nurse educators across The Ottawa Hospital as part of my recruitment strategy for my research study as part of my graduate studies. This study has received approval from the Research Ethics Board (REB) from both The Ottawa Hospital and the University of Ottawa and will be supervised by Dr. Christine McPherson.

The Ottawa Hospital is one of the few hospitals in Ontario that have implemented an open visiting hours policy, where visiting hours are 24-hours and have no restriction to the number of visitors and duration of visits. I am conducting a research study to explore the experiences of nurses working on in-patient medical units that have open visiting hours, and to understand how open visiting hours impacts their practice, specifically, their ability to provide person-and-family-centered care.

I am looking to recruit 10 to 12 participants. These can be both registered practical nurses and registered nurses who are working on in-patient medical units. Nurses who are interested in sharing their experience for this study are asked to contact me via e-mail or telephone. I will then set up a date and time for an in-person or telephone interview that will last approximately 45 to 60 minutes. The location of the interview will be a place that is of convenience to participants. Nurses will not be identified in the study and all information that is shared will be confidential. Nurses will receive an information and consent form outlining this information in detail and will have the opportunity to ask any questions regarding the study. To thank nurses for their participation in this study, nurses will receive a $10 Second Cup gift card. Please forward the attached information and poster to nurses.

Best regards,
Angelina Raghubir, BScN, RN
MScN Student
University of Ottawa

Appendix C

Recruitment Poster

The Ottawa Hospital | L'Hôpital d'Ottawa

Inspired by research. Driven by compassion. Inspiré par la recherche. Guidé par la compassion.

Are you a registered practical nurse (RPN) or registered nurse (RN) who works on an in-patient medical unit with open visiting hours?

We want to hear about your experience!

If you would like more information regarding the study or are interested in participating, please contact:

Researcher: Angelina Raghubir, BScN., RN

Email: [redacted]

Telephone: [redacted]

(ask to speak to Angelina Raghubir or leave a message)

Version: September 13, 2017

uOttawa

Nurses will receive a $10 Second Cup Gift Card for their participation!

This research study has been approved by the Ottawa Science Network Research Ethics Board:
Protocol # 20170515-01H

THE EXPERIENCE OF PROVIDING PERSON-AND-FAMILY-CENTERED CARE WITH AN OPEN VISITING HOUR POLICY: AN INTERPRETIVE DESCRIPTION OF NURSES' PERSPECTIVES

Appendix D

Recruitment Post Card

The Ottawa Hospital | L'Hôpital d'Ottawa

Inspired by research. Driven by compassion. Inspiré par la recherche. Guidé par la compassion.

Are you a registered practical nurse (RPN) or registered nurse (RN) who works on an in-patient medical unit with open visiting hours?
We want to hear about your experience!

If you would like more information regarding the study or are interested in participating, please contact:

Researcher: Angelina Raghubir, BScN., RN

Email: [redacted]

Telephone [redacted]
(ask to speak to Angelina Raghubir or leave a message)

Version: September 13, 2017

uOttawa

Nurses will receive a $10 Second Cup Gift Card for their participation!

This research study has been approved by the Ottawa Science Network Research Ethics Board:
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We want to hear about your experience!

If you would like more information regarding the study or are interested in participating, please contact:

Researcher: Angelina Raghubir, BScN., RN

Email: [redacted]

Telephone: [redacted]
(ask to speak to Angelina Raghubir or leave a message)

Version: September 13, 2017

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Are you a registered practical nurse (RPN) or registered nurse (RN) who works on an in-patient medical unit with open visiting hours?
We want to hear about your experience!

If you would like more information regarding the study or are interested in participating, please contact:

Researcher: Angelina Raghubir, BScN., RN

Email: [redacted]

Telephone [redacted]
(ask to speak to Angelina Raghubir or leave a message)

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The Ottawa Hospital | L'Hôpital d'Ottawa

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Are you a registered practical nurse (RPN) or registered nurse (RN) who works on an in-patient medical unit with open visiting hours?
We want to hear about your experience!

If you would like more information regarding the study or are interested in participating, please contact:

Researcher: Angelina Raghubir, BScN., RN

Email: [redacted]

Telephone: [redacted]
(ask to speak to Angelina Raghubir or leave a message)

Version: September 13, 2017

uOttawa

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Appendix E

Recruitment E-mail for Snowball Sampling

Hi (Participant's Name),

Thank you again for taking the time to participate in my study. I am currently still looking to recruit participants. I am e-mailing to ask if you would kindly share my recruitment poster with some of your colleagues who you think may be interested in participating. I would appreciate it very much. I've attached the recruitment poster to this email which contains my contact information.

Many thanks,
Angelina Raghubir, BScN., RN.

Appendix F

Interview Guide

The first few questions asked will be used to describe the people who took place in the study

How old are you?

What gender do you identify as?

Are you a RN or RPN?

How long have you been practicing for?

What unit are you working on? What kind of unit is it?

How long have you been working on the current unit for?

Are you working full-time, part-time or casual?

How long are your shifts?

Do you work days, nights, or both?

The next series of questions are about your role as a staff nurse providing care

1. What is the philosophy of care like on your unit? Or in other words, can you describe to me what nursing care looks like on your unit? If this question is too broad, in a nutshell, walk me through what a typical day looks like for you
2. On your unit, would you say that care is focused on patients, families, both, or neither? What are your thoughts on this? Do you agree with the way it is or disagree?
3. Do you view families as part of your care? What is your understanding of a nurses; role in family care? What do you do to provide care for families? Can you provide me with an example?
4. What have you done in your practice to make families and patients feel like they are a part of the care? What kind of things do you do within your practice to engage in patient and family centered care? Can you provide me with some examples?

The next few questions will be regarding open visiting hours

5. How long has your unit had open visiting hours? What is your understanding of the rationale for open visiting hours?
6. Can you describe to me how open visiting hours works on your unit? Is there any flexibility or leeway to the way open visiting hours works? Do nurses have a say regarding how open visiting hours work?
7. Explain to me what some benefits of open visiting hours has to your practice.

8. Does open visiting hours help with patient and family centered care? How? Can you provide me with some examples?
9. Are there any challenges or difficulties that you experience with open visiting hours? If so, what are they?
10. What helps you when these challenges occur?
11. How can these challenges be addressed? What are your suggestions?
12. What would best support you in order to provide patient and family centered care?
13. How do your peers view open visiting hours? Does this impact or influence your practice at all? If so, in what ways? Are you aware of other colleagues' perspectives?
14. Aside from your current position, have you ever worked in another setting with open visiting hours? Was it any different from your unit now?
15. Have you worked in an area with restricted visiting hours? If so, explain some of the benefits and challenges.
16. Do you have a preference for restricted or open visiting hours? Summarize why.
17. Is there anything else regarding open visiting hours or the type of care that you provide that you would like to share?

Appendix G

Information and Consent Form

PARTICIPANT INFORMED CONSENT FORM

Title of Study: A thematic analysis of nurses' experiences with open visiting hours on medical units

Principal Investigator (PI): Chantal Backman
Participation in this study is voluntary. Please read this Informed Consent Form carefully before deciding whether to participate in this study or not. Ask the study team as many questions as you like.

Why am I being given this form?
You are being asked to participate in the above-mentioned research study because you are a registered nurse or a registered practical nurse who works on an inpatient unit with open visiting hours.

Why is this study being done?
Person-and-family-centered care is an approach to care that takes into account the needs of the patient and their family members. Open visiting hours where there are no restrictions on the timing and frequency of visits by family members of inpatients is thought to be one aspect of person-and family-centered care. In this study, we are interested in learning more about your experiences and views on open visiting hours as it relates to person-and-family-centered care. The findings will add to knowledge to help better support nurses working in open visiting hours settings, and how their ability to provide person-and-family-centered care is facilitated or inhibited by open visiting hours

How is the study designed?
In this study, we will be collecting data through individual interviews about nurses' experience of open visiting hours working in an inpatient setting. The information from the interviews will be analysed to capture an overall interpretation of the range of experiences of nurses. We estimate that approximately 12 nurses will be recruited for this study.

What is expected of me?

Participation will consist of one individual in-person or telephone interview with the researcher Angelina Raghubir. In this interview, you will be asked open-ended questions about your roles and responsibilities as a staff nurse providing person-and-family-centered to patients on an inpatient unit with open visiting hours. The interview will last approximately 45 to 60 minutes and will be scheduled at a time and place that best fits your schedule, outside of work hours. You may skip any questions that make you uncomfortable or that you do not wish to answer. The

interview will be audio-recorded, with your permission, to facilitate transcription and analysis of the information.

How long will I be involved in the study?

The entire study will last approximately 12 months, starting October 2017. Your participation in the study will last approximately 45-60 minutes. Over this time, you will be required to visit have 1 interview.

What are the potential risks I may experience?

Although the risk is minimal, describing experiences caring for patients and families could be uncomfortable. You can choose not to answer certain questions or can stop the interview should you wish to at any point.

Can I expect to benefit from participating in this research study?

You will not receive any direct benefit from participation in this study. Your participation will provide a better understanding of open visiting hours and how this policy relates to patient-and-family-centered care, which may benefit future patients, families, and nurses.

Do I have to participate? What alternatives do I have?

Your participation in this study is voluntary. The alternative to this study is not to participate. You may decide not to be in this study, or to be in the study now, and then change your mind later without affecting the education, employment or other services to which you are entitled or are presently receiving at The Ottawa Hospital.

If you withdraw your consent, the study team will no longer collect your personal identifying information for research purposes. All information collected before your withdrawal will be destroyed.

Will I be paid for my participation or will there be any additional costs to me?

You will be paid $10 for your time taken to participate in the study in the form of a Second Cup gift card. You will receive this gift card after completing the interview.

How is my personal information being protected?

- All information collected during your participation in this study will be identified with a unique study number (for example participant # ID1) and will not contain information that identifies you.
- A Master List provides the link between your identifying information and the coded study number. This list will only be available to Angelina Raghubir and her supervisor and will not leave the University of Ottawa.
- The audio recording and all paper records, including this consent form, will be securely brought to the University of Ottawa for storage.
- Documents leaving The University of Ottawa will be de-identified and will only contain the coded study number.
- All paper records will be kept in a locked filing cabinet at the research team's office at the University of Ottawa, specifically in the office of the thesis supervisor. All electronic data will remain on the secure University of Ottawa server.
- The audio recording and all paper records, such as consent forms, will be securely brought to the University of Ottawa for storage in the thesis supervisor's office, immediately after obtaining them.

- Audio files will be transferred to the secure University of Ottawa server immediately after the interviews. All audio recordings will be transcribed offsite and will be sent using an encrypted USB key. All information sent, and all transcriptions will be de-identified.
- Audio-recordings will be erased immediately after transcription.
- Information that identifies you will be released only if it is required by law.
- You will not be identified in any publications or presentations resulting from this study.
- Research records will be kept for 10years, as required by the OHSN-REB.
- At the end of the storage time, all paper records will be shredded, and all electronic records will be securely deleted.
- Representatives from the Ottawa Hospital Research Institute, the Ottawa Health Science Network Research Ethics Board, and the University of Ottawa's Research Ethics Board may access personal identifiable information and study files/data for audit/inspection purposes.

Do the investigators have any conflicts of interest?
There are no conflicts of interest to declare related to this study.

What are my responsibilities as a study participant?
It is important to remember the following things during this study:

- Ask the researcher if you have any questions or concerns at any time

Will I be informed about any new information that might affect my decision to continue participating?
You will be told in a timely fashion of any new findings during the study that could affect your willingness to continue in the study. You may be asked to sign a new consent form.

Who do I contact if I have any further questions?
If you have any questions about this study, please contact Angelina Raghubir at 613-562-5800

ext. 8394 and ask to speak to Angelina Raghubir.

The Ottawa Health Science Network Research Ethics Board (OHSN-REB) has reviewed this protocol. The Board considers the ethical aspects of all research studies involving human participants at The Ottawa Hospital. If you have any questions about your rights as a study participant, you may contact the Chairperson at 613-798-5555, extension 16719.

A thematic analysis of nurses' experiences with open visiting hours on medical units

Consent to Participate in Research

- I understand that I am being asked to participate in a research study about the experiences of registered nurses providing family-centered care in adult medical units with open visiting hours.
- This study was explained to me by Angelina Raghubir
- I have read, or someone has read to me, each page of this Participant Informed Consent Form.
- All of my questions have been answered to my satisfaction.
- If I decide later that I would like to withdraw my participation and/or consent from the study, I can do so at any time.
- I voluntarily agree to participate in this study.
- I will be given a copy of this signed Participant Informed Consent Form.

I agree to be audio taped. Yes ☐ No ☐ Initials ___

_____	_____	_____
Participant's Printed Name	Participant's Signature	Date

Investigator or Delegate Statement

I have carefully explained the study to the study participant. To the best of my knowledge, the participant understands the nature, demands, risks and benefits involved in taking part in this study.

_____	_____	_____
Investigator/Delegate's Printed Name	Investigator/Delegate's Signature	Date

Assistance Declaration

Was the participant assisted during the consent process? ❑ Yes ❑ No

❑ The consent form was read to the participant/substitute decision-maker, and the person signing below attests that the study was accurately explained to, and apparently understood by, and consent was freely given by the participant/substitute decision-maker.

❑ The person signing below acted as a translator for the participant/substitute decision-maker during the consent process. He/she attests that they have accurately translated the information for the participant/substitute decision-maker, and believe that the participant/substitute decision-maker has understood the information translated.

_____	_____	_____
Name of Person Assisting (Print)	Signature	Date