Ente Ospedaliero Cantonale

Il Paziente al centro della cura

Le buone pratiche: il progetto Open.ICU

Claudio Speroni (Capo-Reparto infermieristico, Ospedale Regionale di Lugano)

Campus SUPSI Trevano - 29 novembre 2018

ICU

Intensive Care Unit

Ospedale Regionale di Mendrisio

Terapia intensiva aperta

obiettivo

la narrazione

parola chiave

Il tempo

contenuto

la memoria

2012

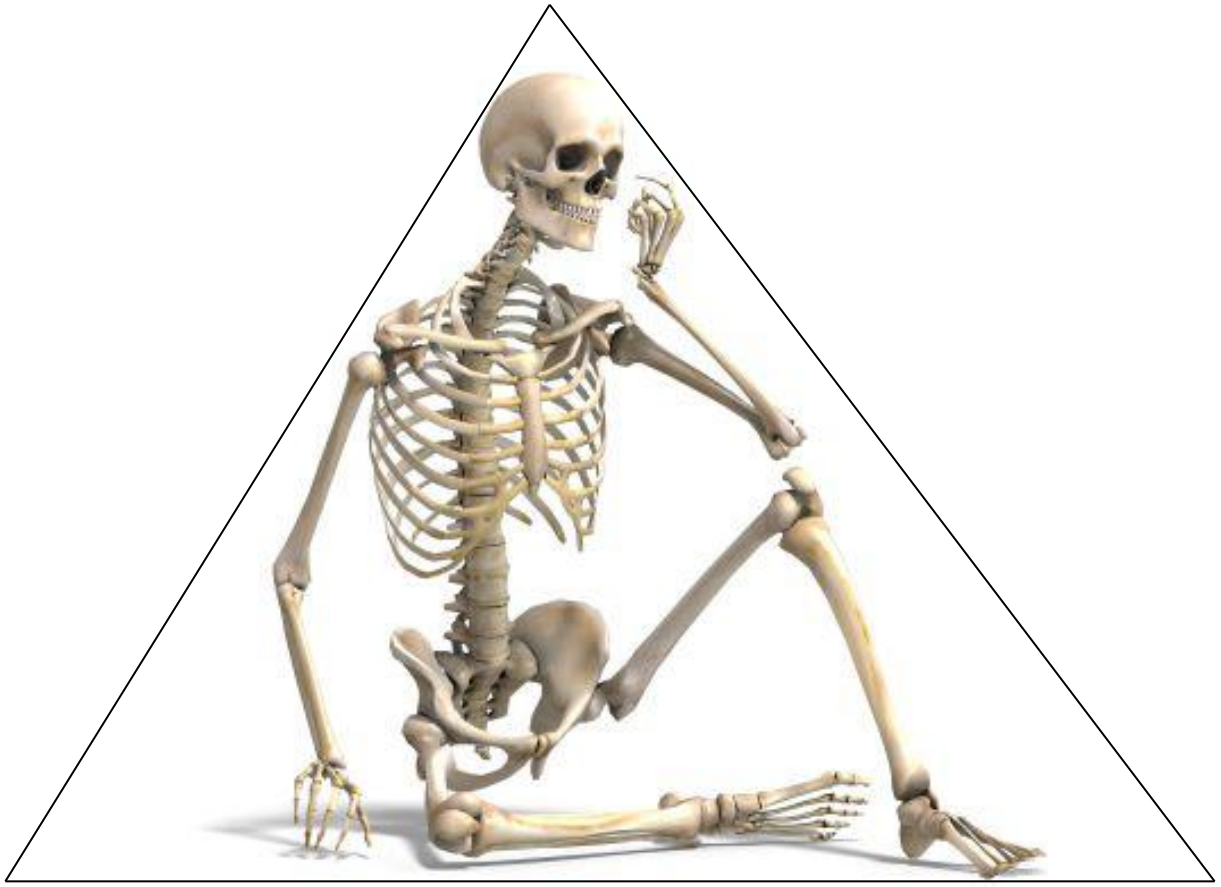
2018

ora mi presento

background

c’era una volta

c’era una volta



il sapere

Revisioni sistematiche

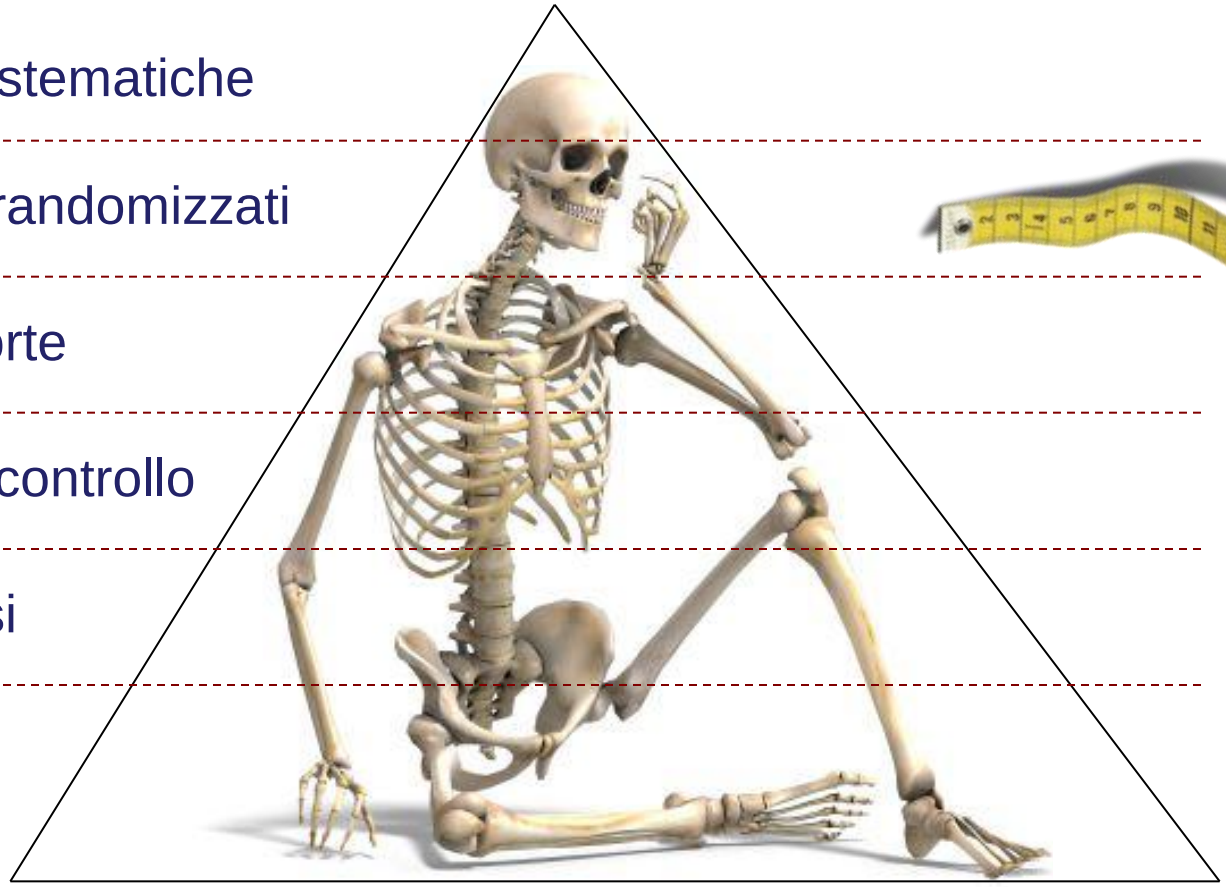
Trial clinici randomizzati

Studi di coorte

Studi caso-controllo

Serie di casi

Opinioni di esperti



o deboli evidenze

Revisioni sistematiche

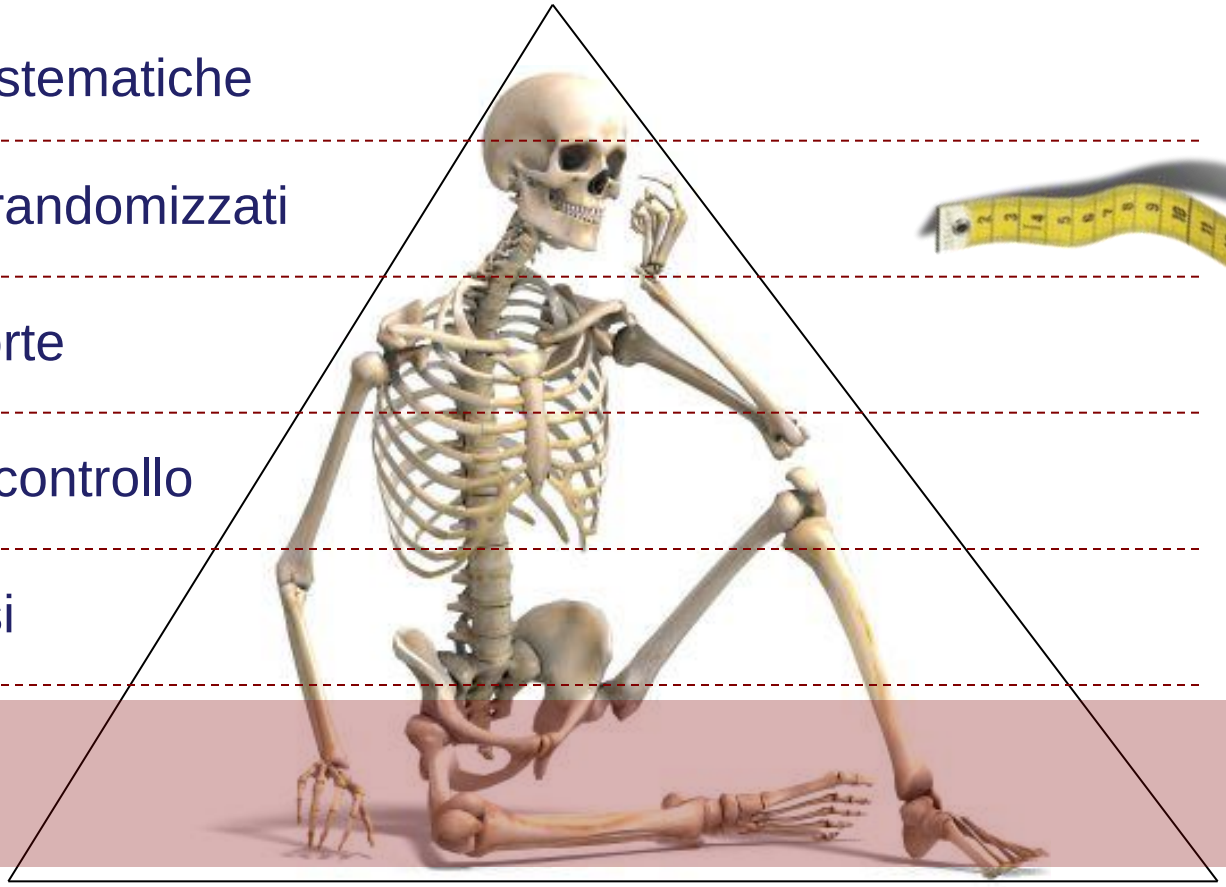
Trial clinici randomizzati

Studi di coorte

Studi caso-controllo

Serie di casi

Opinioni di esperti



i bisogni

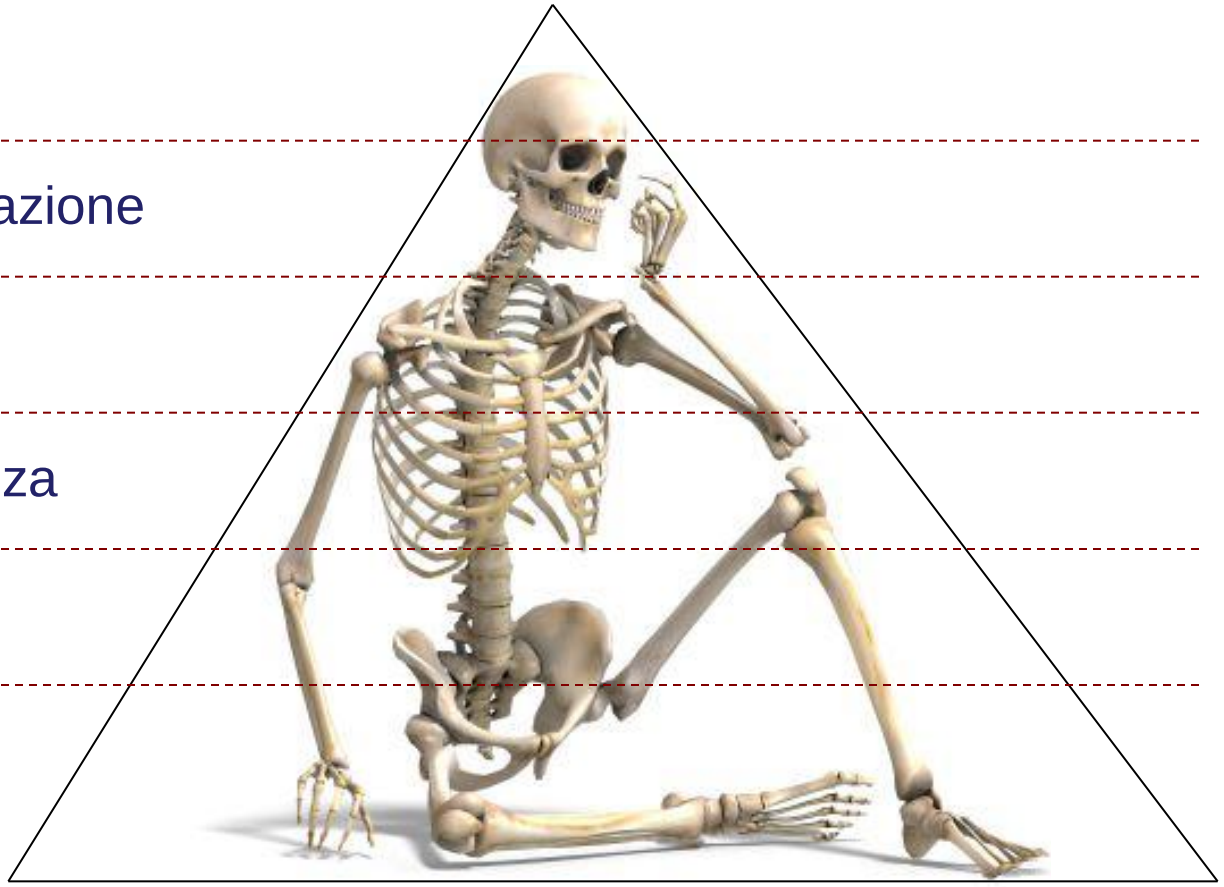
Autorealizzazione

Stima

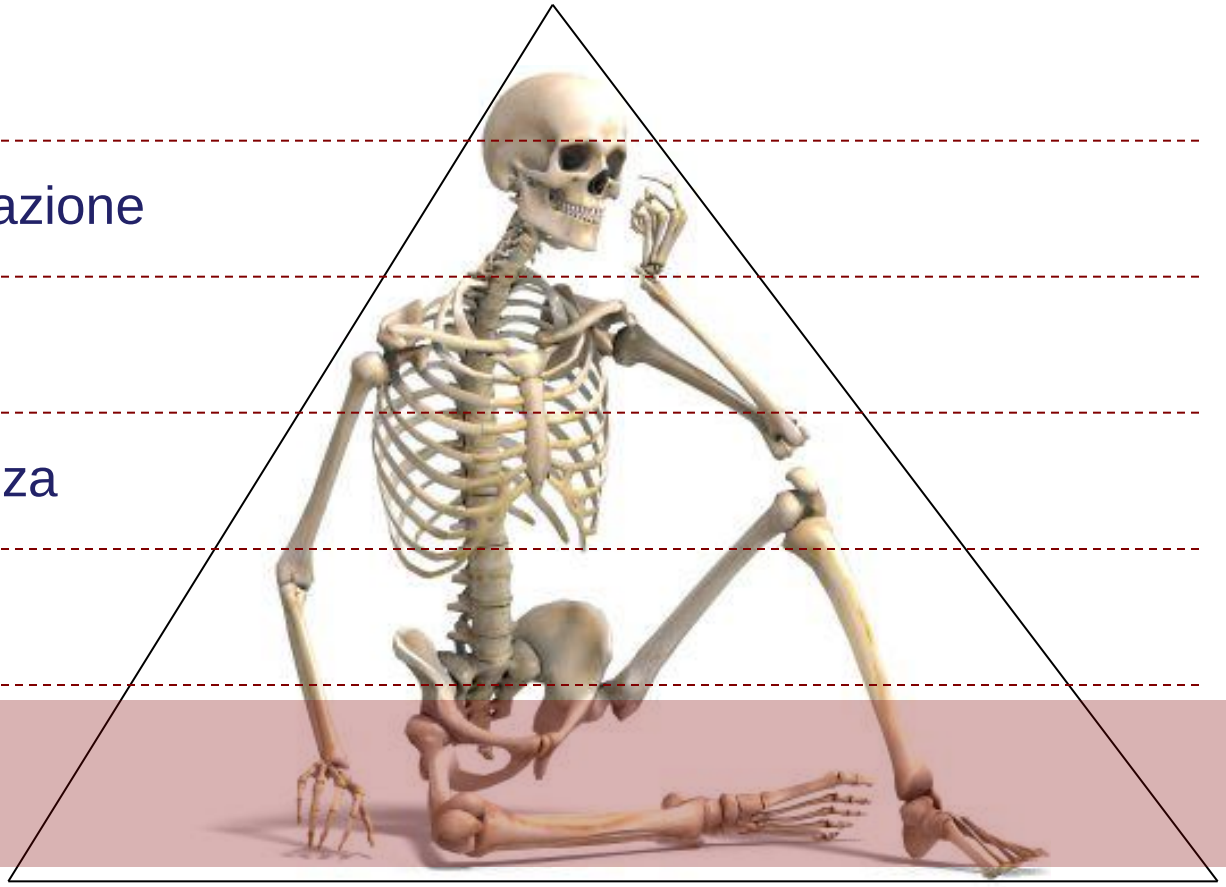
Appartenenza

Sicurezza

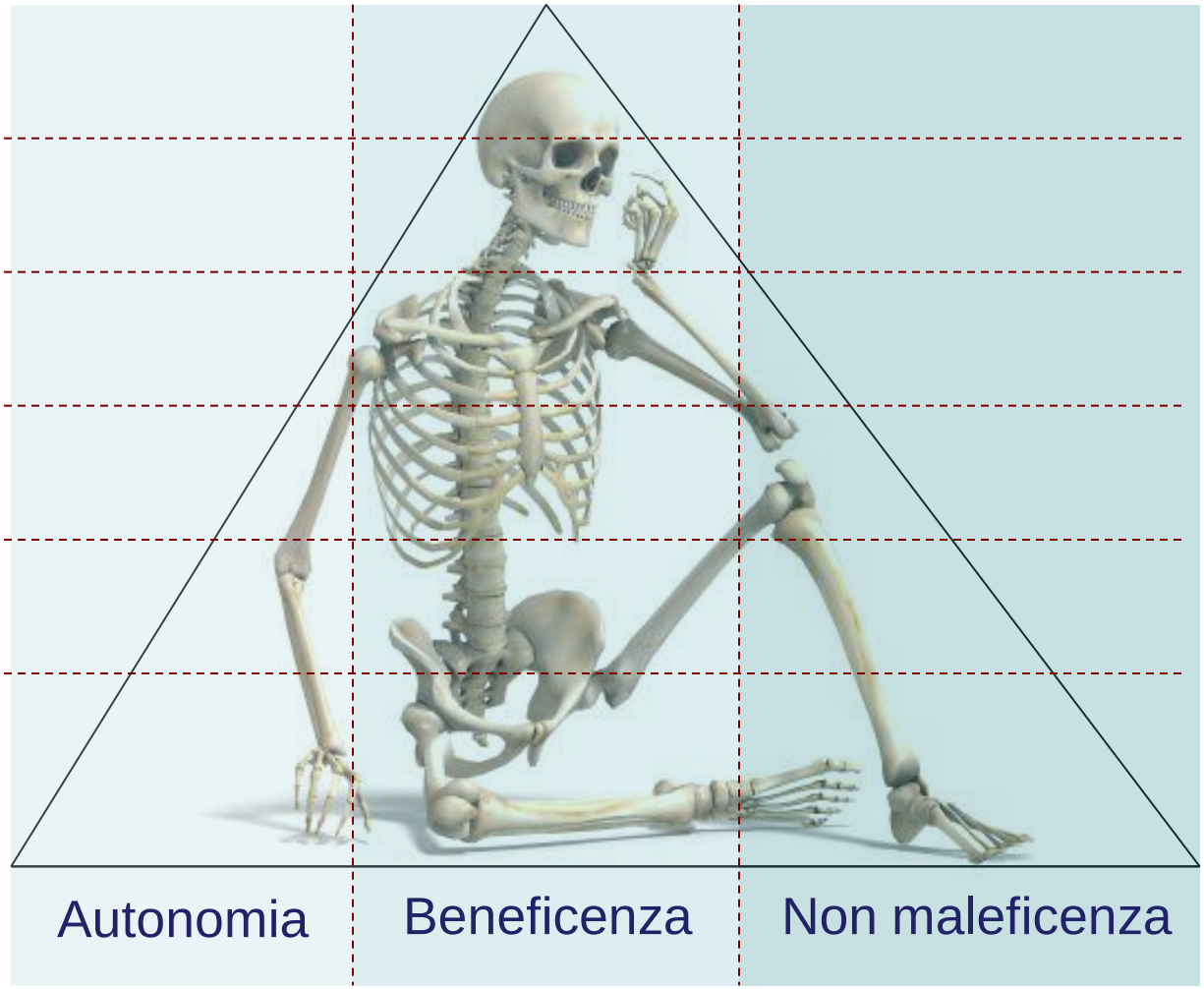
Bisogni fisiologici



o le sole necessità vitali



tra l’ideale di una cura etica



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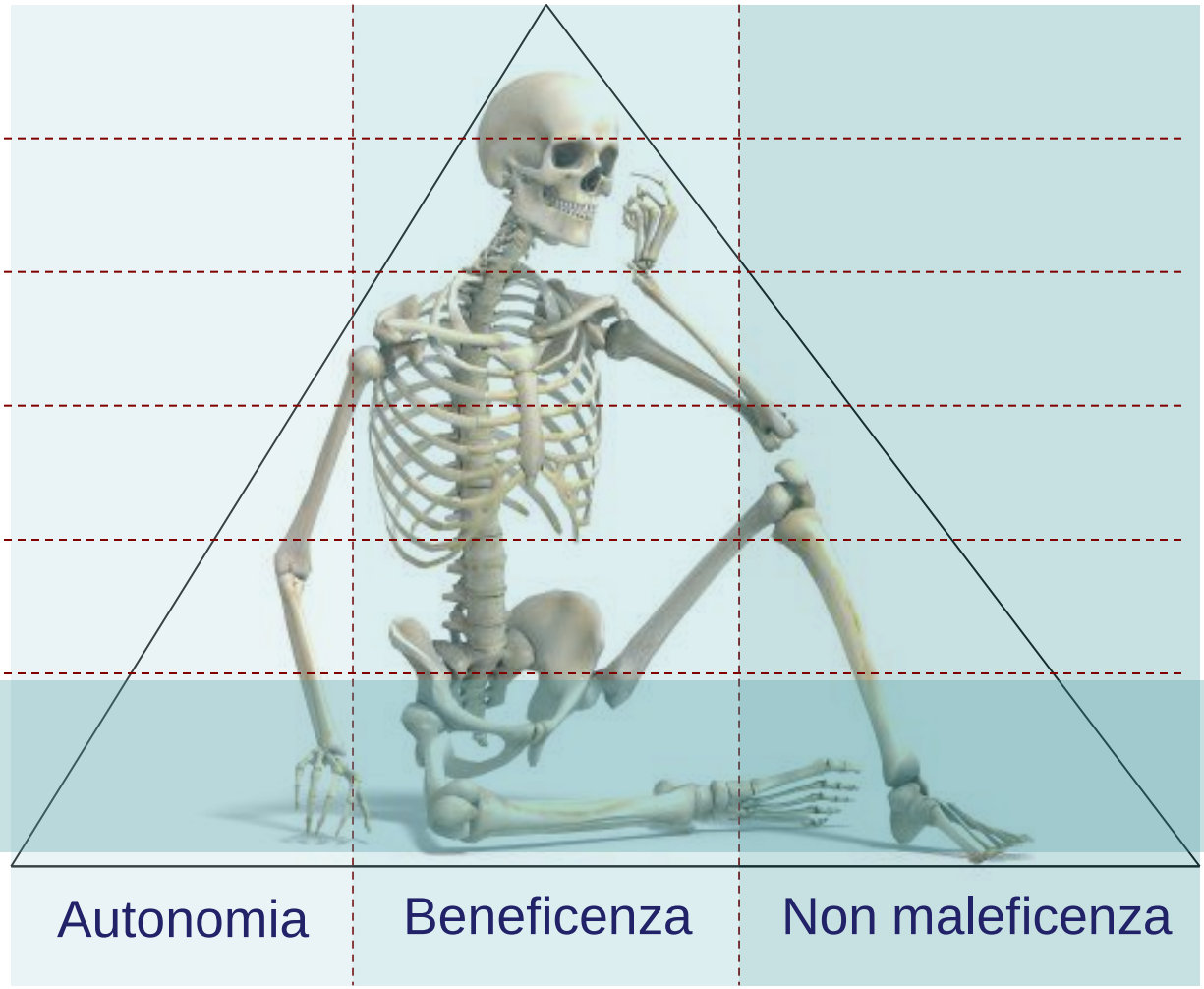
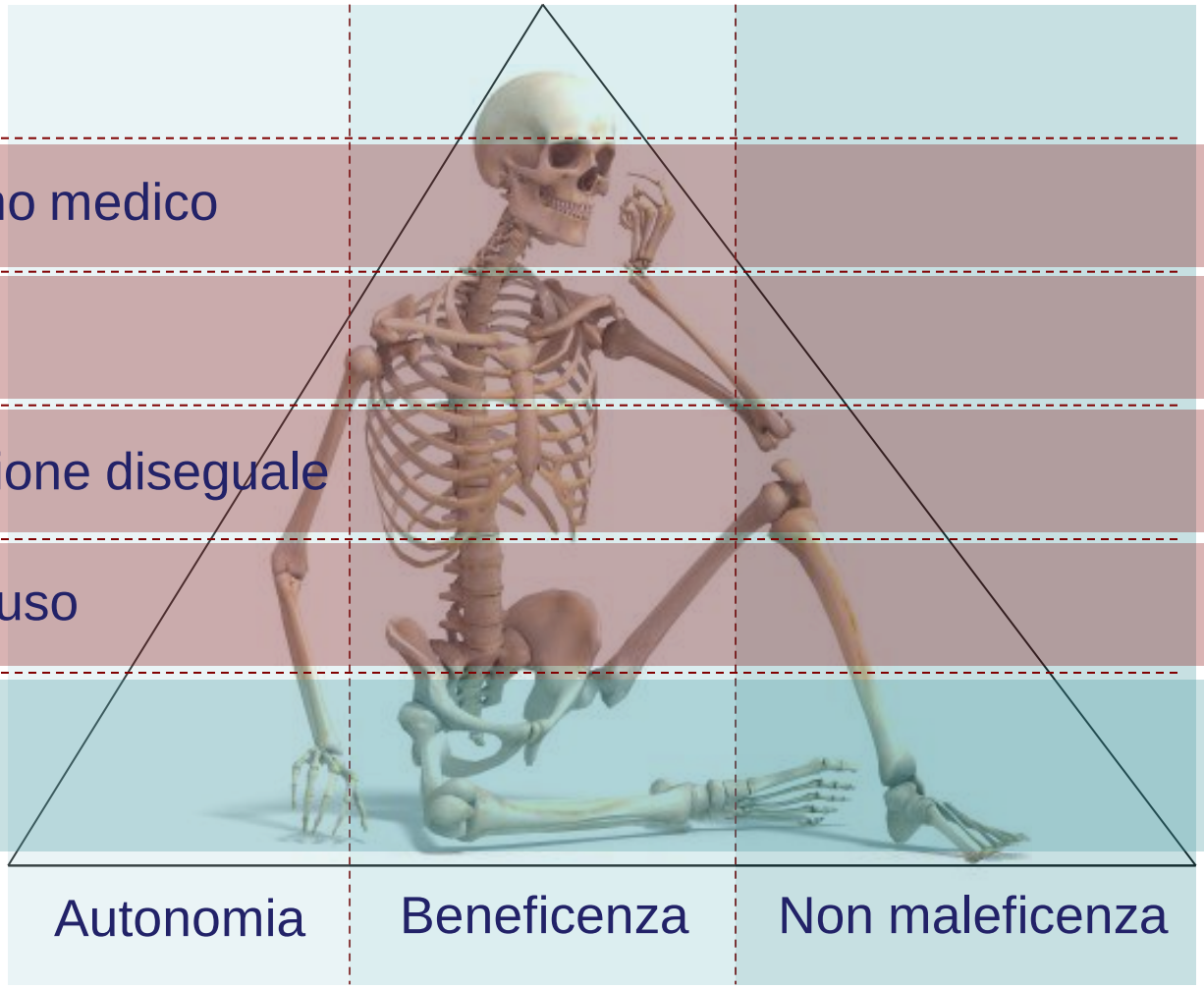
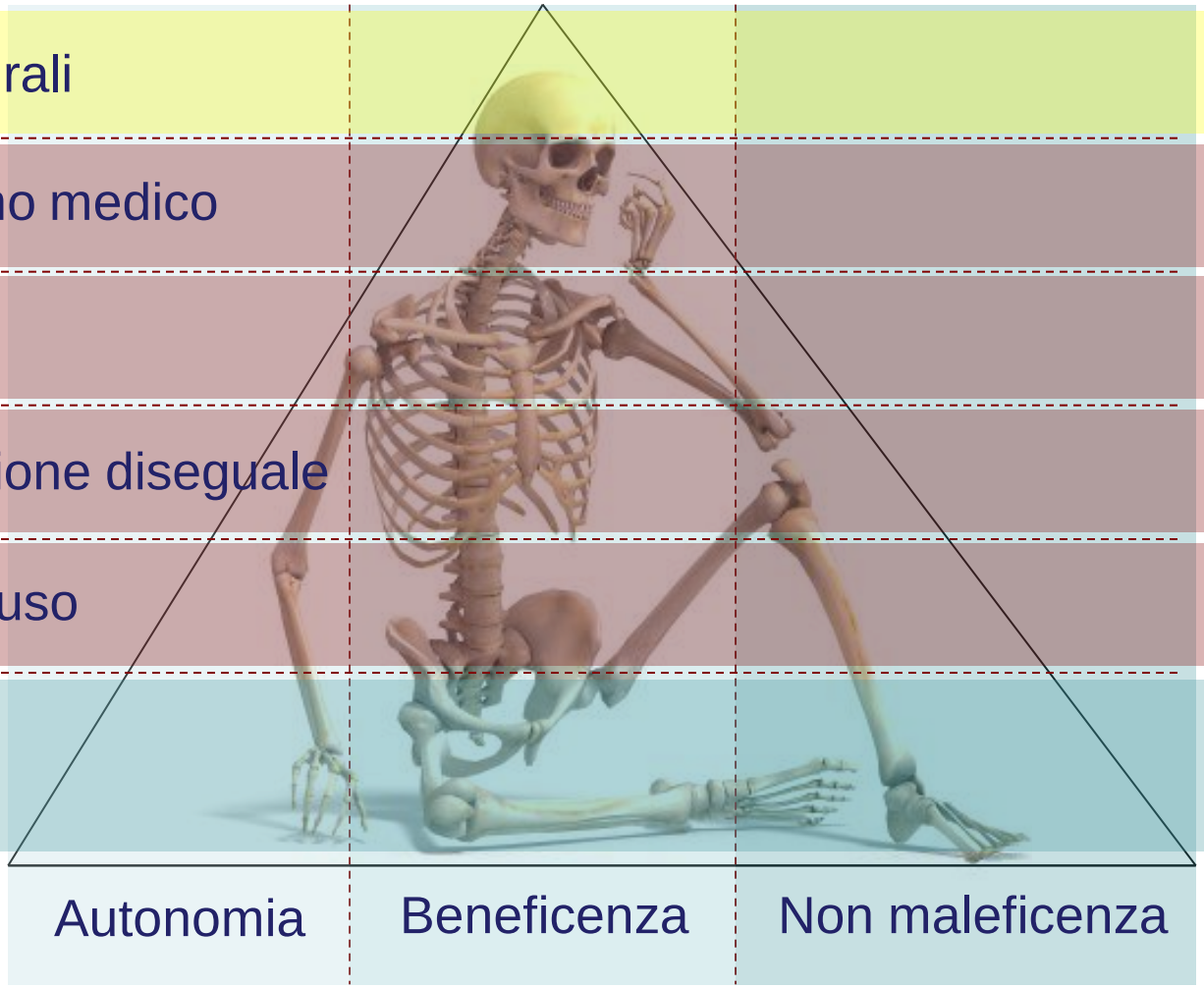


e molti dilemmi

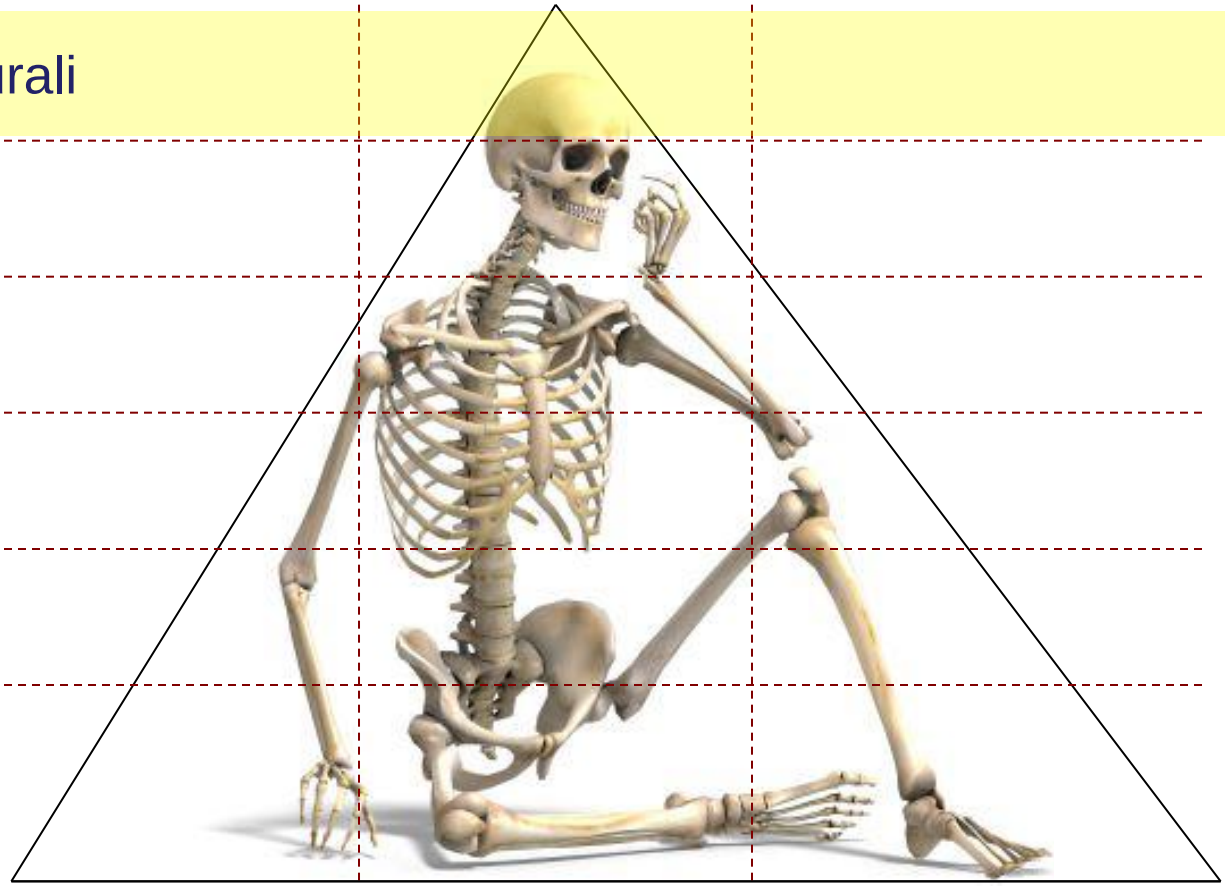


molti dilemmi e nessuna soluzione



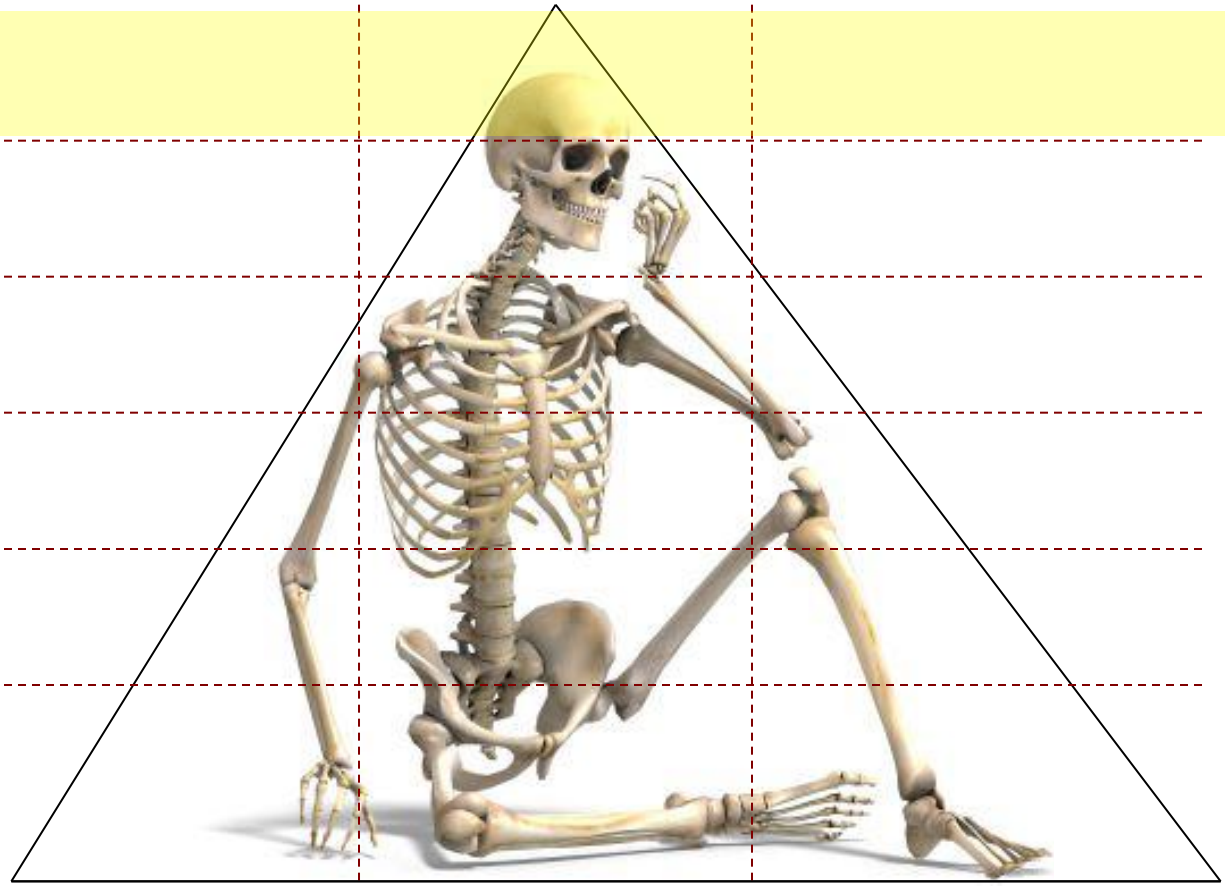
o forse un solo dilemma

Fattori culturali

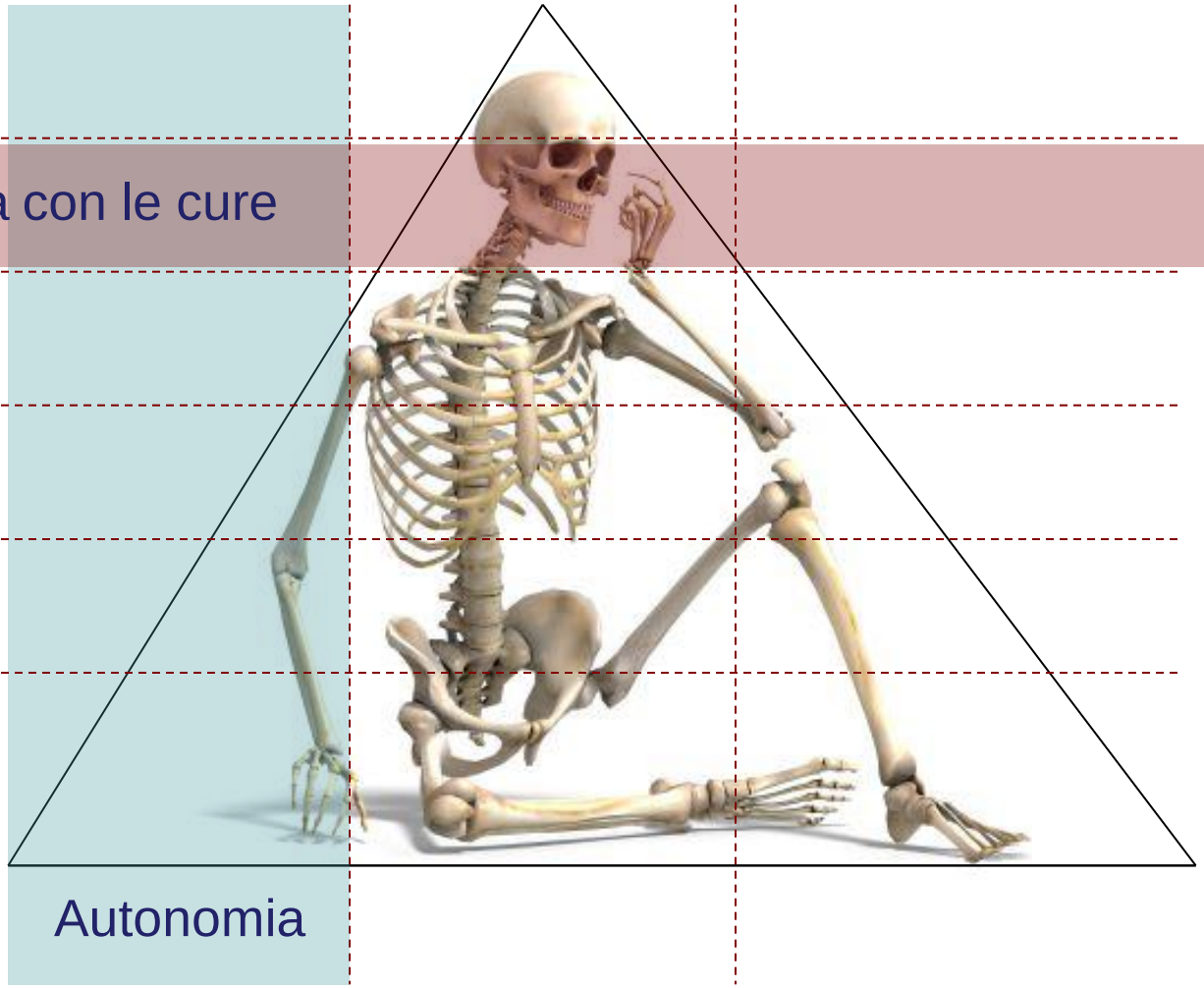


un solo dilemma e una possibile soluzione

Timori



i nostri timori



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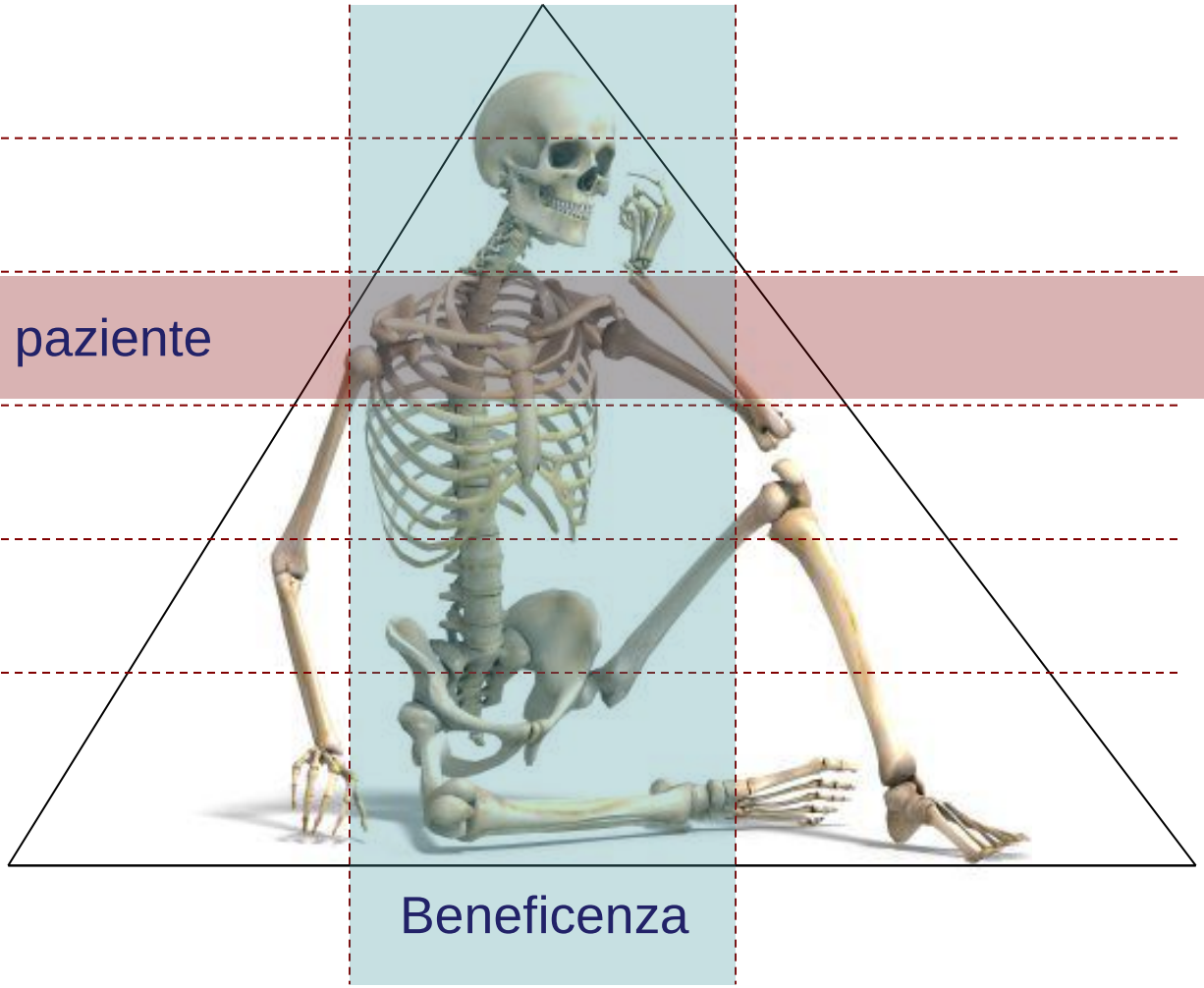
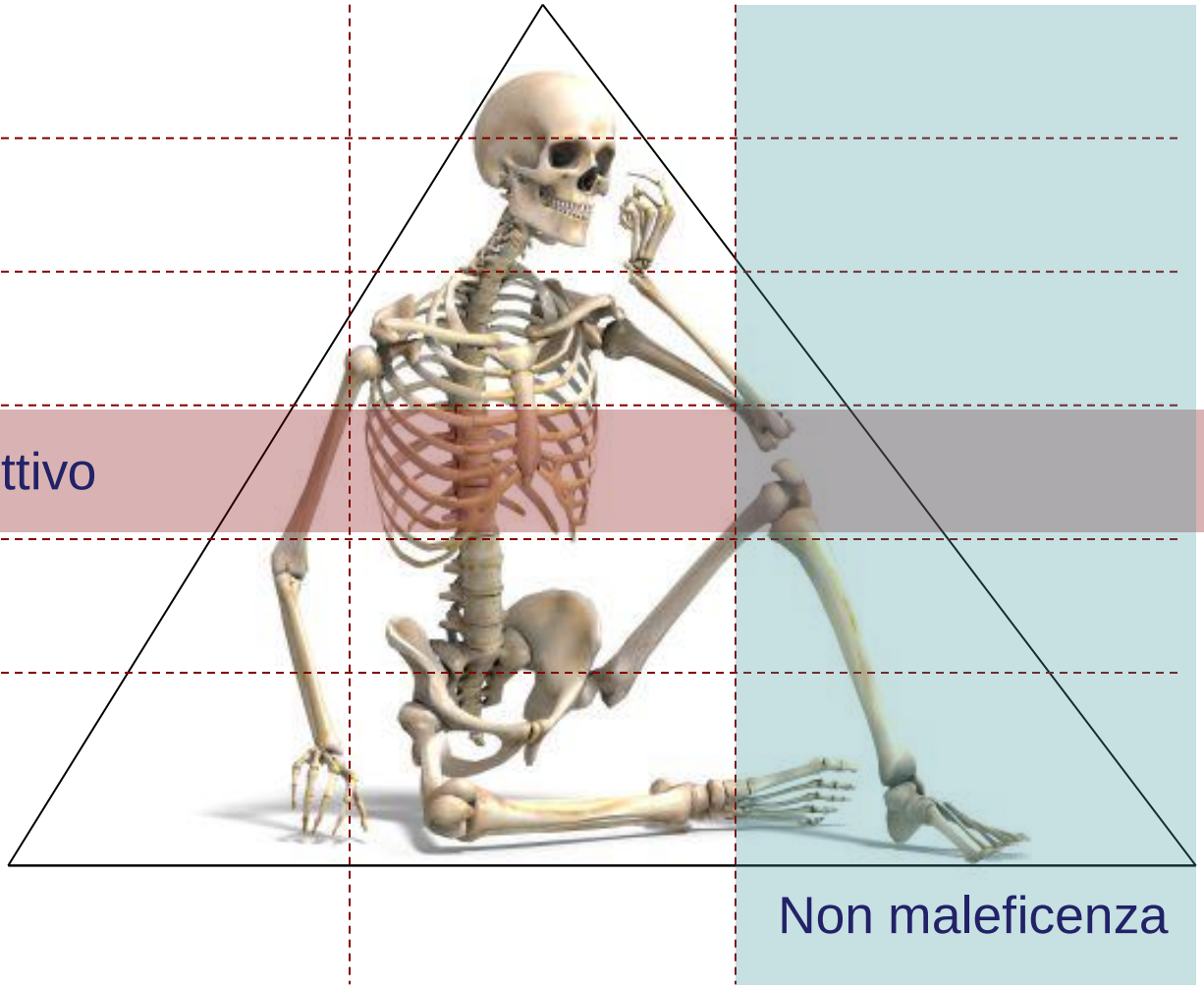


i nostri timori



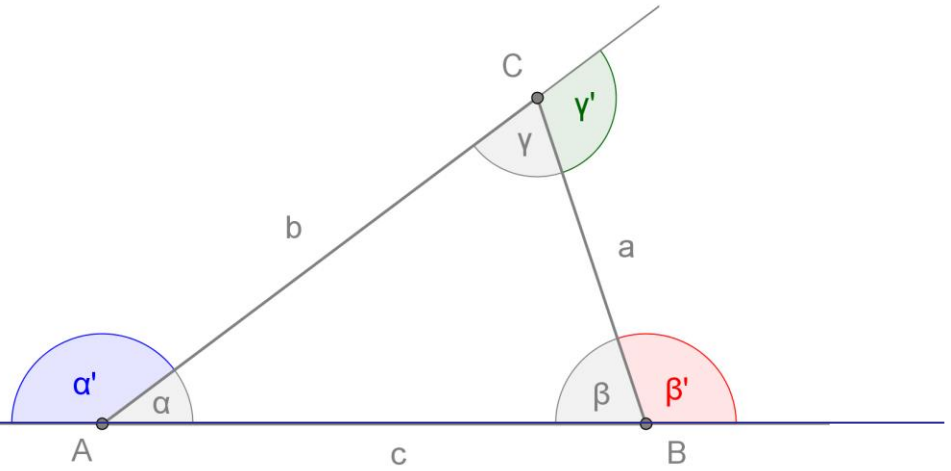
assioma

verità che si
ammette
senza
discussione

grazie per

l’attenzione

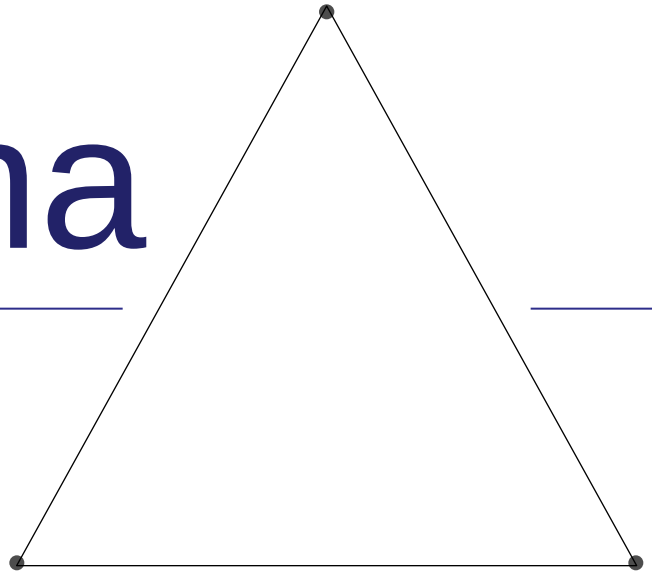
assioma



geometria

La somma degli angoli interni di un qualsiasi triangolo è pari a 180°

assioma



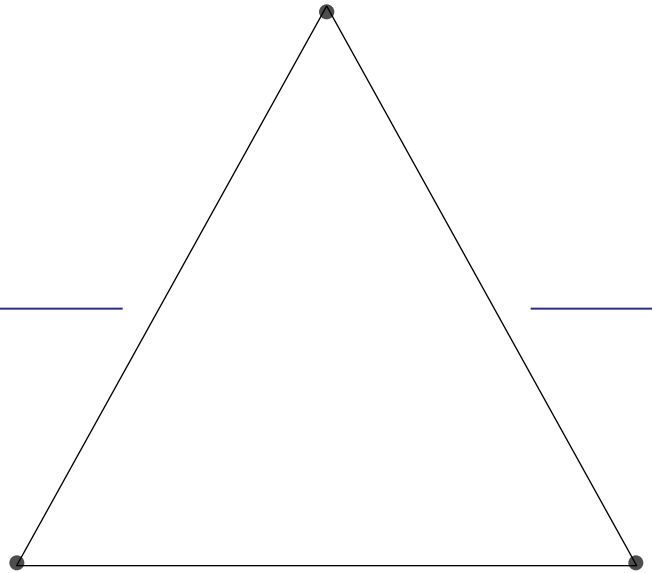
geometria

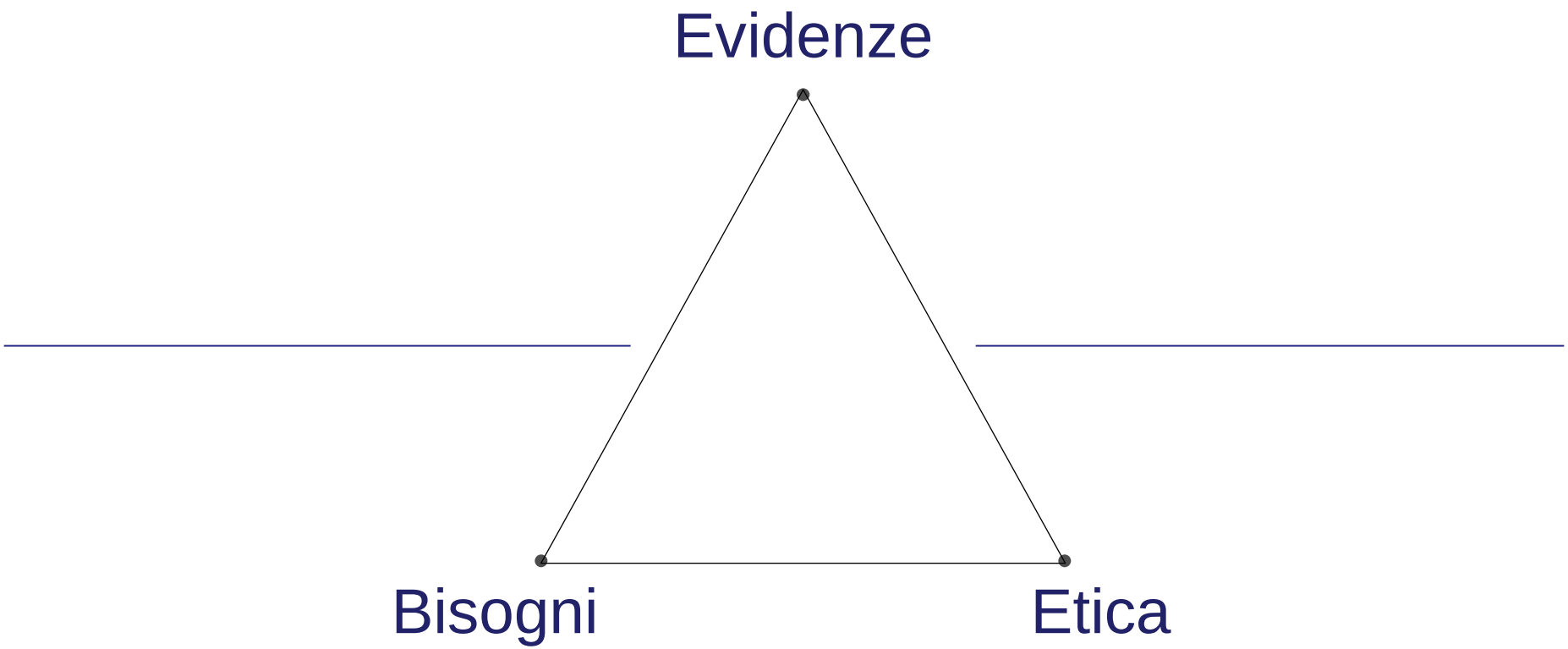
della cura

dell’incertezza

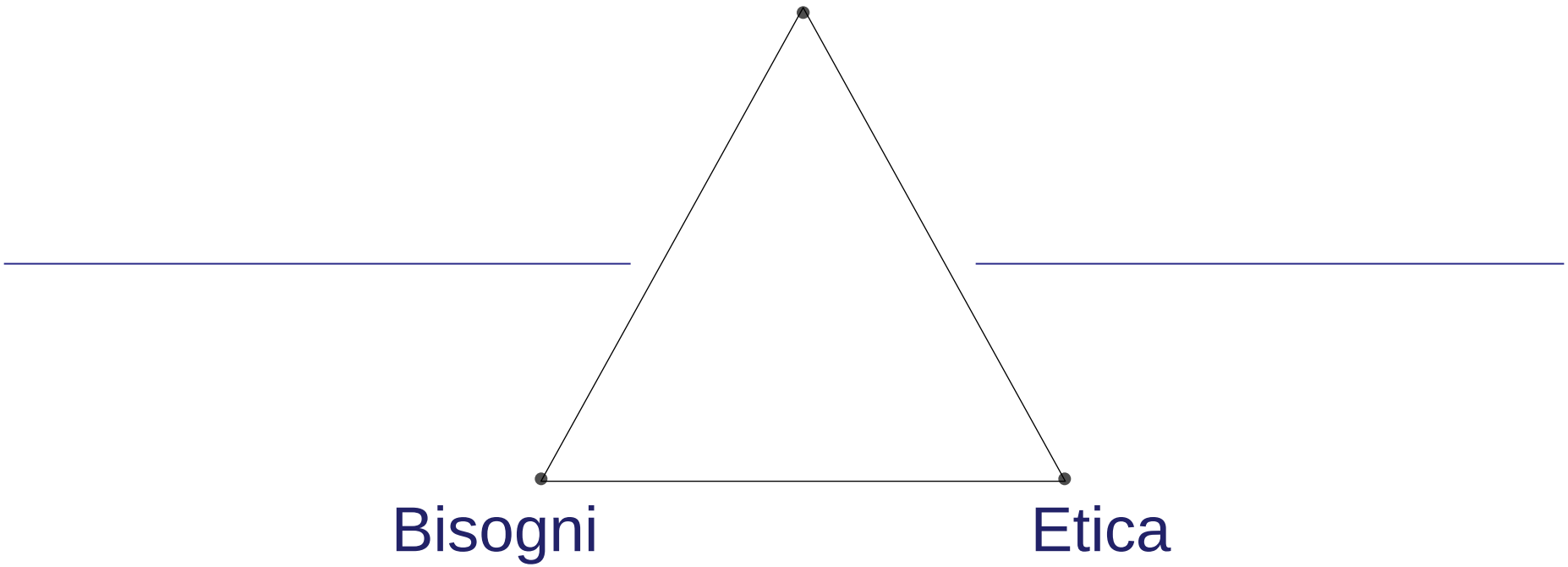
della variabilità

ideali



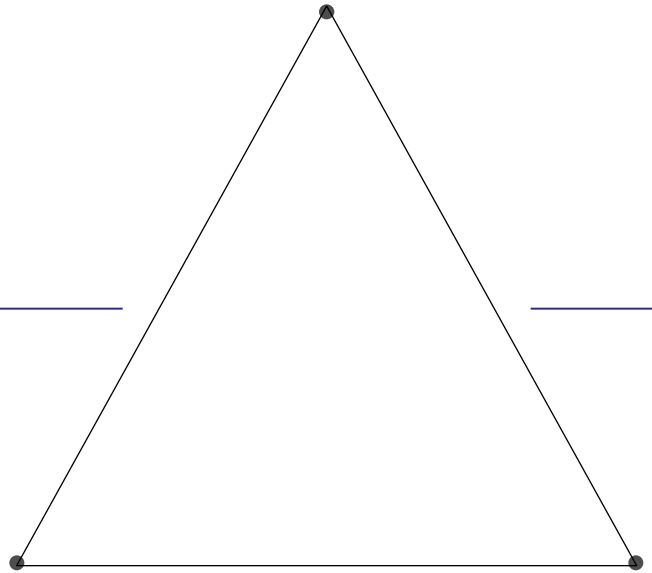

Evidenze
Bisogni
Etica

Il tempo dell'appropriatezza



Il tempo
dell'appropriatezza

Evidenze

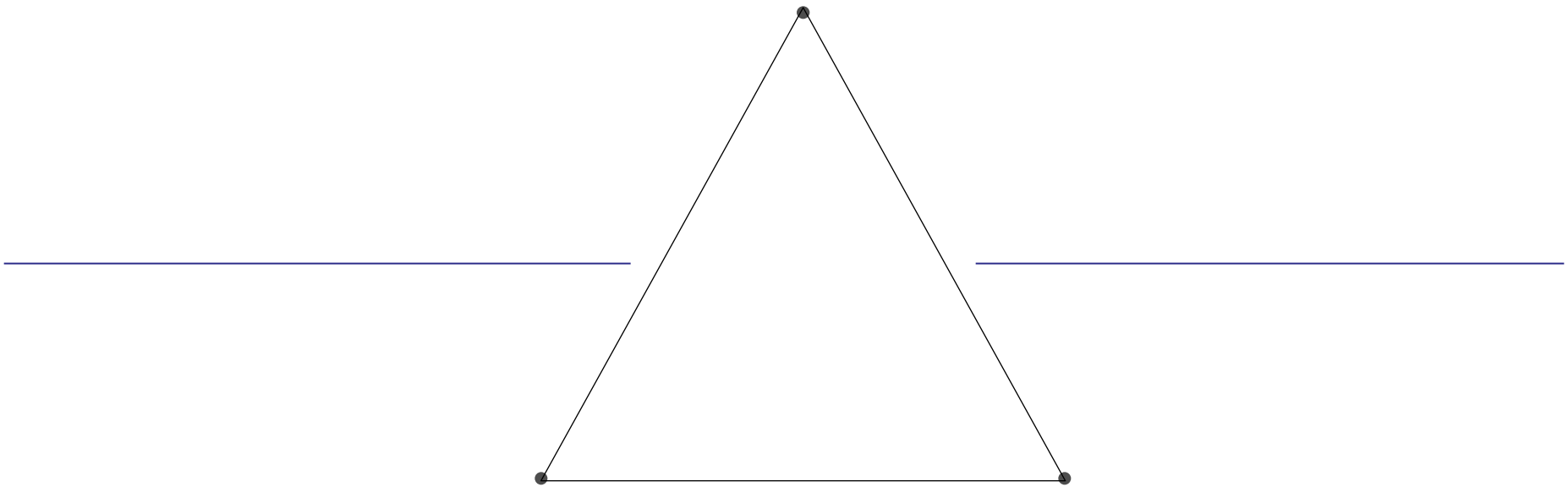


Bisogni

Etica

Il tempo dell'ascolto

Il tempo dell’appropriatezza

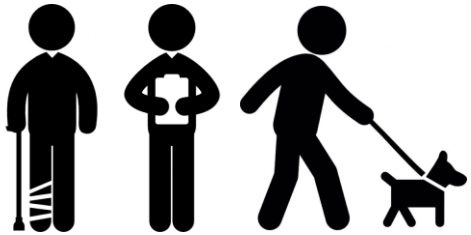


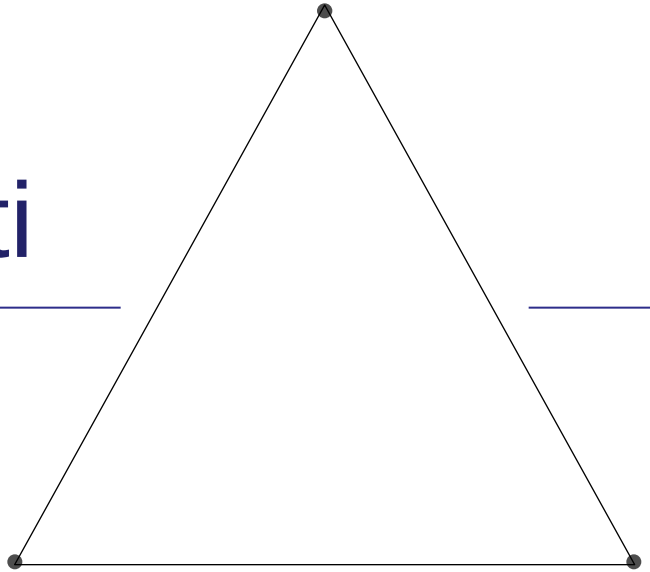
Il tempo dell’ascolto

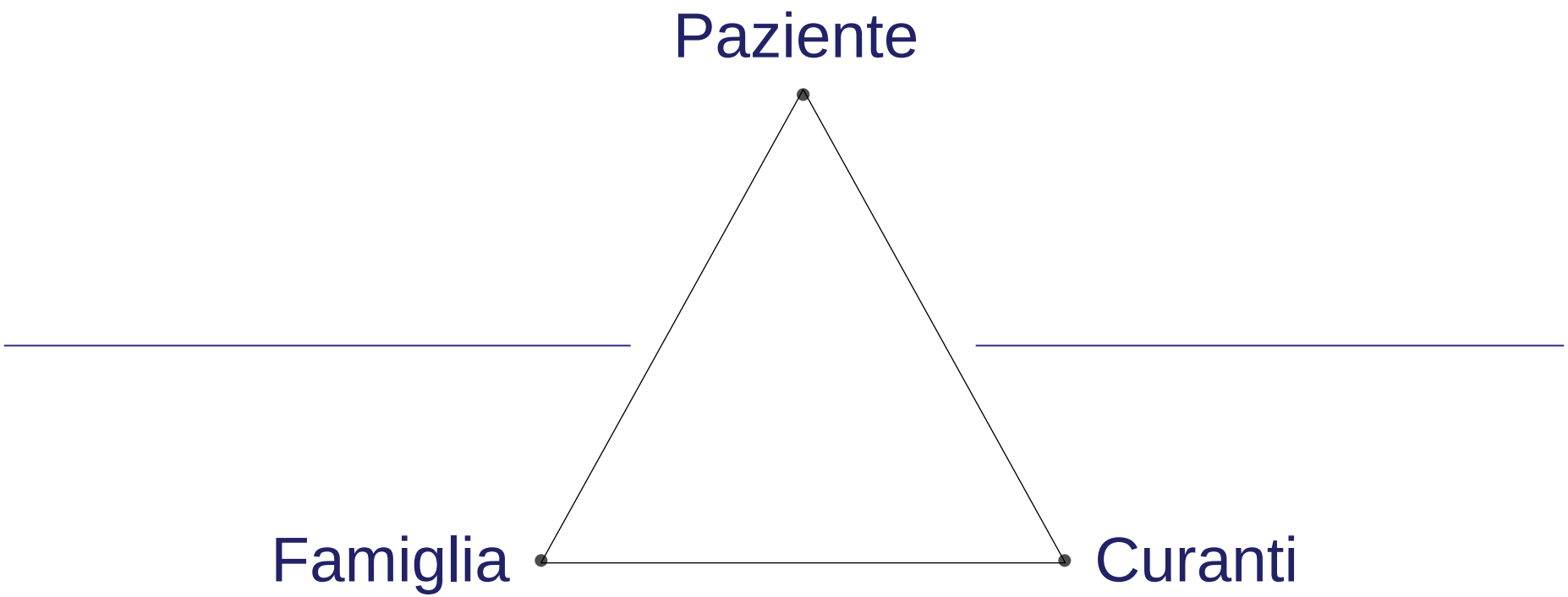
Il tempo del rispetto

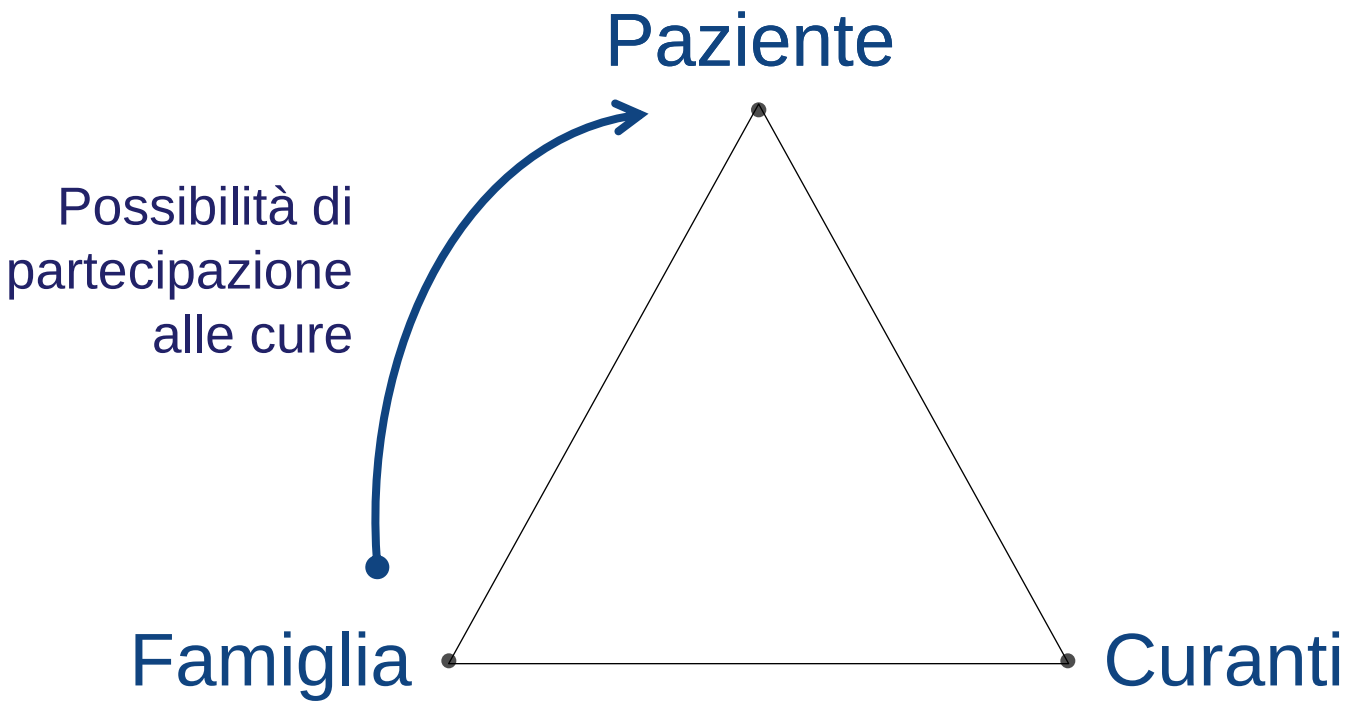

Il tempo
dell'appropriatezza
Evidenze
best
practice
Bisogni
Il tempo dell'ascolto
Etica
Il tempo del rispetto

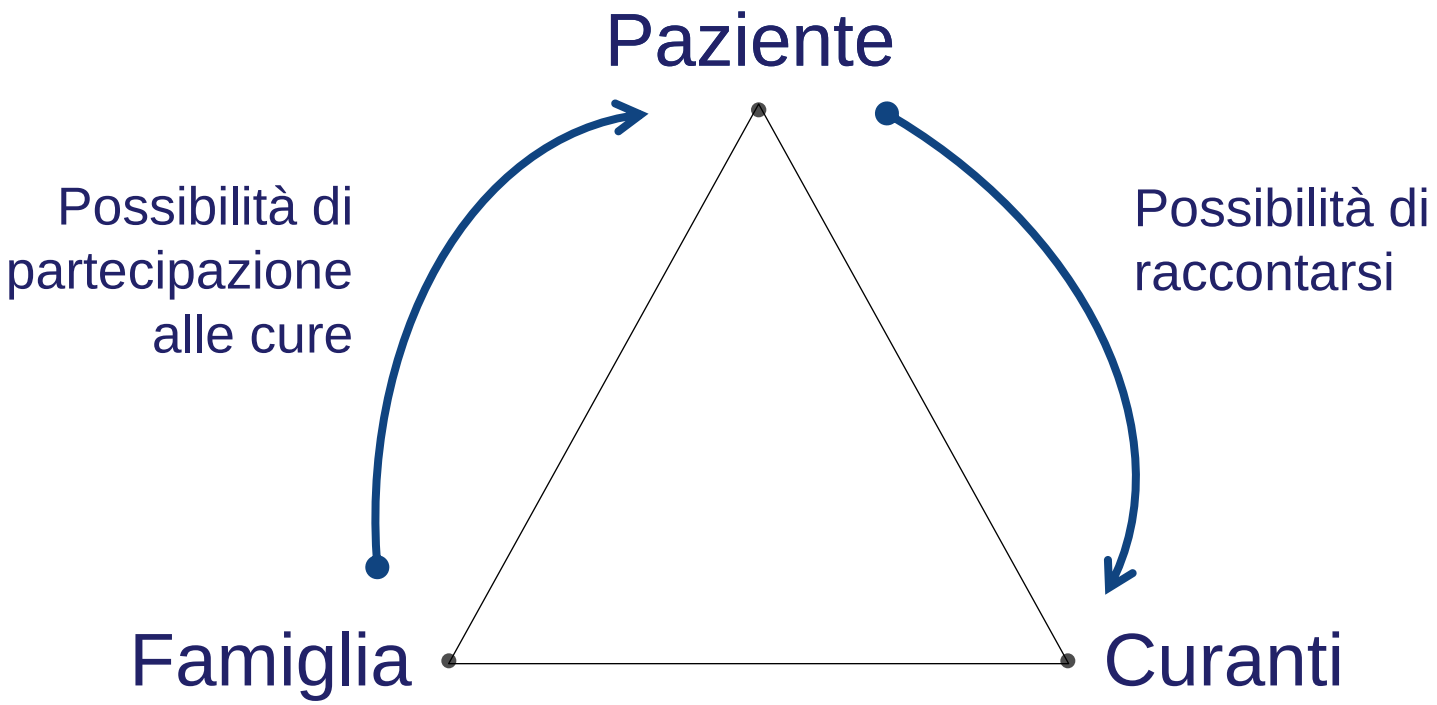
i protagonisti

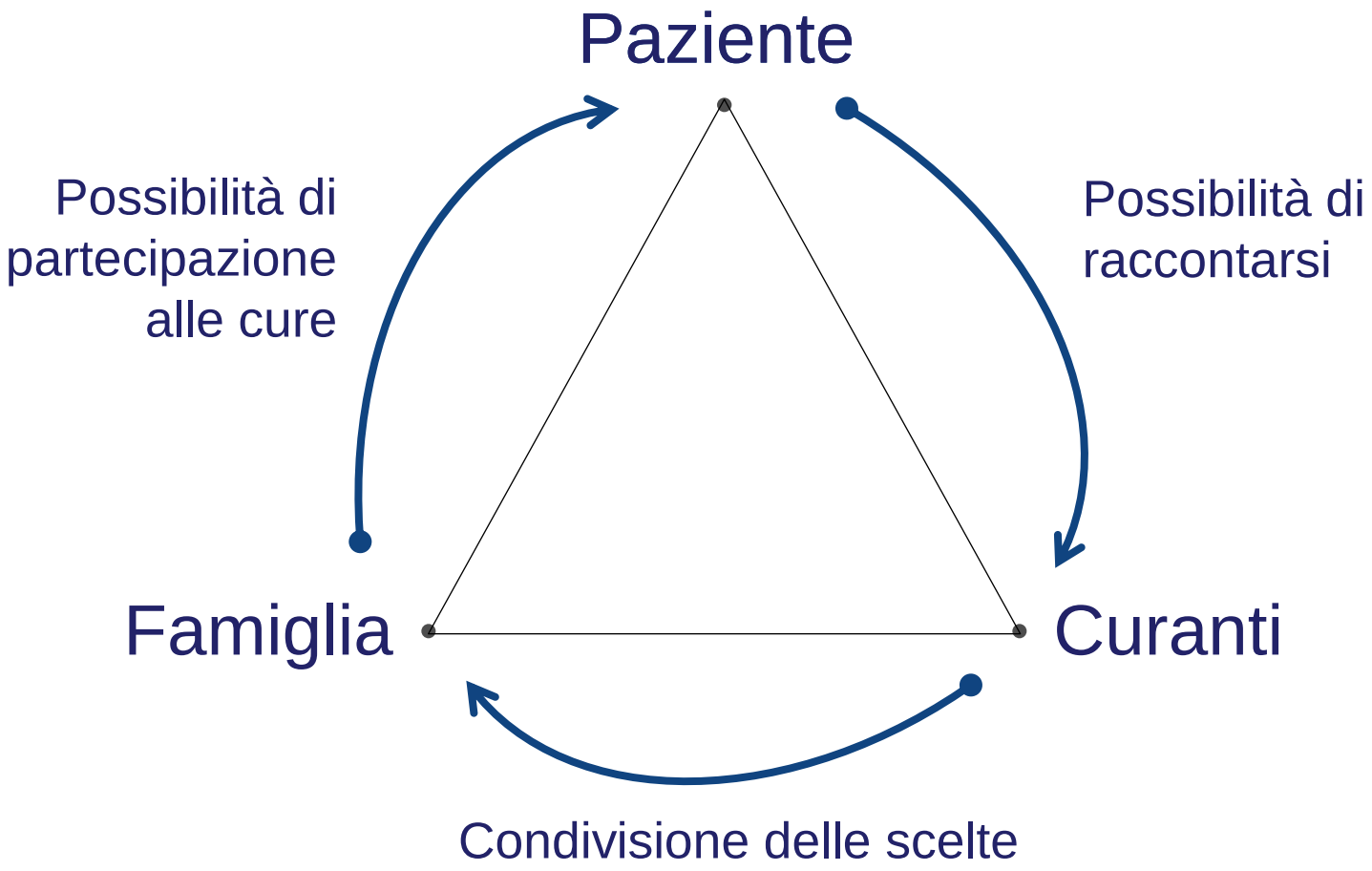





Paziente
Famiglia
Curanti

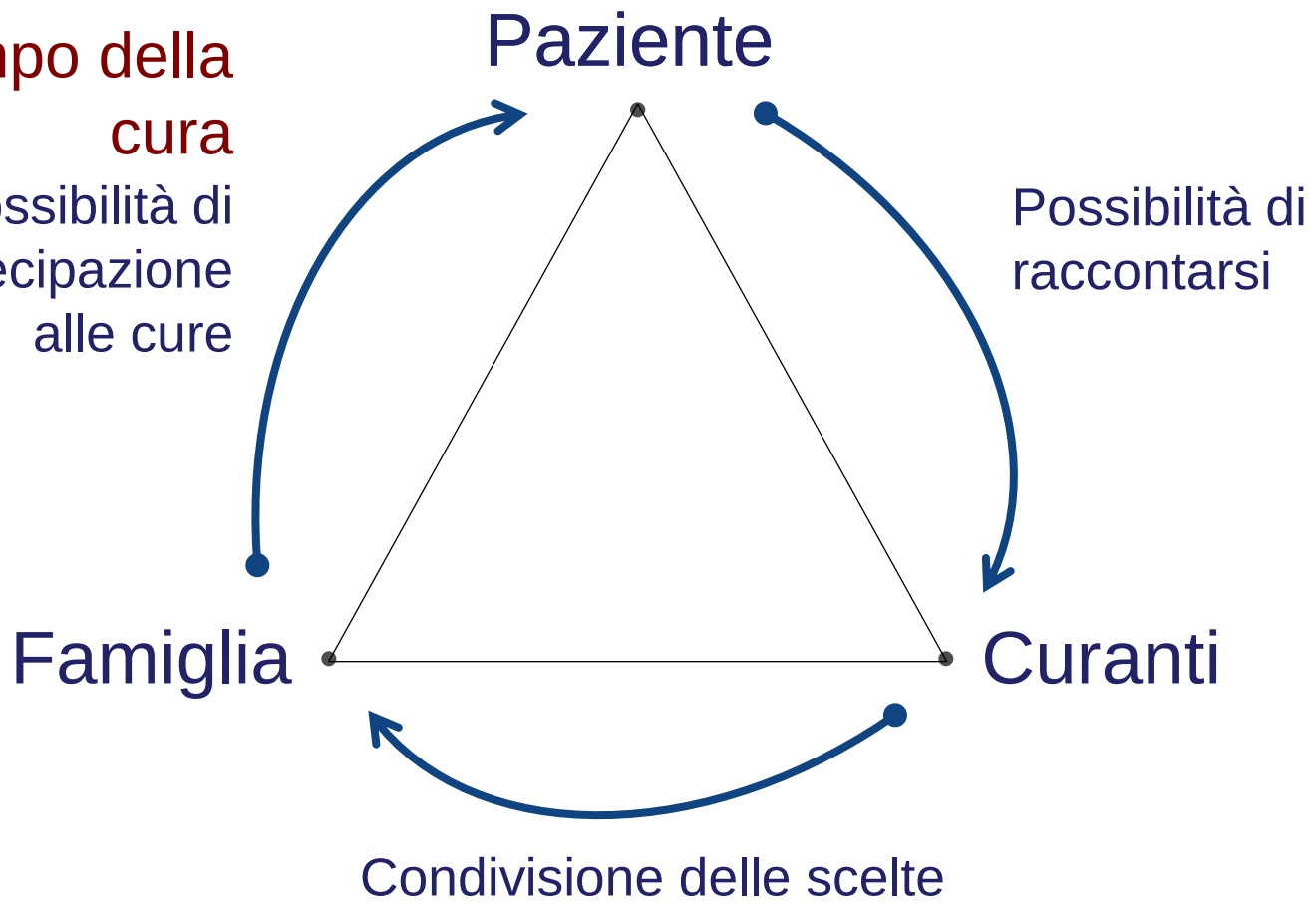

Paziente
Possibilità di partecipazione alle cure
Famiglia
Curanti

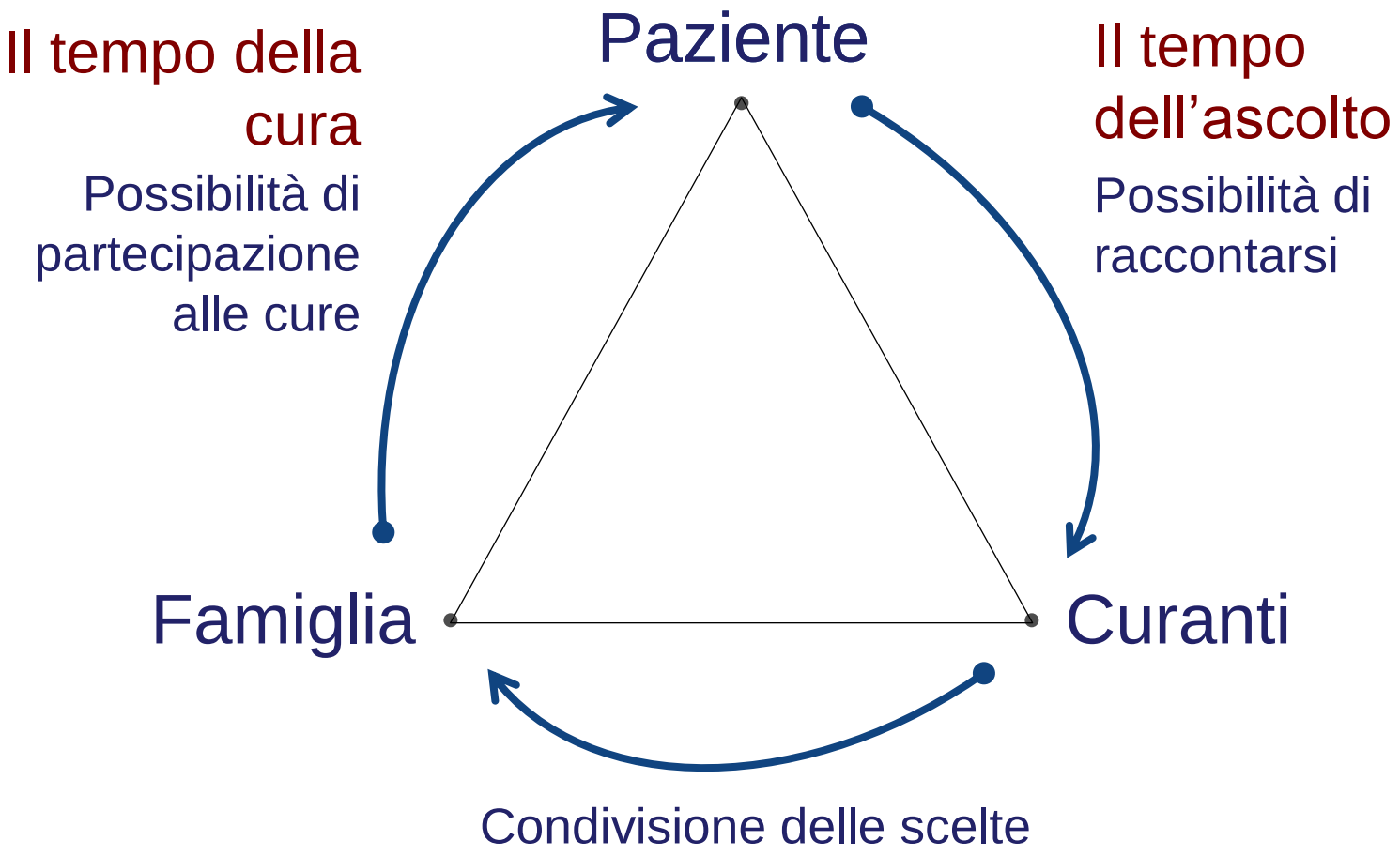

Paziente
Possibilità di partecipazione alle cure
Possibilità di raccontarsi
Famiglia
Curanti

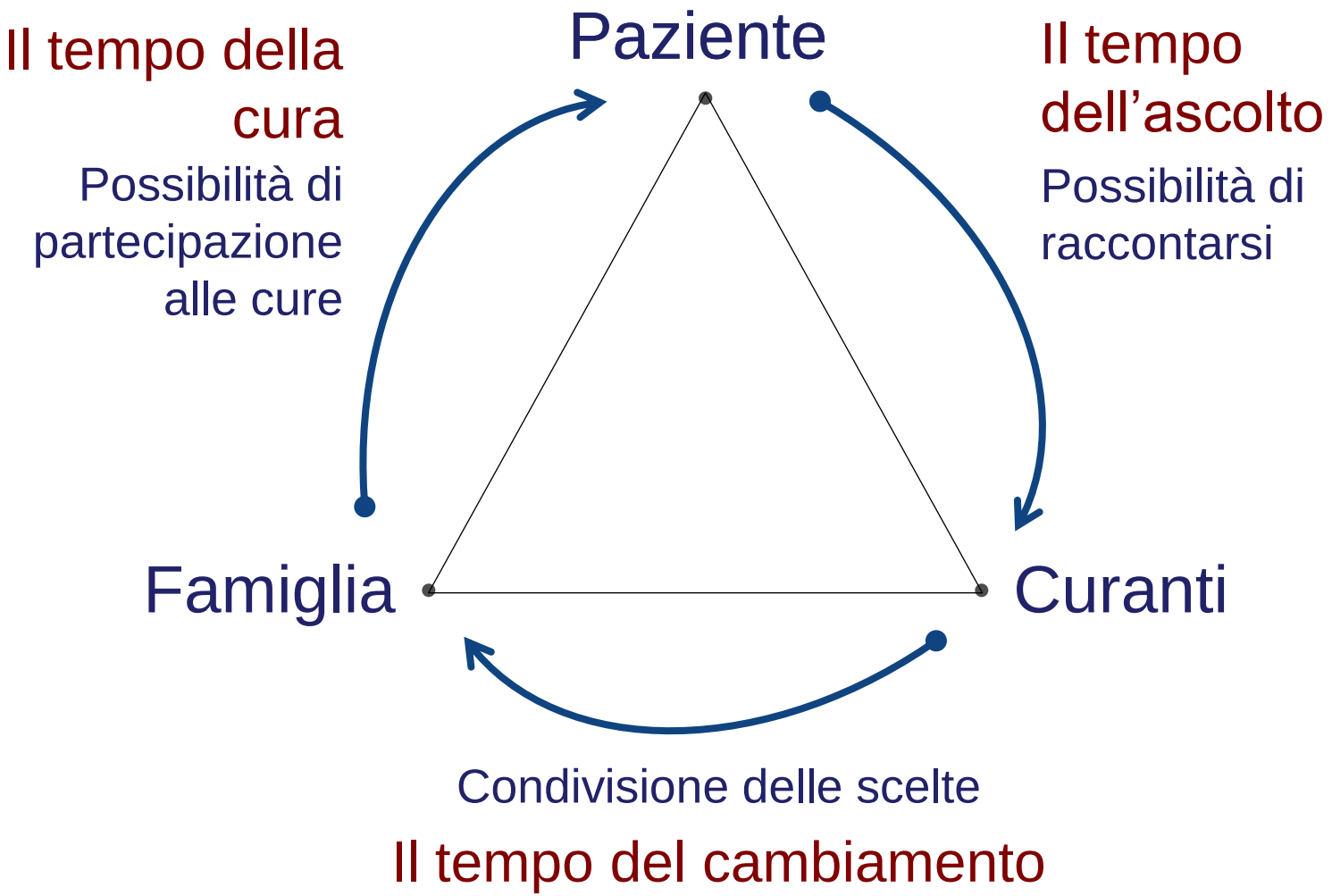

Paziente
Possibilità di partecipazione alle cure
Possibilità di raccontarsi
Famiglia
Curanti
Condivisione delle scelte

Il tempo della cura

Possibilità di partecipazione alle cure

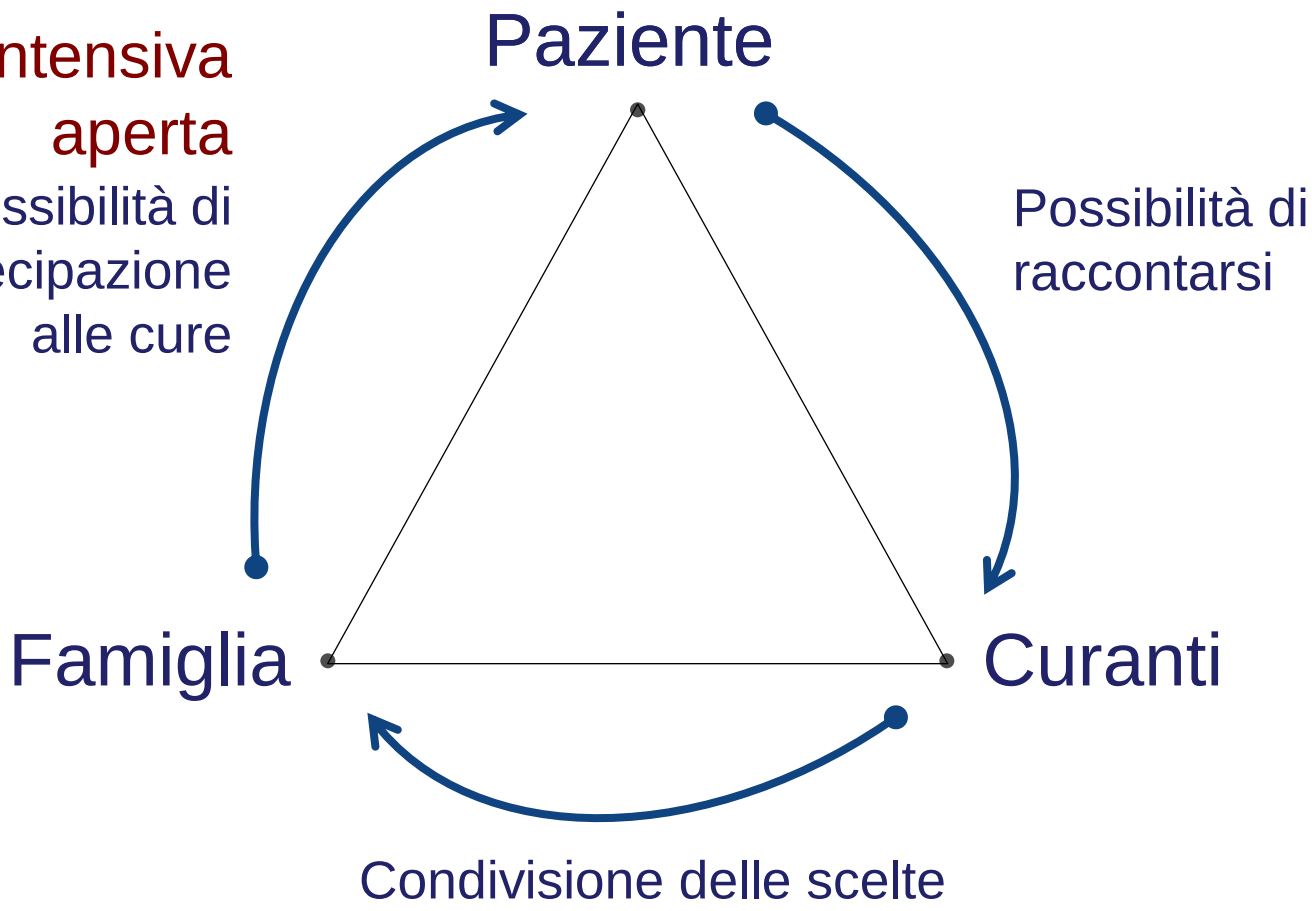


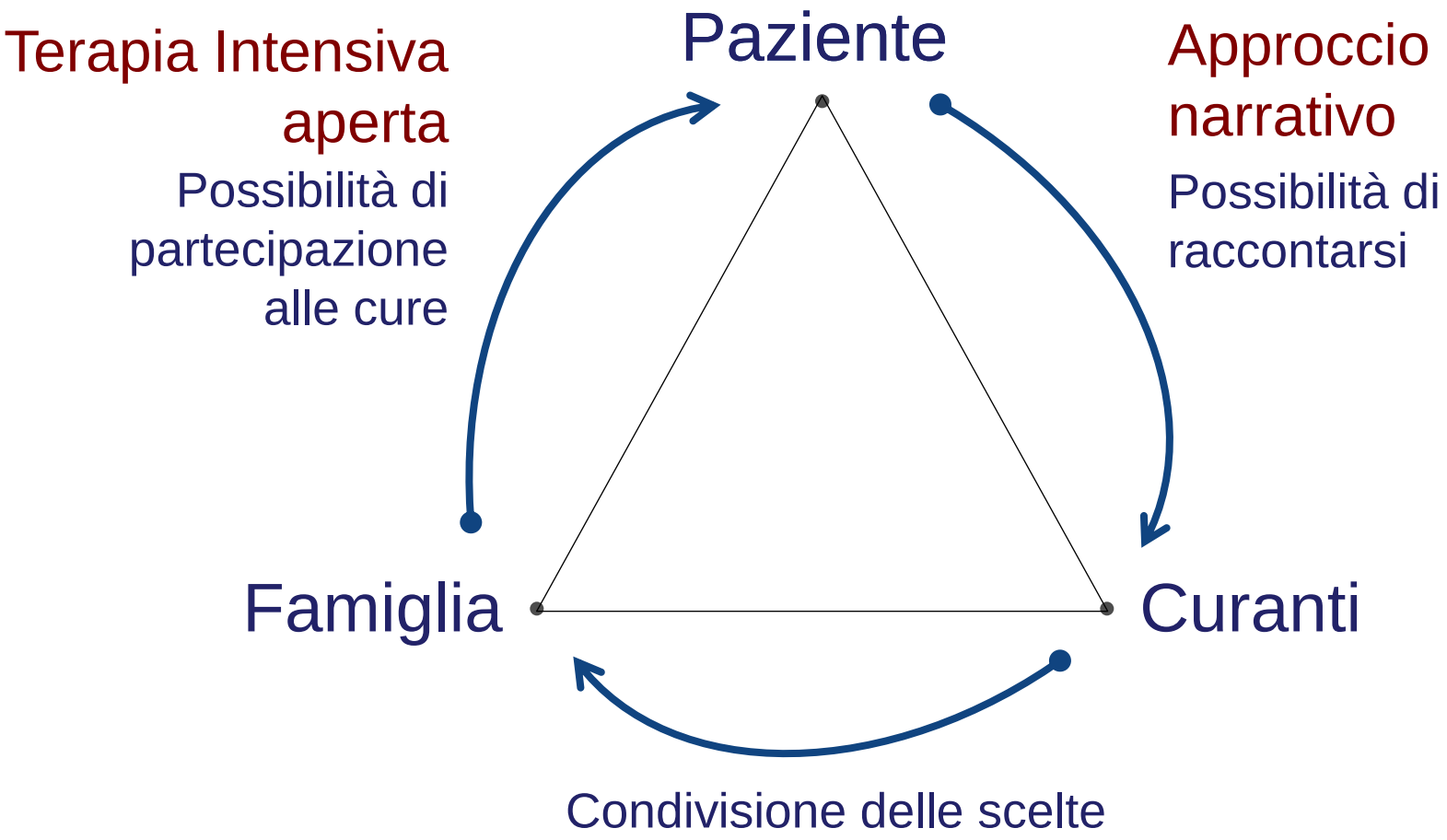

Il tempo della cura
Possibilità di partecipazione alle cure
Paziente
Il tempo dell'ascolto
Possibilità di raccontarsi
Famiglia
Curanti
Condivisione delle scelte

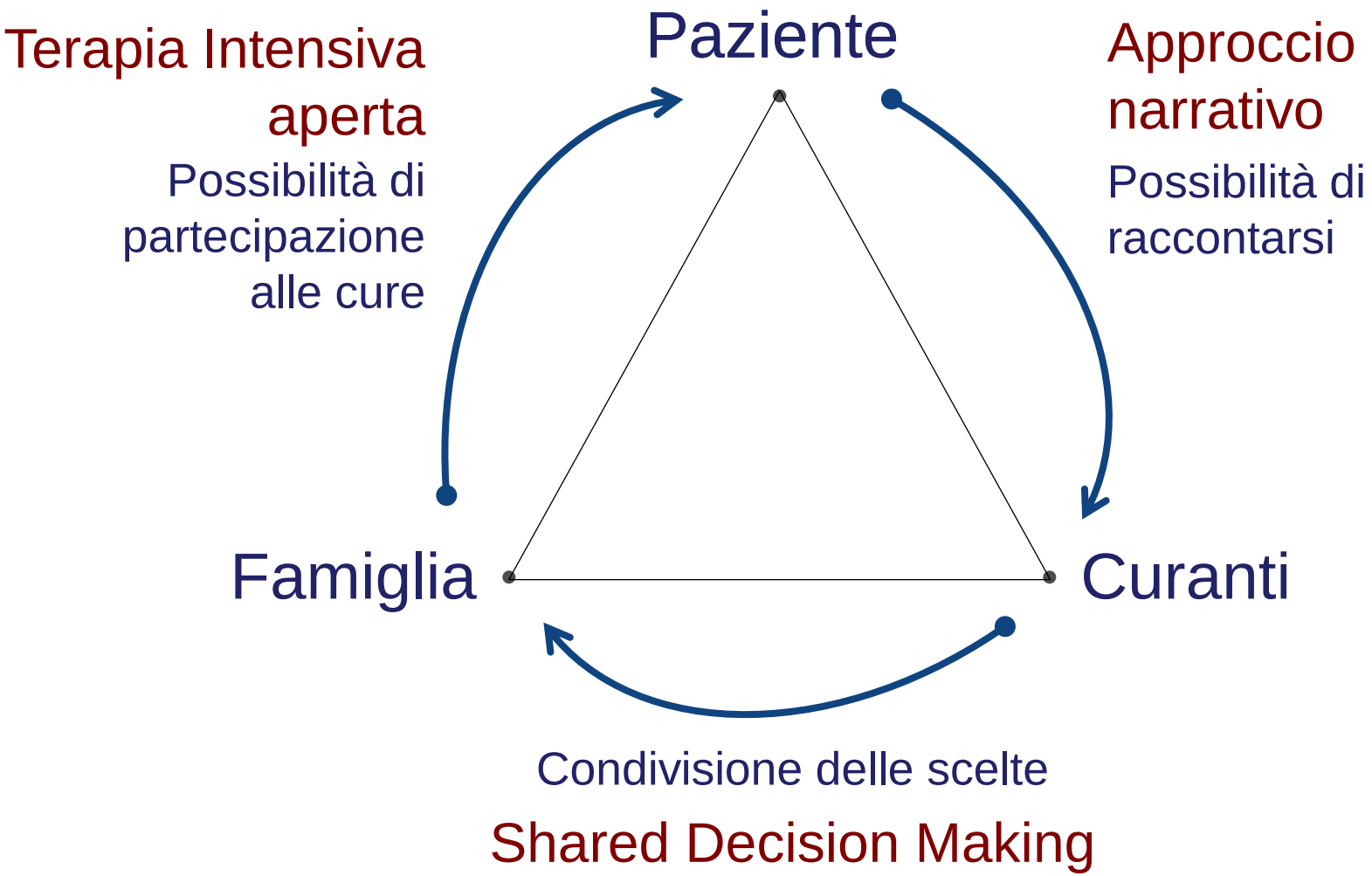

Il tempo della cura
Possibilità di partecipazione alle cure
Paziente
Il tempo dell'ascolto
Possibilità di raccontarsi
Famiglia
Curanti
Condivisione delle scelte
Il tempo del cambiamento

Terapia Intensiva aperta

Possibilità di partecipazione alle cure



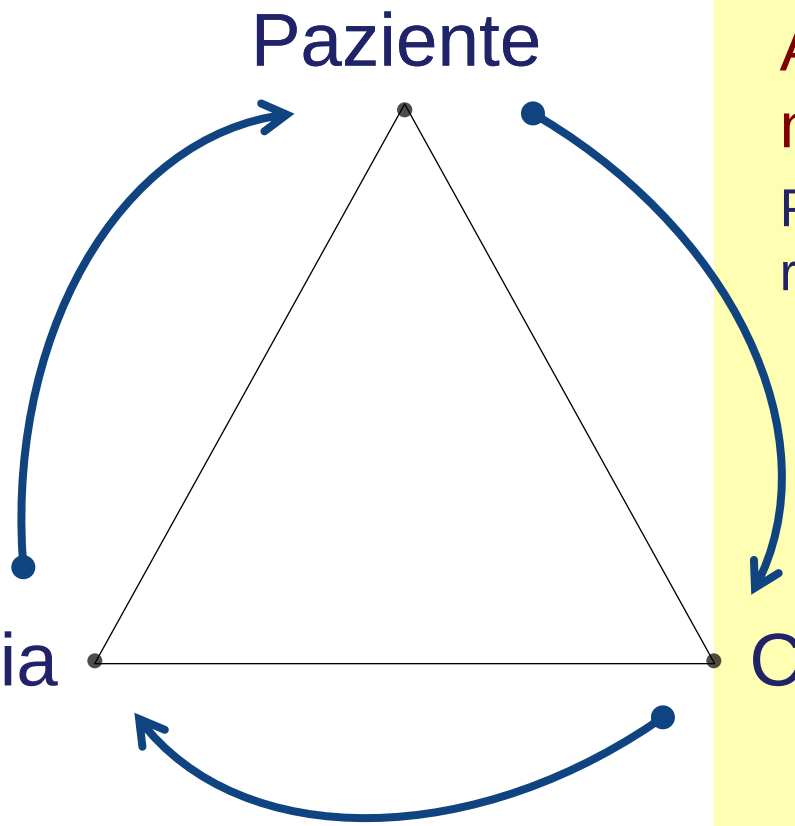

Terapia Intensiva aperta
Possibilità di partecipazione alle cure
Paziente
Approccio narrativo
Possibilità di raccontarsi
Famiglia
Curanti
Condivisione delle scelte


Terapia Intensiva aperta
Possibilità di partecipazione alle cure
Paziente
Approccio narrativo
Possibilità di raccontarsi
Famiglia
Curanti
Condivisione delle scelte
Shared Decision Making

Cambiamento CULTURALE

Terapia Intensiva aperta

Possibilità di partecipazione alle cure



Approccio narrativo

Possibilità di raccontarsi

Condivisione delle scelte

Shared Decision Making

Cambiamento STRUTTURALE

Cambiamento CULTURALE

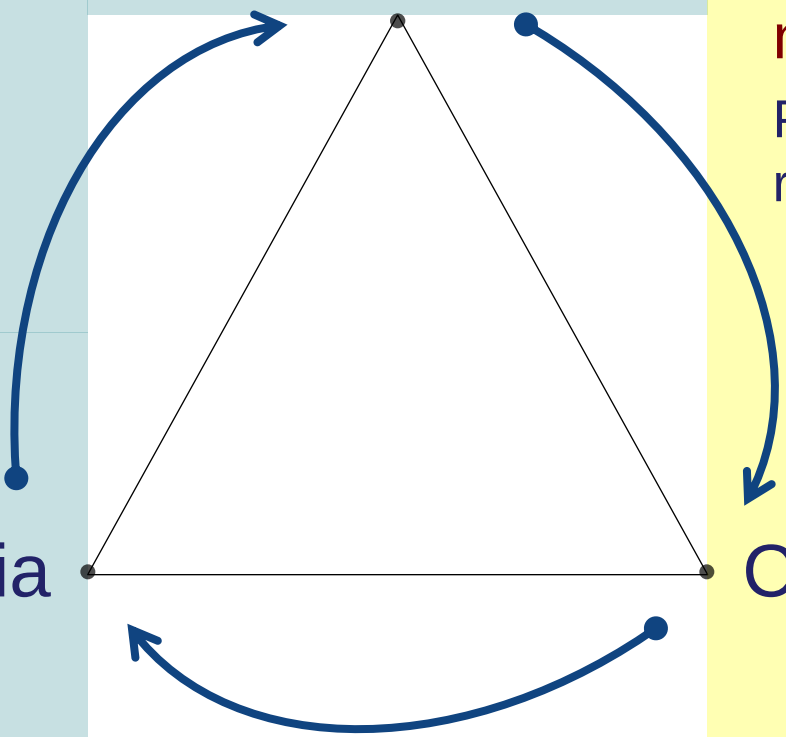
Terapia Intensiva aperta

Possibilità di partecipazione alle cure

Paziente

Approccio narrativo

Possibilità di raccontarsi



Famiglia

Curanti

Condivisione delle scelte

Shared Decision Making

Cambiamento STRUTTURALE

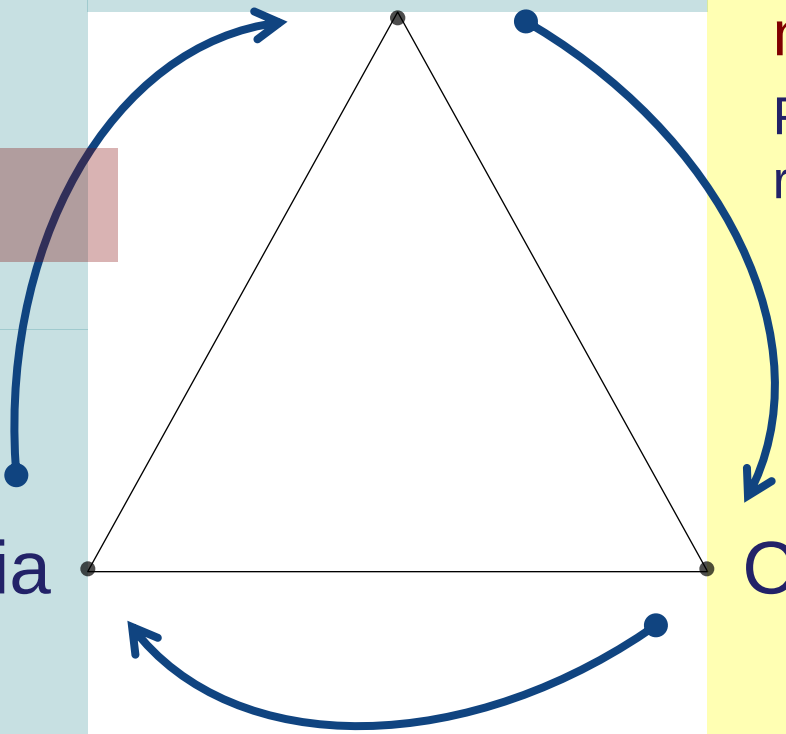
Cambiamento CULTURALE

Terapia Intensiva aperta

Possibilità di

esserci

Paziente



Famiglia

Curanti

Approccio narrativo

Possibilità di raccontarsi

Condivisione delle scelte

Shared Decision Making

Cambiamento STRUTTURALE

Essere RICONOSCIUTI

Cambiamento CULTURALE

Terapia Intensiva aperta

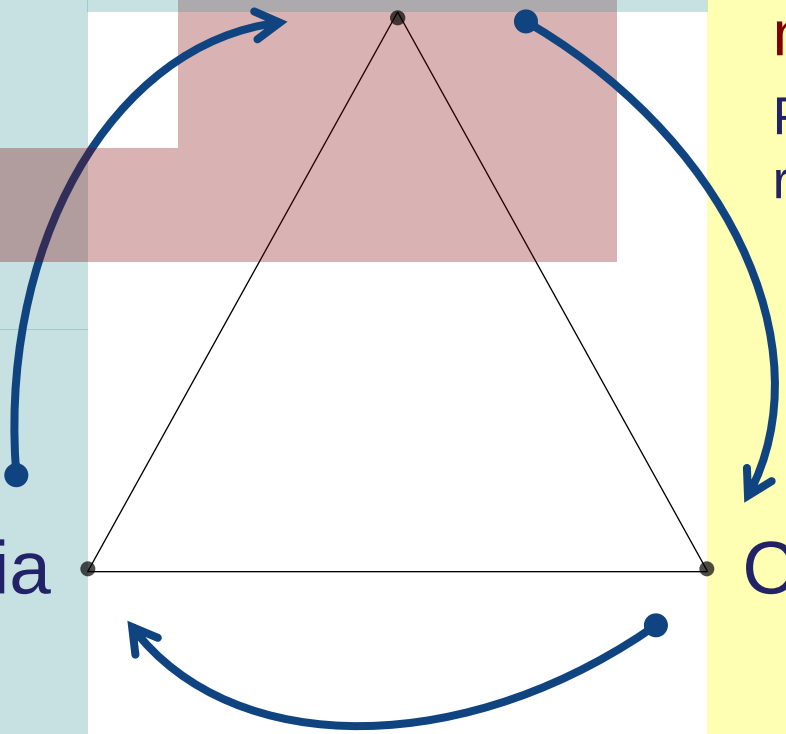
Possibilità di

esserci

Paziente

Approccio narrativo

Possibilità di raccontarsi

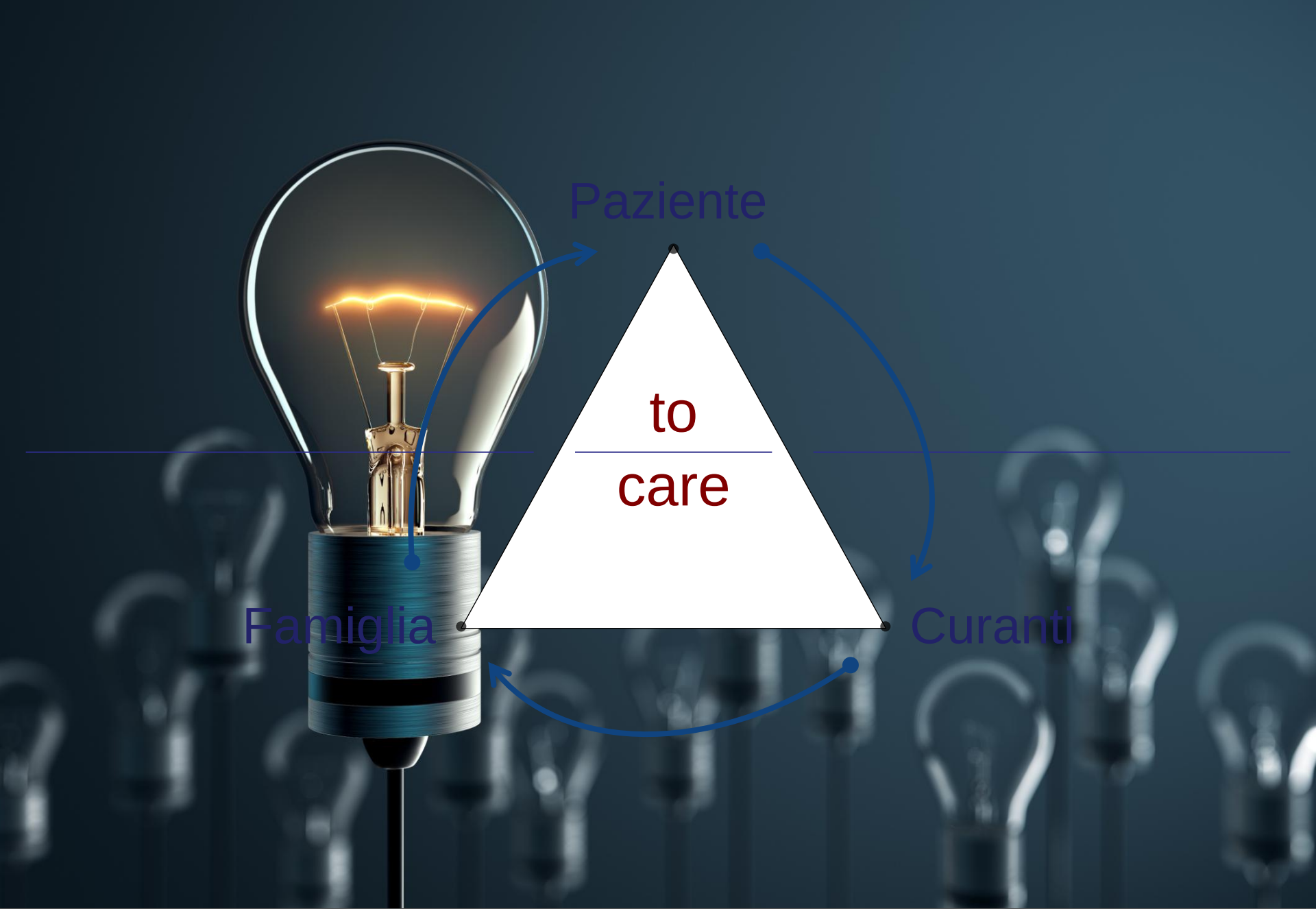


Famiglia

Curanti

Condivisione delle scelte

Shared Decision Making


Paziente
to
care
Famiglia
Curanti

tra mito

idealizzare

e realtà

realizzare

Mezzogiorno, riposo dal lavoro

Vincent van Gogh, 1890

Prima sogno i miei dipinti …

Mezzogiorno, riposo dal lavoro

Vincent van Gogh, 1890

Prima sogno i miei dipinti … poi dipingo i miei sogni (Vincent van Gogh)

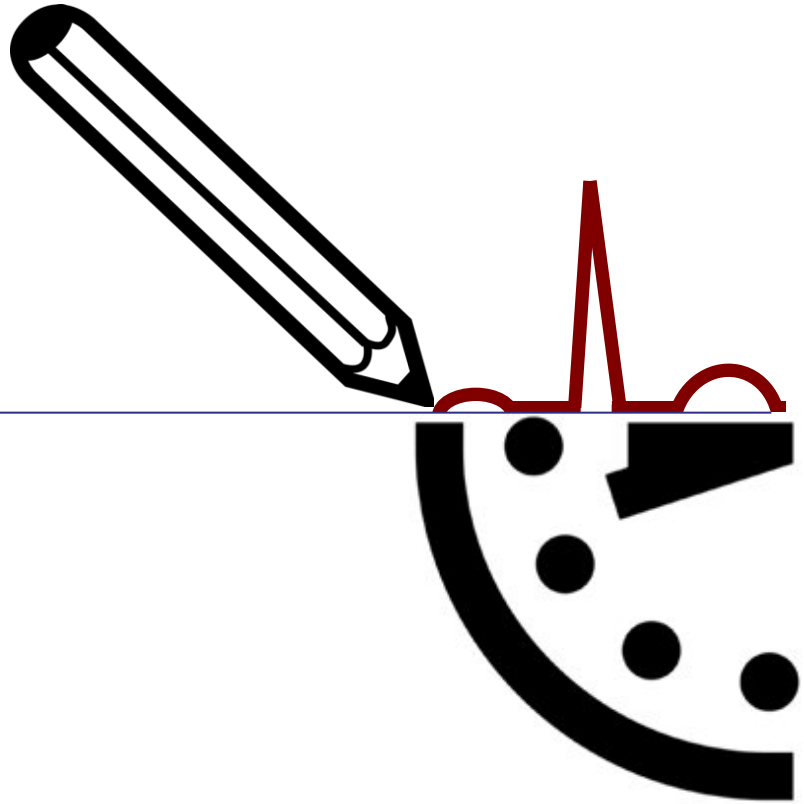
Mezzogiorno, riposo dal lavoro

Vincent van Gogh, 1890

cosa possiamo realizzare

il tempo

il tempo



di ridisegnare la cura in terapia intensiva

Let’s open the door !

H.Burchardi

Intensive Care Med (2002)

Intensive Care Med (2002) 28:1371–1372
DOI 10.1007/s00134-002-1401-8

EDITORIAL

H. Burchardi

Let’s open the door!

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Tel.: +49-551-396027, Fax: +49-551-396530

A recent survey of 95 intensive care units in France [1] has revealed some restrictive visiting policies in nearly all of them. For example, in 97% there were limited visiting hours, in 90% the number of visitors was restricted, in 55% children were not (or were only restrictively) allowed to visit their relatives, and in 40% only immediate relatives were permitted. We all should be grateful that this matter has been called to our attention. It is time to think over our relationship with our patients and their families and friends. Back in 1993 the United States American Association of Critical Care Nurses (AACN) held a consensus conference on fostering a more humane critical care [2]. Apparently, caregivers’ perceptions are slowly changing. At least the needs of the families are now well noticed [3].

In my view, there are five good reasons to open the ICUs for relatives and visitors:

1. Opening the ICU to Ïthe public does not pose a medical risk. We know that ICUs are sites with a high risk of infection. However, this is due mainly to nosocomial infections [4]. The incidence of nosocomial infections in ICUs is five to ten times higher than the incidence in general wards [5]. The European Prevalence of Infection in Intensive Care (EPIC) study, a prevalence study conducted in 1417 ICUs in 17 European countries in 1992, found that 45% of the ICU patients were infected and 21% had ICU-acquired infections, often with multiresistant micro-organisms [6]. In a more recent epidemiological European study in 14,364 ICU patients, 21% already had infections on admission [7]. Of those previously without infection, 8% acquired an infection during their ICU stay. One-half of the ICU-acquired infections, however, occurred in patients already infected when they were admitted to the ICU. It is generally accepted that the predominant risk of infection is the transfer of micro-organisms from patient to patient by caregivers’ activities. Therefore consistent and frequent handwashing is recommended as the most important preventive measure. The risk of nosocomial infections is not caused by visitors from outside the hospital. Even protective clothing for visitors (including shoes) is not recommended as a measure of infection control [8]; it may, however, have some psychological effects for the visitors to bear in mind the special conditions of an ICU. Consequently we opened our ICU to visitors many years ago. They are allowed to come more or less whenever they want (except some busy hours during medical rounds). Our team is now accustomed to the fact that most of the time there are visitors and relatives present. At most, the team members sometimes complain of being held up in their routine work – but, honestly, we should be ashamed of such arguments! An important improvement would be some intimate place in all ICUs, close to the unit, where visitors can wait, relax, and contemplate, and where they can have confidential conversations with nurses and physicians. We must never forget that relatives are often exposed to unexpected grief and sorrow in the ICU.

2. Repeated communication with relatives is an essential part of the medical information process. Providing information and guidance is an important part of our medical mission. The goal is not merely to provide information about the disease and our medical activities. Even more important is the creation of a relationship of trust and confidence with the relatives. This may be even more important in intensive care than anywhere else, because of the mostly acute and threatening characteristic of the situation. Open-minded and compassionate conversation with family members creates confidence much more effectively than a businesslike, hasty transmission of objective facts. Building up such a confidential relationship takes time. Both sides must learn to understand the other.

Let’s open the door !

H.Burchardi

Intensive Care Med (2002)

“ È tempo di riconoscere che le terapie intensive devono essere un luogo dove l’umanità abbia alta priorità. È tempo di aprire quelle terapie intensive che sono ancora chiuse “

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A recent survey of 95 intensive care units in France [1] has revealed some restrictive visiting policies in nearly all of them. For example, in 97% there were limited visiting hours, in 90% the number of visitors was restricted, in 55% children were not (or were only restrictively) allowed to visit their relatives, and in 40% only immediate relatives were permitted. We all should be grateful that this matter has been called to our attention. It is time to think over our relationship with our patients and their families and friends. Back in 1993 the United States American Association of Critical Care Nurses (AACN) held a consensus conference on fostering a more humane critical care [2]. Apparently, caregivers’ perceptions are slowly changing. At least the needs of the families are now well noticed [3].

In my view, there are five good reasons to open the ICUs for relatives and visitors:

1. Opening the ICU to Ïthe public does not pose a medical risk. We know that ICUs are sites with a high risk of infection. However, this is due mainly to nosocomial infections [4]. The incidence of nosocomial infections in ICUs is five to ten times higher than the incidence in general wards [5]. The European Prevalence of Infection in Intensive Care (EPIC) study, a prevalence study conducted in 1417 ICUs in 17 European countries in 1992, found that 45% of the ICU patients were infected and 21% had ICU-acquired infections, often with multiresistant micro-organisms [6]. In a more recent epidemiological European study in 14,364 ICU patients, 21% already had infections on admission [7]. Of those previously without infection, 8% acquired an infection during their ICU stay. One-half of the ICU-acquired infections, however, occurred in patients already infected when they were admitted to the ICU. It is generally accepted that the predominant risk of infection is the transfer of micro-organisms from patient to patient by caregivers’ activities. Therefore consistent and frequent handwashing is recommended as the most important preventive measure. The risk of nosocomial infections is not caused by visitors from outside the hospital. Even protective clothing for visitors (including shoes) is not recommended as a measure of infection control [8]; it may, however, have some psychological effects for the visitors to bear in mind the special conditions of an ICU. Consequently we opened our ICU to visitors many years ago. They are allowed to come more or less whenever they want (except some busy hours during medical rounds). Our team is now accustomed to the fact that most of the time there are visitors and relatives present. At most, the team members sometimes complain of being held up in their routine work – but, honestly, we should be ashamed of such arguments! An important improvement would be some intimate place in all ICUs, close to the unit, where visitors can wait, relax, and contemplate, and where they can have confidential conversations with nurses and physicians. We must never forget that relatives are often exposed to unexpected grief and sorrow in the ICU.

2. Repeated communication with relatives is an essential part of the medical information process. Providing information and guidance is an important part of our medical mission. The goal is not merely to provide information about the disease and our medical activities. Even more important is the creation of a relationship of trust and confidence with the relatives. This may be even more important in intensive care than anywhere else, because of the mostly acute and threatening characteristic of the situation. Open-minded and compassionate conversation with family members creates confidence much more effectively than a businesslike, hasty transmission of objective facts. Building up such a confidential relationship takes time. Both sides must learn to understand the other.

Let’s open the door !

2002

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EDITORIAL

H. Burchardi

Let’s open the door!

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Paziente al centro della cura: mito o realtà ? / Pag. 61

benvenuti in terapia intensiva

Una medicina

Una medicina

- Tecnicismo clinico
- Riduzione del contat
- Depersonalizzazione
- Depersonalizzazione
- Parcellizzazione del

Una medicina

- Tecnicismo clinico
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Una medicina

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- Depersonalizzazione
- Depersonalizzazione
- Parcellizzazione del

Sospensione del tempo

L’attesa della malattia

to cure

to care

La camera di Vincent ad Arles, Vincent van Gogh 1888

La Terapia Intensiva Aperta

Rimozione delle barriere

temporali, fisiche e relazionali

non necessarie alla cura del paziente

Il tempo

barriera temporale

Il tempo

il tempo che si dilata
il tempo dell’attesa
il tempo della solitudine

Il luogo

barriera fisica

Il luogo

dove si sperimenta il limite

le persone

barriera relazionale


le persone
narrazione
percorso di vita
percorso di malattia

...ma
c'è un

prezzo da pagare

il dolore

Patient's perceptions of intensive care (Lancet 1999)

- Sete
- Paura / ansia
- Privazione del sonno
- Senso di solitudine / isolamento
- Dolore
- Caldo
- Mancanza di informazioni
- Freddo
- Fame

Patients' perceptions of intensive care

Bruno Simini

Pain, noise, sleep deprivation, thirst, hunger, heat, cold, fear, anxiety, isolation, physical restraint, want of information, and absence of daylight were common memories of patients surviving intensive care.

How comfortable are patients receiving intensive care? To answer this question, all patients in the intensive care unit in Lucca, Italy from October, 1998, to March 1999 were assessed. Of 162 patients, 35 (22%) died. 51 patients were not interviewed (18 because of psychiatric or neurological disease, 13 were transferred to other hospitals, four went straight home, four died on the wards they were transferred to, and 12 left before interview).

Within 3 days of discharge from the intensive-care unit, 76 patients were interviewed by an intensive-care specialist who had not seen them before. Medical and nursing staff on the intensive-care unit were unaware that patients would be interviewed. There were 50 men and 26 women, mean age 62 years (range 17–92 years). They stayed an average of 4·4 days (range 1–19). Admission diagnosis was postoperative care for 37 (49%), trauma for 18 (24%), acute exacerbation of chronic respiratory failure for 10 (13%), and other medical conditions for 11 (14%) patients. Patients not interviewed did not differ from those who were interviewed in age, sex, length of stay, or diagnosis.

Pain was reported by 33 (43%) patients; of these patients, 31 (94%) said that analgesics requested did not yield the expected pain relief, 46 (61%) reported sleep deprivation, 48 (63%) recalled being thirsty, 10 (13%) had been hungry, and 28 (37%) and 21 (28%) had been uncomfortably hot and cold, respectively. 47 (62%) patients had been afraid or anxious, 35 (46%) had felt lonely or isolated, and 25 (33%) lacked information about their condition and procedures.

Patients were asked to recall their worst memories. 21 (28%) patients had none, 55 (72%) patients reported the following (some reported more than one): thirst (nine), feeling lonely or abandoned (nine), unceasing noises (seven), tracheal and gastric tubes (seven), pain (six), being tied to the bed (six), seeing or hearing others suffer and die (six), insomnia (four), absence of windows and daylight

Patient's perceptions of intensive care (Lancet 1999)

- Sete (63%)
- Paura / ansia (62%)
- Privazione del sonno (61%)
- Senso di solitudine / isolamento (46%)
- Dolore (43%)
- Caldo (37%)
- Mancanza di informazioni (33%)
- Freddo (21%)
- Fame (13%)

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1979

Needs of relatives of critically ill patients: a descriptive study
(Heart Lung. 1979)

- Bisogno di informazione
- Vicinanza al proprio caro
- Ricevere rassicurazioni
- Ricevere supporto
- Comfort

1979

Needs of relatives of critically ill patients: a descriptive study
(Heart Lung. 1979)

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- Vicinanza al proprio caro
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- Comfort

% terapie intensive aperte

2018

Sweden	70	Intensive Crit Care Nurs 2004
UK	19-22	Intensive Crit Care Nurs 1993 Intensive Crit Care Nurs 1996 Anaesthesia 2010
USA	20	Critical Care 2013
Netherlands	14	Intensive Crit Care Nurse
France	7-8	J Clin Nurse 2012 Ann Intensive Care 2013
Belgium	0-3	Intensive Care Med 2007 Heart Lung 2010
Switzerland	3	Minerva Anestesiol 2014
Italy	0.4-2	Intensive Care Med 2008 Intensive Care Med 2011

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Stress-Inducing Factors in ICUs: What Liver Transplant Recipients Experience and What Caregivers Perceive

Gianni Biancofiore,[1] Maria L. Bindi,[1] Anna Maria Romanelli,[2] Lucio Urbani,[3] Franco Mosca,[4] and Franco Filipponi[3]

Stress-inducing factors in ICU (40 items)	Pz dopo trapianto di fegato	Pz dopo chirurgia addominale maggiore	Infermieri	Medici
Impossibilità a dormire	1	2	6	3
Sentire dolore	2	3	2	1
Tubo endo-tracheale / Sonde	3	4	1	2
Vedere la famiglia / amici solo per pochi minuti al giorno	5	1	7	11

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Esperienza complessa e faticosa

I familiari dei

pazienti ricoverati in ICU

(J Crit Care 2005) hanno …

… un'elevata incidenza di

- Ansia (73,4%)
- Depressione (35,3%)

Journal of Critical Care (2005) **20**, 90–96

ELSEVIER

Journal of Critical Care

Symptoms of anxiety and depression in family members of intensive care unit patients before discharge or death. A prospective multicenter study☆

Frédéric Pochard MD, PhD, Michaël Darmon MD, Thomas Fassier MD, Pierre-Edouard Bollaert MD, PhD, Christine Cheval MD, Madeleine Coloigner MD, Asri Merouani MD, Serge Moulront MD, Etienne Pigne MD, Juliette Pingat MD, Jean-Ralph Zahar MD, Benoît Schlemmer MD, Élie Azoulay MD, PhD*, The French FAMIREA Study Group

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Received 2 August 2004; revised 9 November 2004; accepted 24 November 2004

Keywords:
Families;
Epidemiology;
Stress;
Bereavement;
Ethics

Abstract

Study Objectives: More than two thirds of family members visiting intensive care unit (ICU) patients have symptoms of anxiety or depression during the first days of hospitalization. Identifying determinants of these symptoms would help caregivers support families at patient discharge or when death is imminent.

Design and Setting: Prospective multicenter study including 78 ICUs (1184 beds) in France.

Participants: Family members completed the Hospital Anxiety and Depression Scale on the day of patient discharge or death to allow evaluation of the prevalence and potential factors associated with symptoms of anxiety and depression.

Results: Three hundred fifty-seven patients were included in the study, and 544 family members completed the Hospital Anxiety and Depression Scale. Symptoms of anxiety and depression were found in 73.4% and 35.3% of family members, respectively; 75.5% of family members and 82.7% of spouses had symptoms of anxiety or depression ($P = .007$). Symptoms of depression were more prevalent in family members of nonsurvivors (48.2%) than of survivors (32.7%) ($P = .008$). The multivariate model identified 3 groups of factors associated with symptoms: (1) patient-related: severity as assessed by the Simplified Acute Physiology Score II (odds ratio [OR] 1.017 per point) and patient age (OR 0.984 per year) predicted anxiety, and Simplified Acute Physiology Score II (OR, 1.015 per point), patient death (OR 2.092), and patient age (OR 0.981) predicted depression; (2) family-related: the spouse predicted anxiety (OR 2.085); and (3) ICU-related: a room with more than 1 bed (OR 1.539) predicted depression.

PTSD

Post Traumatic Stress Disorder

Family presence during CPR (NEJM 2013)

- RCT
- 570 familiari
- Pre-ospedaliero

End-point primario

- % PTSD a 90 giorni

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Family Presence during Cardiopulmonary Resuscitation

Patricia Jabre, M.D., Ph.D., Vanessa Belpomme, M.D., Elie Azoulay, M.D., Ph.D., Line Jacob, M.D., Lionel Bertrand, M.D., Frederic Lapostolle, M.D., Ph.D., Karim Tazarourte, M.D., Ph.D., Guillem Bouilleau, M.D., Virginie Pinaud, M.D., Claire Broche, M.D., Domitille Normand, M.S., Thierry Baubet, M.D., Ph.D., Agnes Ricard-Hibon, M.D., Ph.D., Jacques Istria, M.D., Alexandra Beltramini, M.D., Armelle Alheritiere, M.D., Nathalie Assez, M.D., Lionel Nace, M.D., Benoit Vivien, M.D., Ph.D., Laurent Turi, M.D., Stephane Launay, M.D., Michel Desmaizieres, M.D., Stephen W. Borron, M.D., Eric Vicaut, M.D., Ph.D., and Frederic Adnet, M.D., Ph.D.

ABSTRACT

BACKGROUND

The effect of family presence during cardiopulmonary resuscitation (CPR) on the family members themselves and the medical team remains controversial.

METHODS

We enrolled 570 relatives of patients who were in cardiac arrest and were given CPR by 15 prehospital emergency medical service units. The units were randomly assigned either to systematically offer the family member the opportunity to observe CPR (intervention group) or to follow standard practice regarding family presence (control group). The primary end point was the proportion of relatives with post-traumatic stress disorder (PTSD)–related symptoms on day 90. Secondary end points included the presence of anxiety and depression symptoms and the effect of family presence on medical efforts at resuscitation, the well-being of the health care team, and the occurrence of medicolegal claims.

Family presence during CPR (NEJM 2013)

Table 3. Psychological Assessment of Family Members Enrolled in the Study at 90 Days (Observed-Cases Population).*

Variable	Intervention Group (N = 233)	Control Group (N = 242)	P Value†	Family Member Present (N = 289)	Family Member Absent (N = 186)	P Value†
IES score — median (interquartile range)‡	22 (12–33)	24 (13–35)	0.26	21 (11–32)	26 (15–36)	0.007
Presence of PTSD-related symptoms — no. (%)§	64 (27)	90 (37)	0.01	78 (27)	76 (41)	0.01
HADS score — median (interquartile range)¶	10 (6–16)	11 (6–19)	0.44	9 (5–16)	12 (7–19)	0.02
Symptoms of anxiety — no./total no. (%)‖	34/230 (15)	55/239 (23)	<0.001	46/287 (16)	43/182 (24)	<0.001
Symptoms of depression — no./total no. (%)‖	39/230 (17)	50/239 (21)	0.13	42/287 (15)	47/182 (26)	0.009
Saw a psychologist after resuscitation of the patient — no./total no. (%)	20/232 (9)	18/242 (7)	0.83	25/289 (9)	13/185 (7)	0.23
Received newly prescribed psychotropic drugs after resuscitation of the patient — no./total no. (%)	64/230 (28)	77/238 (32)	0.22	72/287 (25)	69/181 (38)	<0.001
Made a suicide attempt after resuscitation of the patient — no./total no. (%)	2/227 (1)	3/238 (1)	—	5/285 (2)	0/180	—

Family presence during CPR (NEJM 2013)

PTSD

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Il nostro percorso

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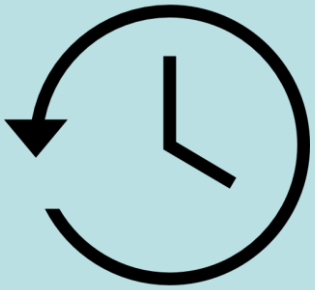

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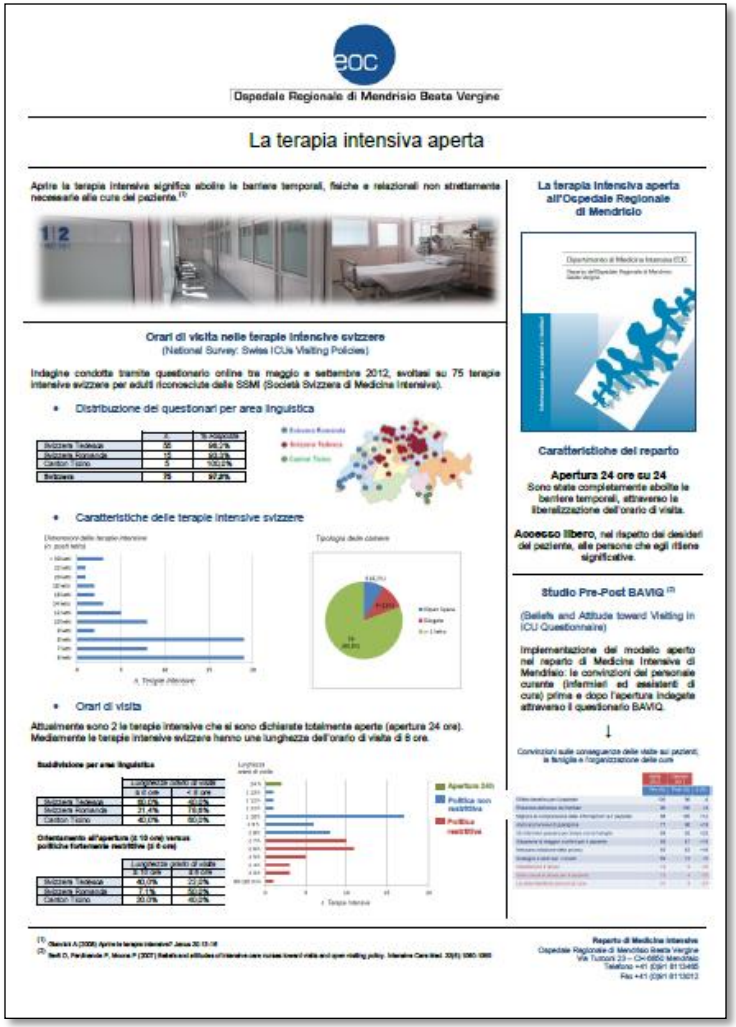

Ospedale Regionale di Mendrisio Beata Vergine

La terapia intensiva aperta

Aprire la terapia intensiva significa abolire le barriere temporali, fisiche e relazionali non strettamente necessarie alla cura del paziente.[1]

Orari di visita nelle terapie intensive svizzere
(National Survey: Swiss ICUs Visiting Policies)

Indagine condotta tramite questionario online tra maggio e settembre 2012, svoltasi su 75 terapie intensive svizzere per adulti riconosciute dalla SSMI (Società Svizzera di Medicina Intensiva).

- Distribuzione dei questionari per area linguistica

	n	% risposte
Svizzera Tedesca	55	98,2%
Svizzera Romanda	15	93,8%
Cantion Ticino	5	100,0%
Svizzera	75	97,4%

- Caratteristiche delle terapie intensive svizzere

- Orari di visita

Attualmente sono 2 le terapie intensive che si sono dichiarate totalmente aperte (apertura 24 ore). Mediamente le terapie intensive svizzere hanno una lunghezza dell'orario di visita di 8 ore.

Suddivisione per area linguistica

	Lunghezza orario di visita	
	8 ore	< 8 ore
Svizzera Tedesca	60,0%	40,0%
Svizzera Romanda	21,4%	78,6%
Cantion Ticino	40,0%	60,0%

Orientamento all'apertura (≥ 10 ore) versus politiche fortemente restrittive (≤ 6 ore)

	Lunghezza orario di visita	
	≥ 10 ore	≤ 6 ore
Svizzera Tedesca	40,0%	22,2%
Svizzera Romanda	7,1%	50,0%
Cantion Ticino	20,0%	40,0%

La terapia intensiva aperta all'Ospedale Regionale di Mendrisio

Caratteristiche del reparto

Apertura 24 ore su 24
Sono state completamente abolite le barriere temporali, attraverso la liberalizzazione dell'orario di visita.

Accesso libero, nel rispetto dei desideri del paziente, alle persone che egli ritiene significative.

Studio Pre-Post BAVIQ [2]

(Beliefs and Attitude toward Visiting in ICU Questionnaire)

Implementazione del modello aperto nel reparto di Medicina Intensiva di Mendrisio: le convinzioni del personale curante (infermieri ed assistenti di cura) prima e dopo l'apertura indagate attraverso il questionario BAVIQ.

Convinzioni sulle conseguenze delle visite sui pazienti, la famiglia e l'organizzazione delle cure

[1] Ramick A (2009) Aprire le terapie intensive? Janus 26: 15-18
[2] Bell D, Pardavicini F, Moore P (2007) Beliefs and attitudes of intensive care nurses toward visits and open visiting policy. Intensive Care Med. 33(6): 1060-1065

Reparto di Medicina Intensiva
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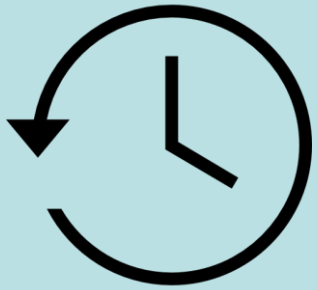
Fax +41 (0)91 8113012

Il nostro percorso



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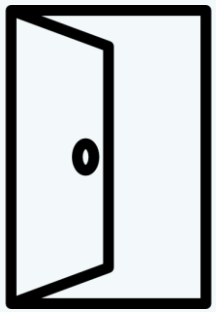

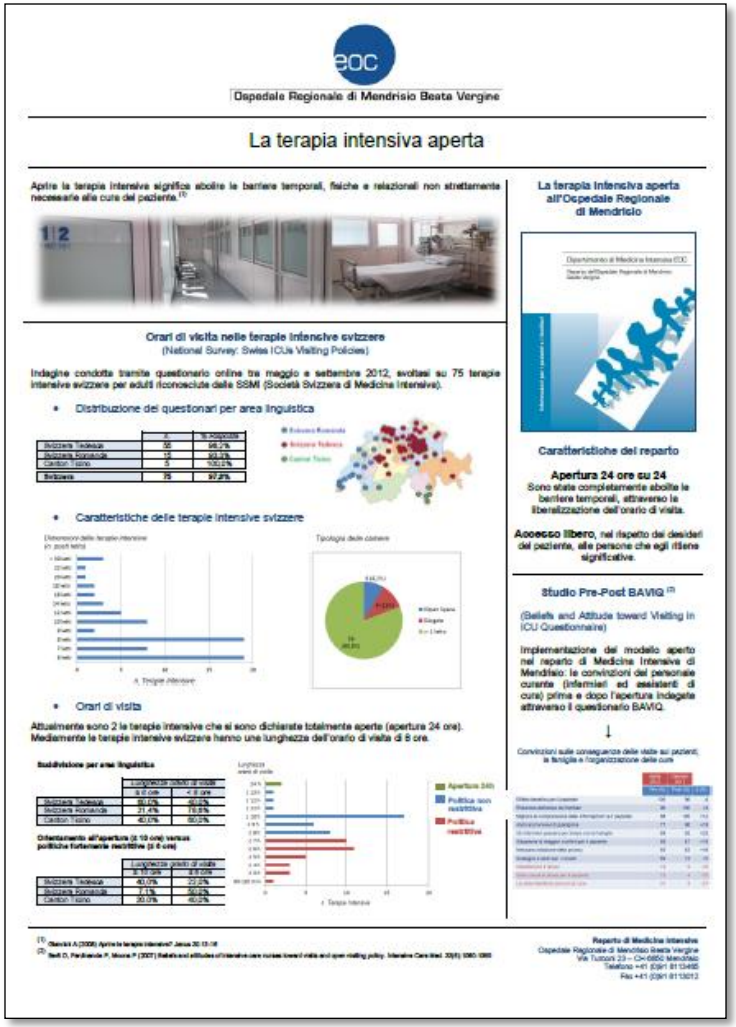

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Indagine condotta tramite questionario online tra maggio e settembre 2012, svoltasi su 75 terapie intensive svizzere per adulti riconosciute dalla SSMI (Società Svizzera di Medicina Intensiva).

- Distribuzione dei questionari per area linguistica

	n	% risposte
Svizzera Tedesca	55	98,2%
Svizzera Romanda	15	93,8%
Cantone Ticino	5	100,0%
Svizzera	75	97,4%

- Caratteristiche delle terapie intensive svizzere

- Orari di visita

Attualmente sono 2 le terapie intensive che si sono dichiarate totalmente aperte (apertura 24 ore). Mediamente le terapie intensive svizzere hanno una lunghezza dell'orario di visita di 8 ore.

Suddivisione per area linguistica

	Lunghezza orario di visita	
	8 ore	< 8 ore
Svizzera Tedesca	60,0%	40,0%
Svizzera Romanda	21,4%	78,6%
Cantone Ticino	40,0%	60,0%

Orientamento all'apertura (≥ 10 ore) versus politiche fortemente restrittive (≤ 6 ore)

	Lunghezza orario di visita	
	≥ 10 ore	≤ 6 ore
Svizzera Tedesca	40,0%	22,2%
Svizzera Romanda	7,1%	50,0%
Cantone Ticino	20,0%	40,0%

La terapia intensiva aperta all'Ospedale Regionale di Mendrisio

Caratteristiche del reparto

Apertura 24 ore su 24
Sono state completamente abolite le barriere temporali, attraverso la liberalizzazione dell'orario di visita.

Accesso libero, nel rispetto dei desideri del paziente, alle persone che egli ritiene significative.

Studio Pre-Post BAVIQ [2]

(Beliefs and Attitude toward Visiting in ICU Questionnaire)

Implementazione del modello aperto nel reparto di Medicina Intensiva di Mendrisio: le convinzioni del personale curante (infermieri ed assistenti di cura) prima e dopo l'apertura indagate attraverso il questionario BAVIQ.

Convinzioni sulle conseguenze delle visite sui pazienti, la famiglia e l'organizzazione delle cure

[1] Ranzini A (2008) Aprire le terapie intensive? Janus 26: 15-18
[2] Bell D, Pardavicini F, Moore P (2007) Beliefs and attitudes of intensive care nurses toward visits and open visiting policy. Intensive Care Med. 33(6): 1060-1065

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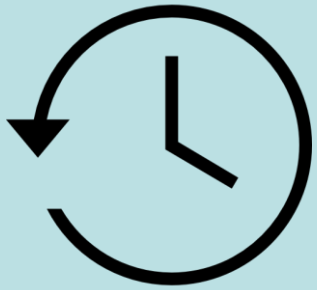

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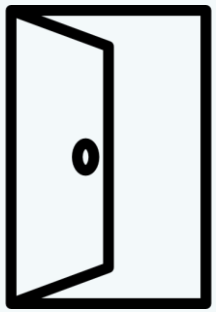

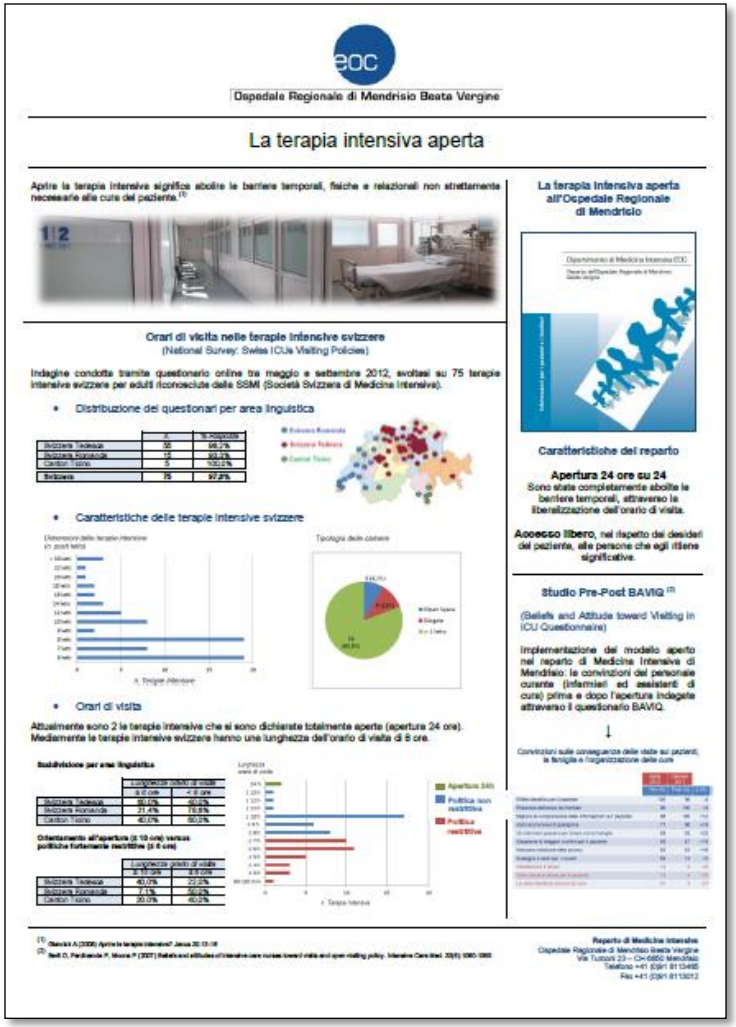

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La terapia intensiva aperta

Aprire la terapia intensiva significa abolire le barriere temporali, fisiche e relazionali non strettamente necessarie alla cura del paziente.[1]

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- Distribuzione dei questionari per area linguistica

	n	% risposte
Svizzera Tedesca	55	98,2%
Svizzera Romanda	15	93,3%
Cantone Ticino	5	100,0%
Svizzera	75	97,3%

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- Orari di visita

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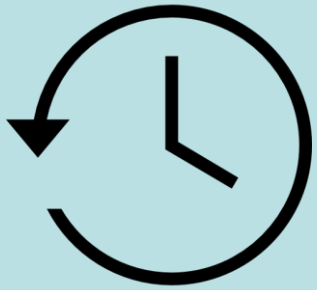
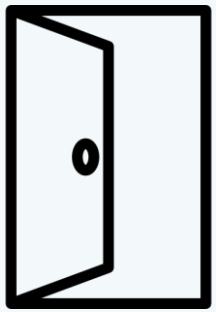


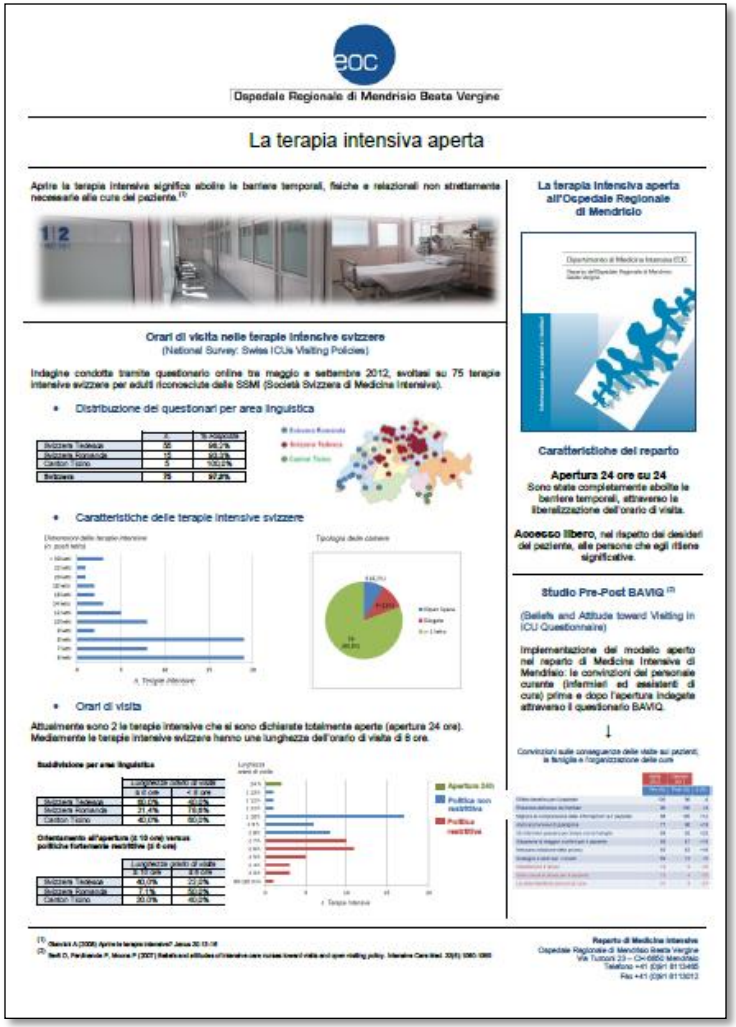
24h

~~Barriera temporale~~



~~Barriera fisica~~

~~Barriera relazionale~~



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il tempo della conoscenza

di sé

Il nostro percorso

BAVIQ

Beliefs and Attitudes towards Visitation in ICU Questionnaire

Moons P, et al. Intensive Care Med 2007; 33:1060-1065

PRE

Aprile 2012

BAVIQ

Beliefs and Attitudes toward Visitation in ICU Questionnaire

Convinzioni e atteggiamenti verso le visite in Terapia Intensiva

Progetto Open.ICU – Medicina Intensiva, Ospedale Regionale di Mendrisio

- **Professione** □ Assistente di cura □ Infermiere □ Infermiere specializzato in cure intensive
- **Sesso** □ M □ F
- **Età** □ Anni:
- **Esperienza professionale in terapia intensiva** □ Anni:

1. CONVINZIONI SULLE CONSEGUENZE DELLE VISITE SUI PAZIENTI, LA FAMIGLIA E L'ORGANIZZAZIONE DELLE CURE

		Forte disaccordo	Disaccordo	Indifferente	D'accordo	Fortemente d'accordo
1	**Penso che le visite abbiano un effetto benefico sui pazienti.**	□	□	□	□	□
2	Penso che le visite impediscano il riposo dei pazienti.	□	□	□	□	□
3	**Penso che le visite causino stress fisiologico al paziente.**	□	□	□	□	□
4	Penso che le visite causino alterazioni emodinamiche nei pazienti.	□	□	□	□	□

Il nostro percorso

BAVIQ

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POST

Gennaio 2013

BAVIQ

Beliefs and Attitudes toward Visitation in ICU Questionnaire

Convinzioni e atteggiamenti verso le visite in Terapia Intensiva

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Convinzioni sulle conseguenze delle visite

	Aprile 2012	Gennaio 2013	
	Pre (%)	Post (%)	Δ (%)
Effetto benefico per il paziente	100	96	-4
Riduzione dell'ansia dei familiari	96	100	+4
Migliora la comprensione delle informazioni vs il paziente	88	100	+12
Aiuto al processo di guarigione	77	96	+19
Gli infermieri passano più tempo con le famiglie	69	92	+23
Situazione di maggior comfort per il paziente	69	87	+18
Nessuna violazione della privacy	65	83	+18
Sostegno e aiuto per i curanti	69	74	+5
Impediscono il riposo	19	9	-10
Sono causa di stress per il paziente	19	4	-15
Le visite interferiscono con le cure	31	4	-27

Convinzioni sulle conseguenze delle visite

	Aprile 2012	Gennaio 2013	
	Pre (%)	Post (%)	Δ (%)
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Convinzioni

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Convinzioni

Timori

prove di (*in*)efficacia

Punti di vista

J-L Vincent, Université Libre de Bruxelles

Belgium

Intensive Care Med (2017) 43:122-123

EDITORIAL

Evidence supports the superiority of closed ICUs for patients and families: Yes

Jean-Louis Vincent*

"*Too many cooks…*"

Most intensive care units (ICUs) around the world, with the general exception of the USA, now operate according to a "closed" model, i.e., patients are admitted under the full responsibility of a trained intensivist, as opposed to the "open" format in which patients are admitted under the care of another attending physician and intensivists are just available for consultation [1]. In a worldwide study of 1265 ICUs in 75 countries in 2007, 83 % of the units were closed: North America had the lowest proportion of closed ICUs (63 %) and Western Europe the highest (89 %) [1]. Of 111 ICUs across nine Canadian provinces, 94 (85 %) reported a closed format model of care in 2015 [2]. In Asia, Arabi et al. [3] reported that 216 of 335 (65 %) ICUs surveyed in 2013 were closed format and in the UK, all ICUs analyzed as part of the ICNARC project in 2010/2011 reported that their unit model was closed [4]. Similar to the situation in the UK, in Australia and New Zealand the vast majority of ICUs are run in closed format [5].

There is good evidence that closed ICUs are associated with better outcomes and better quality of care, both in general [6–10] and in subspecialty [11] units. Several studies have reported a positive impact on outcomes when the ICU model was changed from open to closed [6–8]. In one example, a before-after cohort study, Parikh et al. [7] reported that the change from an open to a closed format was associated with shorter ICU stay and improved quality measures, including less ventilator-associated pneumonia and central vein access device infection. ICU costs were also reduced [7]. Kahn et al. also reported improved quality of care in closed (high-intensity) compared to open (low-intensity) ICUs, as shown by increased use of evidence-based quality indicators including sedation interruption and intensive insulin treatment [9]. In an early meta-analysis of 26 such studies comparing closed and open ICU models, Pronovost et al. [10] reported that a closed model (or high-intensity intensivist staffing) was associated with lower mortality and shorter length of stay than an open format (low-intensity intensivist staffing). More recently, Wilcox et al. similarly reported that high-intensity intensivist staffing was associated with reduced ICU and hospital mortality and shorter stay in a meta-analysis of 52 studies [12].

Clearly, therefore, closed-format ICUs have a beneficial impact on patient outcomes. However, they also have positive effects on other aspects, including staff and family satisfaction. These concepts are difficult to define and quantify, and the published data on this issue are relatively sparse. Nevertheless, good communication with adequate provision of coherent information is known to be a key factor in family satisfaction with intensive care [13]. Having a single physician in charge of patient management (closed format) will ensure that communication about treatments and prognoses is consistent; having several specialists involved in patient management can result in mixed and confusing messages. In an early study by Carson et al. [6], nurses working in closed ICUs were more likely to feel confident in the clinical judgment of the attending physician than those in open ICUs. Paul Olson et al. reported that surgeons working in a unit where an ICU physician was primarily responsible for all patients were significantly less likely to report conflicts with their intensivist colleagues than surgeons working on a unit where the operative surgeon was primarily responsible for his/her patients [14]. Such conflicts are likely to impact negatively on communication with patients and families. Evaluation of prognosis may

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For contrasting viewpoints, please go to doi:10.1007/s00134-016-4438-9 and doi:10.1007/s00134-016-4510-5.

Punti di vista

G.E. Weissman, University of Pennsylvania, Philadelphia

Intensive Care Med (2017) 43:124-127

EDITORIAL

Evidence supports the superiority of closed ICUs for patients and families: No

Gary E. Weissman[1,2*] and Scott D. Halpern[1,2,3,4*]

In "closed" intensive care units (ICUs), primary responsibility for admitted patients is transferred to an intensivist. In "open" units, the attending physician of record is typically a non-intensivist from another service who may have a longitudinal relationship with the patient and who may or may not consult an intensivist for assistance with management. Open staffing models are much more common in North America [1], whereas closed models predominate in Europe [2].

On its face, it seems obvious that a trained intensivist would provide higher quality intensive care than a physician trained in a different area. Yet, perhaps surprisingly, there exists no compelling evidence that this premise is true. As a result, clinicians, policymakers, patients, and families cannot be sure which models to advocate. Most of the available research comes from North America where full implementation of "high intensity" staffing (closed and/or 24-h intensivist coverage) staffing models has proved impractical given workforce limitations. More than a decade ago, the Leapfrog group recommended mandatory intensivist management of all critically ill patients [3], yet recent guidelines from the American College of Critical Care Medicine are more circumspect [4]. What can we make of the available evidence?

Initial evidence in support of closed ICUs was based on the single-center, before–after study performed by Carson and colleagues [5]. The systematic review by Pronovost et al. in 2002 [6] provided even stronger support for closed ICUs. However, this review did not distinguish between closed models and open models with mandatory intensivist consultation. And because outcomes were compared between ICUs that chose to adopt high-intensity models versus not to do so, differences among ICUs and hospitals beyond the chosen physician staffing model likely contributed to the results.

A more recent systematic review and meta-analysis examining the relationship between intensivist staffing models and mortality included a much larger number of studies [7]. In this review, the observed mortality benefit associated with "high intensity" staffing was concentrated in surgical rather than medical units, and was not consistent across all decades of analysis. The benefit was strongest during the 1980s, disappeared in the 1990s, re-occurred in the 2000s, and then disappeared again beginning in 2010. The lack of temporal consistency undermines the argument that high-intensity staffing models causally contribute to mortality benefits in the modern era.

Indeed, in the one large observational study to surmount the limitations of among-ICU analyses, those patients for whom management by trained intensivists was chosen experienced higher mortality than those who were never treated by an intensivist [8]. Although we strongly suspect that this apparent harm was attributable to unmeasured confounding by indication, the study certainly casts doubt on the notion that evidence supports a benefit for the type of staffing found in closed ICUs.

In the most robust analysis of this question to date, Nagendran et al. [9] asked whether ICUs experience declines in risk-adjusted mortality after transitioning from open to closed staffing models. This study overcomes many of the center-level and patient-level confounders that plagued prior studies by using a longitudinal difference-in-difference approach in which each ICU serves as its own control. Further, because different ICUs adopted the closed model at different time points, the design mitigates temporal biases associated with simpler before–after designs. Thus, it is notable that

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Full author information is available at the end of the article

In fact, a sound scientific basis for restricting visitors in ICUs does not exist

Slota M et al.
Crit Care Med, 2003

… non solo punti di vista

Intensive Care Med (2013) 39:2180-7

“ … small but significant increase in staff members’ burnout levels “

Alberto Giannini
Guido Miccinesi
Edi Prandi
Carlotta Buzzoni
Claudia Borreani
The ODIN Study Group

Partial liberalization of visiting policies and ICU staff: a before-and-after study

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Presented, in part, at the 32nd International Symposium on Intensive Care and Emergency Medicine (Brussels, Belgium, 20–23 March 2012) and at the 25th Annual Congress of the European Society of Intensive Care Medicine (Lisbon, Portugal, 13–17 October 2012).

Members of ODIN (Open Doors in INtensive care) Study Group are listed in the Appendix.

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G. Miccinesi · C. Buzzoni
Unit of Clinical and Descriptive Epidemiology, Istituto per lo Studio e la Prevenzione Oncologica—ISPO, Via Cosimo il Vecchio, 2, 50139 Florence, Italy

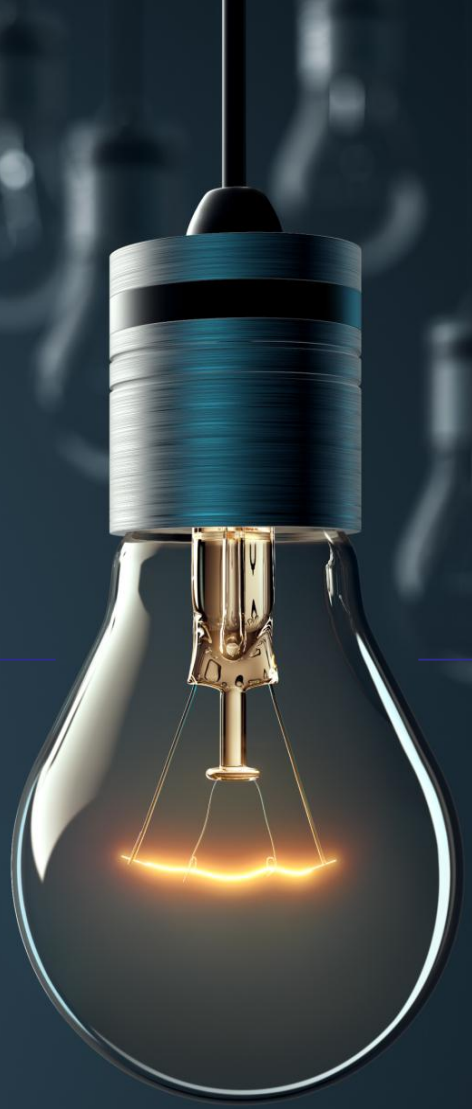
C. Borreani
Unit of Clinical Psychology, Fondazione IRCCS Istituto Nazionale dei Tumori, Via Venezian, 1, 20133 Milan, Italy

Abstract *Purpose:* To investigate possible psychological distress among staff after partial liberalization of visiting policies in intensive care units (ICUs). *Methods:* We surveyed eight Italian ICUs planning to increase daily visiting to at least 8 h. Participants completed the Maslach–Jackson Burnout Inventory and the State-Trait Anxiety Inventory before policy change (T0), after 6 months (T1) and 12 months (T2). At T0 and T2, their opinions on the new policy were solicited. Analyses were adjusted for main known confounders (age, gender, centre, educational and marital status, experience in ICU, baseline level of burnout or anxiety, and mortality rate). *Results:* Baseline response rate was 89 % (230/258); 198 subjects (77 %) responded at T0 and T2, whereas 184 (71 %) participated in all three phases. High burnout levels were identified in 34.5 % of participants at T0 and 42.6 % at T2 (adjusted $p = 0.001$). All three phases showed a predominance of high burnout among nurses (adjusted $p = 0.002$). State and trait anxiety scores remained stable (adjusted $p = 0.100$ and 0.288, respectively). Most participants viewed the change positively at T0 (doctors 81.7 %; nurses 67.7 %) and T2 (doctors 87.0 %; nurses 62.7 %). At T2, 129 participants made comments (180 positive, 136 negative). Subjects with high burnout were more likely to comment negatively ($p = 0.011$). *Conclusions:* Partial liberalization of ICU visiting policies was associated over the course of a year with a small but significant increase in staff members’ burnout levels. Nonetheless, doctors and nurses viewed the policy positively, maintaining this opinion after 1 year. Negative views were strongly correlated with burnout.

Keywords Intensive care · Visiting policies · Burnout · Anxiety · Stress · Family

a chi tocca la prima mossa ?

$E=mc^2$



C=2a

1a

accountability

2a

advocacy

Infermieri protagonisti del cambiamento

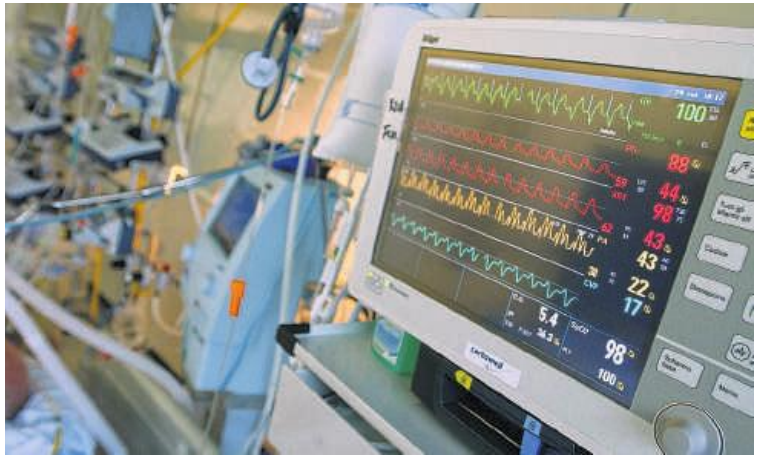
laRegioneTicino | venerdì 19 aprile 2013

All'Obv nessun limite di orario per le famiglie dei degenti nel reparto

Terapia intensiva aperta

Non vi sono più limiti di orario per le famiglie dei pazienti degenti nel reparto di cure intensive all'Obv di Mendrisio. Una possibilità che fino a oggi, in Svizzera, veniva concessa solo a Winterthur

di Prisca Colombini



La presenza della famiglia è di fondamentale importanza ARCHIVIO TI-PRESS

I familiari dei pazienti degenti nel reparto di medicina intensiva dell'Ospedale regionale della Beata Vergine di Mendrisio, potranno assistere i loro cari sull'arco delle 24 ore. Una possibilità che, in Svizzera, esisteva solo all'Ospedale cantonale di Winterthur. L'Eoc ha quindi voluto facilitare ulteriormente la vicinanza al paziente, ritenendo che la presenza della propria famiglia sia di fondamentale importanza in un momento così delicato del ricovero in ospedale.

L'estensione dell'orario è stata decisa secondo le convinzioni del personale curante, infermieri e medici, che è stato attivamente coinvolto in questo cambiamento. In particolare, sono state seguite le conclusioni a cui è giunto un lavoro di master presentato alla Supsi da Claudio Speroni, infermiere in cure intensive all'Obv. La letteratura scientifica dimostra che per i pazienti che necessitano di cure continue l'isolamento è motivo di sofferenza. È stato d'altra parte dimostrato che il rischio infettivo non aumenta qualora i visitatori rimangano per periodi prolungati all'interno del reparto. Non vi sono, inoltre, ragioni in favore di una restrizione dell'orario, che rimane legata generalmente a fattori culturali di un servizio la cui nascita è collocata, nella storia della medicina, attorno agli anni Sessanta del secolo scorso. Durante lo studio, sono inoltre stati interpellati tutti i reparti di medicina intensiva svizzeri, 75 in totale, nei quali l'orario di visita è mediamente di otto ore.

Nel reparto cure intensive dell'Obv che dispone di sei posti letto, lavorano a turno 24 infermieri e 4 assistenti di cura. Il reparto è gestito dal dr Alberto Pagnamenta, coadiuvato dal dr Alessandro Chiesa. L'accesso al reparto avviene attraverso una sala d'attesa riservata alle famiglie; l'entrata è libera per le persone che il paziente ritiene significative. Nelle ore notturne, dalle 19 alle 7, la porta resta chiusa e occorre annunciarsi.

OBV **Cure intensive: visite 24 ore al giorno**

Le visite dei famigliari dei pazienti ricoverati nel reparto di cure intensive all'Ospedale regionale Beata Vergine (OBV) di Mendrisio sono ora possibili sull'arco delle 24 ore. L'estensione dell'orario delle visite, finora dalle 11 alle 20, è stata decisa secondo le convinzioni del personale curante, a conclusione di un lavoro di master presentato alla SUPSI da Claudio Speroni, infermiere del reparto. La letteratura scientifica dimostra come per i pazienti che necessitano di cure continue l'isolamento sia motivo di sofferenza. La restrizione dell'orario, per contro, è legata generalmente a fattori culturali. La «Terapia intensiva aperta» riprende il modello dell'Ospedale San Giovanni Bosco di Torino, uno dei pochi in Italia a disporre dell'orario esteso. Durante lo studio sono stati interpellati tutti i reparti di medicina intensiva della Svizzera, dove l'orario di visita è mediamente di otto ore. Solo la struttura dell'OBV, insieme con l'ospedale di Winterthur, risulta essere aperta 24 ore. Dalle verifiche risulta che l'apertura continuata è la norma in Inghilterra, negli Stati Uniti e in Svezia. In Francia la media è invece di 3 ore, mentre è di un'ora soltanto in Italia, con orari più estesi nelle province che confinano con il Mendrisiotto (3 ore per quelle di Como e Varese). All'OBV l'accesso al reparto avviene attraverso una sala d'attesa riservata alle famiglie. Solo durante le ore notturne, dalle 19 alle 7, la porta resta chiusa e occorre annunciarsi. Al personale resta la facoltà di sconsigliare le visite.

Infermieri protagonisti del cambiamento

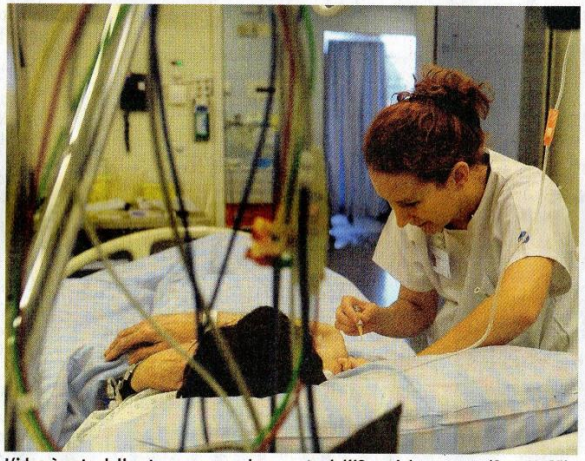
BEATA VERGINE DI MENDRISIO Ospedale sempre aperto per i propri cari

Porte aperte 24 ore su 24 per chi ne ha più bisogno

Riorganizzazione? Meno servizi? No, anzi, l'OBV spalanca le sue porte per i pazienti in terapia intensiva. Una nuova misura che va incontro a chi affronta la malattia.

di **ANDREA FINESSI**

Porte aperte ai cari di chi sta soffrendo in ospedale. L'Ospedale Beata Vergine di Mendrisio non si riorganizza: si rivoluziona. E la rivoluzione nasce proprio dal personale sanitario, infermieri e medici, che dopo anni di lavoro, osservazione ed esperienza accanto ai pazienti del reparto di terapia intensiva, hanno chiesto e ottenuto dall'Ente Ospedaliero Cantonale questa concessione: di tenere aperte, senza restrizioni di orario, le porte del reparto per i famigliari di chi è in cura. Finora all'OBV – così come anche nelle altre strutture dell'EOC – vi è sempre stata la massima disponibilità ad accogliere le famiglie dei pazienti nelle cure intensive anche oltre l'orario di visita ma ora è ufficiale. La decisione che è stata comunicata ieri nell'ambito di un aggiornamento promosso dal settore infermieristico del dipartimento di medicina intensiva dell'Ente ospedaliero cantonale ed è stata maturata nella convinzione che la presenza della propria famiglia sia di fondamentale importanza per il paziente in un momento così delicato del ricovero in ospedale.



L'idea è nata dallo stesso personale curante dell'Ospedale. (foto Maffi)

Ci sarà forse più lavoro per gli infermieri, sarà necessaria forse più pazienza, ma l'estensione dell'orario è stata decisa proprio partendo dal personale curante, infermieri e medici, coinvolto attivamente in questo cambiamento. Sono state seguite, in particolare, – rende noto la clinica – le conclusioni cui è giunto un lavoro di master presentato alla SUPSI da Claudio Speroni, infermiere in cure intensive presso l'OBV. La letteratura scientifica dimostra che per i pazienti che necessitano di cure continue l'isolamento è motivo di sofferenza e il rischio infettivo non aumenta qualora i visitatori rimangano per periodi prolungati all'interno del reparto. Non vi sono inoltre ragioni in favore di una restrizione dell'orario, che rimane legata generalmente a fattori culturali di un servizio la cui nascita è collocata, nella storia della medicina, attorno agli anni sessanta del secolo scorso. La "terapia intensiva aperta" adottata all'OBV riprende il modello dell'Ospedale San Giovanni Bosco di Torino, uno dei pochi in Italia a disporre dell'orario esteso. Lo studio condotto da Claudio Speroni, che si è avvalso della collaborazione dei colleghi dell'OBV, ha interpellato tutti i reparti di medicina intensiva svizzeri (ben 75), nei quali l'orario di visita è mediamente di otto ore. Nel mondo l'apertura estesa si trova solo in Inghilterra, Stati Uniti e Svezia. L'OBV è dunque il primo in Ticino e il secondo in Svizzera ad adottare questa misura, dopo l'Ospedale Cantonale di Winterthur.

Cosa cambia? L'accesso al reparto avviene attraverso una sala d'attesa; la porta rimane aperta e non è più necessario chiedere il permesso di accesso tramite citofono. Nelle ore notturne, dalle 19 alle 7, la porta resta chiusa e occorre annunciarsi.

Infermieri protagonisti del cambiamento

Potential predictors of visiting hours policies in the intensive care setting

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ABSTRACT

Background. Restrictions on visiting hours in the intensive care unit (ICU) are usually adopted worldwide. Current knowledge shows that these limitations are not necessary. In order to identify potential variables that are associated with restricted visiting times we carried out an observational study on visiting policy.

Methods. We conducted a questionnaire-based nationwide survey among all certified adult Swiss ICUs. An electronic questionnaire was sent by e-mail between May and June 2012 to all chief nurses. Length of permitted visiting time was taken as main endpoint to assess the association with different potential predictor variables using simple and multiple linear regression analysis.

Results. Response rate was 73 of 75 ICUs (97%). Only two ICUs (3%) have an unrestricted visiting policy. Median daily visiting time was 8 hours (range: 1.5 to 24 hours; interquartile range: 6-10 hours). Simple and multiple linear regression analysis demonstrated a significant effect in visiting hours between Italian- and French-speaking parts of Switzerland with 4.0 hours longer visiting hours in the former (P=0.039) without identifying other predictors.

Conclusion. Swiss ICUs have less restrictive visiting policies compared to other Western countries; nevertheless very few Swiss ICUs have unrestricted visitations. Neither medical type of ICU, nor ICU infrastructure was determining the visiting policy in Swiss intensive care setting. Cultural factors, as captured by the linguistic areas are the only identified predictors of visiting hours. Since the current policy is not justified by clinical outcomes but based only on cultural settings, it needs to be definitively reconsidered and unrestricted visiting policies must become the rule rather than the exception. *(Minerva Anestesiol 2015;81:1338-45)*

Key words: Visitors to patients - Intensive care units - Patient care.

“ C’era davvero un vaso di fiori “

“ C’era davvero un vaso di fiori “

Lucia Fontanella, ex-paziente della Terapia Intensiva Aperta dell’Ospedale San Giovanni Bosco di Torino e autrice del libro “La comunicazione diseguale”

Take-Home Message

Abbiamo ancora bisogno di crescere

grazie
per l'attenzione