UNIVESITY OF MALAWI

KAMUZU COLLEGE OF NURSING

KNOWLEDGE AND PERCEPTIONS OF FAMILY/FRIENDS TOWARDS VISITING TIME IN INTENSIVE CARE UNIT AT QUEEN ELIZABETH CENTRAL HOSPITAL

BY

MADALITSO MAPIRA (BScN-IV)

RESEARCH DISSERTATION SUBMITTED TO UNIVERSITY OF MALAWI, FALCULTY OF NURSING, IN PARTIAL FULFILLMENT FOR THE AWARD OF BACHELOR OF SCIENCE IN NURSING.

SUPERVISED BY DR I. MBENDERA

30TH NOVERMBER 2010

DECLARATION

I hereby declare that this dissertation is the result of my own work and that it has never been submitted before for award of any other degree at any other institution. It is also my pleasure to declare that all the sources that I have used or quoted have been acknowledged by means of complete referencing designed by the American Psychological Association (APA).

STUDENT: **Madalitso Mapira** SIGNATURE Mmapira DATE 23/11/2010

SUPERVISOR: **Dr. I. Mbendera** SIGNATURE [signature] DATE 23/11/2010

DEDICATION

I dedicate this work to my parents, Mr. and Mrs. Mapira for the encouraging words that have opened doors to achieve great success.

ABSTRACT

This is a qualitative study which aimed at exploring the knowledge, and perceptions of family/friends towards visiting time in Intensive Care Unit at Queen Elizabeth Central Hospital. A sample of ten family members/friends was randomly selected and interviewed individually using an interview guide. The data collected was then analyzed manually using content analysis. The study found that most family members/ friends have some knowledge of the importance of restricting visitors in ICU. However, despite the fact that much is known on importance of restricting visiting hours in ICU, the study found that family and friends were not happy with the current visiting time. The main concern was on the actual period of 30 minutes, which they viewed as not enough for all the visitors. Majority of the respondents suggested extending visiting time to an hour or two. However, the findings of this study may not be generalized because of a small sample size.

TABLE OF CONTENTS

CONTENT **PAGE**

CHAPTER 3.

CHAPTER 4.

APPENDICES

ACKNOWLEDGEMENT

I would like to thank God Almighty for granting me this opportunity to come up with this dissertation.

I wish also to express my heart-felt gratitude to my research supervisor, Dr. I Mbendera, for her expertise, patience, and tireless effort rendered during the whole process of proposal writing and dissertation.

I also whole heartedly thank Mr. Ngwale and Mr. Muocha the research and methodology Lecturers for equipping me with knowledge and skills for the whole research process.

Lastly, I would like to thank my parents for their encouragement, material and financial support. May the Almighty God bless you all!

LIST OF ABBREVIATIONS

CCMU - Complex Care Medical Unit

CCU - Complex Care Unit

ICU - Intensive Care Unit

QECH - Queen Elizabeth Central Hospital

USA - United States of America

RNs - Registered Nurses

MDs - Medical Doctors

DEFINITION OF KEY TERMS

- **Family**

According to Alspach (2006), a family by tradition refers to a group of two or more people who reside together and who are related by birth, marriage, or adoption. In contemporary aspect it refers to a group of people who love and care for each other. Finally a family is defined as the patient defines it because he / she knows who is a family member.

- **Friend**

A friend is someone whom a person knows and like very much and enjoy spending time with, (Longman, 2003).

- **Intensive Care Unit**

Freshman and Maslin, (2005) defines Intensive Care Unit as a special area in hospital where critically ill patients who need close observation and frequent ministrations can be cared for by highly qualified, especially trained staff. It is also known as Intensive Therapy Unit (ITU).

- **Knowledge**

Knowledge refers to the information, skills and understanding that one has gained through learning or experiences (Longman, 2003).

- **Perception**

Perception is the reception of a conscious impression through the senses by which people distinguish one object from another and recognition of their characteristics according to different sensations they generate (Brooker, 2006).

- **Visiting time**

Visiting time refer to period of time at which visitors can visit patients in hospital. It varies according to hospital policies. Visiting can provide psychological support and help to prevent boredom and institutionalization and to encourage rehabilitation (Brooker, 2006).

CHAPTER ONE

1.0 Introduction

The presence or absence of an admitted patient's family or friends can affect recovery and quality of life. Sorrentino, (2005) documented that the patient has the right to visit with family and friends in a private and without unnecessary interruptions. According to Gonzalez et al. (2004), family and friends help to meet safety, security, love, belonging and self esteem needs of a patient. Hence, family members and friends of patients should be allowed to visit patients. Family members of critically ill patients in particular also share a variety of predictable psychosocial needs. The needs of family members include obtaining information, receiving support and to be with the patient (Alspach, 2006). However, due to restricted visiting hours for intensive care patients, sometimes family and friends' needs are not met.

Visiting hours refer to the time at which friends and family can visit patients in the hospital. It varies according to hospital policies. Visiting can provide psychological support and help to prevent boredom and institutionalization and to encourage rehabilitation (Brooker, 2006). In Intensive Care Unit, visiting time restriction is emphasized because frequent visits by family members and others induce physiologic stress to the patient (Sorrentino, 2005). However, there is still need to balance patient's family needs and professionals' need. This research study aims at exploring knowledge and perceptions of family/ friends towards current visiting time in Intensive Care Unit at Queen Elizabeth Central Hospital.

1.1 Background Information

Advances in science and technology have made nursing practice in acute care settings highly complex, rapid, and demanding, (Gonzalez et al. 2004). Within this challenging healthcare environment are patients and their families.

Caring for the patient's family is another way of caring for the patient. In health care the patient's family and significant others such as friends are viewed as a unit in provision of care (Stannard, 2000). Visitors are the common sight in most hospitals. They are comprised of family, friends and other significant others to the patients. Families want proximity to and information

about their loved ones but the benefits of having a patient' s family members present during hospitalization depends on the patient's condition and the visiting time policies (Peterson, 2005).

According to Sorrentino, (2004), visiting rules depend on hospital's policy and the person's age and condition. Parents can visit children and as they want. Usually, only short visits are allowed in special care units such as Intensive Care Unit (ICU).

Kumar, (2005) defines ICU as a specialized area in a hospital where critically ill patients are given most closely supervised level of continuous care and treatment. Compared with general wards, a larger area is allocated for each bed space. Bulky monitoring equipment occupies space and some of this extra room is also needed for several nurses and physicians to attend to a patient at once. Roland et al. (2001) points out that patients nursed in ICU especially with coronary and neuro-surgical critical conditions require very minimal stimulation hence the need to restrict visitors. Roland et al. (2001) further stated that critical illness is associated with panic, anxiety, loss of control, and crisis functioning therefore the need to support the patient and the family to cope positively. Positive coping mechanisms include more liberalized visitation which is often beneficial in facilitating communication between family, patient and health care team. Peterson, (2005) emphasized also that having family and friends present lessened anxiety levels in both patients and family or friends.

According to Horne and Cowan, (1996) visiting time is break the monotony and boredom of the hospital routines. Visiting time is also not merely an interruption of ward routine, but it is an opportunity to keep a patient in touch with the outside world, which in turn makes the patient easier to fit in when discharged from the hospital.

Despite the advantages of liberalized visitation, ICU visiting time remains restricted in the entire hospitals worldwide. Sims and Miracle (2006) documented that restricting visiting time in ICU promotes bed rest to conserve energy and oxygen in patients who are not eating and with low oxygen concentration respectively. Sims and Miracle (2006) further stated that restricting visiting time minimizes infection transmission because it reduces congestion. In addition, visitors may not be more knowledgeable and skilled in infection prevention. Merenstein and Gardener,

(2006) also discovered the respect for confidentiality and privacy as determinants for strict visiting policies in ICU.

ICU at QECH just like any other specialized area for critical illness has four beds. Bulky monitoring equipment, ventilators and resuscitators are in between each bed. All these equipments occupy a larger space. The environment is also full of noise from monitors and it becomes stressful to some patients and visitors. A multidisciplinary team comprising two nurses, anaesthetist, and a specialist physician work hand in hand on day and night shifts.

Family/friends are allowed to visit the patient in ICU between 7:00am and 7:30am, 12:00noon and 1:00pm, and 5:00 pm and 5:30pm. Two visitors are allowed for one patient and have to spend only ten minutes. Therefore, some of the patient's family and friends may not have the chance to visit the patients due to this short period of time.

1.2 Problem Statement

A very strict visiting policy in ICU is stressful and leads to friction between staff and family (Birdsal, 2000). Despite the importance of visitor restriction as documented by Sims and Miracle (2006), in Malawi the commonest concem of the most patient family and other visitors is that they are denied opportunity to be with their loved ones. It has also been observed that most of the guardians who comprises of the family members and friends cause trouble at entry points manned by security guards. The issue of revising visiting time was also overemphasized by family and friends in a petition written to the District commissioner for Mwanza district in December, 2009. This prompted my interest to embark on a study to explore the knowledge and perceptions of the family and friends towards current visiting time in ICU at QECH.

1.3 Significance of the Study

The findings of this study will help to know the public's level of knowledge on importance of visitor restriction. They will also help to understand the attitudes and perceptions of the family and friends towards current visiting time. These aspects will inturn help to understand the behavior of friends and family members in hospitals.

The study will also get views of family and friends on current visiting time in ICU at QECH. This will inturn help the security guards and nurses to handle visitors appropriately because the visitors will be understood.

The findings will also be a basis for training personnel responsible for controlling patient visitors in ICU.

Finally the findings will add to the body of knowledge on visiting time in ICU and general wards because there have been different opinions about patient visiting time in hospitals internationally.

1.4 Objectives

1.4.1 Broad Objective

To explore knowledge, attitudes and perceptions of family/ friends towards current visiting time in ICU at QECH.

1.4.2 Specific Objectives

i. To assess the knowledge family/friends have on importance of visitor restriction in I.C.U.

ii. To assess the attitudes of family/friends towards current visiting time in ICU at QECH.

iii. To find out challenges faced by family/friends due to current visiting time in ICU.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature related to knowledge, and perceptions of family/ friends towards visiting time in ICU. The purpose is to analyze what is already known and identify the gaps which can be addressed by this study.

In this literature review the researcher will mainly concentrate on:

- The concept of visiting time and current visiting time practices in ICU.
- Family/friends' knowledge on the importance of strict visiting time in ICU.
- Perceptions of the family/friends towards visiting time.
- Summary

2.2 The Concept of Visiting Time and Current Visiting Time Practices in ICU

There were few limitations in many hospitals on visiting patients between 1700s and early 1800s. For example, in United Kingdom, visiting times often became restricted because of epidemics of infections. In 1832 many hospitals including the Royal Devon and Exeter Hospital closed all wards to visitors during a national cholera epidemic. They reopened to visitors the following year, four weeks after the last case. Measles and smallpox outbreaks in Doncaster led to the Royal Infirmary closing to visitors in 1883, and a scarlet fever epidemic in 1887 resulted in St Bartholomew's restricting visiting to one hour a week. Thereafter, hospitals were being closed to visitors during the outbreak of severe acute respiratory syndrome.

Restricted hospital visiting hours began in the late 1800s for nonpaying patients in an attempt to establish order in the general wards. For many decades thereafter, paying patients had the privilege of unrestricted visits at almost any time, (Berwick & Kotagal, 2004).

In the 1960s, however, hospitals instituted visiting hours broadly for both paying and nonpaying patients in ICUs and the general wards. The aim was to protect the patient and family from

exhaustion caused by too many visitors. Visiting cards were introduced as a means of restricting numbers of visitors. The card stated the patient's name, ward, and bed number. It allowed one visitor aged more than 14 years and had to be presented on each visit and returned on the patient's discharge, (Ludmerer, 2004). This entails that family members were to visit their hospitalized friends or relatives at designated time.

An article in the Nursing Times in 1970 referred to a normal pattern of visiting as one hour in three afternoons a week, and 30 minutes in four evenings a week. Standard restrictions currently include two visitors per patient; having afternoon and early evening visiting only; and not allowing visiting during meal times, ward rounds, or ward cleaning, (Ismail & Mulley, 2007). However, in intensive care visiting time continues to vary depending on hospital policy.

In the 1980s and 1990s many hospitals reinstituted restricted visiting time. This was in response to nursing staff's concerns with the disruption caused by patients' visitors, which could inturn interfere with the running of wards and hamper patient care. Other concerns were on disruption of privacy, increased stress levels of patients and breach of confidentiality during ward rounds.

A survey of intensive care units in the United States, in 1984 showed that only 11% allowed visits from children, including immediate family. Children were also not allowed in general wards. The concern was on poor supervision by relatives. As such, the nursing staff or patients were the ones to take care of the children (Ludmerer, 2004).

Federwish, (1998), documented that with cost containment in hospital care, patients are discharged in the dependent state, hence the need for families to observe therapy. Brinker, (2001), concurred that when a loved one is critically ill, family want proximity to them. One way to accommodate the patient and family's needs is to consider a less restrictive visiting policy in ICU.

Currently, QECH adopted the standard policy that allows only two visitors per patient ICU. Visiting is permitted between 7:00 and 7:30 pm, 12:00 pm and 1:00 pm, and 5:00 pm and 5:30 pm. There is no limit for number of visitors in the general wards and visiting time is much longer than in ICU. For instance, visitors are allowed between 6:00am and 7:30 am, 12:00 pm and 1:30

pm, and 5:00 pm and 7:30 pm. These visiting hours are in accordance with the standard visiting time though visitors are allowed at meal times in Malawi.

2.3 Family/friends' Knowledge on Importance of Visitor Restriction in ICU.

In 2004 the Institute for Healthcare Improvement (IHI) challenged a number of hospitals working on improvement of care to open their ICUs by instituting a totally unrestricted visiting policy. This followed the discovery that there was resistance among nurses, and physicians to liberalize visitation in ICU. According to Berwick & Kotagal, (2004), the nurses and physicians were largely focused on three worries. The first worry was on increased physiologic stress for the patient. Secondly, it was the interference with the provision of care. Finally the fear was on physical and mental exhaustion of family and friends. As such there are few ICUs abiding to the IHI challenge, (Berwick and Kotagal, 2004). These findings significantly help to understand the importance of restricting visitors from the nurses' point of view. However it is not very clear as to whether the family and friends of patients are aware of the significance of visitor restriction in ICU.

In another study, Melissa et al, (2007), conducted a two-part study, which includes a survey and focus group, in USA. The main purpose of the study was to explore visiting hours policies in New England intensive care units. The first objective was to determine the visiting hours policies of New England-area hospital ICUs. The study was also aimed at describing challenges and barriers that nursing staff working in an open ICU had experienced. In this study, adult ICUs in the six New England states were located using a library listing of all regional hospitals. A telephone questionnaire interview was used to ascertain visiting hours policies in each ICU. Six focus-group sessions were conducted with nursing staff who work in an urban, north-eastern ICU with 8 years of experience with an unrestricted visiting hours policy.

A total of 171 hospitals completed the questionnaire (96%). From all ICUs surveyed, 62 (32%) had unrestricted, open visiting hours. Out of these, 57 (92%) were medical ICUs or mixed medical/surgical ICUs. Nursing staff identified three major areas of concern with an open visiting hours policy. The first concern was on limited space because of bulky equipments and need for continuous nursing ministrations. Secondly, nurses also concurred with Berwick and

Kotagal, (2004) that visitors were indeed a burden in provision of care. The other concern was on conflict between right to privacy or confidentiality and right to visit by the family. Merenstein and Gardener, (2006), concurs that restricting visitors in ICU holds a chance of avoiding breach of privacy and confidentiality of patients. According to Catalano, (2004), right to privacy and confidentiality are fundamental rights of each individual. Privacy is a state in which one is not observed or disturbed by others. It is also defined as freedom from public attention. On the other hand confidentiality implies to keeping a secret or respecting privileged information. The nurses opted to safeguard the right to privacy and confidentiality so the right to be visited had to be ignored at some occasion (Melissa et al, 2007). This study will include the aspect of human rights, however, the findings from the study done in USA shows that patients' right to be visited by family and friends is contradicting with the right to privacy and confidentiality.

In Malawi, the literature review done in the preliminary stage showed that there was no study done to assess the level of knowledge family/friends have on importance of visitor restriction in I.C.U. Nevertheless there have been informal reports that some family members and friends have come into open to challenge the current ICU visiting policies in Malawi. In all the three tertiary hospitals there have been informal reports from security guards and nurses that there were being forced to let the patient visitors in at unscheduled period of time. In addition, in December 2009, a petition was written to Mwanza District Commissioner. The paper addressed various issues but revision of visiting time was emphasized in all government hospitals, QECH in particular as their referral hospital for critical illness. The national television station captured this in its TVM News program. This is clear evidence that family members and friends are not satisfied with current visiting hours. The question still remains, "do the family members really know and appreciate the importance of visitor restriction in ICU?". This gap is to be revealed by the findings on family/friends' knowledge on importance of visitor restriction in ICU.

2.4 Perceptions of the Family/friends towards Visiting Time in ICU.

According to Ramnath, (2007), keeping family physically away from patients by restricting visiting hours implies that families are a problem. Despite the call for liberalized visiting, ICU visiting time is also restricted at KwaZulu-Natal in the city of Durban where the researcher was working. Visiting times were restricted to immediate family and only two members at a time.

Visitors were allowed between 3:00pm and 6:00pm, and again between 7:15pm and 8:00pm.visiting duration totals 1 hour and 45 minutes in 24 hours The researcher was then motivated to explore perceptions and preferences of patients, nurses and family on visiting time in ICU at KwaZulu –Natal Private hospital in 2007. The aim of the study was to recommend mechanisms with regard to the desired visiting schedule that would enhance patient-centered integrated care in ICUs. The study was conducted in three adult ICUs (medical, surgical, and neuro/coronary).

The findings showed that majority of the patients (97 %) opted for changing visiting time. 50% of these patients were for extended visits, whilst the other half opted for frequent visits. Majority of family members / friends (54.59 %) preferred extended ICU visiting time as well. The family members expressed need to be able to provide physical comfort and emotional support. They also mentioned need to alleviate anxiety, and be kept informed about the patient's progress. These are some of the basic needs of patient and family centered care.

On the other hand, out of 43 nurses, 58.14% were dissatisfied with visiting time at KwaZulu – Natal Private Hospital while 41.86% were satisfied. The dissatisfaction arose from lack of control on the family because they were found at bed side at an awkward time. It was also difficult to control the number of people visiting because the time was not enough. From this study it really shows that there was significant number of patients, family/friends, and nurses who disagree with restricted visiting time.

The American College of Critical Care Medicine Task Force, (2010) also acknowledges the desire of families to play a larger role in decision making and underscores the benefits of family participation in rounds. It also states that although desirable, the practice is met with ambivalence. With this view, Santiago, (2010) noted that family members of patients in ICUs are not being invited to be present at bedside rounds at St. Michael's Hospital, Toronto, Ontario. This motivated her to conduct a self-administered survey of health care practitioners to ascertain their attitudes and perceptions toward family presence at bedside rounds. A significant difference was found among health care providers toward family presence at bedside rounds. Most of the experienced RNs (70%) expressed the greatest reservation. Then the researcher called upon additional research to explore reasons why health care providers, specifically experienced RNs,

express reservations regarding family presence at bedside rounds (Santiago, 2010). However the reasons for restricting visiting hours have already been answered by some researchers such as Gonzalez, (2004), Roland et al. (2001), and Berti et al. (2006). This study is relevant because it gives the views of health care providers such as RNs on family presence in ICU since this research will only concentrate on the views of patient's family members and friends. In addition, this study lacks the aspect of family or friends attitudes or perception towards strict visiting time in ICU.

Gonzalez et al. (2004), in another study also examined patients' preferences for family visiting in an ICU and CCU. It was conducted at Massachusetts General Hospital in USA. Sixty-two patients participated in a structured interview that assessed patients' preferences for visiting, stressors and benefits of visiting, and patients' perceived satisfaction with hospital guidelines for visiting. Gonzalez et al. (2004) clearly demonstrate in the paper that patients in both units rated visiting as a non-stressful experience because visitors offered reassurance, comfort and calming. Patients in the ICU valued the fact that visitors could assist them in interpreting the information provided by healthcare providers and that visitors could provide information to help nurses understand a patient's personality and coping style. These findings could also come up if the researcher also assessed the family and friends since everyone will be a patient at some point in his/her life span.

Similarly, Roland et al. (2001) surveyed 20 critically ill patients in a 15 bed combined medical ICU and Complex Care Medical Unit (CCU) at Veterans Affairs Hospital in New York, regarding their satisfaction with the flexible visiting policy. The study results showed that open visiting hours help to meet the family's needs and have positive effects on the patient. The survey also helped to discover that a more liberalized visiting policy not only improves customer relations and satisfaction, but also may decrease the length of the patient's hospital stay, (Roland et al., p. 10). Although the sample population in this study was small, it is a relevant study but it only concentrated on the views of patients.

2. 5 Summary of Literature Review

Visiting policy in ICU has been a much-debated topic for both critical care practitioners and family members internationally. Liberalization of visiting in ICU has been advocated by most

descriptive studies, (Kleinpell, 2008). However Review of existing literature pertaining to visiting in the ICU demonstrates that visiting practices still vary widely and controversy and speculation continue over the ideal visiting practices in the adult ICU (Berwick & Kotagal, 2004). ICU visiting hours at QECH slightly defers with other local tertiary hospitals and intemationally. This supports the fact that visiting hours vary depending on the hospital policies.

The review has shown that most of intemational studies have covered health workers reluctance to remove restrictions, extend or increase frequency of ICU visiting hours. The international studies, and Ramnath, (2007) have also shown that family/friends prefer an extended and more flexible ICU visiting hour. It is also clear that the patients have the right to guardian who are mostly the family members or friends.

Finally the literature review shows that there is only one related study done in Africa and no studies have been conducted in Malawi related to the topic under study.

CHAPTER THREE

3.0 THEORETICAL FRAMEWORK

3.1 Introduction

A theory is a set of systematically interrelated concepts or hypothesis that seeks to explain or predict phenomena. According to Burns and Groves, (2007) a theoretical framework explains phenomena of interest, expresses assumptions, and reflects a philosophical stance. The theoretical framework that was used to guide this study was the General Systems Theory. Biologist Ludwig Von Bertalanffy originally proposed the theory in 1928. The chapter discusses a brief description of the General Systems theory and its application to the study.

3.2 Description of the General Systems theory

A system is a set of interrelated and interdependent parts arranged in a manner that produces a unified whole (Robbins & Coulter, 2009). The parts rely on one another, they are interrelated, share a common purpose, and together form a whole (Potter & Perry, 2005). The whole is greater than sum of its parts. Wellness exists when all the parts interacts in harmony. This meant that when one part of the system is affected all the other parts are also affected (Craven, (2009); Potter & Perry, (2005); Booyens, (2008). A system has also a specific purpose or goal. It uses its processes to achieve that goal. According to Craven, (2009) the Systems theory looks at the interaction of the parts that make up the whole.

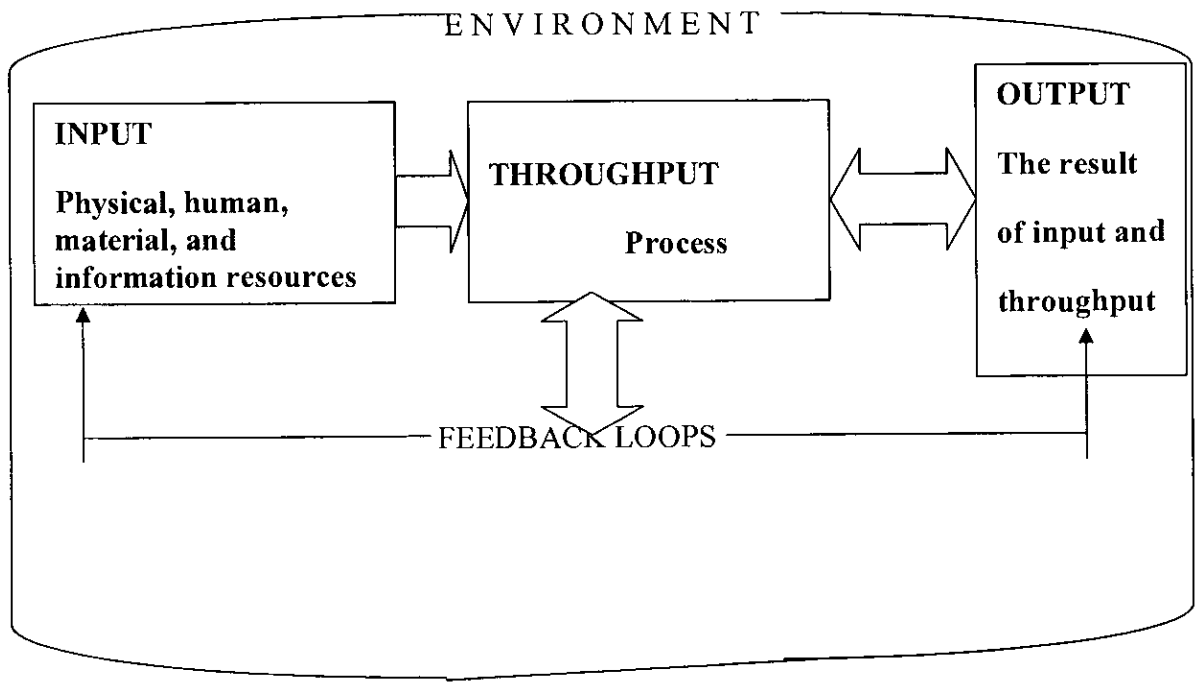
Allender and Spradlley, (2006); Craven and Hirnle, (2009); Booyens, (2008); Potter and Perry, (2005); Robbins and Coulter, (2009), state that every system is composed of inputs, throughput and output. According to Booyens, (2001) input is the energizer and operating material of the system. It includes physical, human, material and information resources. Throughput pertains to the process by which the system utilizes the inputs and converts them into products and services. The end product is the product (Booyens, 2008).

When the system is under stress, it tries to regulate itself by use of feedback loops. Feedback involves the means of communicating errors in the system and the need for collection. This is

based on the measurement of the outputs in terms of specific criteria. This response restores the system's balance, or homeostasis (Potter & Perry, 2005)..

Potter and Perry, (2005) also state that systems can either be open or closed. An open system interacts with its environment. Factors that change their environment can also have an impact on the system. A closed system does not interact with the environment. An example of a closed system is a chemical reaction occurring under specific conditions

Figure 1: Diagrammatic Presentation of the General Systems Theory Health Belief model (Adapted from Booyens, 2001:123)

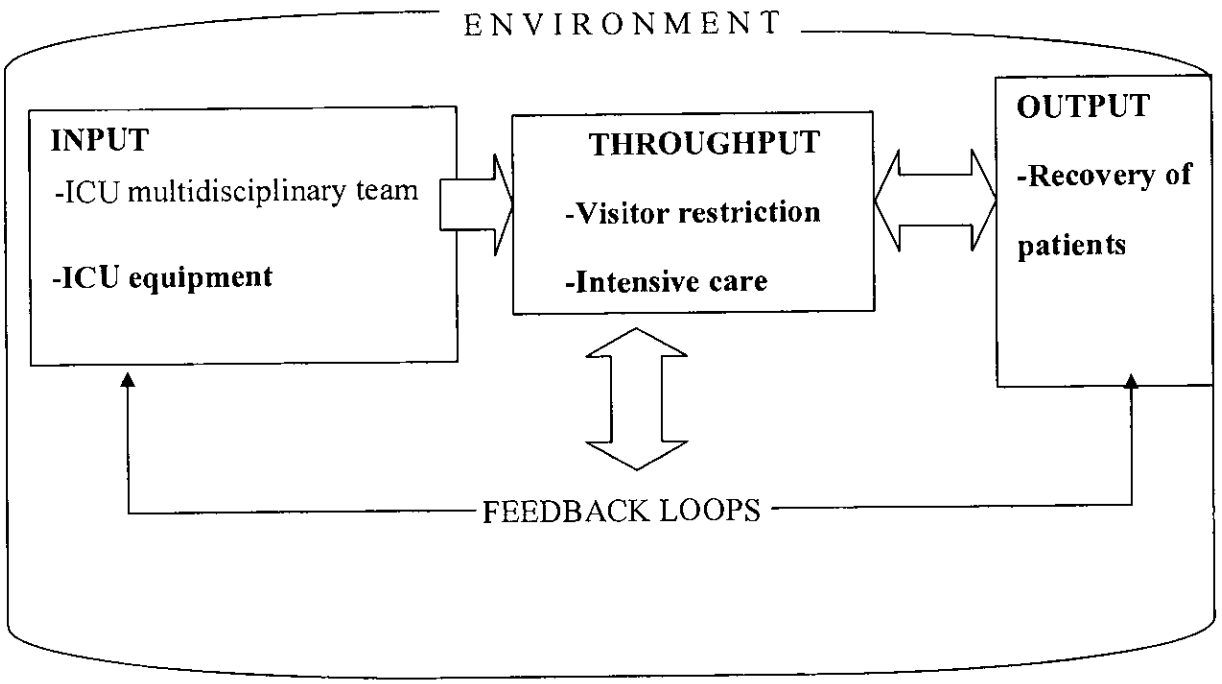


3.3 Application of the General Systems Theory to the study

The referral hospital also operates in an open system because it allows interaction with the external environment to achieve total health of all the people. The General systems theory is being applied to understand the reason for instituting visiting time in ICU.

A critically ill person needs intensive care to recover. As a result, there is need for inputs such as specialist physicians and nurses. A special ward such as an ICU is also required with all required equipment. Examples of such equipments include bulky monitors, resuscitators, and ventilators. All these inputs operate using various means in an attempt to help the patient attain optimal health. The multidisciplinary health care team, for instance, restricts visitors at some point to provide comprehensive intensive care. The patient's family and friends need to abide to visitor restriction. However, a person as a psychosocial being requires love, and sense of belonging. Such needs sometimes can only be achieved when the family and significant others such as friends are present. According to the General Systems Theory, when one part is affected the other parts are also affected, so as the whole. It is only through feedback to the inputs and the processes used to keep the system in harmony. The family and friends need to be encouraged to verbalize their views towards the health care providers' actions and all processes used which might have positive impact towards the health of intensive care patients.

Figure 2 Modified Diagram of the Systems Model as Applied to The study.



CHAPTER 4

4.0 METHODOLOGY

4.1 Introduction

Research methodology refers to the steps, procedures, and strategies employed for collecting, organizing, and analyzing data (Henning et al, 2004). This section gives an overall plan for all procedures and activities that were followed to achieve the research objectives. Included in this chapter is the description of the research design, plan of data collection, ethical consideration, data analysis methods, study limitations, dissemination of the findings, timeframe, and research budget.

4.2 Research Design

The study adopted a qualitative study design. According to Burns & Grove, (2007), a qualitative design should be used where little is known to the group of people being studied because it is descriptive in nature. Therefore, the design was used because there was need to explore the respondents' knowledge, and perceptions. In addition, there is no related research study, which has been conducted in Malawi.

4.3 Plan of Data Collection

Data collection is a systematic way of gathering information relevant for the research purposes, (Burns & Grove, (2007). This section gives an overview of how the researcher planned to come up with valid data. It involved selection of study setting, population, sample size, sampling methods, data collection method, data collection instrument, and pilot study.

4.3.1 Study Setting

The study was conducted at QECH in Blantyre district. This hospital was chosen because it has a well developed ICU. The other reason was the incident that occurred at Mwanza District Hospital whereby family and friends of patients protested against visiting time in 2009. Therefore, QECH was found to be a good setting because it is a referral hospital for other six districts in southern region of Malawi including Mwanza.

4.3.2 Study Population

Study Population is the target population that includes all individuals who have common specific characteristics, (Burns & Grove, 2005). The target population in this study was the family/friends of patients admitted in ICU at QECH. These people are mostly found at the visitors waiting area before ICU opens the doors for visitors. The study was targeting any family member or friend of ICU patients aged 18 and above. People within this age group are considered as adults who can comprehend according to the constitution of Malawi. In addition, every respondent was required to give an informed consent individually, having understood a brief explanation of the study.

4.3.3 Sampling Method

Sampling method is the process of selecting a portion of respondents who represent the population being studied, (Burns & Grove, (2007). The selected elements are referred to as a sample (De Vos, 2000). The respondents were selected amongst the family/friends of patients admitted in ICU using a simple random sampling, as long as they met the criteria. Bordens & Abbott, (2008); Burns & Grove, (2007), state that simple random sampling is a good method because every member of the largest population has a probability higher than zero of being selected.

4.3.4 Sample Size

The sample size was ten participants. According to Sandilowiski, (1998), this sample size is viewed as adequate in qualitative study because it allows in-depth analysis of each respondent and permits maximum understanding. Furthermore, it is very feasible to finish the research in time considering limited resources and time for data collection, data analysis and report writing.

4.3.5 Data Collection Method

A face to face interview was used because it provides an opportunity for greater latitude

in the answers provided (Speziale & Carpenter, 2003). Interviews were conducted in vernacular language (Chichewa), in order to allow participants express themselves without being limited by the language. Data collection was done in two days.

4.3.6 Data Collection Instrument

The study used a semi-structured interview guide. Schneider, (2007), pointed out that a semi-structured interview guide uses both open and close questions to guide the interview. Probing questions were used where the participant did not understand the question, to get real responses. The first part of interview guide contained demographic data followed by other sections whereby each objective was addressed separately.

4.3.7 Pilot Study

The interview guide was tested at Zomba Central Hospital (ZCH) before the actual data collection. ZCH was chosen because it is also a referral hospital in Malawi. The design of the ICU at ZCH is quite similar with the ICU at QECH because it has also four beds, bulky monitoring equipment, ventilators and resuscitators occupying large space. Visiting hours in ICU at ZCH are also similar to those at QECH. The researcher also considered the site as more convenient comparing with other referral hospitals with similar characteristics to QECH due to limited time and financial constraints.

The pilot study helped to examine validity, reliability and feasibility of the interview guide. The validity of an instrument is the determination of how well the instrument reflects the abstract concept being examined (Burns & Grove, (2007). On the other hand, reliability of data collection instrument is concerned with the consistency and accuracy of instrument, (De Vos, 2000). Three family/friends of patients admitted in ICU were recruited for the pilot. Necessary amendments were made on the interview guide prior to the actual data collection at QECH.

4.4 Data Analysis Methods

The data was analyzed using in-depth content analysis to summarize qualitative data. Content analysis involved coding, categorization and summarization of verbal data. The method was

adopted because it provides a systematic means of measuring the frequency, order, or intensity of occurrence of words, phrases or sentences, (Burns & Grove, 2007).

4.5Ethical Considerations

Ethics is an area of philosophic study that examines values, actions, and choices to determine right and wrong, (Catalano, 2003). It was the responsibility of the researcher to observe a number of rights pertaining to the research participants. Right to full disclosure was met by introducing the researcher fully before explaining the study. Contact number for the researcher was provided to some respondents who needed clarification and feedback on research findigs.

According to Polit & Beck, (2006) potential respondents are likely to make thoughtful decision regarding participation in the study only if they are fully informed of the nature of the study, their role, potential risks, purpose and benefits to be incurred. The right to information was embraced by explaining the nature and purpose of the study, the participant's role in the study, as well as benefits.

The participants were also informed of some of the ethical considerations to be observed such as right to privacy and confidentiality. Anonymity occurs when even the researcher cannot link the participants with any information (Polit & Beck, 2006). This was achieved by using code numbers instead of names. The interview guides were also locked so that they were only accessible to the researcher and the supervisor.

There was also no violation of the right to access services in any way. This meant that the participants and their sick relatives or friends were not and will not be denied any hospital service because of taking part in this study.

The other right observed was the right to self respect and dignity. The researcher ensured that the views of the respondents were respected. Personal space during interviews was also observed to ensure that all the participants are free to talk.

Furthermore, the participants' right as autonomous beings was considered. According to Pera & Tonder, (2005) autonomy, as a right to self-determination, must be respected in health research. Individuals have the freedom to conduct their lives without external control, coercion, or

exploitation, especially when they are asked to participate in a research. To observe the right to self determination the participants were informed of their right to refuse to participate or to withdraw from the study at any stage they decided without prejudice. The respondents were asked to give an informed consent by signing the consent form upon accepting to participate in the study.

Finally, to ensure that the research proposal had met all ethical considerations, clearance to conduct the study was sought from Kamuzu College of Nursing Research and Publications Committee. The permission was also requested from the Hospital director for QECH after the approval of the proposal.

4.6 Dissemination of the Findings

In utilizing the findings, copies of a written research report will be made available at QECH. Another copy will also be submitted to Kamuzu College of Nursing Library, and Research committee.

3.7 Table 1: Timeframe

ACTIVITY.	FEB.	MAR.	APRIL.	MAY.	JUN.	JUL.	AUG.	SEPT.	OCT.	NOV.
Justification of the study										
Literature review										
Proposal writing										
Submission and Clearance of Research proposal.										
Preparation of data collection Instruments.										
Pre-testing of the interview Guide										
Reconstruction of interview Guide										
Data collection										
Data entry										
Data analysis										
Report writing.										
Submission of dissertation.										
Dissemination of findings.										

4.8 Table 2: Research Budget.

Item.	Quantity	Cost in Kwacha.
Flash Diskette @ K3, 500 (2 GB.).	1	3, 500. 00
Ream of papers @ K750 each.	2	1, 500. 00
Pens @ K25 each.	4	100. 00
Internet Access.		1, 500. 00
Printing and Binding proposals @ K650 each.	3	1, 950. 00
Folder files @ K200 each.	3	600. 00
Two return trips (from Lilongwe to Blantyre and from Lilongwe to Zomba) @ K3000 each.		6, 000. 00
Printing, photocopying and binding Research dissertation @ K1,000 each.	4	4, 000. 00
Large envelops @ K20 each.	4	80. 00
10% Contingency		1,923. 00

GRAND TOTAL: K21, 153.00

4.8.1 Budget Justification

The above budget gives a number of expenses that were proposed to cover the costs.

4.8.2 Stationery

Expenses for draft work of the proposal, dissertation and interview guide were covered as part of stationery. The stationery includes reams of plain papers, envelops, pens, photocopying papers

and files for keeping information during data collection.

4.8.3 Printing, Binding, and Internet

The amount covered printing and binding as well as photocopying research proposal and dissertation. Internet services have also been included in this category for sourcing information and communicating with the supervisor.

4.8.4 Transport

The money was used to cover traveling expenses during pre-testing to and from Zomba and for data collection to and from Blantyre.

4.8.5 Contingency

Ten percent of the total cost was used for inconveniences that arose during the study. For instance the researcher had to make extra three trips to QECH during the process of getting permission.

CHAPTER 5

5.0 PRESENTATION OF THE FINDINGS

5.1 Introduction

This chapter presents the results of the study, whose purpose was to explore the knowledge and perceptions of the family or friends towards visiting time in the ICU at Q.E.C.H. The section gives an in-depth analysis of each participant's qualitative data. Therefore, it only fielded a range of qualitative data from ten participant (n=10) which was feasible because of limited resources and time for data collection. The presentation of the findings focus on demographic information, knowledge on the importance of restricting visitors, family/friends' perception towards visiting time in the ICU at Q.EC.H, challenges faced by family/friends, and family/friends' suggestions on visiting time practices in ICU. Frequency tables, pie charts and bar graphs have been used to present the findings.

5.2Demographic Data

Information collected in this section concerns the basic personal data such as relationship with the patient, sex, age, residence, religious denomination, education level, and occupation. It was necessary to measure these variables because they play a significant role in understanding the respondent background and their role in the family and society, including source of the patients support system.

5.2.1 Item 1.1: Relationship with the Patient

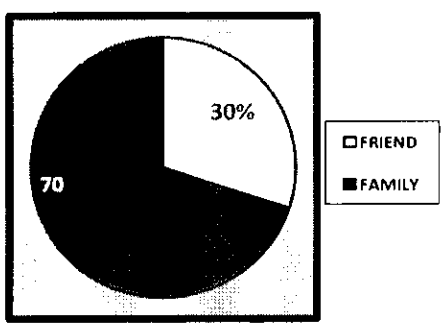


Figure 1.1: Respondents Relationship with the ICU patient.

Of the ten respondents, 70% (n=7) were family members and only (n=3) were friends. This shows that majority of the participants were family members.

5.2.2 Item 2.2: Respondents Sex

Sex	N	Percentage
Females	7	70%
Males	3	30%
Total	10	100%

Table 1: Respondents Sex

Of respondents, 70% (n=7) were females and 30% (n=3) were males. This shows that both sex take part in ICU patient visitation. However majority of the visitors were females.

5.2.3 Item 2.3: Respondents' Age

Of the respondents, 10% (n=1) was a young adult within the age range of 18-25, with the highest 40% (n=4) falling within the range of 26-35 years as shown in the bar graph below;

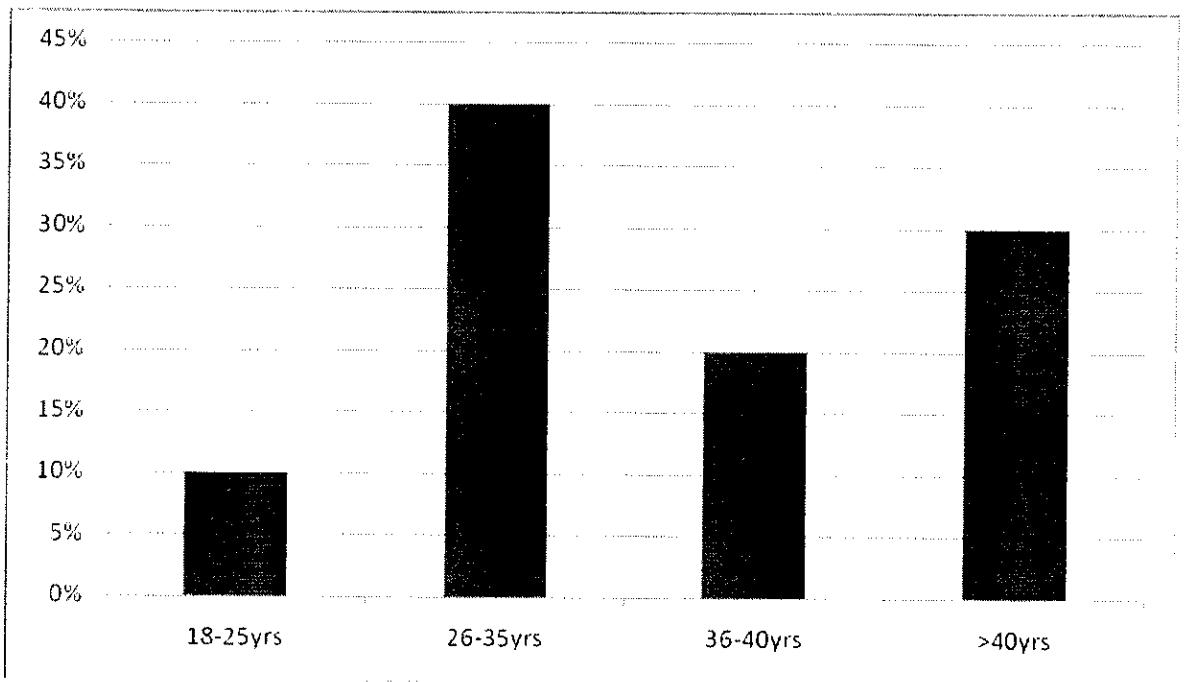


Fig 2.2: Respondents'Age

This shows that majority of the family/friends were young adults who are responsible in

supporting patients at this critical period.

5.2.4 Item 2.4: Respondents' Residence

Of the respondents, 40% (n=4) were residing within Blantyre City; 20% (n=2) reported that they were coming from Machinga district; 20% (n=2) were from Thyolo district, 10% (n=1) from Mwanza district and the other 10% from Mzimba district as shown in the doughnut chart below:

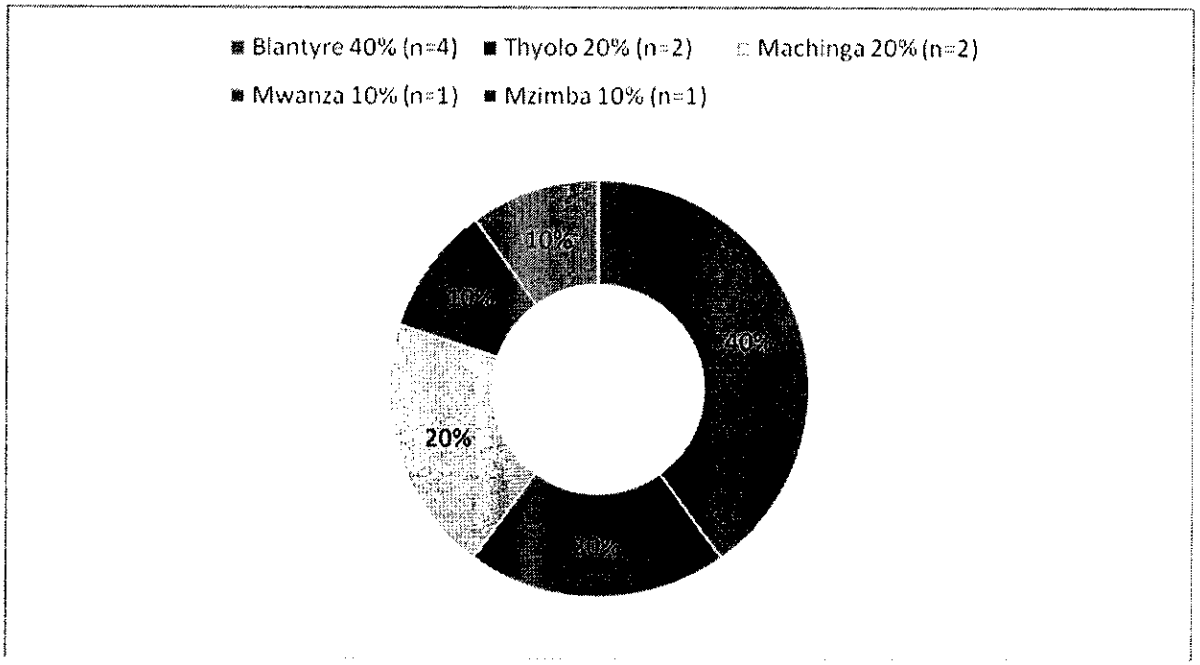


Fig 3: Respondents residence.

This representation shows that majority of the participants (60%) were residing outside Blantyre City where QECH is allocated. Therefore, they are to be negatively affected restrictions on visiting time because of the distance to the hospital.

5.2.5 Item 2.5: Respondents Religious Denomination

All the respondents were believers affiliated to a religious denomination with 40% (n=4) being affiliated to CCAP; 20% (n=2) belonging to Roman Catholic; 20% (n=2) were belonging to Evangelical Church of Malawi (ECOM); 10% (n=1) for Jehovah' Witness and 10% (n=1) belonged to Islam.

Religious denomination	N	Percentage
CCAP	4	40%
Roman Catholic	2	20%
ECOM	2	20%
Jehovah' Witness	1	10%
Islam	1	10%
Total	10	100%

Table 2: Respondents' religious affiliation

5.2.6 Item 2.6: Respondents educational level

Education level	N	Percentage
None	1	10%
Primary 1-4	1	10 %
1-8	1	10 %
JCE	1	10%
MSCE	1	10%
Tertiary Certificate	3	30%
Diploma	2	20%
Total	10	100%

Table 3: Respondents' education level

Of the respondents 90% (n=9) attended formal education and only 10% (n=1) did not attend any school. Amongst the respondents who attended formal education 20% (n=2) had a diploma, 30%

(n= 3) had a Tertiary Certificate, 10% (n=1) had MSCE, 10% (n=1) had JCE, 10% (n=1) attained standard 5-8, 10% (n=1) did not reach Standard 5. This indicates that majority attended formal education and might be able to read, understand and analyze visiting time policy.

5.2.7 Item 2.7: Respondents Occupation

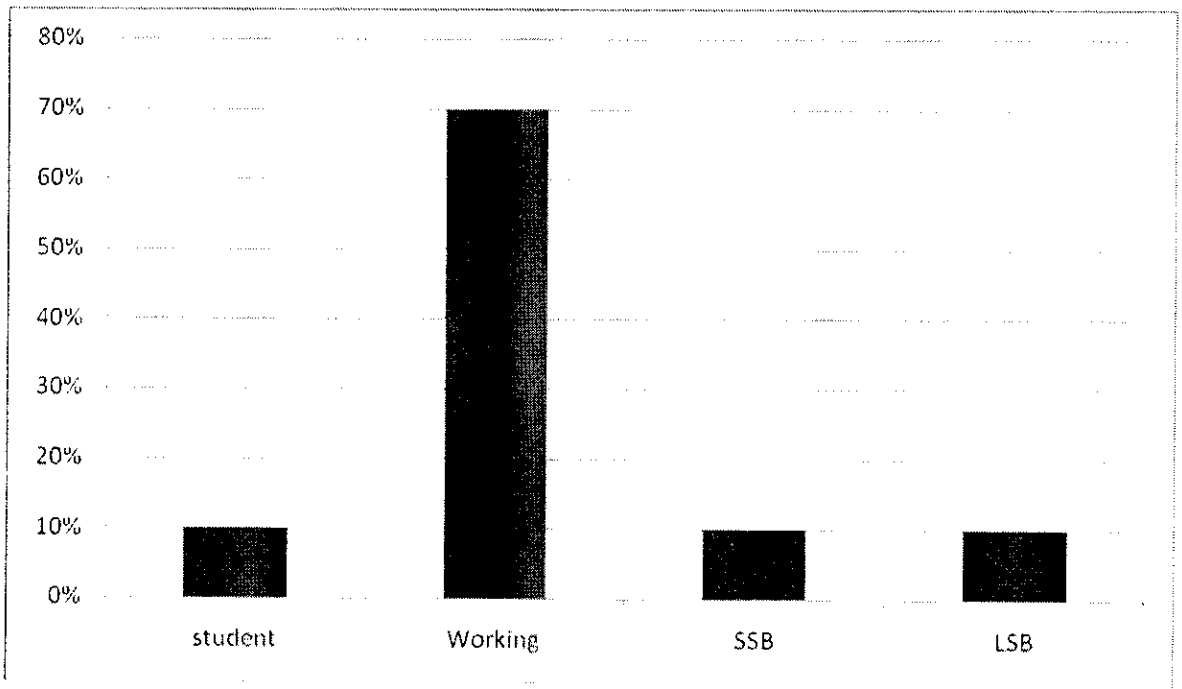


fig 4: Respondents occupation

The responses show that seven participants were employed, one participant was a student, another respondent was doing a small scale business (SSB) and the other one was doing a Large scale business (LSB) as shown in bar graph above. This shows that majority (90%) had a source of income to support themselves and the sick relative or friend. It also entails that the majority were always engaged in various work or business activities despite sacrificing their time to visit the patient.

5.3 Number of visits in ICU

This section was aimed at assessing the respondents' familiarisation to visiting time in ICU. It was found that 80% (n=8) had never had a patient before and that was a second time for the remaining 20% (n=2).

However majority (60%) had chance to enter into ICU to see the patient except four (40%) who were yet to experience ICU environment. Of the majority, three participants reported that they spent almost five minutes inside and they left because there were many people waiting outside to enter as well.

The other two participants said that they were told that time was up for visiting clients. They reported that they felt very unconsidered. One of these participants said, *"I felt very unconsidered because I had come from a far district and I had many questions to ask staff about the illness."*

The last participant said that the least time spent was a minute because one of the patients died so she followed directives from the nurse to move out of the ICU. The participant was convinced so he moved out.

The findings show that majority had experienced visitation of a critically ill patient in the ICU. However, they were very limited because of strict observation and control of visiting time in ICU due to various reasons.

5.4 Family/ friends' Reasons for Visiting a Patient in ICU.

The findings on family/friends reasons for visiting a patient were aimed at assessing knowledge on the importance of visiting a critically ill patient in ICU. The findings would also help to determine how visitor restriction would compromise the perceived benefits both to the patient and the family/friends.

The study collected different views of family/friends on reasons for visiting patient in ICU. Of the respondents, four representing 40% said that they come to observe the care being rendered. Two of these participants reported that it was necessary to observe the care so that they should appreciate the efforts of the ICU staff despite poor prognosis. The other two reported that they come to learn provision of care so that they should be able to support the client at home. They also said that visitors provide information related to the illness which helps in diagnosing and treating the illness.

The other reason reported was to assist in provision of spiritual and emotional care. This response came from three participants representing 30% of all the participants.

Two other respondents said that they come on behalf of other family members or friends so that they should be able to apdate them with the right information.

In addition, one respondent recognized the duty to make decisions for the critically ill patients. The respondent said the following statement;

> *We come to make decisions for the patient who cannot speak because of various medical or surgical conditions. For example I can speak on behalf of the patient not to have blood transfusion because it is against our religious beliefs and values.*

One other respondent said that visitors come just to be closer to the loved ones. The respondent further stated that when visitors are around the dying patients have a sense of belonging so they face a peaceful death.

The findings from this question show that every visitor has a reason for visiting the patients. These reasons are beneficial in a particular way to the family/friends, patients and as well as the ICU staff as a system.

5.5 Family/friends' Awareness of Current Visiting Hours in ICU.

Only 10% (n=1) did not know about current visiting hours in ICU but 90% (n=9) were aware. The following statement summarises respondents` knowledge about visiting hours in ICU;

> *Visiting time scheduled for ICU is 30 minutes. In the morning it starts from 6.00pm to 6.30pm. In the afternoon it is from 12.00pm to 12.30pm.*

This shows that majority (90%) were conversant with visiting hours in ICU at QECH.

5.5.1 Sources of Information reported in item 5.5 above.

The respondents were asked on where they got information on visiting time in ICU. Five respondents (50%) said that they were told by the nurses and hospital guards. Two respondents (20%) got information from other family members and friends and the other two (20%) reported

that they read on notifications placed on entrance walls to ICU as well as from hospital guards and nurses.

5.5.2 Family/friends' Views on the Current Visiting Time in ICU at QECH

The aim of this item was to assess the perception of the family/friends towards visiting time in ICU. The respondents expressed different views on the current visiting time in ICU.

For instance, four participants (40%) viewed visiting time as the only opportunity for the visitors to be with the patient, express love and caring as well as sharing information about the patient illness with staff working in ICU. As such, visitors perceived visiting time as too short that it does not allow them to meet their reasons for visitation. The study collected the following statements on this view;

> *This is the only time to express love and caring towards the patient yet the time for visiting is too short.*
>
> *Visiting time offers us an opportunity to see and talk to a loved one.*
>
> *We learn more about the patient` illness and the progress of care. It is an opportunity to give some information which is beneficial for doctors' assessment.*

The other three participants (30%) said that visiting time is very stressful because they come into contact with a relative or a friend whose prognosis is very uncertain as a result the short period is not sufficient to prepare them psychologically. Visiting time also led to congestion in the corridors as such they receive psychological torture from hospital guards as they try to control the traffic flow. On the same point, one respondent said, *"there is too much congestion in the corridors. Every visitor wants to enter. This is so because the time is too short."*

Two other participants observed that the staff was very strict with visiting time as compared to general wards which could deny some visitors opportunity to enter.

The findings on this item show that all the visitors were not happy with visiting time and strict observation of visiting time by the staff.

5.6 Respondents knowledge on the importance of restricting visitors in ICU

Information collected on this section was mainly aimed at exploring family/friends' knowledge on importance of visitor restriction in ICU. Of the respondents, seven (70%) said that they knew the importance of restricting visitors in ICU. The following were some of statements given by the participants;

> *It allows nurses, and medical doctors to provide critical care and assess patients without interruption from family members or friends.*
>
> *Visitor restriction helps to minimise transmission of infections from patients to visitors or vice versa.*
>
> *Visitor restriction enables the patient to rest.*

Two other participants said that some visitors are easily stressed up that they even faint upon seeing a very sick patient so visiting restriction helps to avoid such risk.

The remaining three subjects, representing (30%), responded that they did not know the importance of restricting visitors in ICU. This shows that majority knew the importance of restricting visiting hours.

5.7 Challenges Encountered by Family Members or Friends due to Current Visiting Time in ICU at QECH.

Nine respondents (90%) were able to point out challenges they face with the current visiting time in ICU. Of these, two respondents said that 30minutes period was not enough for a number of visitors who came to visit a patient in ICU. As a result, some visitors are denied chance to be with their loved ones including at the time of death.

Six respondents considered the long distance and expenses to travel to and from the hospital that they don't come on time to visit the patient;

> *Many people walk from a long distance spending money and time only to be told that the time for visiting is up or you should wait for 5.30 pm when the time is just 2.00pm. Some people miss busses to their location hence we reach home very late.*

The other two respondents also said that the scheduled visiting time is inconvenient to their work and other important business;

Visiting time scheduled is inconvenient to most of us because we have to report on duty in time. Let's think of 7.00am to 7.30am, this is the time we report on duty and for us to seek permission it is not possible to meet the visiting time. We end up being stressed up.

Our businesses cease to run during this painful period when our relative is sick. We use the same little things we get for transport and to support the patients yet when we come we are kept waiting for long hours.

One respondent also pointed out that the ICU staff do not observe the scheduled time sometimes. The respondent said, "the staff kept saying that the room is busy. For example one time they told me that they were doing a doctors round at lunch time. To my understanding ward rounds are routine activities and should be set at a time which can not disturb visiting time."

On contrary, one respondent representing (10%) supported the current visiting time so the statement was as follows;

I don't see any problem with the current visiting time. After all, am used to it and there is no hope that it can change. I believe that the policy makers have very important reasons for the benefits of the patients.

From the findings, it shows that most of the visitors were facing challenges with the current visiting time in ICU at QECH.

5.8 Family/friends' Suggestions on visiting time in ICU

In this section one participant, representing 10%, did not give any suggestion.

One other respondent also representing (10%) said that visiting time and practices in ICU should remain the same because he knew the importance of restricting visiting hours. The respondent further stated, *'' as a family member I am getting used to current visiting hours. I just have to manage my time well. ''*

On the contrary, five respondents (50%) indicated that thirty minutes at every visiting hour is not enough so it should be extended. Some suggested one or two hours so that many family members should not miss it. The following statements express the suggested idea;

> *Visiting time should be extended to one hour at every visiting hour so that it should be from 7.00am to 8.00pm, 12.00noon to 1.00pm and from 5.00pm to 6.00pm.*
>
> *Visiting time should be increased to two hours at each interval but the staff should continue controlling visitors to minimize patient care interruption and infection prevention.*
>
> *Thirty minutes is not enough. Think of traffic jam along the Highway road. We can't make it.*

Other two respondents (20%) suggested increasing both the number of people and the length of time allowed in ICU. The aim was to give a number of visitors an opportunity to visit the patient. They also said that the staff should be considering those coming for the first time as well us people residing away from Blantyre city.

Another respondent opted for free and open visiting practices.

This shows that majority of visitors (80%) suggested for a change of which 50% opted for extending visiting time.

CHAPTER SIX

6.0 DISCUSSION OF RESEARCH FINDINGS

6.1 Introduction

This chapter presents a discussion of the findings of the study. The discussion will be based on the findings which aimed at exploring knowledge and perception of family/friends towards visiting time in ICU at QECH. The chapter also covers recommendations and limitations of the study.

6.2 Demographic Data

Information covered on this item includes the relationship with the patient, sex, age, residence, religious denomination, education level, and occupation. It was necessary to measure these variables because they play a significant role in understanding the respondent background and the possible significant role of others in their lives, including source of their support system.

6.2.1 Item 2.1: Relationship with the client

The study found that majority of the participants were family members. According to Sorrentino, (2005), the family is much affected with critical illness. In addition, direct family members are the ones much closure to the patient, and can give required information and good care.

On the other hand, three participants representing 30% were just friends. This shows that the ICU visiting policy at QECH is not limited to immediate family members only unlike with other ICUs in African or international perspectives.

6.2.2 Item 2.2: Respondents Sex

Both females and males were recruited in the study although only three males (30%) were captured within two days of data collection. This shows that any sex is involved in the care of critically ill clients. However, the results gave a picture that patients are mostly visited by female family members or friends. This is also congruent to an assumption that females are the ones who take very good care of the whole family as a system.

6.2.3 Item 2.3: Participants' Age

The findings revealed that all the age ranges were represented by at least one respondent. According to the general systems theory, when one member of a family or a society is affected all the other members are also affected (Craven, (2009); Potter & Perry, (2005); Booyens, (2008). This meant that every person, including the youth, is concerned with a relative/friends' critical illness and they have a role to play in provision of care. However, it was noted that most of the visitors who were very responsible to come to ICU were young adults within the age range of 25- 35. There was also a good representation for above 35 years.

6.2.4 Item 2.4: Respondents Residence

The study indicates that the majority of respondents (60%) were residing outside Blantyre. This was the case because QECH is a tertiary hospital and most of critical conditions are referrals from distant districts. In the sample some respondents came from Thyolo, Mwanza, Machinga and Mzimba districts. Ramnath, (2007) also found that most of the patients and family members travel far distances and this might contributed to transport problems. As such it was very predictable that some could not meet visiting time. It was also very inconsiderate to let these people return home without achieving their goals for visiting a patient in ICU.

6.2.5 Item 2.5: Religious Denomination

The demographic data also revealed that all participants were affiliated to a religious denomination. This indicates that all the respondents were believers with different ideologies and values which could also affect the respondents' perception towards hospital policies and practices such as visiting time in ICU.

6.2.6 Item 2.6: Education Level

The findings have shown that majority of the participants attended formal education expect one. This makes both verbal and written communication easier. Some family members and friends (60%) even went as far as MSCE and Tertiary education. This implies that these participants were able to understand and critically analyze hospital policies and patient care. Despite the fact that majority were able to lead, very few reported that they got information from written

notifications. This might entail that means that some visitors ignored such written notifications. Therefore, it is recommendable that the hospital staff should continue orienting visitors on visiting time verbally in a polite way.

6.2.7 Item 2.7: Occupation

The study found that the majority of respondents (70%) were employed and the rest were also engaged in business and school as shown in figure 4. This result shows that strict observation of visiting time could interfere with their occupation. For example most of the employees have to report on duty and seek permission at 7.30am which is the exact time that morning visiting time ends as a result they miss the time and have to wait for hours to be let in at the next visiting hour. On the other hand, visitors were supposed to manage their time well to be at the hospital on time.

6.3 Number of Visits in ICU

The results showed that it was the first time for most of the interviewees (80%) to have a patient in ICU although some patients were in ICU for three days. The least time spent in ICU for the some respondents was a minute. The rationale given to allow privacy for preparation of the dead person was acceptable. The other participants were told that time was up for visiting so it was not convincing because they had come from a far districts. All in all, most of the participants had an opportunity to experience visiting a patient in ICU for at least five minutes during their friend of relative' hospitalization.

6.4 Reasons for Visiting a Patient in ICU

The participants were able to give variety of reasons for visiting a patient in ICU. Majority described the visitation as an opportunity to observe and learn provision of care being rendered in ICU. This would help them to appreciate efforts of the staff and continue with the care at home respectively. This agrees with Horne and Cowan, (1996) who documented that visiting time gives an opportunity to keep the patient in touch with the outside world, which in turn makes the patient fit easier when discharged from hospital. Federwisch, (1998) also concurred by emphasizing on the need to allow family members to observe the therapy because with the cost containment in hospital care, the patients are discharged in a very dependent state.

The respondents also said that visitors especially immediate family members provide information related to the illness which helps in diagnosing and treating the illness. This is congruent to findings on benefits of visiting discovered by Gonzalez et al. (2004) in ICU and CCU at Massachusetts General Hospital in USA. Gonzalez et al. (2004) clearly demonstrated that patients in the ICU valued the fact that visitors could assist them in interpreting the information provided by healthcare providers and that visitors could provide information to help nurses understand a patient's personality and coping style.

Some of the participants justified their visit as of significance because they assist ICU staff in provision or physical, emotional and spiritual care to the clients. Ramnath, (2007) also identifies spiritual and emotional support as some of the basic needs of patient and family centred care that help to alleviate anxiety. The respondents' point of view is in line with the duty to create atmosphere where family members or friends are allowed to provide physical and emotional support so long as they have good skills and when it does not complicate the patient's condition. The findings also concur with those of Ramsey et al, (2000) and Berwick & Kotagal, (2004).

Furthermore, the respondents also highlighted that family members come to make decision for the critically ill patient, who is incapable because of the illness. According to Pera and Tonder, (2005), in nursing ethics there is an obligation to allow every person to make informed decision so long as they do not impinge on the rights of others. This falls under the ethical principle of autonomy which means self-determination. According to Davis, Tschudin and De Raeve, 2006), some individuals are limited to make such choices or actions because of they are children or mentally disturbed and they cannot comprehend. Unconscious patients are also considered as vulnerable, as such immediate family members can make decisions for them, hence, the need for the presence of family members in ICU. This was also depicted in a study conducted by Ramnath, (2007) on patients' preference for visitation in critical care units in USA. The study found that patients needed the family members to take over and make decisions for them when they could not comprehend. The findings have revealed that some family members identified the role of making decision as a reason for visiting patients which is recommendable.

Nursing has also an element of transcultural consideration with the diverse and universal cultural ideologies (Craven and Hinle, 2009). Some respondents were very anxious to see a

dying patient so that the patient should have a peaceful death. On the other hand, the family or friends also anticipate a positive grieving process. This is one of the aspects to be put into consideration when handling family or friends of critically ill patient. The whole purpose of intensive care is indeed to restore life but death should also be anticipated hence the need to meet the family needs in the dying process.

These findings show that every visitor has got a reason for coming to the hospital. Therefore, jeopardizing the opportunity to visit patient could deny patients/family needs. These needs are also beneficial to the overall care of an intensive care client.

6.5 Knowledge on the Current Visiting hours in ICU at QECH

The study revealed that the majority of the respondents (90%) were well conversant with the visiting hours scheduled for ICU at QECH. Despite the knowledge, not all the visitors abide by the current visiting hours. Infact a minority of the respondents was not aware of current visiting hour. Therefore regardless of a small percentage, health workers have a responsibility to give information and educate all clients, (Charter for Patients and Health Service Providers' Rights and Responsibilities, 2002).

6.5.1 Sources of Information

It was found that most of the visitors were oriented on visiting time practices by the nurses. This is good because clients have the right to receive information at the right time.

However, only a few respondents (20%) reported that they read from notifications posted on the entrance walls although the demographic data revealed that most of respondents attained a highest education level so much that they were able to read. This might mean that most of the patients' visitors ignore these notifications hence the need to be orienting the visitors verbally. On the other hand, the result might also imply that notifications were not visible enough to attract visitors' attention.

6.6 Family/friends Views on Visiting Time Practice

The findings on the perceptions of visitors on current visiting time revealed that most of the respondents were not happy with current visiting time Practice in ICU at QECH. Some described

it as a very stressful moment because they are not given enough time to talk and observe the patient care. To some respondents, visiting time led to congestion in the corridors as a result they receive psychological torture from hospital guards who often use embarrassing and intimidating words as they try to control traffic flow.

Ramnath, (2007) discovered that keeping family physically away from patients implies that they are a problem. This is in line with views of some of the respondents who said that they were subjected to very strict policies which did not consider the visitors as part of the patient's system.

6.7 Respondents knowledge on the importance of restricting visitors in ICU

The study has discovered that the respondents have some knowledge on the importance of restricting visitors in ICU. The respondents expressed the importance of restricting visitors mainly to avoid interrupting staff and allowing patients to rest. This is similar to what led to strict ICU visitor restriction policies in USA by the year 2004. According to Berwick and Kotagal, (2004), the Institute for Healthcare Improvement (IHI) challenged a number of hospitals working on improvement of care to open their ICUs by instituting a totally unrestricted visiting policy. It was discovered that nurses and physicians refuted the call on three worries. The first worry was on increased physiologic stress for the patient. Secondly, it was the interference with the provision of care. Finally the fear was on physical and mental exhaustion of family and friends. In a similar survey, Melissa et al, (2007), also discovered that the nursing staff were concerned with limited space because of the bulky equipment and need for continuous ministrations.

The study also found that the majority of the respondents were able to understand visitor restriction as one way of preventing infection transmission from patients to visitors or vice versa. Sims and Miracle, (2006) documented that restricting visiting time minimizes infection transmission because it reduces congestion. In addition, visitors may not be more knowledgeable and skilled in infection prevention.

Much as the knowledge is appreciated, there is a lot on importance of restricting visitors in the ICU which did not come up from the respondents. For instance, Merenstein and Gardener, (2006), stated that restricting visitors in ICU holds a chance of avoiding breach of privacy and confidentiality of patients. According to Catalano, (2004), right to privacy and confidentiality are

fundamental rights of each individual. Privacy is a state in which one is not observed or disturbed by others. It is also defined as freedom from public attention. On the other hand, confidentiality implies to keeping a secret or respecting privileged information. This is the reason some institutions emphasize strict visiting hours mainly during ward rounds where the care providers often discuss confidential issues regarding the patient progress. In regards to this, it is recommendable that the healthcare team in ICU and hospital policy makers should initiate in-depth informative and educative activities for family/friends on importance of visitor restriction. The few respondents (30%) who were not aware of the importance might also represent a large population if the sample size is to be increased so they can also benefit from such education.

6.8 Challenges Encountered by Family Members or Friends due to Current Visiting Time in ICU at QECH.

The study found that majority of the visitors were facing challenges with the current visiting time. The first challenge was on the time factor that 30 minutes was a very short period to cater for a number of visitors. These visitors also come from far distance since QECH is a referral hospital so they could not meet visiting hours because of transport contingencies such as traffic jam.

The other problem was that the scheduled time was causing inconveniencies with the visitors work and other personal business. The visitors are also physical, psychological and social beings with responsibilities at work and homes. For instance, majority of the respondents were employed so some had to request for permission from their bosses. This meant that they could not meet the exact time for morning hours. The respondents were also forced to return home late because when they missed morning visiting hour then they had to come at lunch or wait for 5:00pm when they came after afternoon visiting hour.

Respondents also reported that the ICU staff were not observing the scheduled ICU visiting time at QECH. For instance, the respondents gave an example that ICU staff shift some of their routine activities such as ward round to lunch hour which is also visiting time. This was really seen as a challenge because it disturbed some of the visitors programmes. In spite of this, some of the ICU staff have a very huge workload that they also cover shortage in other departments.

As a result, they found it necessary to carry out ward rounds during lunch time. This entails that communication is very necessary so that no party should suffer. In addition, when there is no good reason for such inconveniences the ICU staff should always abide to the scheduled visiting time.

6.9 Family/friends' Suggestions on visiting time in ICU

The study found that almost all the respondents suggested for change. Majority of these participants opted for extending visiting time so that more visitors should be able to enter at each visiting hour. Others suggested increasing the number of people being allowed which was two people per patient for five minutes. Very few suggested free and open visiting practices. The aim was to give a number of visitors an opportunity to visit the patients. They also said that the staff should be considering those visitors coming for the first time as well us people residing away from Blantyre city.

Roland et al, (2001) discovered that flexible visiting hours in ICU at Veterans Affairs Hospital in new York helped to meet the family's needs and had positive effects on the patients health outcome. The survey also discovered that a more liberalized visiting policy not only improves customer relations and satisfaction, but also may decrease the length of hospital care. Patients and their family were viewed as customers because they are consumers of care.

6.10 Summary

This study aimed at exploring the knowledge and perceptions of the family/friends towards visiting time in ICU at QECH. The study found that most family members or friends have some knowledge of the importance of restricting visitors in ICU. However, despite the fact that much is known on importance of restricting visiting hours in ICU, the study has revealed that family and friends are not happy with current visiting time as a tool of restricting visitors. The main concern was on the actual period of thirty minutes, which they viewed as not enough for all the visitors. Suggestions given especially on extending visiting time to an hour also sounds good as long as the ICU staff remain in control off traffic flow.

6.11 Limitations

The study required an in-depth analysis of qualitative data so it only managed to collect data from ten participants. It was not feasible to conduct a large scale study because the research was being conducted in partial fulfillment of the award of Bachelor of Science in Nursing which offered very limited time and other resources. Therefore, the findings can not reflect a true representation of the entire population.

6.12 Recommendations

Based on the findings of this study, the researcher makes the following recommendations;

- **Nursing Education**

Introduce and improve in-service training programmes including topics on patient and family centred care to nurses and support staff such as hospital guards.

- **Nursing practice**

The nurse practitioners should involve the family members/ friends when caring for their loved ones. The nurses should also continuously be orient family members/ friends on visiting hours. Family/ friends should also be educated on importance of restricting visitors in ICU to impart knowledge which may help visitors to perceive visitor restriction positively.

- **Nursing Management**

The study recommends that nursing managers at QECH and other hospitals should look into such suggestions and put mechanisms to examine if extending visiting time could really be the best option for its critical care unit.

- **Nursing Research**

The study recommends a wider exploratory study on patients, family members/friends, nurses and physicians` preferences and perceptions regarding visiting time in ICU in Malawi and other settings. This will help to come up with desired visiting time schedules to both clients and health workers.

REFERENCE

1) Allender, J. & Spradlley, B. (2005). *Community Health Nursing.* (6th Edition). New York: Lippincott.
2) Alspach, G.J. (2006). *Core Curriculum for Critical Care Nursing.* St. Louis: Saunders Elsevier Inc.
3) Bordens K.S. & Abbott B.B. (2008). *Research Design and Methods: A Process Approach Design.* (7th Edition). Boston: Mc Graw-Hill.
4) Brinker, D. (2001), Myths VS Reality: visitation in critical care units: *AACN News* 18(6):2-5. Retrieved April 20, 2010 from http://www.academon.com
5) Brooker, L. (2006). *Churchill Livingstone's Dictionary of Nursing.* (19thEdition). London: Churchill Livingstone.
6) Burns N. & Grove S.K. (2007). *Understanding Nursing Research.* (4th edition). St. Louis: Saunders Elsevier Inc.
7) Catalano, S. (2003). Nursing Law and liability: Ethical Principles in Nursing. Retrieved November 20, 2008 from http:mhtml:file://E:\Nursing Law & Liability.mht.
8) Craven, R.F. & Hinle C.J. (2009) *Fundamentals of Nursing- Human and Function,* (6thedition) Philadelphia, Lippincott Williams & Wilkins.
9) Davis J.A., Tschudin V., & De Raeve, L., (2006) *Essentials of Teaching and Learning in Nursing Ethics,* (3rd Edition) Edinburgh, Elsevier Ltd.
10) De Vos, A.S. (2000). Research at Grassroots: a Primer for the caring Professionals. *American Journal of critical Care 13 (3)*: 194-198. Retrieved April 20, 2010 from http://aja.acenjournals.org
11) Federwisch, A. (1998). *Visiting Hours:* Get Longer, and Working Space Gets Smaller. *AACN News* 18(6):2-5. Retrieved April 20, 2010 Http://ww.nurseweek.com/features/98-6/vizit.html
12) Freshman, D.E., & Maslin, E.S. (2005). *Blackwell's Nursing Dictionary.* (2ndEdition). London: Blackwell Publishing Ltd.
13) Fumagalli, et al. (2006). Reduced Cardio-Circulatory complications with Unrestricted Visiting Policy in an Intensive Care Unit. *Circulation* 13:946-952. Retrieved March 29, 2010 from http://aja.acenjournals.org

14) Gonzalez, C., Carroll, D., Elliott, J., Fitzgerald, P., & Vallent, H. (2004). Visiting Preferences of patients in Intensive Care Unit. *American Journal of critical Care 13 (3)*: 194-198 Retrieved April 20, 2010 from http://aja.acenjournals.org/

15) Henning, E., Van Rensburg, W. & Smit, B. (2004). *Finding Your Way in Qualitative research*. Pretoria: Van Schark.

16) Horne, E.M. & Cowan, T. (1996). *Ward Sisters Survival Guide.* (2nd edition). London: Mosby Year Book Ltd.

17) Kumar, B. (2005). *Working in the Operating Department.* (2nd edition). Edinburgh: Elsevier Ltd.

18) Longman, P. (2003). *Longman Dictionary of Contemporary* English. (4th Edition). Edinburgh: Pearson Education Ltd.

19) Merenstein, G.B., & Gardener, S.L. (2006). *Hand Book of Neonatal Intensive Care.* (6th edition). St. Louis: Mosby Elsevier Inc.

20) National Research Corporation and Picker Institute Brochure, (2005). *The Confidence that Comes from Knowing that You're Making a Difference* 1-15. Retrieved March 20, 2010 from http//nrcpider.com/

21) Pera, S.A. & Tonder V.S. (2005). *Ethics in Health Car.* (2nd Edition). Lansdowne: Juta..

22) Peterson, M. (2005), Process Helped Gain Acceptance for Open Visitation Hours. *Critical Care Nurse*, 25:70-72 (p 70). Retrieved March 20, 2010. from http//nrcpider.com/

23) Polit D. F. & Beck C. T, (2006*), Essentials of Nursing Research: Methods, Appraisal and Utilization.* (6th edition). Philadelphia: Lippincott Williams & Wilkins.

24) Robbins P. & Coulter S. (2009). *Management.* (10th Edition). New Jersey: Pearson Education.

25) Roland, P., Russell, J., Richards, K., & Sullivan, S. (2001). Visiting in critical Care: Processes and Outcomes of a Performance Improvement Initiative. *Journal of Nursing Care Quality, 15*(2): 18-26. Retrieved April 27, 2010 from http://ww.safetyleader.org\pdf

26) Sandilowiski, M. (1998). The Problem of Rigor in Qualitative Research Advances in Nursing Science 8 (3), 27-33. Retrieved 4 May 2000 from http://www.ihi.org

27) Schneider J. (2007). Nursing and Midwifery Research: Methods and Appraisal for Evidence Based Practice. (3rd Edition). Edinburgh: Mosby Elsevier.

28) Sims, M.J. & Miracle, A. (2006). A look at Critical Care Visitation: the case for flexible visitation. *Dimensions of Critical Care Nursing* 25(4):175-180 p177. Retrieved April 27, 2010 from http://ww.safetyleader.org\pdf

29) Speziale, H. J. S. & Carpenter, D. R. (2003). *Qualitative Research in Nursing: Advancing the Humanistic Imperative.* (3rd edition). Philadelphia: Lippincott Williams & Wilkins.

30) Sorrentino, S.A. (2005), *Textbook for Nursing Assistant.* (6th Edition) St. Louis: Mosby.

31) Stannard, D., (2000), *Family Care in Critical Care Nursing secretes.* Philadelphia: Hanley and Belfus.

APPENDIX -A

INTERVIEW GUIDE

Date.....

Code.....

KNOWLEDGE AND PERCEPTIONS OF FAMILY/FRIENDS TOWARDS VISITING TIME IN INTENSIVE CARE UNIT AT QUEEN ELIZABETH CENTRAL HOSPITAL

INSTRUCTIONS TO THE INTERVIEWER

- Welcome the interviewee.
- Introduce self.
- Explain the purpose of the interview and the respondent role.
- Explain all ethical considerations such as right to refuse participation and to withdraw, right to privacy and confidentiality and right to services.
- Ask for consent and let the respondent sign or provide finger print.
- Ask all questions.
- Write and tick the appropriate bracket where applicable.
- Record all responses on the spaces provided on the guide.
- Thank the respondent after the interview.

KNOWLEDGE AND PERCEPTIONS OF FAMILY/FRIENDS TOWARDS VISITING TIME IN INTENSIVE CARE UNIT AT QUEEN ELIZABETH CENTRAL HOSPITAL

PART I- Demographic Information

Q1. What kind of relationship is there between you and the patient?

a) Friend [ ]

b) Family member [ ]

c) Others specify.....

Q2. Sex.

Male [ ]

Female [ ]

Q3. How old are you?

18-25 [ ]

26-35 [ ]

36-40 [ ]

ABOVE 40 [ ]

Q4. Where do you stay?.....

Q5. To which religious denomination do you belong?

CCAP [ ] c) Others (specify).....

Roman Catholic [ ]

Q6. Have you ever been to school? Yes [ ] No [ ]

Q7. If yes to Q6, what is your highest level attained?

Primary Std 1-4 [ ]

Std 5-8 [ ]

Secondary JCE [ ]

MSCE [ ]

Tertiary Certificate [ ]

Diploma [ ]

Degree [ ]

Q8. What is your current occupation?

Student.....[ ]

Working (specify) .....[ ]

Business (specify) ..... [ ]

Others specify.....

PART II

<u>Knowledge and Perceptions towards current visiting time in ICU at QECH</u>

Q9.a) Have you ever had a patient in ICU Before?

Yes [ ] No [ ]

b) If yes to Q12.a, how many times?.....

c) What is the least time you spent and why?.....

.....

d) What was the longest time you spent in ICU and why?.....

.....

Q10. Why is it important for the family and friends to visit the patient in ICU?.....

.....

.....

.....

.....

.....

.....

.....

Q11. Do you know anything about visiting hours in ICU?

Yes [ ] No [ ]

b) If yes, what do you know..... .....

.....

.....

.....

c)Where did you hear this information?.....

d) What are your views on the current visiting hours in ICU at QECH?.....

.....

.....

.....

.....

.....

Q12.) Do you know the importance of restricting visitors in ICU?

Yes [ ] No [ ]

b) If yes to Q12.a, explain the importance of restricting visitors in ICU

.....

.....

.....

.....

.....

.....

.....

.....

Q13. What challenges do you face with the current visiting hours in ICU?

.....

.....

.....

.....

.....

.....

.....

.....

Q21. What are your suggestions on visiting hours in ICU?

.....

.....

.....

.....

.....

.....

APPENDIX–B CONSENT FORM

University Of Malawi,

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

Dear Participant,

I am a fourth year student from Kamuzu College of Nursing, pursuing a Bachelor of Science in Nursing. In partial fulfillment of the programme, I am required to conduct a research study. The topic of my study is 'Knowledge, Attitudes, and Perceptions of Family/Friends towards Visiting Time in ICU at QECH. '

The study aims at examining the knowledge, attitudes and perceptions that family members or friends of patients have towards current visiting time in ICU.

You are one of the ten participants recruited to answer questions contained in this study. Participation in this study is voluntary. No penalty will be imposed for not participating. I am also pleased to inform you that you are free to withdraw at anytime and this again will not attract any penalty. Any clarification or question that you may have will be answered appropriately.

In this study, an interview guide will be used. It will be a face to face interview. The interview will take approximately thirty minutes. You are asked to be free and flexible during the interview.

You are also informed that no name of participant will appear in this study for privacy and confidentiality purposes. This means that you are not supposed to provide your name. The information provided will only be used by the researcher for educational purposes.

As a participant, you are also informed that there are no physical or psychological risks in this study. In addition, you may not have direct benefits. However, your views will significantly provide positive impact to visiting time.

You may also wish to know that permission has been granted from the Research and Publications Committee at Kamuzu College of Nursing, and from the director of QECH.

Finally, you are required to sign a consent form if willing to participate in the study.

Yours truly,

Madalitso Mapira.

DECLARATION

I have understood all the explanations about the study. I hereby voluntarily give consent to participate in this study.

Signature/Thumbprint of the Participant.....Date.....

Signature of the Researcher.....Date.....

APPENDIX –C

CHIKALATA CHOVOMEREZA KUTENGA MBALI PA KAFUKUFUKU

University of Malawi,

Kamuzu College of Nursing,

Private Bag, 1,

Lilongwe.

Wokondedwa Bambo/Mayi,

Ndine wophunzira m'chaka chachinayi ku sukulu ya ukachenjede wa unamwino ku Kamuzu College of Nursing. Pomaliza maphunziro a ukachenjedewa ndikuyenera kuchita kafukufuku ngati gawo limodzi lokwaniritsa maphunziro.

Mukafukufukuyi ndikufuna kupeze maganizo a achibale kapena abwenzi a anthu odwala pa zanthawi yoonera odwala mu intesivi keya yuniti.

Inu ndinu modzi mwa anthu khumi amene asankhidwa kuti ayankhe mafunso akafukufuku. Kutenga gawo pakafukufukuyu ndikongozipereka ndipo palibe chilango chilichonse ngati simuvomereza. Mukuziwitsidwanso kuti muli omasuka kuchoka mkafukufukuyu panthawi iliyonse mwaganiza kutero. Funso lililonse lomwe mungakhale nalo lidzayankhidwa.

Mafunsowa atenga mphindi makumi atatu okha. Zomwe tikambirane zikhala zachinsinsi ndipo dzina lanu silidzatchulidwa.

Ngati wotenga gawo pakafukufuku, muli kudziwitsidwa kuti palibe chovuta chilizonse chomwe chingabwere chifukwa chotenga mbali. Powonjezera, pachifukwa choti kafukufukuyu ndi wongozipereka palibe chomwe mulandire ngati malipiro, koma pali chikhulupiriro choti maganizo anu athandizira kuti nthawi yoonera odwala ikhale yabwino.

Kungowonjezera pa zomwe zakambidwa, ndine wokondwa kukudziwitsani kuti chilolezo chaperekedwa ndi bungwe lowona za kafukufuku ku sukulu yathu ya Kamuzu college of Nursing komanso kwa wamkulu wa pachipatala pano.

Pomaliza, ndikukupephani kuti ngati muli womasuka kulowa nawo mukafukufukuyu mupereke siginecha yanu.

Ndine,

Madalitso Mapira.

KUPEREKA CHILOLEZO

Ndamva zonse zokhuzana ndi kafukufuku ameneyu ndipo ndikuvomera kulowa nawo popanda kuumilizidwa.

Saini ya wotenga mbali..... Tsiku.....

Saini ya wopangitsa kafukfuku..... Tsiku.....

Finally the findings will add to the body of knowledge on visiting time in ICU and general wards because there have been different opinions about patient visiting time in hospitals internationally.

I will be looking forward for your consideration.

Yours faithfully,

Madalitso Mapira.

APPENDIX–E

University of Malawi,

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

13th June, 2010.

The Director,

Zomba Central Hospital,

Private Bag 21,

Zomba.

Dear Sir/Madam,

APPLICATION TO CONDUCT A PILOT STUDY

I am Madalitso Mapira, a fourth year student pursuing a Bachelor of Science in Nursing at Kamuzu College of Nursing. In partial fulfillment of the programme, I am required to conduct a research study. The title of the study is 'Knowledge, Attitudes, and Perceptions of family/friends towards Visiting Time in ICU at QECH.'

I write to apply for clearance to conduct a pilot study for the above mentioned topic at your hospital. This pilot study is aimed at examining reliability, validity and feasibility of the designed interview guide.

Clearance has been sought from the Research and Publications Committee to go ahead with the study.

I will be looking forward to your consideration.

Yours faithfully,

MADALITSO MAPIRA

APPENDIX–F

University of Malawi,

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

13th June, 2010.

The Director,

Queen Elizabeth Central Hospital,,

Private Bag 95,

Chichiri,

Blantyre.

Dear Sir/Madam,

RE: REQUEST FOR CLEARANCE TO CONDUCT A RESEARCH STUDY

I am Madalitso Mapira, a fourth year student pursuing a Bachelor of Science in Nursing at Kamuzu College of Nursing. In partial fulfillment of the programme, I am required to conduct a research study. The title of the study is 'Knowledge, and Perceptions of family/friends towards Visiting Time in ICU at QECH.'

I therefore write to apply for clearance to conduct a research study for the above mentioned topic at your hospital.

It is my sincere hope that the results will positively add impact to visiting time and patient care.

I am looking forward to your consideration.

Yours faithfully,

MADALITSO MAPIRA

University of Malawi
KAMUZU COLLEGE OF NURSING

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE: **Knowledge, Attitudes and Perceptions of Family/friends towards visiting time in Intensive Care Unit at Queen Elizabeth Central Hospital**

INVESTIGATOR: **MADALISO MAPIRA**

DEPARTMENT/YEAR OF STUDY: Year 4

UNIVERSITY OF MALAWI
KAMUZU COLLEGE OF NURSING
2010 -09- 23
DEAN OF POSTGRADUATE & RESEARCH STUDIES.
PRIVATE BAG 1, LILONGWE.

REVIEW DATE : 06 SEPTEMBER 2010

DECISION OF THE COMMITTEE: Approved

SIGNATURE: .....**DATE:** 23/09/10
CHAIRPERSON, RESEARCH AND PULBICATIONS COMMITTEE

cc Supervisor:

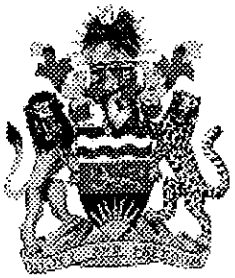
DECLARATION OF INVESTIGATOR(S)

I/we fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/we guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/we will resubmit the proposal to the committee.

DATE....23/09/10.....SIGNATURE(S).....Mmapira.....

Telephone: (265) 01 874 333 / 677 333
Facsimile: (265) 01 876928
Email: queenshosp@globemw.net

All communications should be addressed to:
The Hospital Director



In reply please quote **No.**

QUEEN ELIZABETH CENTRAL HOSPITAL
P.O. BOX 95
BLANTYRE
MALAWI

Ref No. QE/10

19th October, 2010

Madalitso Mapira
Kamuzu College of Nursing
Private Bag 1
LILONGWE

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH AT QUEEN ELIZABETH CENTRAL HOSPITAL

This is to inform you that permission has been granted to collect data on "**Knowledge, attitudes and Perceptions of family/friends towards Visiting Time in ICU at QECH**".

We will appreciate if a copy of your findings is shared with the hospital.

All the best in your studies.

Yours faithfully,

E. Nkangala
PRINCIPLA NURSING OFFICER
For: HOSPITAL DIRECTOR