NURSES' PERSPECTIVES ON THE IMPLEMENTATION OF OPEN VISITATION OF PATIENTS ADMITTED IN THE INTENSIVE CARE UNIT AT MUHIMBILI NATIONAL HOSPITAL IN DAR ES SALAAM.

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MSc.Nursing (Critical Care and Trauma) Dissertation

Muhimbili University of Health and Allied Science

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Department of Nursing

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By

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A Dissertation Submitted in Partial Fulfilment of the Requirements at

Degree of Master of Science in Critical Care Nursing and Trauma at

Muhimbili University of Health and Allied Sciences

October 2024

CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by the Muhimbili University of Health and Allied Sciences published a dissertation entitled. “Nurses' perspectives on the implementation of the open visitation policy of relatives of patients admitted to the Intensive Care Unit of Muhimbili National Hospital in Dar es Salaam” in partial fulfillment of the requirements for the degree of Master of Science in Nursing (Critical Care and Trauma) of Muhimbili University of Health and Allied Sciences.

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Date

DECLARATION AND COPYRIGHT

I, Bukulu Julius, declare that this dissertation is my own original work and that it has not been presented and was not presented to any other university for a similar or any other degree award.

Signature ……..Date ……

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DEDICATION

This dissertation is dedicated to God Almighty, my creator, rock, and source of all of my knowledge, insight, inspiration, and understanding. Throughout the program, he has been my source of strength. This work is also dedicated to my wife, Millicent Joseph Anney, for her unwavering support, comprehension, and patience with my rigorous academic schedule throughout my master's program. To my darling child, Jesus Bukulu, for putting up with my absence when I arrived home from school late. This dissertation is also dedicated to my parents, Julius Kakopa and Meckline Wistone, who provided me with an excellent educational foundation that has enabled me to reach this point.

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LIST OF ABBREVIATIONS

AACN	American Association of Critical Care Nurses
ANO	Assistant Nursing Officer
FGD	Focus group discussion
HBM	Health Believe Model
ICU	Intensive Care Unit
MNH	Muhimbili National Hospital
NO	Nursing Officer
PICS	Post Intensive Care Syndrome
PICS-F	Post Intensive Care Syndrome Family
PTSD	Posttraumatic Stress Disorder
PT	Participant
QDA	Qualitative Data Analysis
RN	Registered Nurse
WHO	World Health Organization

DEFINITION OF TERMS

Attitudes	A person's perception of the results of a certain action (1)
Intensive care unit	Is defined as a unit that provides critical care and life support for acute ill and injured patients (2)
Nurse	Is defined as a someone who has finished a basic and broad nursing education program and has been granted permission by the relevant regulatory body to practice nursing in his or her nation (International Council of Nurses 2002)
Open visitation	This is a practice which allow no any limits on the number of family members, length of time spent visiting, access per visitation (3). In this study, an open visitation means a practice that allows family members to visit patients 24 hours a day without restriction on the number of visitors, time for visitation, duration per visitation, or access to visitation.

ABSTRACT

Background: Patients and their families often experience anxiety upon ICU admission due to pain and uncertainty. Restrictions on visiting hours exacerbate stress and sadness. Open visitation, allowing longer visiting hours and more access, has been suggested to reduce stress for patients and their families. As healthcare evolves toward patient and family-centered care, the introduction of unrestricted visiting regulations in ICUs becomes a critical consideration.

Aim: This study aimed to comprehensively explore nurses' perspectives on the implementation of open visitation for patients admitted to the Intensive Care Unit at Muhimbili National Hospital in Dar es Salaam.

Methodology: A descriptive qualitative study design was employed, utilizing focus group discussions for data collection. The study took place in the medical and surgical adult ICUs of Muhimbili National Hospital, Tanzania. The sample size was 22 participants. Discussions were transcribed verbatim from audio recordings; the transcription was then subjected to content analysis with qualitative data analysis software using Qualitative analysis software miner version 15 (QDA).

Results: 22 participants, averaging 34 years of age, took part. About 77.3% had over three years of nursing experience, 54.5% worked in the surgical ICU, and 63.6% had over three years of ICU experience. Participants understood the concept of open visitation, generating themes such as understanding, attitudes, impacts, challenges, and recommendations.

Conclusion: Nurses appreciate the emotional support and satisfaction open visitation provides to patients and families but have concerns about increased infection risks, disruptions to patient care, and logistical challenges. The results highlight the need to balance the benefits of open visitation with practical considerations to ensure patient care, safety, and efficiency.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

The concept of "open visitation" in the intensive care unit (ICU) refers to allowing unrestricted family members and loved ones to visit patients admitted to the ICU, offering support and enhancing care through emotional and social connections (4). Both patients and their families experience extreme stress upon being admitted to an intensive care unit (5,6). They are overcome with anxiety and worry about their prognosis. Families are a person's primary social, psychological, and spiritual support system and serve as the basic unit of that person's existence. One family member's suffering and illness in some way eclipsed the health of the entire family (4).

Family members may find it necessary to remain by their loved one's bedside due to adverse strong emotions, which might include anger, irritation, shock, sadness, and lack of control. These behaviors are frequently observed outside of intensive care units. In recent years, interest has increased in exploring novel approaches for introducing extended visiting hours in critical care environments, focusing on enhancing quality and providing family-centered care (4).

Throughout the past 200 years, there has been a considerable evolution in the connection between hospitals and family members or caregivers. Since visitors frequently helped with food and general patient care, hospitals in the 19th century adopted a pragmatic dynamic and tolerated them. Hospitals shifted to a more rigorous organizational structure in the late nineteenth century. Adult and pediatric hospitals followed strict visiting hours at this time. The medical and nursing staff were concerned that visitors would interfere with everyday activities, bring in alcohol, smoke, or other forbidden materials, or encourage the spread of infection (3).

At first, ICUs welcomed the rigorous visitation policy because they were worried that family members or caretakers might interfere with the treatment being provided, put the patient under unnecessary stress, or wear out the family. Instead of being based on facts, these practices were dictated by historical policy and opinion (3).

An agenda for research assessing the advantages of family participation in the ICU has been sparked by the societal shift toward patient- and family-centered care. Family members and caregivers are those who are more than just "social visitors"; they are integral to the patient's

care. Restricted visitation describes restrictions on the quantity, timing, or length of visits. While there are certain limitations, flexible visitation can be changed to accommodate the hospital's and the patient's requirements, preferences, and unique situations (3).

It’s critical to comprehend how visiting policies were conceptualized within their historical context. To keep order in the general ward, visiting hours for non-paying patients were instituted in the late 1800s; in contrast, paying patients were permitted to have visitors in their semi-private or private quarters. For several decades, this pattern persisted. By the late 1960s, when ICUs were being created, hospitals had started to restrict visiting hours for both patients with and without payments in the normal medical wards and ICUs to lessen patient tiredness brought on by an overabundance of visitors (5).

These limitations were established without considering or understanding the effect of visits on relatives and patients. Despite published research supporting open or less limited visits, most critical care units had limitations during the late 1980s and early 1990s on the number, age, frequency, and duration of visitors. In 2004, the Institute for Healthcare Improvement (IHI), namely under the leadership of former IHI president and Chief Executive Officer Donald Berwick, focused on pushing hospitals to embrace open visitation within ICUs.

Many hospitals worldwide are still reluctant to implement open visitation, despite the evidence showing that visitors can provide a range of benefits to patients, nurses, and other staff (6). Several studies developed in Europe and North America have demonstrated that most ICUs have a restrictive visiting policy. Open visitation is very common in the pediatric ICU setting but is still uncommon in an adult ICU (7).

Additionally, open visiting in ICUs is least prevalent in South Asia, the Middle East, and Africa and is mostly adopted in Europe, North America, and Australia (5). In Tanzania, open visitation is commonly practiced to care giver not to other relatives in neonates and pediatric ICUs at MNH and not in adult ICUs, where restricted visitation is practiced.

Open visitation generally refers to any length of time spent visiting, including longer visiting hours and more guest access (3). Access to family members is always permitted (24 hours a day) under an “open visitation,” which may or may not place limits on the number of family members who may visit at any one time (8). This is also one of the tactics that administrators

and legislators suggested to decrease the anxiety that patients and their families suffer when they are hospitalized in the ICU (9).

There's a chance the patient's family has specific requirements. The ability of family members to help their patients can be enhanced by correctly identifying these requirements and trying to meet them. In addition to relieving patients' stress throughout their hospital stay in critical care units, this assistance can help patients recover more quickly. Additionally, attending to the needs of patients' families in critical care units can speed up the healing process and shorten the duration of hospital stays for patients (10).

Consequently, better communication and stronger bonds with the medical team are made possible by empowering families and including them in the care of their loved ones. The medical team has seen open visits as generally helpful in reducing anxiety and depression symptoms in family members and caregivers. However, it may also be linked to more tremendous psychological suffering for critical care nurses (3). Nurses have also noted that family visits make patients feel less bored and give them more motivation to live. Nurses believed that while family visits raised a patient's pulse rate and blood pressure, they did not significantly worsen the patient's health (4).

In situations where patients may be afraid of specific treatments, having family members there offers them comfort and emotional support. Additionally, these advantages could shorten ICU stays and provide better staff-to-relative contact (4).

Although having family and friends there can help patients throughout their stay in a strange and uncomfortable setting, there is ongoing debate over the impact of open visiting hours on intensive care unit staff. From the standpoint of medical practitioners, the primary drawback of open visits is the potential for distraction(9). This can lead to difficulties in providing treatment in the intensive care unit and heightened anxiety while managing patients for extended periods during the day in the presence of their families.

Additionally, the task for nurses is significantly heavier. The various requests of visitors must be attended to by nurses in these situations in addition to providing crucial care for critically ill patients, which exacerbates compassion fatigue and reduces professional quality of life. Because of this, even though open visitation benefits patients and their families, ICU staff have been reluctant to implement it (9).

Not much has been explored on healthcare workers' acceptability of "open visitation" in low-resource countries such as Tanzania. This research seeks to explore the nurses' perspectives on the implementation of open visitation of relatives of patients admitted at MNH in Dar es Salaam to adopt such open visitation policies and their views on the feasibility of such a policy in the context of critical care in Tanzania.

1.2 Problem statement

International visiting policies now in place range from free daytime visitation to locked intensive care units, suggesting this is still a contentious issue. Expanding visiting hours has raised worries among nurses about various issues, including disruptions in patient care, psychological strain from anxious relatives, and potential negative impacts on patients' physical health and infection control. Most general intensive care units limit visiting hours despite efforts to address the need for more accommodating regulations (4).

As in many low- and middle-income countries, a restrictive visitation policy is still widely practiced in Tanzania. The current visitation policy in the intensive care units of the national referral hospital in Tanzania allows two visitation schedules per day, one hour each: early in the morning and late evening on weekdays and for weekends or public holidays; there is an exception where visiting hours span for 3–4 hours in the afternoons. Visitors can swap with other family members as much as they like, but only one visitor at a time and a maximum of 10 minutes with the patients are allowed. In the case of a technical operation or emergency, family members were sent to the waiting area until further notice. Due to the potential for illness transmission and psychological effects, it is not advised for children under the age of eight to visit. Children may, however, make brief visits, always escorted by an adult, if the patient's clinical condition permits.

At the patient's bedside or the physician's office in the ICU at MNH, family conferences and medical briefings are also held daily. Participants include attending nurses, the patient's next of kin, and any additional family members who have been given permission by the patient or next of kin to attend. Only the patient's basic medical care and general condition are disclosed by the nurses upon request from the patient's or next of kin to other family members.

Nonetheless, research has shown that the involvement and presence of family members and caregivers—as partners in care—reduces costs, improves the quality of care received by patients and their families, better manages acute and chronic illnesses, strengthens continuity

of care, and lowers the risk of readmission to the hospital. Patients who are isolated from their closest social support system are more vulnerable to medical mistakes, psychological distress, inconsistent treatment, and expensive, needless medical care (11).

Moreover, a number of studies have revealed that more healthcare system personnel oppose open visitation . They acknowledge, nonetheless, that patients and families could benefit from unrestricted ICU visits. This study aims to explore nurses' perspectives on the implementation of open visitation of patients admitted to the ICU at MNH in Dar es Salaam that involves family members participating in the patient's care.

1.3 Conceptual framework

The intention of a person to participate in an action at a certain time and location is predicted by the Theory of Planned Behavior (1). According to this theory, three constructs—a person's attitude toward conduct, subjective norms, and perceived behavioral control—drive an individual's behavioral intentions (12).

Attitude toward behavior: These measures an individual's favorable or unfavorable attitudes about the conduct of interest. It involves considering the results of engaging in the action (12).

Subjective norms: This speaks to whether or not others believe the person has carried out the conduct. It has to do with how an individual views the social context in which the action occurs.

Perceived behavioral control: This is the degree to which the person believes that carrying out the activity is simple or complex. It rises when people believe they have greater means and self-assurance. It is decided by controlling beliefs about the ability of both external and internal factors to encourage or prevent the behavior from being performed (12).

Behavioral intention: This serves as a stand-in for conduct. In the sense of their deliberate intention or choice to carry out a specific activity, it symbolizes an individual's motivation (12). In general, the likelihood that an action will be carried out increases with the strength of the intention.

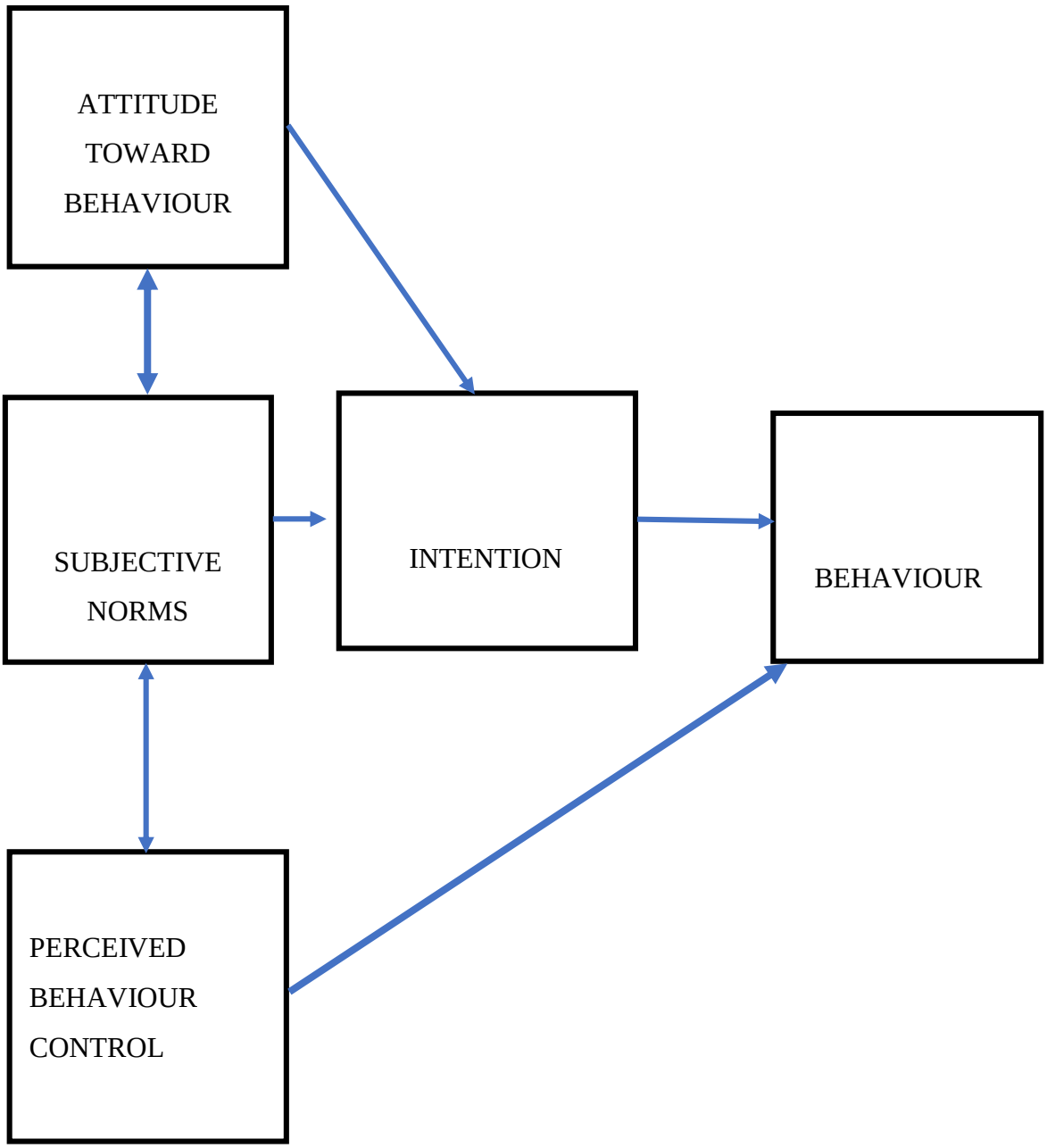


Figure 1: Theory of Planned Behavior

In this study conceptual framework under the theory of planned behavior was used as follows;

Attitude toward Behavior: This construct helped the researcher explore how nurses feel about open visitation, whether they favor it or not. It also enabled the researcher to understand nurses' opinions on the possible advantages of an open visitation, such as increased patient satisfaction, emotional support, reduced stress and anxiety, and family-centered care. Furthermore, it facilitates understanding perceived disadvantages like increased workload and disruption of care, impaired confidentiality, increased risk of infection, increased chance of mental distress, medical errors, and inconsistent treatment (11).

Subjective Norm: Through this, a researcher could pinpoint the beliefs nurses hold about the social pressures or expectations that influence their intentions and behavior. It also gives insight into how patients, families, the atmosphere of the healthcare facility, management, and other healthcare professionals affect nurses' perceptions of open visiting policies. This involves examining how different ICU stakeholders are considered supportive, appreciative, or resistant to implementing open visitation.

Perceived Behavioral Control: This enabled the researcher to investigate nurses' perceptions of obstacles and enablers to open visiting policies. This entails investigating elements including organizational support, chances for training, available resources, and self-assurance in handling difficulties related to implementing policies.

Therefore, by using the theory of planned behavior, I was able to explore nurses' perceptions towards implementing open visitation in the ICU and nurses' perceptions of the risks, advantages, disadvantages, and challenges of having open visitation in the ICU and how it impacts patient care, nurse well-being, and hospital operations, which might include infection control.

Privacy violations, security and safety, increased nurse burnout, resource constraints, disruption of routine, limited space, resistance to change, negative impact on healing resource constraints, and managing visitor emotions.

Understanding nurses' attitudes, norms, and perceived control provided key insights into their views on open visitation policies at MNH ICU, helping to develop initiatives for effective policy adoption.

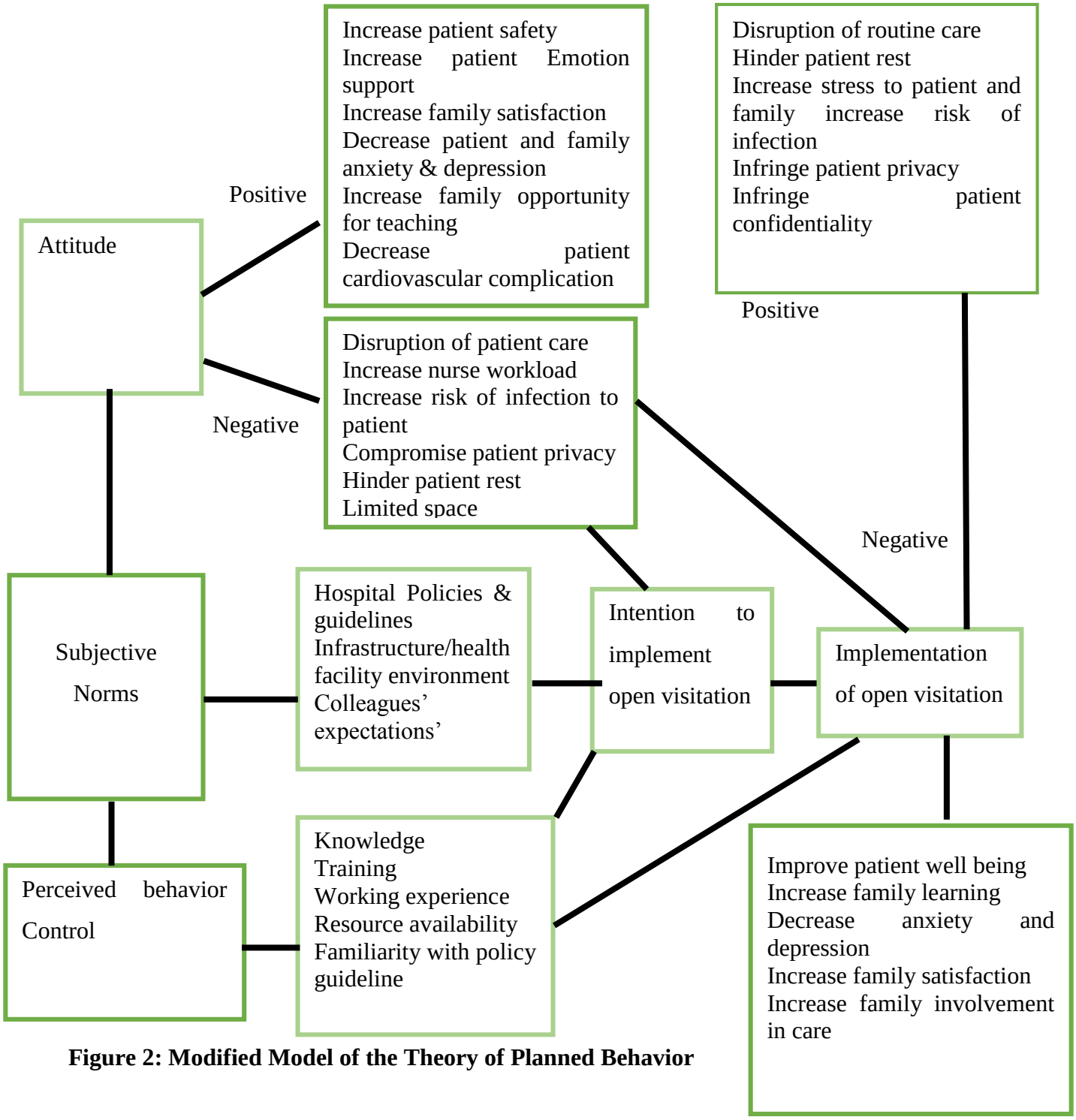


Figure 2: Modified Model of the Theory of Planned Behavior

1.4 Rationale

There are several advantages to an open visitation for patients, family members, and nurses, such as enhanced patient outcomes, work satisfaction for nurses, family happiness, and patient satisfaction (15). To our knowledge, no studies have been done in Tanzania to explore the nurses' perspectives on implementing open visitation of patients admitted to the intensive care unit at MNH in Dar es Salaam. Considering that this was among the first research studies in Tanzania to explore nurses' perspectives on the implementation of open visitation of patients admitted in the intensive care unit at MNH in Dar es Salaam, the findings from this research might be helpful to guide the development and recommendation of this policy for the benefit of patients' outcomes.

1.5 Main objective

To explore nurses' perspectives on the implementation of open visitation of patients admitted in the intensive care unit at Muhimbili National Hospital in Dar es Salaam.

1.5.1 Specific objectives

1. To describe nurses understanding regarding implementing open visitation in the intensive care unit at Muhimbili National Hospital in Dar es Salaam.
2. To describe the attitude of nurses toward open visitation in the intensive care unit at Muhimbili National Hospital in Dar es Salaam.
3. To describe nurses' perceived impact of open visitation on patient care in the intensive care unit at Muhimbili National Hospital in Dar es Salaam.
4. To describe nurses' beliefs regarding the role of family members in the patient's care during open visitation in the intensive care unit at Muhimbili National Hospital in Dar es Salaam.

1.6 Main research question

What are nurses' perspectives on the implementation of open visitation of patients admitted to the intensive care unit at Muhimbili National Hospital in Dar es Salaam?

1.6.1 Specific research question

1. What is the nurse's understanding regarding implementing an open visitation in the intensive care unit at Muhimbili National Hospital in Dar es Salaam?
2. What is the nurses' attitude toward open visitation in the intensive care unit at Muhimbili National Hospital in Dar es Salaam?
3. What are nurses' perceived impact of open visitation on patient care in the intensive care unit at Muhimbili National Hospital in Dar es Salaam?
4. What are nurses' beliefs regarding the role of family members in the patient's care during open visitation in the intensive care unit at Muhimbili National Hospital in Dar es Salaam?

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Nurses' understanding of open visitation

Many ICU staff members, particularly nurses, had mixed understandings of the of the positive and negative aspects of open visitation in the ICU. Positive aspects of open visitation, such as how it aids in the patient's rehabilitation by lowering stress and anxiety, and negative aspects, such as how it hinders the organization of patient care and interferes with their work. The ICU staff did not see any advantage regarding family members (5).

For instance, they contend that open visitation isn't always beneficial for lowering stress and anxiety levels or improving family happiness. Other studies indicate that staff members, particularly nurses, favored the limited visiting regulations because they believed that an open visitation in the intensive care unit (ICU) may disrupt their ability to provide care (7).

Although open and patient-tailored visits have been advocated as the optimal visitation paradigm, many critical care units have restricted attendance (13). Restrictive visiting hours make it difficult for families to participate in their loved ones' care. However, once a system with a broad approach to open visitation was put in place, both patients and families felt better informed, and the nursing staff was courteous and provided family members with clear explanations (5).

Although it can have an impact on nurses' work environments, open visiting in the ICU is good for patients and their families. Enhancing nurses' job satisfaction in the intensive care unit (ICU) can be achieved by implementing evidence-based techniques that mitigate the stress and burden caused by open visitation (5).

In addition, open visitation assists guests in obtaining the things they need, such as reassurance, the ability to visit whenever they'd like, familiarity with the medical personnel, and the sense that the patient is well-cared for (14).

2.2 Nurses' attitudes on open visitation

Open visitation in the ICU is seen negatively or positively by nurses, depending on the situation. Curiously, despite the data, ICU staff members are skeptical about the advantages of unrestricted visits for critically ill patients and their families. Four subthemes were discerned: doubt over the advantages; a sense of losing control; an increase in effort; and careless

interruptions. No participant chose open visitation as their preferred ICU visiting policy in a survey that looked at nurses' perspectives (15).

2.2.1 Nurse's positive Attitude about benefits of open visitation

ICU staff members are hesitant to believe that unrestricted visits increase family satisfaction with care, give relatives more knowledge and comfort than limited access, or lessen family members' tension and worry (7).Conversely, relatives may become weary of being around their family all the time. Since open visiting disrupts patients' sleep and may worsen their condition, there is additional uncertainty regarding the assertion that it is crucial for critically ill patients to recover (15).

2.2.2 Nurse's negative attitude about open visitation

ICU patients are more vulnerable to infection because of their comorbid conditions, invasive medical procedures, indwelling central lines and catheters, hemodialysis, and extended hospital stays. Open visiting exposes patients to any unsanctioned visits from outsiders and increases the risk of infection transmission because the hands of visitors and healthcare professionals are the main source of transmission (9).

Additionally, a patient's privacy may be violated by an open visitation. Open visitation can lead to care interruptions that jeopardize patient safety, particularly during high-risk nurse interventions. It also degrades care coordination since greater family presence interferes with care planning and delivery (15).

Furthermore, nurses felt that having more families there increased their workload because they now had to tend to patients in addition to the family members at the bedside.

Nurses believed that open visitation takes them away from providing direct patient care as they need to answer family members' questions, which is very time-consuming (4).

2.3 Nurses' perceived impact of implementing open visitation

2.3.1 Nurse's perceived positive impact of implementing open visitation

Visits from family members are crucial to the patient's recovery because they may provide the patient with the emotional support and self-assurance that a critically ill patient so desperately needs, something critical care nurses might not always be able to do. The absence of time constraints during the visit confers a beneficial psychological impact on the individual and their family, as opposed to prolonged separation. It benefits patients by offering a network of

support, enhancing environmental comfort, and promoting flexibility. Having relatives around improves the quality of life of the individuals receiving care and offers a diversion from the hospital's daily schedule. The patient's capacity to adapt might potentially lead to better sleep. Patients may unwind in between sessions and don't need to try to stay awake at specific times. One might extend an invitation (9).

Open visiting increases family teaching opportunities, lowers anxiety and sadness, and raises family member satisfaction. Families could start to participate more in the patient's treatment. Consequently, there are several advantages to visiting for nurses, patients, and family members. These advantages may result in better patient care results, staff job satisfaction, and family and patient satisfaction. Therefore, as a vital part of a patient- and family-centered strategy, open visiting is considered a high priority by the American Association of Critical-Care Nurses (9).

2.3.2 Nurses perceived negative impact on implementation of open visitation in Intensive care unit

Nurses are particularly concerned about the possibility of infection that open visitation may offer to their most fragile patients. Health care professionals worry about the spread of infections from guests, particularly youngsters and siblings. Patients contend that visits are unpleasant for them as well as their family members, which can disrupt communication, make it harder for patients to get enough sleep, infringe on their right to privacy and confidentiality, and make it more difficult to plan and coordinate their treatment.

When family members provided care, several ICU healthcare personnel found it difficult to uphold the patients' autonomy, privacy, dignity, and integrity. They also voiced reservations about the appropriateness of certain care behaviors, which again depended on the patient-relative connection (16).

The ICU staff is also impacted, in addition to the patients and their relatives. The inability of ICU personnel to provide holistic care—which includes offering families emotional support and direction throughout the ICU experience, especially when a patient is nearing the end of their life—can result in moral harm (17).

2.4 Nurses' belief on the role of family members during open visitation in ICU

Family members are the most knowledgeable about their loved one's past because they are their caregivers. Family members are an invaluable resource, even if they might not be medical professionals. They are frequently acutely aware of any physical or cognitive changes in the

patient, and they may even know more about the patient and their own capacity to care for them than we clinicians might realize (16).

Taking part in intensive care unit care might lessen a family member's sense of helplessness and lower their chance of getting post-care syndrome upon discharge (18).

While most patients, family members, and ICU nurses supported taking care of one's eyes, moisturizing the mouth, and using body and lip balm, there was disagreement over taking a bath or washing one's hair (19). Some family members said that their involvement in "private care" (such as for incontinence or vomiting) relied on their relationship with the patient, while others did not want to engage at all. About one-third of the families in the Wong et al. research chose to share physical patient care with ICU healthcare staff, while the rest opted to participate passively (20).

To feel helpful and to be permitted to participate, relatives either desired or were wishing to assist the patient when asked. According to one survey, the majority of patients supported family involvement in critical medical treatment. For many reasons, including maintaining one's reputation, feeling embarrassed, maintaining physical modesty, being safe, and believing that intensive care unit nurses possess superior skills, the other person did not want their family members to take part (20).

Relatives should participate, according to a varying number of ICU healthcare workers who had a good attitude about family engagement (at their request). Attitudes toward family engagement were favorably impacted by individual ICU nurses' characteristics, such as age, education, and critical care experience (20).

Family participation has to be customized based on each family's requirements, as determined by nursing personnel. To enable nurses to customize their approach to each family caregiver, more thought must be given to the establishment of classification criteria for caregivers (such as caregiver knowledge base, prior care experience, motivation, self-efficacy, and preparation). To properly communicate possibilities and safely guide family engagement in the ICU setting, nurses may require additional education and training (21).

CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1 Study Design

A descriptive qualitative study design was employed to assess nurses' perspectives on the implementation of open visitation of relatives of patients admitted to the ICU at MNH in Dar es Salaam. This study design was employed because it allows a deeper understanding of the phenomenon. The design was also chosen due to its appropriateness for capturing a snapshot of nurses' perspectives towards open visitation and patient care in an ICU. It also allowed for the simultaneous collection of data from multiple sources, aiding in the comprehensive assessment of the situation under investigation.

3.2 Study Area

The study was conducted at two adult ICUs of MNH Tanzania, which are medical and surgical ICUs. These units were selected based on their significance in providing intensive care services to a diverse population and their role in managing critically ill patients in Tanzania.

MNH is located in the Upanga ward of the Ilala District. MNH receives patients with serious illnesses nationwide who need tertiary care as a national referral hospital. The medical ICU has 13 beds, while the surgical ICU has 18. Both ICUs admit more than 500 patients annually, on average. The medical ICU has 27 nurses, of whom 3 are critical care nurses' specialists, 8 are nursing officers (NO), and 16 are assistance nursing officers (ANO). The surgical ICU has 31 nurses, of whom 1 is a critical care nurse specialist, 13 are nursing officers, and 17 are assistant nursing officers.

The current visitation in the intensive care units of the national referral hospital in Tanzania at medical and surgical ICUs allows two visitation schedules per day, one hour each: early in the morning and late evening on weekdays and for weekends or public holidays; there is an exception where visiting hours span for 3–4 hours in the afternoons. Visitors can swap with other family members as much as they like, but only one visitor at a time and a maximum of 10 minutes with the patients are allowed. In the case of a technical operation or emergency, family members were sent to the waiting area until further notice. Due to the potential for illness transmission and psychological effects, it is not advised for children under the age of

eight to visit. Children may, however, make brief visits, always escorted by an adult, if the patient's clinical condition permits.

3.3 Study Population

The study population consisted of nurses working in the medical and surgical ICUs of the MNH. The study included these nurses regardless of age, education level, or other demographic characteristics.

3.4 Recruitment of participants

Purposeful sampling was employed to select nurses working at the ICU for at least one year to form a group for focused group discussion. This is because purposeful sampling allows researchers to efficiently allocate resources and time by focusing on participants most likely to contribute valuable information to the study. This targeted approach minimizes the need to recruit many participants and facilitates in-depth exploration of critical issues. Also, purposeful sampling enabled researchers to choose individuals with various viewpoints, experiences, or traits related to the study subject. Researchers can capture a broad spectrum of views and enhance the richness and depth of the data collected.

3.5 Data Collection Methods, Procedures and Guide

3.5.1 Data collection methods and procedures

Data was collected through four FGD sessions with ICU nurses working at MNH's medical and surgical ICU in Tanzania, two FGD at each ICU.

Five to seven nurses per group were enough to promote insight conversations, and FGDs from each medical and surgical ICU were conducted. The group's makeup and the conversation's nature were deliberately designed to foster an open and honest dialogue among participants.

Once the focus group session was confirmed, all participants were notified in advance of the day, time, length, and location so they could make appropriate plans. The focus group session's location was a conference room at the medical ICU and was easily accessible to all participants. The room has a large space with adequate light and ventilation and also has a large table with chairs arranged in circular seating arrangements as it allows everyone to see, hear, and interact with one another throughout the conversations.

During data collection, researchers moderated FGDs in collaboration with a co-moderator. The co-moderator supported the moderator and assisted in managing logistical aspects of the FGD, including monitoring audio recording equipment to ensure uninterrupted capture of the discussion. The co-moderator also assisted in taking observational notes on participant interactions, non-verbal cues, and emergent themes and making a summary per group discussion. Despite this important duty, the moderator refrained from taking charge of the discussion and imposing their opinions. Instead, they fostered a group dynamic by being transparent and perceptive and encouraging everyone to participate in the conversation.

The researcher and moderators also worked with nurse management to schedule targeted group discussions, ensuring they were suitable for their workload and shifts. The FGDs were conducted during various shifts and incorporated into existing staff meetings or educational sessions to ensure accessibility and convenience for nurses. All participants consented before the discussion, and the conversations were audio-recorded. The duration of FGDs was 55 to 67 minutes.

The iterative data collection approach was used where the researcher conducted one FGD on the first day and listened, transcribed, read, and re-read the transcript and analyzed the audio-recorded FGDs to check for the quality of the collected information. This helped the researcher identify missing information and improve the group discussion guide.

3.5.2 Data Collection Guide

In this study, a semi-structured discussion guide was developed based on the literature and modified to suit the study's specific objectives. The guide gathered information about nurses' perspectives on implementing open visitation for patients admitted to the ICU at MNH in Dar es Salaam. A background information sheet was used to collect socio-demographic information from the study participants. The FGD was conducted in Kiswahili, a national language.

3.6 Data Management

To ensure the confidentiality and safety of the collected information, all transcriptions and audio recordings were kept in a computer folder secured with a password and only accessible to the researcher. Notes on hard papers were stored in a filing cabinet in the researcher's office at MUHAS.

3.7 Data Analysis

A qualitative content analysis approach was used in handling data using both inductive and deductive approaches to maximize the depth of analysis, and even unexpected themes can be considered. First, one must familiarize oneself with the collected data by repeatedly reading the transcribed data and taking appropriate notes. The second phase involved generating initial codes through data reduction and compilation. Searching for categories among the codes was the third step. The aim was to combine the data with the proposed categories and widen the data patterns. The fourth phase involved searching for data that agreed or disagreed with the proposed articles. Defining and naming the categories was the last stage. Also, summaries and quotations were presented from information obtained from major themes and subthemes. And the final phase was reporting writing (22).

The interviews were transcribed verbatim and entered into the Qualitative Data Analysis software, Miner version. Codes were generated verbatim and grouped into sub-categories and categories. Frequency was run to obtain the most recurring codes, and code retrieval was done using Qualitative Data Analysis software, Miner version. The codes were grouped into 35 sub-categories, and further analysis yielded eight main categories with four themes.

The table below shows how different themes and categories were obtained from meaning units, condensed meaning and code.

Table 1: Example of meaning unit, condensed meaning unit, codes, categories and Theme

MEANING UNIT	CONDENSED MEANING	CODE	CATEGORY	THEME
I think this concept of not having a limit on relatives should not exist because it will affect many things in terms of performance. But also, for the improvement of our patients because, as brothers, as I said, they will become so many that they will interfere with many things that we cannot provide services as they should. So, at the end of the day, even for those patients that we have to attend to, improvement will be delayed.	Unlimited visitor access negatively impacts performance and patient recovery. Too many visitors cause interference, hindering the ability to provide proper services and delaying patient improvement.	-Impact performance -Interference of healthcare services -Delay patients' improvement -Disruption routine of care	Not ready to implement open visitation	Nurses perceived attitude toward implementing open visitation
I think it is possible to implement it, but it requires the preparation of guidelines that determine which sibling should be allowed in which modalities, and it requires the preparation of the environment to ensure privacy for all patients to ensure how the patients' information is secured. It needs guidelines on how we will control infection prevention, and so on. It will also need training for service providers on how they will be able to cooperate with relatives who will be there all the	It is possible to implement open visitation for patient and relatives. It requires preparation, infrastructure improvement, IPC, commitment, customer care, interdisciplinary collaboration, ensure privacy, ensure secure patient information, it need guideline, control infection	-Possible to implement open visitation -Require Preparation -Infrastructure improvement -Interdisciplinary collaboration -Need training -Consider Infection control -Maintain privacy	Ready to implement open visitation	

time. Also, what is the time when relatives will be required to be absent for some time, perhaps by what procedure, and when should relatives be present? And the training, because we have had a system that is like this, if we change it, people must retrain how we will go this way, and this way we were doing the procedure while we were alone now; sometimes we will need to be there with relatives; if this is the way, let's go along.	and staff involvement.	-Create guideline		

3.7.1 Trustworthiness

The study's trustworthiness is contingent on rich, appropriate, and well-saturated data availability. This study ensured trustworthiness by using four criteria: credibility, dependability, transferability, and conformability (Lincoln & Guba 1985).

3.7.2 Credibility

Credibility is the extent to which the study's interpretations, results, and conclusions are credible, based on the experiences and viewpoints of the participants, and believable. To ensure the credibility of this study before beginning the actual fieldwork of data collection, the researcher acquainted himself with the group discussion guide to establish trust. Also, peer debriefing and external review were done by seeking feedback from peers, colleagues, or experts in qualitative research.

Also, credibility was ensured by prolonged engagement and trust-building with study participants. Also, researchers used triangulation of data sources. The researcher used multiple data sources and focus group discussions to enhance credibility. This includes incorporating interviews, observations, or document analysis to triangulate findings and provide a

comprehensive understanding of nurses' perspectives on implementing open visitation of patients admitted to the ICU at MNH in Dar es Salaam.

3.7.3 Dependability

This refers to the consistency of the research process and results over time and across different contexts. To enhance the study's dependability, the researcher ensured methodological transparency, which was achieved through transparent documentation of the research methodology, including recruitment procedures, data collection techniques, and analysis processes. The researcher was consistent in data collection; this was done by standardizing data collection procedures across FGDs to minimize variability and bias Lastly, researchers collected data until data saturation was achieved, where no new information or themes emerged from the data.

3.7.4 Transferability

This refers to how far a research's interpretations, findings, and conclusions can be extrapolated to groups or situations outside the original study participants. The researcher described the characteristics of the ICU setting, including the layout, staffing levels, and existing visitation policies, to enable readers to understand the context in which the study was conducted (Yin, 2018). Also, the researcher provided detailed descriptions of the research context, participants, and data collection procedures to facilitate the transferability of findings. Lastly, the researcher purposefully selected richly informed participants who represented diverse perspectives and experiences relevant to the research topic. (Charmaz, 2014).

3.7.5 Conformability

This is a term used to describe the extent to which a study's interpretations, findings, and conclusions are based on the facts and represent the opinions of the participants rather than the researcher's biases, preferences, or assumptions. To guarantee conformity in this study, the `researcher-maintained reflexivity throughout the research process to acknowledge and address researcher biases and preconceptions. The researcher reflected on how personal experiences, values, and assumptions may influence data collection, analysis, and interpretation (Charmaz, 2006). Other ways to ensure conformability are to report the research methods, data analysis techniques, and interpretations of the research findings. The researcher provided detailed

descriptions of how the data were collected, analyzed, and interpreted to enable readers to assess the confirmability of the study's findings (Creswell & Creswell, 2017).

3.8 Ethical clearance

Muhimbili University of Health and Allied Science (MUHAS) Research and Publications' ethics committee provided the study's ethical approval, and before conducting research, authorization from MNH was requested. Written informed consent was obtained from intensive care nurses working in medical and surgical ICUs. The study's rationale and the option to opt out of the focused group discussion were clarified. Permission for audio recording was sought before the start of focused group discussions. Privacy and confidentiality were respected throughout the research.

The recorded data were not disclosed to any outside parties other than in an anonymous manner for research reasons. The researcher could access all field data in a password-protected computer folder. Additionally, only authorized people were allowed to use the computer, which was password-protected throughout data entry, analysis, and report authoring.

3.9 Dissemination plan

A research report will be presented to the School of Nursing and the Directorate of Postgraduate Studies at MUHAS as partial fulfillment of the requirement for the award of a Master's Degree in Nursing. The results of the study will be communicated to MNH. Efforts will be made to publish a result in a peer-reviewed scientific journal and present it at seminars, scientific conferences, and workshops. Hard and soft copies will be available at the MUHAS library, the MNH library, and finally, the Ministry of Health.

CHAPTER FOUR

4.0 RESULTS

This chapter presents the findings from FGDs with twenty-two participants from two ICUs at MNH. The findings have been discussed in response to the specific objectives, which generally include: assessing nurses understanding regarding implementing open visitation; describing the attitude of nurses toward open visitation; understanding nurses' perceived impact of open visitation on patient care; and examining nurses' beliefs regarding the role of family members in the patient's care during open visitation in the ICU at MNH in Dar es Salaam.

4.1 Socio-demographic characteristics of the study participants

Twenty-two participants were interviewed in this study; their mean (SD) age was 34 ± 7. Most were male (54.5%) and married (54.5%). Single were 45.5%, and the working experience as nurses was more than three years in 77.3% of the participants. About 54.5% were in the surgical ICU, and the remaining were in the medical ICU, with working experience > 3 years, or 63.6% of the respondents **(Table 2).**

Table 2: Sociodemographic characteristics of the study participants

Variable	Frequency	Per cent
Age category		
< 30years	10	45.5
> 30years	12	54.5
Sex		
Male	12	54.5
Female	10	45.5
Marital status		
Single	10	45.5
Married	12	54.5
Education level		
Diploma	12	54.5
Bachelor degree	10	45.5
Work experience as a nurse		
< 3years	5	22.7
> 3years	17	77.3
ICU unit		
Medical ICU	10	45.5
Surgical ICU	12	54.5
Work experience in ICU		
< 3years	8	36.4
> 3years	14	63.6

Organization of themes and categories

The content analysis revealed four themes, nine categories, and 37 sub-categories addressing the concept of open visitation in ICUs. The themes encompass nurses' understanding of open visitation, positive impacts of open visitation, roles of family members in open visitation, negative impacts of open visitation, challenges around implementation of open visitation, and recommendations. (See **Table 3**).

Table 3: Summary of Findings

THEME	CATEGORY	SUB-CATEGORY
Nurses' Understanding of Open Visitation in ICUs	Flexibility in visitation	Time restrictions
		Visitor limitation
		Visitors' status
	Familiarity with open visitation	Source of awareness
		Practice experience
		Level of familiarity
	Roles of family members in open visitation	Assisting activity of daily living
		Assisting with Nursing care
		Provide patient information
		Financial support
		Emotional support
Nurses perceived Attitude toward implementing open visitation	Ready to implement open visitation	Willing to implement open visitation
	Not ready to implement open visitation	Unwilling to implement open visitation
		Security concerns
		staff-relative conflicts

		Family dynamics and conflicts
Nurses' Insights into the Impact of Open Visitation	Perceived positive impact of open visitation	Reduced Stress Among Family Members
		Family Satisfaction
		Enhanced Family Engagement
		Enhanced interaction between families and nurses
		Improved patient condition
		Emotional Support

	Perceived negative impacts of open visitation	Disruption of patient care
		Breach in infection control prevention practices.
		Increased stress for patients
Perceived Challenges and recommendations for implementing open visitation	Perceived challenges implementing open visitation	Patient privacy & confidentiality concerns
		Limited capacity
		Increase patient stress
	Recommendations to implement open visitation	Allocated Time and specified duration of open visitation
		Selecting number of visitors
		Remodeling infrastructure
		Create policies and guidelines
		Infection control precautions

4.2 Theme 1: Nurses' Understanding of Open Visitation in ICUs

Participants in the study described their understanding of open visitation in the ICU through three main categories, each with its own subcategories. The first category is flexibility in visitation, familiarity with open visitation, and the perceived role of family members in open visitation. This comprehensive framework highlights the multifaceted perspectives nurses hold regarding the implementation of open visitation in the ICU, emphasizing the various factors that influence their understanding.

Flexibility in Visitation

Nurses in the ICU have a comprehensive understanding of open visitation, recognizing it as a significant shift from rigid traditional visiting hours to a more flexible and inclusive practice. This practice allows relatives to visit patients at any time, removing fixed schedules and traditional time-related barriers. Nurses emphasized that open visitation provides complete freedom for relatives to visit without constraints on time or the number of visitors, allowing multiple family members to be present simultaneously. This understanding influences how nurses implement and advocate for open visitation in their daily practices, ensuring that the policy's core aspects of unlimited access and lack of visitor limitations are upheld.

"The concept of open visitation, we can put it in two parts, either the time relative they have no limit, that is, we don't set a time for them to come to see the patients, or another aspect not to have a limit, in the number of relatives who come to see the patients." ***(FGD #4: p2)***

Also, other participants emphasized the idea of open visitation based on visitor status, which refers to permitting unrestricted relative visitation while taking visitors' socioeconomic and social status into account. Those with greater social standing or financial means may be able to take advantage of more possibilities and visitation flexibility, which would increase their benefits from open visitation. On the other hand, patients whose visitors don't have this status might not gain the same advantages from open

visitation because of their visitors' inability to take time off from work or attend to other obligations.

"So, I think it applies, say, I don't know, it has more to do with having a certain status in life or having money." ***(FGD #3: p2)***

Familiarity with Open Visitation

Nurses' familiarity with open visitation varies widely, influenced by diverse sources and practice experiences in different healthcare settings. Many nurses have encountered the concept through their professional experiences in various hospitals, both locally and internationally. For instance, some have heard about open visitation from their experiences in private hospitals and observing practices abroad, including MNH, Benjamini Mkapa Hospital, Saifee Hospital, and Hubert Kairuki Memorial Hospital.

"I have practiced it in my experience. There was a time when I worked at a private hospital in Masaki where there was no limit, and the patient was an ICU patient". ***(FGD #1: p4)***

Others have learned about this practice through second-hand information from colleagues or literature, contributing to a collective understanding within the healthcare community. Practical experience in different hospital environments, especially private hospitals, highlights the implementation and impacts of open visitation. Despite this, the degree of familiarity among nurses varies, with some having extensive exposure and others encountering it for the first time, reflecting the broader spectrum of exposure and experience with open visitation practice.

"In my case, I have never heard of it, this is the first time I have heard of it here, but in the private hospital there is a place where I have worked, there was this concept" ***(FGD #4: p1)***

Last but not least, other participants revealed that they had never heard about open visitation in the ICU prior to this study. Despite their extensive experience and expertise in critical care, this concept was entirely new to them. They had no prior knowledge or exposure to practices that would allow unrestricted visitation for family members in the ICU. This lack of familiarity suggests a gap in current training and policies at MNH, highlighting the need for educational initiatives to inform and prepare staff for the potential implementation of open visitation practices.

"I have never heard of it, but I think it has the potential to be useful in removing the complaints of the relatives." ***(FGD #2: p1)***

4.2.1.1 Perceived Roles of Family Members in Open Visitation

The roles of family members during open visitation in ICUs are multifaceted, encompassing assistance with daily living activities, nursing care, providing patient information, financial support, and emotional support. Family members often take on essential responsibilities related to assisting ICU patients with personal hygiene, feeding, and mobility, which significantly improve the patient's comfort and dignity. Additionally, family members can assist with various aspects of nursing care, particularly non-professional or supportive tasks that complement the healthcare provided by nurses, such as changing a patient's position to prevent pressure sores.

Family members presence during procedures can also offer comfort and reassurance. Family members are valuable sources of detailed and contextual information about the patient, which can be critical for effective treatment and care planning. They ensure that vital information is communicated promptly and accurately. Financially, family members play a crucial role in providing support for the patient's treatment, ensuring that payments for medical procedures and necessary supplies are made promptly, and maintaining the continuity and quality of care. Emotionally, the presence of loved ones can significantly reduce stress and anxiety for ICU patients, promoting a sense of security and well-being and offering comfort, reassurance, and spiritual solace, which fosters a positive environment encouraging recovery and emotional stability.

"The first responsibility is feeding the patient and the second responsibility is in bathing the patient. So, if he comes to be bathed by someone close to him who is in need, it will bring hope. The other responsibility is paying for patient investigation which we need to do. He supposed to pay that investigation and we get result at the right time." ***(FGD #2: p6)***

Other participants expressed a strong belief that there is no benefit for relatives to participate in the care of ICU patients due to the critical nature of their conditions. They argue that relatives are primarily social visitors who come to see the patient and then leave. Involving relatives in patient care could exacerbate their stress and anxiety, given the severity of the patient's condition and the highly stressful ICU environment. The participants feel that the complexity and intensity of ICU care require professional expertise and that the presence of stressed and anxious relatives could potentially hinder the care process rather than help, making their involvement more of a burden than a benefit.

"For me, I don't see if there is any benefit of relatives helping us in the service according to the nature of the patients we had because when the relatives help you take care of the patient, he is under stress, so he will not perform well, and maybe the service provider will not be able to assist due to the stress and anxiety he has." ***(FGD #1: p3)***

4.3 Theme 2: Nurses' Perceived Attitudes Toward Implementing Open Visitation

Participants described perceived nurses' attitudes toward implementing open visitation in the ICU, categorizing their insights into two main areas: ready to implement open visitation and not ready to implement open visitation. In the Ready to implement Open Visitation category, nurses recognize the potential benefits but also acknowledge being willing to implement open visitation. These nurses believe that, despite the challenges, open visitation could enhance patient care and family satisfaction if managed correctly. Nurses in this group also felt that the potential for conflict and the added burden on staff outweigh the benefits, leading to a reluctance to adopt open visitation practice. These insights reveal a spectrum of attitudes, from cautious optimism to significant reservations, highlighting the complexity of implementing such policies in the ICU.

Ready to Implement Open Visitation

Nurses who are supportive of implementing open visitation believe it can enhance patient care and family satisfaction. They emphasize the potential benefits of patient recovery and improved service delivery when implemented alongside adequate staffing and preparation.

"It will be good if it is implemented, it will be better and it will help us in the healing of our patients to recover quickly." FGD #2: pt2

Unwilling to Implement Open Visitation

Some nurses expressed concerns about the potential negative impacts of open visitation, such as increased workload, compromised patient care, and space limitations in the ICU. They believe current restrictions are necessary to maintain quality care and safety. Concerns about security risks are also prominent, including potential theft, breaches of patient privacy, and confidentiality issues. Nurses highlight the risk of unauthorized individuals accessing sensitive patient information or posing physical threats. Additionally, nurses anticipate conflicts between healthcare providers and visitors due to differing perceptions of patient care needs and appropriate behaviors in the ICU. They foresee misunderstandings and tensions arising during critical care procedures. Family dynamics and conflicts among relatives regarding visitation schedules and roles are also

acknowledged as potential issues, necessitating structured visitation policies to prevent misunderstandings and maintain a conducive environment for patient care.

"I think this concept of not having a limit on relatives should not exist because it will affect many things in terms of performance. But also, for the improvement of our patients, because, as relatives, they will interfere with many things that we will not be able to provide services as they should. So, at the end of the day, even for those patients that we have to attend improvement will be delayed." ***(FGD #1: p3)***

4.4 Theme 3: Nurses' Insights into the Impact of Open Visitation

Participants described nurses' insights into the impact of open visitation in the ICU, identifying two main categories: perceived positive impacts and perceived negative impacts. The perceived positive impacts category reflects the belief that open visitation can foster a supportive environment where family presence contributes positively to the patient's recovery and well-being, strengthens family bonds, and facilitates better communication with the healthcare team. Conversely, the perceived negative impacts category highlights the challenges and risks associated with open visitation, such as the possibility of interfering with medical procedures, compromising sterile environments, causing additional stress to critically ill patients, and the need to maintain patient confidentiality and privacy.

Perceived Positive Impact of Open Visitation

Open visitation in ICUs has several perceived positive impacts, as identified by nurses. First, it significantly reduces stress among family members, providing them peace of mind and alleviating anxiety by allowing them to see their loved ones without stringent restrictions. This visibility into the patient's care helps manage their stress levels by keeping them informed and reassured about the patient's wellbeing.

"It will help reduce the stress for the relatives because they know we got access to see my relative." ***(FGD #4: p3)***

Second, open visitation enhances family satisfaction, as it allows families to spend time with their loved ones, reduces complaints, and provides a sense of involvement and comfort. Third, it leads to enhanced family engagement in patient care, fostering a sense of shared responsibility and cooperation between healthcare providers and the patient's family, and facilitating better information exchange and decision-making. Fourth, open visitation improves interaction between families and nurses, building trust and rapport, which are crucial for effective communication and care coordination. Fifth, it positively impacts the patient's condition, both physically and emotionally, by providing emotional support, comfort, and encouragement and by allowing families to provide valuable input about the patient's needs and preferences. Lastly, emotional support from family members helps patients cope better with stress and anxiety, fosters a sense of belonging and community, and provides spiritual support that enhances emotional care.

"Open visitation offers emotional support, maintains well-being, and may improve medication effectiveness for patients with various illnesses, despite limitations on relatives' support." ***(FGD #3: p2)***

Perceived Negative Impacts of Open Visitation

Nurses highlighted several negative impacts of open visitation in ICUs, primarily focusing on the disruption of patient care, breaches in infection control prevention, and increased stress for patients. Open visitation often leads to significant disruptions in patient care, as the constant presence of family members can impede the efficient delivery of medical services. This can delay procedures, reduce work efficiency, and cause emotional strain on the nursing staff as they need to manage and accommodate family members, leading to operational challenges and delays. Nurses also expressed concerns about the impact of open visitation on infection control. The ICU is a controlled environment with strict protocols to minimize infection risk. Allowing unrestricted access to family members can compromise these protocols, increasing infection risks for patients, visitors, and healthcare providers due to the introduction of external pathogens and potential cross-contamination. Lastly, the presence of visitors, while often emotionally supportive, can increase stress and reduce rest for ICU patients. Patients in critical care require extensive rest and minimal

stimulation to aid their recovery. Constant interaction with family members can disrupt their sleep and relaxation, leading to higher stress levels and potentially slower recovery.

"Open visitation can hinder infection prevention control, as relatives or patients may be contaminated. Additionally, shortages of nurses can limit the time spent on services. The concept of one patient, one nurse may be limited due to communication issues with neighbors who may not listen or be disrespectful. It is crucial to prioritize patient care and prioritize communication to ensure the best possible outcomes." ***(FGD #4: p3)***

Theme 4: Perceived Challenges and Recommendations of Implementing Open Visitation

Participants described the perceived challenges and recommendations of implementing open visitation in the ICU, highlighting two main categories: challenges and recommendations. The challenges reflect the complexities and potential drawbacks that need careful consideration to ensure the safety and well-being of both patients and staff. The recommendations aim to create a structured and controlled environment that maximizes the benefits of open visitation while mitigating its risks and challenges.

Perceived Challenges of implementing open visitation

Participants expressed significant concerns regarding the implementation of open visitation policies in ICU settings. Key challenges include patient privacy and confidentiality concerns, as well as fears of unauthorized photography and dissemination of patient information. Participants highlighted the need for privacy during medical procedures to prevent interactions between healthcare providers and relatives that could compromise patient confidentiality. Additionally, concerns about infection prevention control were raised, with participants emphasizing the potential for relatives to introduce infections from outside and the importance of maintaining limits on visitation to mitigate these risks. Other challenges discussed included limited capacity issues, such as overcrowding and noise in already constrained ICU spaces, which could impact patient care and comfort. Participants also noted potential increases in patient stress due to noise and activity from visitors,

suggesting a need for balanced visitation policies to support patient recovery and well-being.

"The influx of relatives in the ICU will cause crowding, delays in services, and a shortage of staff. This will cause noise, increased noise levels, and increased risk of contracting diseases like flu. The service providers will need to wait for relatives to be present, affecting patient care and increasing the risk of contracting diseases." ***(FGD #1: p1)***

Recommendations to Implement Open Visitation

Participants provided comprehensive recommendations for implementing open visitation policies in ICUs, addressing key operational aspects to ensure effective integration. They emphasized the need for defining specific visiting hours aligned with ICU routines, suggesting morning, midday, and evening periods to manage visitor flow without disrupting critical care. Participants stressed the importance of setting brief visit durations, typically ranging from 5 to 20 minutes per visitor, to maintain ICU operations and patient care continuity. Limiting the number of simultaneous visitors to a few close family members was recommended to uphold patient privacy and minimize infection risks. Infrastructure upgrades, such as adding partitions for confidentiality and enhancing infection prevention controls, were deemed essential. Clear policies and guidelines for visitor behaviors and entry protocols were proposed to ensure safety and streamline operations, along with education on ICU protocols for relatives. Participants also highlighted the critical role of infection prevention measures, including wearing masks and using designated footwear, to mitigate disease transmission risks in the ICU environment.

"Let us consider that the number of relatives who come to see the patients should be a few per day. The other is about the strategy to prevent infection, and improve the environment that will be friendly to all in implementing this program and set a friendly policy for all that will protect the service provider and those who come so that it does not cause conflict." ***(FGD #2: p2)***

CHAPTER FIVE

5.0 DISCUSSION

5.1 Discussion

This discussion looks into the points of view of the nurses at MNH concerning the open visitation in the ICUs. Four themes were generated, such as Nurses' understanding of open visitation, Nurses perceived Attitude toward implementing open visitation, Nurses' insight into the impact of open visitation, perceived challenges and recommendation of implementing open visitation.

5.1.1 Nurses' understanding regarding implementing open visitation in ICU at MNH in Dar es Salaam.

Nurses at MNH ICUs understood open visitation as a shift to flexible, unrestricted access for relatives, guiding their practice towards family-centered care. Their familiarity varied based on diverse backgrounds and experiences, emphasizing hands-on knowledge from private healthcare in implementing open visitation. These findings align with global studies showing that open visitation is a commonly understood concept among nurses and is open to practices across various settings (23,24). In Sub-Saharan Africa, similar positive outcomes have been reported, though the implementation of such policies varies widely due to cultural and institutional differences (9). In East Africa, growing recognition of family involvement in patient care has shown that the concept of open visitation is also being practiced in these settings (15,25). The findings from MNH aligned with these trends, highlighting the universal benefits of open visitation.

Familiarity with open visitation among nurses varied significantly, reflecting diverse professional backgrounds and experiences. This variability underscored the need for targeted training and education to ensure consistent and effective implementation across healthcare settings (26). Addressing these disparities is essential to maximizing the benefits for patients and their families.

5.1.2 Attitude of nurses toward open visitation in ICU at MNH in Dar es Salaam.

The study found varied nurse attitudes towards open ICU visitation. Many supported it for enhancing patient care and family satisfaction with adequate preparation. Others were hesitant due to workload, patient care compromises, and space constraints. Concerns included security risks, conflicts, and family disputes, highlighting the need for structured policies.

These findings aligned with global studies on healthcare providers' attitudes toward open visitation. Studies in North America and Europe indicated support for open visitation due to its benefits for patient and family satisfaction, alongside concerns about increased workload and potential impacts on patient care quality (27,28). In Sub-Saharan Africa, similar mixed attitudes have been reported, with nurses expressing both support for the concept and concerns about practical challenges and resource limitations (29). In East Africa, specifically, studies have noted the importance of addressing logistical and cultural barriers to successfully implement open visitation (30). These comparisons indicate that the attitudes of nurses at MNH are reflective of broader trends observed globally and regionally.

The study at MNH unexpectedly highlighted increased security concerns and potential conflicts between healthcare providers and visitors, emphasizing unique hospital contextual factors, including patient privacy and security (30). It also underscored complex family dynamics and conflicts among relatives regarding visitation schedules and roles, shaping the implementation of open visitation (31).

5.1.3 Nurses' perceived impact of open visitation on patient care in ICU at MNH in Dar es Salaam.

The findings have shown that open visitation has mixed impacts. Positively, it reduces family stress, enhances satisfaction, and improves communication, aiding patient recovery. However, on the negative side, it may cause care disruptions, infection risks, and patient stress, highlighting the need for careful management to optimize care and support family involvement.

These findings are consistent with global studies that highlight both the benefits and disadvantages of open visitation in ICUs. Research in North America and Europe has shown that open visitation is good for both the family and the patient, but it also poses disadvantages primarily related to infection control and staff workload (23,27). In Sub-Saharan Africa, studies similarly report the dual nature of open visitation, noting both the positive impacts on patient and family satisfaction and the practical challenges in maintaining infection control and managing increased workloads (9). In East Africa, research underscores the importance of balancing the benefits of family involvement with the need to maintain strict infection control measures and ensure adequate rest for patients (30). These comparisons indicate that the findings from MNH reflect broader trends observed globally and regionally.

The intensity of concerns over infection control breaches at MNH highlights the critical role of stringent infection control measures in managing patient outcomes. Moreover, the emphasis on operational problems associated with open visitation underscores the necessity for comprehensive strategies to balance family presence with care efficiency and quality (32,33). These findings indicate a pressing need for targeted interventions, such as enhanced support for nursing staff to manage increased workloads (34). Additionally, understanding patient and family perspectives on open visitation in East African healthcare settings is crucial for refining policies and ensuring their successful implementation in clinical practice.

5.1.4 Nurses' beliefs regarding the role of family members in the patient's care during open visitation in ICU at MNH in Dar es Salaam.

The research findings show that nurses believe family members play crucial roles during ICU open visitation, assisting with daily activities, nursing care, patient information, financial support, and emotional comfort. Their presence enhances patient comfort, dignity, and care coordination, offering vital support during procedures and providing valuable information for treatment planning.

These findings align with global research emphasizing the essential roles family members play in patient care during open visitation. Studies in North America and Europe have highlighted the positive role of family involvement in patients' treatment and subsequent outcomes, underscoring the importance of emotional support, information provision, and participation in care activities (36,37). In Sub-Saharan Africa, similar findings have been reported, with studies noting the vital role of family members in providing emotional and financial support as well as assisting with daily care activities (9). In East Africa, specifically, research underscores the cultural significance of family involvement in patient care, with family members often taking on substantial caregiving responsibilities to support the patient's recovery (30). These comparisons indicate that the beliefs of nurses at MNH regarding the roles of family members in patient care are reflective of broader global and regional trends.

The study found that nurses highly value financial support from family members, which is crucial in Tanzania's out-of-pocket healthcare system. This underscores families' role in ensuring timely access to medical care and supplies, enhancing care quality (15,25,38).

5.1.5 Perceived Challenges and Recommendations of Implementing Open Visitation

The study explored challenges and recommendations for ICU open visitation. Concerns included patient privacy issues like unauthorized photography and information dissemination and advocating for strict privacy measures during procedures. Infection control was also a concern, with suggestions for limited visitation to reduce infection risks. Capacity issues such as overcrowding and noise levels were noted. Recommendations included structured visiting hours, brief visits, and visitor restrictions for privacy and infection control. Infrastructure upgrades and clear guidelines were proposed to enhance safety and efficiency in ICUs.

Global studies generally support the notion that open visitation can positively impact patient outcomes by enhancing emotional support and family involvement (39). However, challenges related to infection control and privacy concerns echo findings from studies conducted in sub-Saharan and East African contexts (34, 40). These regions often face

unique challenges such as resource constraints and differing cultural norms regarding healthcare practices, which can influence the implementation and outcomes of open visitation.

Participants highlighted concerns about potential conflicts between healthcare providers and visitors, stressing the need for clear communication and mutual understanding regarding patient care. These underscore complex dynamics in ICU settings and the importance of proactive conflict resolution. Future research should assess the long-term impacts of open visitation on patient recovery and healthcare outcomes. Studying strategies to manage visitor expectations during open visitation could optimize ICU care environments (41).

5.2 Study Limitation and Mitigations.

Nurses' perspectives in a particular ICU setting were influenced by unique organizational cultures, patient populations, and policy frameworks, limiting the applicability of findings to other healthcare settings. To address the limitation of limited transferability, researchers contextualize their findings within the ICU's specific organizational and cultural context. By providing detailed descriptions of the ICU setting, including staffing levels, patient acuity, visitation policies, and organizational dynamics, researchers helped readers understand the unique factors that influenced nurses' perspectives on the implementation of open visitation of patients admitted to the ICU at MNH in Dar es Salaam.

Another limitation of the study was participant bias. Nurses participating in FGD about open visitation felt pressure to conform to perceived norms or expectations, leading to underreporting or inaccurate responses. To prevent social desirability bias in focus group discussions about open visitation, researchers created a safe environment, emphasized confidentiality, encouraged open dialogue, and used open-ended questions. This allowed nurses to express their thoughts and concerns without being constrained by predefined response options, minimizing the influence of bias and capturing a more authentic representation of their views and perspectives on implementing open visitation in the ICU.

CHAPTER SIX

6.0 AND RECOMMENDATIONS

6.1 Conclusion

The study conducted at Muhimbili National Hospital (MNH) provides valuable insights into nurses' perspectives on implementing open visitation in the ICU. It reveals that while nurses recognize the emotional support and satisfaction it offers to patients and their families, they also express significant concerns regarding infection risks, potential disruptions to patient care, and the logistical challenges of managing visitors in a high-stress environment. These findings suggest a need for balanced policies that enhance patient and family welfare without compromising safety and efficiency.

Furthermore, the study highlights the importance of comprehensive education and clear communication strategies to address the diverse attitudes and understandings among nurses regarding open visitation. Tailored training programs are essential to ensure that all nursing staff are adequately prepared to manage the dynamics of open visitation, including infection control and family interaction. Future research should focus on evaluating the long-term effects of open visitation on patient outcomes, staff satisfaction, and the overall ICU environment. Additionally, incorporating feedback from patients and their families will be crucial in refining policies to better meet their needs while maintaining high standards of care and safety.

6.2 Recommendations

The recommendations are presented and directed towards the Ministry of Health, health policy makers, the management of MNH, and healthcare workers at MNH. They are based on nurses' perspectives on implementing open visitation for patients admitted to the ICU at MNH. This study highlights the benefits and challenges of open visitation, offering actionable insights to guide policy development, hospital administration, and clinical practice. The aim is to enhance patient care and family satisfaction while addressing the concerns and practicalities identified by the nursing staff, thereby ensuring a balanced and effective implementation of open visitation in the ICU.

Recommendation on Nurses' Understanding of Open Visitation in ICUs

MNH should implement targeted educational programs to enhance nurses' understanding of open visitation practices. Given the varying familiarity among nurses, training sessions should cover core concepts, benefits, and challenges associated with open visitation. This training could include seminars, workshops, and exposure visits to hospitals already practicing open visitation. It should also address practical issues such as managing multiple visitors, ensuring privacy, and recognizing cultural or social factors influencing visitation. Incorporating experiences from both local and international healthcare settings can bridge knowledge gaps and promote a unified understanding of open visitation in ICU. Additionally, policymakers should develop and promote standardized guidelines for hospitals to follow, ensuring that open visitation is implemented uniformly and effectively. These guidelines should include educational initiatives for visitors to understand their roles and responsibilities in supporting patient care.

Recommendations on Nurses' Perceived Attitudes toward Implementing Open Visitation.

Due to the diverse attitudes of nurses' toward implementing open visitation in ICUs, there should be fostering a supportive environment that encourages a balanced view. For nurses who are hesitant or opposed to open visitation, provide opportunities for discussions, peer support, and mentorship from colleagues with more positive experiences. Highlighting successful case studies where open visitation improved patient outcomes may help shift attitudes. Additionally, MNH management should actively create forums where nurses can openly discuss their concerns, leading to collaborative solutions that address fears about workload, security, and care quality. Support for adequate staffing and security measures could help mitigate the reluctance to implement open visitation.

Recommendations on Nurses' Insights into the Impact of Open Visitation

The Ministry of Health and MNH management should develop guidelines that maximizing the positive impacts of open visitation while minimizing negative impacts of open visitation. Specific protocols should include clear visitation schedules that strike a balance between open visitation and the need for uninterrupted clinical activities. Flexibility can be maintained, but with considerations for critical care procedures and patient rest times. Additionally, implementing a visitor education program can help family members understand how to positively contribute to patient care without interfering with medical processes or breaching infection control measures. The guidelines should also include mechanisms to support staff in handling any emotional or practical challenges related to managing visitors.

Recommendations on Perceived Roles of Family Members in Open Visitation

MNH should foster a culture of collaboration by formally defining and promoting the supportive role family members can play during open visitation. Clear role definitions and training for both nurses and family members can enhance the involvement of relatives in activities such as assisting with daily living tasks, providing emotional support, and participating in decision-making. Nurses should receive training on how to effectively engage family members in care, ensuring that family participation is beneficial rather than burdensome. Creating educational materials for families about the appropriate ways to support patients can help alleviate nurse concerns about interference, stress, or inappropriate behaviors. Structured roles and training can make family involvement more predictable and manageable for nurses.

Recommendations for future research on open visitation in ICU

To advance the understanding of nurses' perspectives on implementing open visitation for ICU patients at MNH, future research should consider several key areas. First, longitudinal studies are recommended to evaluate the long-term effects of open visitation on patient outcomes, nurse workload, and the overall ICU environment.

This approach will provide a more comprehensive understanding of the sustained impacts and help identify any evolving challenges or benefits over time.

Second, comparative studies across different hospitals or regions within Tanzania could offer valuable insights into how varying contexts and resources influence the implementation and effectiveness of open visitation. By comparing diverse settings, researchers can identify best practices and potential pitfalls, facilitating the development of more universally applicable guidelines and strategies.

Finally, future research should incorporate the perspectives of patients, their families, and other healthcare professionals, such as physicians and support staff. Understanding their experiences and expectations regarding open visitation will help create a more holistic view of its impacts and inform more patient-centered policy development. Additionally, exploring the views of other healthcare professionals, such as doctors and support staff, can provide a more nuanced understanding of the multidisciplinary challenges and benefits associated with open visitation in the ICU.

7.0 REFERENCES

1. Ajzen I. The theory of planned behavior. Organ Behav Hum Decis Process. 1991;50(2):179–211.
2. Marshall JC, Bosco L, Adhikari NK, Connolly B, Diaz J V., Dorman T, et al. What is an intensive care unit? A report of the task force of the World Federation of Societies of Intensive and Critical Care Medicine. J Crit Care [Internet]. 2017;37:270–6. Available from: http://dx.doi.org/10.1016/j.jcrc.2016.07.015
3. Dragoi L, Munshi L, Herridge M. Visitation policies in the ICU and the importance of family presence at the bedside. Intensive Care Med [Internet]. 2022;48(12):1790–2. Available from: https://doi.org/10.1007/s00134-022-06848-1
4. Athanasiou A, Papathanassoglou EDE, Patiraki E, Mary S. Family Visitation in Greek Intensive Care Units: Nurses' Perspective. 2014;(800):326–33.
5. Mckenna SP. Nurses ' Perceptions of Open Visiting Policy in the Adult Intensive Care Unit : An Integrative Review. 2019;
6. Zupanets IA, Dobrova VY. Introduction of open visiting policy in intensive care units in Ukraine : policy analysis and the ethical perspective. 2018;105–21.
7. da Silva Ramos FJ, Fumis RRL, Azevedo LCP, Schettino G. Perceptions of an open visitation policy by intensive care unit workers. Ann Intensive Care. 2013;3(1):1–8.
8. José F, Rego R, Fumis L, Cesar L, Azevedo P, Schettino G. Perceptions of an open visitation policy by intensive care unit workers. 2013;9–12.
9. Ibrahim H, Abu A, Jarrah S, Yateem N Al, Ahmed FR. Open visitation policy in intensive care units in Jordan : cross‐sectional study of nurses ' perceptions. BMC Nurs [Internet]. 2022;1–8. Available from: https://doi.org/10.1186/s12912-022-01116-5
10. Al-akash H, Maabreh R, Aburuz M, Khader K, Shajrawi A. Jordanian Patients ' Family Members Need Perceptions in the Critical Care Settings : Nurses ' Perspectives versus Family Members ' Perspectives in the Context of Health Informatics. 2021;2021.
11. Montesanti S, MacKean G, Fitzpatrick KM, Fancott C. Family caregivers as essential partners in care: examining the impacts of restrictive acute care visiting policies during the COVID-19 pandemic in Canada. BMC Health Serv Res [Internet]. 2023;23(1):320. Available from: https://doi.org/10.1186/s12913-023-09248-3
12. Chen L, Yang X. Using EPPM to Evaluate the Effectiveness of Fear Appeal Messages Across Different Media Outlets to Increase the Intention of Breast Self-Examination Among Chinese Women. Health Commun. 2019;34(11):1369–76.
13. Chapman BDK, Collingridge DS, Mitchell LA, Wright ES, Hopkins RO. e V R m -

p i C u. 2016;25(1):46–50.

14. Jia M. 乳鼠心肌提取 HHS Public Access. Physiol Behav. 2017;176(3):139–48.

15. Yakubu YH, Esmaeili M, Navab E. Family members ' beliefs and attitudes towards visiting policy in the intensive care units of Ghana. 2019;(November 2018):526–34.

16. Wyskiel RM, Chang BH, Alday AA, Thompson DA, Rosen MA, Dietz AS, et al. Towards expanding the acute care team: Learning how to involve families in care processes. Fam Syst Heal. 2015;33(3):242–9.

17. Haave RO, Bakke HH, Schröder A. Family satisfaction in the intensive care unit, a cross-sectional study from Norway. BMC Emerg Med. 2021;21(1):1–12.

18. Davidson JE, Jones C, Bienvenu OJ. Family response to critical illness: Postintensive care syndrome-family. Crit Care Med. 2012;40(2):618–24.

19. Dijkstra BM, Felten-Barentsz KM, van der Valk MJM, Pelgrim T, van der Hoeven HG, Schoonhoven L, et al. Family participation in essential care activities: Needs, perceptions, preferences, and capacities of intensive care unit patients, relatives, and healthcare providers—An integrative review. Aust Crit Care [Internet]. 2022;36(3):401–19. Available from: https://doi.org/10.1016/j.aucc.2022.02.003

20. Kydonaki K, Kean S, Tocher J. Family INvolvement in inTensive care: A qualitative exploration of critically ill patients, their families and critical care nurses (INpuT study). J Clin Nurs. 2020;29(7–8):1115–28.

21. Daniel E Shumer, Natalie J Nokoff NPS, Erin C. Dowd, M.D.a, Michael J. Frank, Ph.D.b, Anne Collins, Ph.D.c, James M. Goldd, and Deanna M. Barch PD. 乳鼠心肌提取 HHS Public Access. Physiol Behav. 2017;176(12):139–48.

22. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105–12.

23. Khaleghparast S, Joolaee S, Ghanbari B, Maleki M, Peyrovi H, Bahrani N. A Review of Visiting Policies in Intensive Care Units. Glob J Health Sci. 2015;8(6):267–76.

24. Brauchle M, Nydahl P, Pregartner G, Hoffmann M, Jeitziner MM. Practice of family-centred care in intensive care units before the COVID-19-pandemic: A cross-sectional analysis in German-speaking countries. Intensive Crit Care Nurs. 2022;68:103139.

25. Klaas N, Baliki O. Family satisfaction with involvement in decision making in the intensive care unit : A scoping review . 2024;1–20.

26. Mulyana B, Trisyani Y, Nur'aeni A, Pamungkas RA. A Systematic Review of Family-Centered Intervention Among Critical Ill Patients. Indones J Nurs Heal Sci ISSN. 2021;6(2):133–57.

27. Ciufo D, Hader R, Holly C. A comprehensive systematic review of visitation models in adult critical care units within the context of patient- and family-centred care. Int J Evid Based Healthc. 2011;9(4):362–87.

28. Ning J, Cope V. Open visiting in adult intensive care units – A structured literature review. Intensive Crit Care Nurs. 2020;56(xxxx):102763.

29. Imanipour M, Kiwanuka F. International Journal of Africa Nursing Sciences Family nursing practice and family importance in care – Attitudes of nurses working in intensive care units. Int J Africa Nurs Sci [Internet]. 2020;13(May):100265. Available from: https://doi.org/10.1016/j.ijans.2020.100265

30. Muthoni Maina P. Involvement of Patients' Families in Care of Critically Ill Patients at Kenyatta National Hospital Critical Care Units. Am J Nurs Sci. 2018;7(1):31.

31. Scott P, Thomson P, Shepherd A. Families of patients in ICU: A Scoping review of their needs and satisfaction with care. Nurs Open. 2019;6(3):698–712.

32. Mahajan RK, Gupta S, Singh G, Mahajan R, Gautam PL. Continuous family access to the intensive care unit: A mixed methods exploratory study. Indian J Crit Care Med. 2021;25(5):540–50.

33. Patil SJ, Ambulkar R, Kulkarni AP. Patient Safety in Intensive Care Unit: What can We do Better? Indian J Crit Care Med. 2023;27(3):163–5.

34. Soleimani M, Fakhr-Movahedi A, Yarahmadi S. Family engagement in the care of infectious patients in intensive care units: A hybrid concept analysis. Nurs Open. 2024;11(3):1–14.

35. Mistraletti G, Giannini A, Gristina G, Malacarne P, Mazzon D, Cerutti E, et al. Why and how to open intensive care units to family visits during the pandemic. Crit Care. 2021;25(1):1–6.

36. Hunter JD, Goddard C, Rothwell M, Ketharaju S, Cooper H. A survey of intensive care unit visiting policies in the United Kingdom. Anaesthesia. 2010;65(11):1101–5.

37. Fumagalli S, Boncinelli L, Lo Nostro A, Valoti P, Baldereschi G, Di Bari M, et al. Reduced cardiocirculatory complications with unrestrictive visiting policy in an intensive care unit: Results from a pilot, randomized trial. Circulation. 2006;113(7):946–52.

38. Wong P, Redley B, Digby R, Correya A, Bucknall T. Families' perspectives of participation in patient care in an adult intensive care unit: A qualitative study. Aust Crit Care. 2020;33(4):317–25.

39. Hashavya S, Pines-Shwartz N, Guzner N, Ohana Sarna Cahan L, Gross I. The Impact of Parental Presence on Invasive Procedures in the Pediatric Emergency Department: A Prospective Study. J Clin Med. 2023;12(17).

40. Hart JL, Turnbull AE, Oppenheim IM, Courtright KR. Family-Centered Care

During the COVID-19 Era. J Pain Symptom Manage. 2020;60(2):e93–7.

41. Davidson JE, Aslakson RA, Long AC, Puntillo KA, Kross EK, Hart J, et al. Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult ICU. Crit Care Med. 2017;45(1):103–28.

8.0 APPENDICES.

8.1 Appendix I: Consent Form

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED HEALTH SCIENCES DIRECTORATE OF RESEARCH AND PUBLICATIONS

ID. NO

Consent Form for Participating in a Research

Introduction: I'm Bukulu Julius, a postgraduate student; pursuing a Master of Science in Critical Care Nursing and Trauma at Muhimbili University of Health and Allied Sciences (MUHAS) in the School of Nursing. I am researching on Nurses' perspectives on the implementation of open visitation of patients admitted in the intensive care unit at Muhimbili National Hospital in Dar es Salaam.

Aim: The purpose of the research is to investigate Nurses' perspectives on the implementation of open visitation of patients admitted in the intensive care unit at Muhimbili National Hospital in Dar es Salaam.

The finding from this research was then be able to guide the development and recommendation of this policy for the benefits of patients' outcomes.

Procedure: You are selected because you are one of the nurses who are experienced nurse working in intensive care unit for more than one year in providing care to critical ill patients at Muhimbili National Hospital. If you choose to participate you was participate in focused group discussion with fellow nurses who also work in intensive care unit at Muhimbili National Hospital for about 45 minutes and in order to capture all the information and since the researcher is unable to write down everything you say, the focused group discussion was recorded on audio.

Confidentiality: All answers was kept private. This implies that your answers was only be utilized for study purposes and shared with MUHAS as required. I'll make sure that your

identity as the respondent is hidden from any information in my report. Throughout the group discussion and the presentation of findings, no identities was used.

Ability to resign: You have the option to take part in this research or not. Furthermore, you are free to end the focused group discussion at any moment for any reason without facing consequences, and you are not required to discuss anything you do not want to. Nonetheless, since your experience is crucial to our study, I strongly advise you to take part.

Advantage: While taking part in this study might not directly benefit you, it might yield insightful data that was help others and enhance your own and your peers' quality of life and health outcomes.

Risks: You won't suffer any consequences from taking part in this study, even if some of the questions can be private.

Who to Speak With: Please get in touch with the researcher if you have any questions, Bukulu Julius from MUHAS, P. O. BOX 65001, Dar es Salaam, mobile number 0620 401 578. If you have any inquiries concerning your participant rights, please, you can get in touch with MUHAS's Director of Research, Publications, and Innovation. P.O. Box 65001, Dar es Salaam-Tanzania.

Do you agree to participate? ☐ Put a tick in the appropriate box

participant does NOT agree ☐

I,..... have read and comprehended the contents of this form. I accept to take part in this study after having my questions addressed.

Signature of participant…….
Date……. Signature of researcher …….
Date……

8.2 Appendix II. Fomu Ya Ridhaa (Kwa Kiswahili)

CHUO KIKUU CHA AFYA NA SAYANSI SHIRIKISHI MUHIMBILI KURUGENZI YA UTAFITI NA MACHAPISHO

Namba ya utambulisho Fomu ya Ridhaa ya Kushiriki Katika Utafiti

Utangulizi: Kwa majina ni Bukulu Julius, ninasomea digrii ya uzamili ya uuguzi bobezi wa magonjwa mahututi na ajali katika Chuo Kikuu cha Afya na Sayansi Shirikishi Muhimbili (MUHAS), Shule ya Uuguzi. Ninafanya utafiti kuhusu mitazamo ya wauguzi katika utekelezaji wa dhana ya kutokua na ukomo wa ndugu kuwatembelea wagonjwa waliolazwa katika chumba cha wagonjwa mahututi katika Hospitali ya Taifa Muhimbili jijini Dar es salaam.

Dhumuni: Madhumuni ya utafiti huo ni kuchunguza mitazamo ya wauguzi kuhusu utekelezaji wa dhana ya kutokua na ukomo wa ndugu wa kuwautembelea wagonjwa waliolazwa katika chumba cha wagonjwa mahututi katika Hospitali ya Taifa Muhimbili jijini Dar es salaam.

Matokeo kutoka kwa utafiti huu yataweza kuongoza uundaji na mapendekezo ya sera hii kwa manufaa ya matokeo ya wagonjwa.

Utaratibu wa kushiriki: Umechaguliwa kwa sababu wewe ni mmoja wa wauguzi ambao ni muuguzi mzoefu anayefanya kazi katika chumba cha wagonjwa mahututi kwa zaidi ya mwaka mmoja katika kutoa huduma kwa wagonjwa mahututi katika Hospitali ya Taifa Muhimbili. Ukiamua kushiriki utashiriki katika majadiliano ya kikundi na wauguzi wenzako ambao pia wanafanya kazi katika chumba cha wagonjwa mahututi katika Hospitali ya Taifa Muhimbili kwa takribani dakika 45 na ili kupata taarifa zote na kwa kuwa mtafiti hawezi kuandika kila kitu unachosema. , majadiliano ya kikundi yaliyolengwa yatarekodiwa kwa sauti.

Usiri: Majibu yote yatawekwa faragha. Hii ina maana kwamba majibu yako yatatumika tu kwa madhumuni ya masomo na kushirikiwa MUHAS inavyohitajika. Nitahakikisha kuwa utambulisho wako kama mhojiwa umefichwa kutokana na maelezo yoyote katika ripoti yangu. Katika kipindi chote cha majadiliano ya kikundi na uwasilishaji wa matokeo, hakuna utambulisho utakaotumika.

Una chaguo la kushiriki katika utafiti huu au la. Zaidi ya hayo, uko huru kumaliza mjadala wa kikundi lengwa wakati wowote kwa sababu yoyote bila kukabili matokeo, na hutakiwi kujadili chochote usichotaka. Hata hivyo, kwa kuwa uzoefu wako ni muhimu kwa somo letu, nakushauri sana ushiriki.

Manufaa: Ingawa kushiriki katika utafiti huu kunaweza kusikufaidi moja kwa moja, kunaweza kutoa data ya kina ambayo itasaidia wengine na kuboresha ubora wa maisha na afya ya wenzako.

Hatari: Hutapata madhara yoyote kwa kushiriki katika utafiti huu, hata kama baadhi ya maswali yanaweza kuwa ya faragha.

Nani wa Kuzungumza Naye: Tafadhali wasiliana na mtafiti kama una maswali yoyote, Bukulu Julius kutoka MUHAS, P. O. BOX 65001, Dar es Salaam, nambari ya simu 0620 401 578. Ikiwa una maswali yoyote kuhusu haki zako za mshiriki, tafadhali, wewe unaweza kuwasiliana na Mkurugenzi wa Utafiti, Machapisho na Ubunifu wa MUHAS. P.O. Box 65001, Dar es Salaam-Tanzania.

Je, unakubali kushiriki? Weka tiki kwenye kisanduku kinachofaa

KAKUBALI ☐ HAKUBALI ☐

Mimi,..... nimesoma na kuelewa yaliyomo katika fomu hii. Ninakubali kushiriki katika utafiti huu baada ya maswali yangu kushughulikiwa.

Saini ya mshiriki ……. Tarehe……. Saini ya mtafiti ……. Tarehe……

8.3 Appendix III: Group Discussion guide

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED HEALTH SCIENCES
DIRECTORATE OF RESEARCH AND PUBLICATIONS

This is a patient's focused group discussion guide for exploring Nurses' perspectives on the implementation of open visitation of relatives of patients admitted in the intensive care unit at Muhimbili National Hospital in Dar es Salaam.

Introduction

I chose you above the others in the hopes that you would be able to answer my inquiries and have a wealth of knowledge. Without reservation, we welcome your replies, so please don't hesitate to ask. Additionally, just to remind you, this focused group discussion was taped so that you can easily recall the information you provided. It was run around 45 minutes.

Part I: Demographic Information May you kindly tell me about your

1. Age: --------
2. Sex:
    a) Male [ ]
    b) Female [ ]
3. Marital status
    a) Single [ ]
    b) Married [ ]
    c) Widow/ widower [ ]
    d) Divorced [ ]
    e) separated [ ]

f) cohabitating [ ]

4. Education level
    a) Diploma [ ]
    b) Bachelor [ ]
    c) Masters [ ]
5. Working experience

Years as a general nurse: a) less than one year [ ]

b) 1-3 year [ ]

c) More than 3 years [ ]

Years working in ICUs a) less than one year [ ]

b) 1-3 year [ ]

c) More than 3 years [ ]

PART II: Nurses understanding on open visitation

6. What do you understand by the term ‘open visitation’
7. Have you ever heard about this concept before? If yes: Where?
8. What are the key components of open visitation?

Probe: Visiting hour, Duration of visitation, Number of visitors and role of the family.

PART III: Nurses Attitude toward implementation of open visitation

9. In your opinion, how does the open visitation influence the overall quality of patient care in intensive care unit of Muhimbili National Hospital?
   Probe: Enhanced Family Engagement, Improved Communication, Early Detection of Changes, Facilitated Care Transitions.
10. What do you think about implementing open visitation in intensive care unit of Muhimbili National Hospital?

Probe: security and safety, infection control, privacy, confidentiality, decision making family's anxiety and stress, family's trust, family access to information, patient's recovery, patient's rest, family's satisfaction.

PART IV: Nurses Perceived Impact toward implementation of open visitation Intensive Care Unit of Muhimbili National Hospital.

11. What are positive impacts of open visitation having on patient outcome and well-being?

    Probe on positive impact: Emotional support, Comfort to patients, Influence on Recovery, increase patient satisfaction, increase patient centered care, reduce patient anxiety and depression, reduces cardiovascular complication, Family members satisfaction, increased opportunity for family teaching, improve patient healing, decreases family's anxiety and stress, allow family to stay with the patient, allows family to have more information about the patient

12. What are negative impacts do you believe the open visitation has on patient outcome and well-being?

    Probe on negative impact: Increase stress for patients, Disruption of patient care, Patient privacy, Infection control

13. What are potential challenges do you think are associated with implementing open visitation in intensive care unit of Muhimbili National Hospital?

    Probe on challenges of implementing open visitation: infection control, Patient privacy, workload and staffing issues, Limited space, family dynamic and conflict, Disruption of patient care, Training and Education needs, Communication issues, Security concerns, Cultural and ethical consideration, End of life care, Resources allocation, Organization policies and guideline

PART V: Nurses Belief on Role of Family Members during open visitation in Intensive Care Unit of Muhimbili National Hospital

14. What do you think about relatives participating in the treatment of patients in the intensive care unit, particularly considering the open visiting policy?

Positive probe on family member presence on implementing open visitation: Advocacy, Emotion support, Communication Facilitation, Assistance with care, Decision Making involvement, End of life support, Comfort and Familiarity, Collaboration with Healthcare team.?

Negative probe on family member presence on implementing open visitation: Negatively: Disruption of care, Increase nurse's workload, Privacy and security, Infection control.

15. What are the things family members can do during the implementation of the open visitation for patients' admissions to the intensive care unit of Muhimbili National Hospital?

Probe on role of family member: Feeding, Bed-bath, assist in range of motion, toileting and perineal care, Oral care

PART VI: ENDING

Do you have any other details on the study that you think would be relevant to me about nurses' perspectives on the implementation of open visitation of relatives of patients admitted in the intensive care unit at Muhimbili National Hospital in Dar es Salaam? When I need additional clarification regarding our focused group discussion, I was once again ask for your assistance.

I am quite grateful for your assistance.

8.4 Appendix IV: Muongozo wa kuendesha mahojiano yakikundi (Chapisho la Kiswahili)

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED HEALTH SCIENCES
DIRECTORATE OF RESEARCH AND PUBLICATIONS

Huu ni mwongozo wa majadiliano ya vikundi vya wauguzi wakijadili Maoni na mitazamo ya wauguzi kuhusu utekelezaji wa sera ya wazi yakutokua na ukomo wa ndugu na jamaa wa kuwautembelea wagonjwa waliolazwa katika chumba cha wagonjwa mahututi katika Hospitali ya Taifa Muhimbili jijini Dar es salaam.

Utangulizi

Nilikuchagua wewe juu ya wengine kwa matumaini kwamba utaweza kujibu maswali yangu. Bila kutoridhishwa, tunakaribisha majibu yako, kwa hivyo tafadhali usisite kuuliza. Zaidi ya hayo, ili kukukumbusha tu, majadiliano haya ya kikundi yaliyolengwa yatarekodiwa ili kuweze kukumbuka kwa urahisi habari uliyotoa. Madjadiliano kwenye kikundi yatachukua kama dakika 45.

Sehemu ya I: Taarifa za Kidemografia Naomba uniambie kuhusu yako

1. Umri: --------
2. Jinsia:
    a. Mwanaume [ ]
    b. Mwanamke [ ]
3. Hali ya ndoa
    a. Sijaoa [ ]
    b. Nimeoa [ ]
    c. Mjane/ Mgane [ ]
    d. Walioachika [ ]

e. Kutengana [ ]

f. Kuishi pamoja [ ]

4. Kiwango cha elimu

g. Astashahada [ ]

h. Shahada [ ]

i. Shahada ya kwanza [ ]

j. Shahada ya udhamili [ ]

5. Uzoefu wa kazi

Miaka kama muuguzi mkuu: a) chini ya mwaka mmoja [ ]

b) mwaka 1-3 [ ]

c) zaidi ya miaka 3 [ ]

Miaka ya kufanya kazi katika kitengo cha wagonjwa mahututi a) chini ya mwaka mmoja

b) mwaka 1-3 [ ]

c) zaidi ya miaka 3 [ ]

SEHEMU YA PILI : Uelewa wa Wauguzi juu ya Kutokua na ukomo wa ndugu kutembelea mgonjwa wao waliolazwa kitengo cha wagonjwa mahututi Hospitali ya Muhimbili

6. Unaelewa nini kuhusu dhana ya kutokua na ukomo wakutembelea wagonjwa' (open visitation)
7. Je, umewahi kusikia kuhusu dhana hii hapo awali? Uliisikia Wapi?
8. Kama ndiyo, ni vipengele gani muhimu vya kuzingatia katika utekelezaji wa dhana hii ya kutokua na ukomo wa kuwautembelea wagonjwa ? Ikiwa hapana, Je, unafikiri ni vipengele gani muhimu vya kuzingatia dhana hii ya kutokua na ukomo wa kuwautembelea wagonjwa ?

   Uchunguzi: Saa ya Kutembelea, Muda wa kutembelewa, Idadi ya Wageni na jukumu la familia.

9. Je, kwa maoni yako, ni kwa namna gani dhana hii ya kutokua na ukomo wa kuwatembelea wagonjwa waliolazwa katika chumba cha wagonjwa mahututi katika Hospitali ya Taifa Muhimbili inaathiri vipi kwa ujumla ubora wa huduma kwa wagonjwa ?

   Uchunguzi: Uhusiano wa Familia Ulioimarishwa, Mawasiliano Iliyoboreshwa, Utambuzi wa Mapema wa Mabadiliko, Mipito ya Utunzaji Uliowezeshwa.

10. Unafikiria nini kuhusu utekelezaji wa dhana hii ya kutokua na ukomo wa kuwautembelea wagonjwa waliolazwa katika chumba cha wagonjwa mahututi katika Hospitali ya Taifa ya Muhimbili?

    Uchunguzi: usalama na usalama, udhibiti wa maambukizi, faragha, usiri, kufanya maamuzi mahangaiko na mafadhaiko ya familia, imani ya familia, ufikiaji wa habari kwa familia, kupona kwa mgonjwa, mapumziko ya mgonjwa, kuridhika kwa familia.

SEHEMU YA NNE: Matokeo ya mtazamo wa Wauguzi katika utekelezaji wa sera ya kutokua na ukomo wa kuwatembelea wagonjwa katika Kitengo cha Wagonjwa Mahututi cha Hospitali ya Taifa ya Muhimbili.

11. Je, ni matokeo gani chanya unaamini dhana hii ya kutokua na ukomo wa kuwautembelea wagonjwa inaleta katika ustawi wa wagonjwa?

Chunguza juu ya chanya: Usaidizi wa kihisia, Faraja kwa wagonjwa, Ushawishi wa Kupona, Ongeza kuridhika kwa mgonjwa, Kuongeza utunzaji unaozingatia mgonjwa, kupunguza wasiwasi wa mgonjwa na unyogovu, kupunguza matatizo ya moyo na mishipa, kuridhika kwa wanafamilia, fursa ya kuongezeka kwa mafundisho ya familia, kuboresha uponyaji wa mgonjwa, hupunguza familia. wasiwasi na dhiki, kuruhusu familia kukaa na mgonjwa, inaruhusu familia kuwa na habari zaidi kuhusu mgonjwa

12. Je, ni matokeo gani hasi unaamini kuwa dhana hii ya kutokua na ukomo wa kuwautembelea wagonjwa inaleta katika ustawi wa wagonjwa?

    Chunguza juu ya hasi: Usaidizi wa kihisia, Faraja kwa wagonjwa, Ushawishi wa Kupona, Ongeza kuridhika kwa mgonjwa, Kuongeza utunzaji unaozingatia mgonjwa, kupunguza wasiwasi wa mgonjwa na unyogovu, kupunguza matatizo ya moyo na

mishipa, kuridhika kwa wanafamilia, fursa ya kuongezeka kwa mafundisho ya familia, kuboresha uponyaji wa mgonjwa, hupunguza familia. wasiwasi na dhiki, kuruhusu familia kukaa na mgonjwa, inaruhusu familia kuwa na habari zaidi kuhusu mgonjwa

13. Je, ni changamoto zipi unadhani zinaweza kutokea wakati wa utekelezaji wa dhana hii ya kutokua na ukomo wa kuwatembelea wagonjwa waliolazwa katika kitengo cha wagonjwa mahututi katika Hospitali ya Taifa Muhimbili?

    Uchunguzi: udhibiti wa maambukizo, Faragha ya mgonjwa, mzigo wa kazi na masuala ya wafanyakazi, Nafasi finyu, mabadiliko ya familia na migogoro, Usumbufu wa utunzaji wa mgonjwa, Mahitaji ya Mafunzo na Elimu, Masuala ya mawasiliano, Maswala ya kiusalama, Kuzingatia kitamaduni na maadili, Mwisho wa utunzaji wa maisha, Mgao wa rasilimali, Sera na miongozo ya shirika

    SEHEMU YA TANO: Imani ya Wauguzi juu ya Wajibu wa Wana-familia wakati wa Sera ya Wazi ya Ziara katika chumba cha wagonjwa mahututi cha Hospitali ya Taifa ya Muhimbili.

14. Je, unafikiliaje ushiriki wa wanafamilia katika kumuhudumia mgonjwa aliyelazwa kitengo cha wagonjwa mahututi katika Hospitali ya Taifa Muhimbili kwa kuzingatia dhana ya kutokua na ukomo wa kuwatembelea wagonjwa?

    Uchunguzi: Utetezi, Usaidizi wa Hisia, Uwezeshaji wa Mawasiliano, Usaidizi wa uangalifu, Ushiriki wa Kufanya Maamuzi, Mwisho wa Usaidizi wa Maisha, Faraja na Ufahamu, Ushirikiano na timu ya Afya.

15. Je, unadhani ni majukumu gani wanafamilia wanaweza kuyafanya wakati wa kutekeleza dhana ya kutokua na ukomo wa kuwatembelea wagonjwa katika kitengo cha wagonjwa mahututi katika Hospitali ya Taifa Muhimbili?

Uchunguzi: Kulisha, Kuogesha kitandani, kusaidia katika mazoezi mbalimbali ya viungo vya mwili , choo na matunzo ya perineal, Huduma ya mdomoSEHEMU YA IV: MWISHO

Je, una maelezo mengine kuhusu utafiti huu ambayo unadhani yangenifaa kuhusu utayarifu wa wauguzi katika kutekeleza sera ya wazi ya kutembelea chumba cha wagonjwa mahututi

katika Hospitali ya Taifa ya Muhimbili? Nitapohitaji ufafanuzi wa ziada kuhusu mjadala wetu wa kikundi lengwa, nitaomba tena usaidizi wako.

Ninashukuru sana kwa msaada wako.

8.5 Appendix V: Ethical Clearance

UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR – RESEARCH, PUBLICATIONS AND INNOVATIONS

Ref. No.DA.282/298/01.C/2185 Date: 22/04/2024

MUHAS-REC-04-2024-2185
BUKULU JULIUS
SHOOL OF NURSING
MUHAS

RE: APPROVAL FOR ETHICAL CLEARANCE FOR A STUDY TITLED: NURSES' PERSPECTIVES ON THE IMPLEMENTATION OF OPEN VISITATION OF PATIENTS ADMITTED IN THE INTENSIVE CARE UNIT AT MUHIMBILI NATIONAL HOSPITAL IN DAR ES SALAAM.

Reference is made to the above heading,

I am pleased to inform you that the Chairperson has on behalf of the University Senate, approved ethical clearance of the above-mentioned study, on recommendations of the Senate Research and Publications Committee meeting accordance with MUHAS research policy and Tanzania regulations governing human and animal subjects research.

APPROVAL DATE: 22/04/2024
EXPIRATION DATE OF APPROVAL: 22/04/2025

STUDY DESCRIPTION:
Purpose:
The purpose of this observational cross sectional study is to explore the readiness of nurses on implementing an open visitation policy in intensive care unit of National Referral Hospital of Tanzania.

The approved protocol and procedures for this study is attached and stamped with this letter, and can be found in the link provided: https://irb.muhas.ac.tz/storage/Certificates/Certificate%20-%2015541.pdf and in the MUHAS archives.

The PI is required to:

1. Submit bi-annual progress reports and final report upon completion of the study.
2. Report to the IRB any unanticipated problem involving risks to subjects or others including adverse events where applicable.
3. Apply for renewal of approval of ethical clearance one (1) month prior its expiration if the study is not completed at the end of this ethical approval. You may not continue with any research activity beyond the expiration date without the approval of the IRB. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.
4. Obtain IRB amendment (s) approval for any changes to any aspect of this study before they can be implemented.
5. Data security is ultimately the responsibility of the investigator.
6. Apply for and obtain Data Transfer Agreement (DTA) from NIMR if data will be transferred to a foreign country.
7. Apply for and obtain Material Transfer Agreement (MTA) from NIMR, if research materials (samples) will be shipped to a foreign country.
8. Apply for and obtain permission to publish the results from National Institute for Medical Research. The application should be before submitting to a publisher and not concurrently through the email publications@nimr.or.tz.
9. Any researcher, who contravenes or fail to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine as per NIMR Act No. 23 of 1979, PART III section 10 (2)
10. The PI is required to ensure that the findings of the study are disseminated to relevant stake holders.
11. PI is required to be versed with necessary laws and regulatory policies that govern research in Tanzania. Some guidance is available on our website https://drp.muhas.ac.tz/.

Muhimbili University of Health and Allied Sciences
DIRECTOR
Research, Publications & Innovations
Box 65001

Dr. Nahya Salim Masoud,
Chairperson, MUHAS Research and Ethics Committee

8.6 Appendix VI: Permission letter

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

MUHIMBILI NATIONAL HOSPITAL

In reply please quote:

Ref. No.: MNH/CRTCU/Perm/2024/202 Date: 07th May, 2024

Block Manager,

Mwaisela,

Muhimbili National Hospital

RE: PERMISSION TO COLLECT DATA AT MNH

Name of PI	**Bukulu Julius**
Title	**"Nurses Perspectives Towards Implementation of Open Visitation Policy in Intensive Care Unit at Muhimbili National Hospital in Tanzania"**
Institution	Muhimbili University of Health and Allied Sciences
Supervisor	Dr. Agnes F. Massawe (MUHAS)
Co – Investigators	Zainab K. Manji Nazahed Richard (MNH)
Period	07th May 2024 to 30th June, 2024

Approval has been granted to the above principal investigators to collect data at MNH. Dissemination of study findings at MNH shall be overseen by **Nazahed Richard (**MNH) supervisor.

Kindly ensure the named principal investigator abide to the ethical principles and other conditions of the research approval.

Sincerely,

Dr. Sima Rugarabamu
For: Head of Clinical Research, Training and Consultancy Unit

c.c DNS

c.c Dr. Nazhed Richard

c.c **Bukulu Julius**

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