

LETTER TO THE EDITOR

In response to “Intensive care nurse perspectives on open visiting in an ICU”[☆]



En respuesta a «Perspectivas de los profesionales de enfermería de cuidados intensivos sobre las visitas abiertas en una UCI»

Dear Editor,

The paper entitled “Perspectives of intensive care nurses on open visits in an ICU” by Alonso Rodríguez et al.¹ was recently published in this journal. Open visits are part of the changes in model that are taking place in intensive care units (ICU), where the focus of attention is shifting from technology to the patient. In this context, visiting hours are becoming more flexible; however, there are still few units that have implemented what is known as an open-door policy,² and there is little information on the subject.

The article provides very interesting information as it reflects the opinion of professionals in a unit with experience of extended visiting hours. The study concludes that most of the health professionals have a negative opinion towards the open-door policy, although they acknowledge that it can be beneficial for patients and families.

Do these results currently correspond to most units in our setting?

An open visiting regime was implemented in December 2019 in our unit (ICU Hospital del Mar, Barcelona), allowing one visitor to stay with the patient 24 h a day if they wish, in addition to 2 shifts of 2 h in the morning and afternoon for 2 other visitors. Unfortunately, in March 2020 this was interrupted by COVID-19. Our experience with the absence of family members in the units has made us even more aware of their importance.

Before this regimen was started, the opinion of all the healthcare staff in the unit (nurses, nursing assistants (TCAE), doctors, physiotherapists, porters) was sought through an informal survey. The survey found that most (69%) of the health professionals agreed with the regimen’s imple-

mentation, because they considered it beneficial for both the patient and the family. However, in agreement with the data from the study by Alonso Rodríguez et al.,¹ they believed that the presence of the family added to the workload and could create problems of privacy for patients, and issues with space in the rooms.

The above prompts us to make some observations.

Firstly, we work in an environment with complex emotional situations, and we need to incorporate communication skills into our training, as Alonso Rodríguez et al.¹ state. This will help us improve our relationship with patients and families, provide better emotional support and enhance our professional satisfaction.

Secondly, ICUs were designed for the monitoring and care of patients, but not their wellbeing. We must rethink physical spaces that facilitate our work and that are also pleasant, more spacious and allow us to safeguard privacy.

Finally, if we assume that open visiting is beneficial for the patient³ and the family, we must be able to provide it. Families also require care and as such cause an increase in workload. Would this make us stop providing a therapy?

The nurse-to-patient ratio having been shown to affect mortality and patient safety,⁴ we need to demonstrate to managers the importance of this ratio on the quality of care we provide, for example, that caring for the family does not compromise patient care. We should convince them (and ourselves) that care to ensure the emotional wellbeing of patients and their families is also therapy.

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F. Vela-Cano (RN)*, D. Ruiz-Sánchez (RN),
J. Granado-Solano (RN), A. García-Sanz (RN),
M. Ortega-Botías (RN), J. Marín-Corral (PhD)

*Servicio de Medicina Intensiva, Hospital del Mar,
Barcelona, Spain*

* Corresponding author.

E-mail address: FVela@parcdesalutmar.cat (F. Vela-Cano).

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Oral hygiene with chlorhexidine and bacterial resistance in intubated patients[☆]



Higiene bucal con clorhexidina y resistencias bacterianas en los pacientes intubados

Several studies affirm that the oral cavity can be the gateway and focus of dissemination of potentially pathogenic micro-organisms. Infections are very prevalent in Intensive Care Units and are an important morbidity and mortality factor. Among the infections related to the respiratory system, ventilator-associated pneumonia (VAP) stands out. This is defined as an episode of pneumonia in an intubated patient requiring invasive mechanical ventilation for at least 48 h, without having been diagnosed prior to intubation.¹

In intubated patients, microbiological changes occur in the flora of the oral cavity, forming a specific biofilm. In addition, there is an increase in risk factors such as those arising from the permanent opening of the oral cavity and the decrease in saliva production secondary to pharmacological sedation. All this contributes to the dryness of the oral mucosa, favouring the formation of bacterial plaque, thus reducing the natural defence system and increasing the risk of VAP.¹

For this reason, evidence-based care packages to reduce VAP, known as “zero pneumonia”, have been implemented in recent years. Among the measures included is oral cavity hygiene using chlorhexidine. Recently, however, studies are emerging that address the possible association of VAP and pneumonia with the use of chlorhexidine. Recently, however, studies are emerging that address the possible association of continued exposure to low doses of chlorhexidine with bacterial resistance mechanisms.^{2,3}

In view of the uncertainty raised, it was decided to conduct a literature review to determine the existing evidence on the use of chlorhexidine in oral cavity hygiene and the relationship with bacterial resistance. Among the few studies found, the literature review published by Cieplik et al.² stands out, which has analysed the acquisition of bacterial resistance mechanisms after sustained exposure to chlorhexidine in different bacterial strains and species. However, the results are variable as chlorhexidine remains

effective as an antiseptic, especially in the prevention of infections. At the same time, data are emerging that warn of bacterial tolerance to chlorhexidine and even cross-resistance with some antibiotics.²⁻⁴

Despite this, there are no specific studies available that address this possible causal relationship, especially in intubated patients in whom oral hygiene is performed using chlorhexidine to prevent VAP. However, some recent studies, such as that of Klarin et al.⁵ propose the use of probiotics as an effective alternative to the use of chlorhexidine in oral cavity hygiene in mechanically ventilated patients.

Therefore, this letter to the editor is presented as a call for attention on a hot and topical research topic, especially for the care of Intensive Care Unit patients. Future lines of research should focus on analysing the widespread use of chlorhexidine in oral cavity hygiene for the prevention of VAP. In addition to analysing whether its continued use leads to bacterial tolerance, as well as quantifying and determining possible bacterial cross-resistance with some antibiotics. This will allow a comparative study of the benefits of its use and the risks it may entail. In order to increase patient safety in the future and individualise patient treatment to ensure nursing care based on the best scientific evidence available.

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R. Dadda-García (RN, MSN, PhD student)^a,
J. de Valles-Fernández (RN)^a,
Á. Solaz-García (RN, MSN, PhD student)^{b,*}

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