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REVIEW

Open door model in critical care: challenges, opportunities and intervention strategies

Modelo de puertas abiertas en cuidados críticos: desafíos, oportunidades y estrategias de intervención

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ABSTRACT

Introduction: family-centered care in ICU faces the major challenge of balancing technology and humanization; therefore, we envisioned exploring how the open door model in critical care presents opportunities in care, as well as the challenges it presents in its implementation and the strategies used for its application.
Method: it is a qualitative approach, descriptive design of bibliographic review type that allowed to analyze and interpret data exhaustively, obtained from scientific databases such as PubMed, SciELO, Scopus, Dialnet, as well as the Google Scholar search engine; with a sample of 30 studies that met the selection criteria, organized in a matrix in Excel software, for subsequent critical analysis following the CASPe reading rubric.
Results: the implementation of the open-door model in the ICU promotes the humanization of care, strengthens family bonding. During the COVID-19 pandemic, the restrictions evidenced the need to balance biosecurity and emotional support. This model requires continuous training of personnel, adequacy of infrastructure, and protocols for its implementation, which contributes to a more comprehensive and humanized recovery.
Conclusion: this model promotes the humanization of care and the integral wellbeing of the patient by integrating the family as an emotional support and protective factor in the patient's recovery. The research drives a cultural shift towards more inclusive, empathic and person-centered critical care.

Keywords: Comprehensive Health Care; Critical Care; UCI; Emotional Support; Humanization of Care.

RESUMEN

Introducción: la atención centrada en la familia en UCI enfrenta el mayor reto de equilibrar tecnología y humanización; por lo que, se visualizó explorar como el modelo de puertas abiertas en cuidados críticos presenta oportunidades en la atención, así como los desafíos que presenta en su implementación y las estrategias utilizadas para su aplicación.
Método: es de enfoque cualitativo, de diseño descriptivo de tipo revisión bibliográfica que permitió analizar e interpretar datos de manera exhaustiva, obtenidos de bases científicas como PubMed, SciELO, Scopus, Dialnet, así como el motor de búsqueda Google Académico; con una muestra de 30 estudios que cumplieron criterios de selección, organizados en una matriz en el software Excel, para su posterior análisis críticos siguiendo la rúbrica de lectura CASPe.
Resultados: la implementación del modelo de puertas abiertas en UCI promueve la humanización del cuidado, fortalece el vínculo familiar. Durante la pandemia de COVID-19, las restricciones evidenciaron la necesidad de equilibrar bioseguridad y apoyo emocional. Este modelo requiere la formación continua del personal, adecuación de infraestructura y protocolos para su implementación, que contribuya a una recuperación más integral y humanizada.

Conclusión: este modelo promueve la humanización del cuidado y el bienestar integral del paciente al integrar a la familia como apoyo emocional y factor protector en la recuperación del paciente. La investigación impulsa un cambio cultural hacia cuidados críticos más inclusivos, empáticos y centrados en la persona.

Palabras clave: Atención Integral de Salud; Apoyo Emocional; Cuidados Críticos; UCI; Cuidado Humanizado.

INTRODUCTION

Family-centered care in Intensive Care Units (ICUs) presents one of the most significant challenges in the healthcare setting, considering the need to balance the use of technology, procedures, and care within the context of the family environment; consequently, this poses a risk to the dehumanization of the hospital experience.[1] For this reason, it is recognized that humanization in critical services should be approached from a multidimensional focus, covering physical, emotional and spiritual needs; therefore, this implies applying strategies such as the personalization of care, training in interpersonal communication skills and the incorporation of the family, which favors the recovery process and improves the hospital stay.[2]

It should be noted that the lack of policies under the framework of humanization leads to depersonalization of the patient and all the actors involved in their care, which generates emotional exhaustion in health professionals, as a result of high pressure in high demand and complexity services, where the absence of protocols on family involvement presents challenges for health personnel.[3]

Therefore, critical care units of different population groups face obstacles regarding the reorganization of the care model, related to institutional resistance, adaptation of the infrastructure, and existing protocols.[4]

Similarly, the factors limiting implementation are the high workload of healthcare personnel, which increases the risk of incidents and affects the quality of care; however, moving towards a model of care that not only preserves life but also attends to the emotional and psychosocial needs of the patient.[5]

In this sense, ICUs have restricted visitor access, prioritizing the clinical stability of critically ill patients. However, the integration of loved ones in the care process has positive effects on the emotional health of both patients and their families, considering this a key strategy to humanize health care.[6]

However, there are structural and organizational barriers, such as the absence of clear regulations and the lack of training of health personnel, especially in contexts where the model is not yet consolidated, because family accompaniment, if not properly managed, can generate adverse effects such as anxiety, distress, or risk of cross-infection. For this reason, it is essential to prepare the family caregiver to avoid adverse events and prevent the so-called intensive care syndrome.[7]

Moreover, this represents a source of interruptions or overload for healthcare teams. Despite some initial resistance from professionals, there is evidence of a progressive shift towards a more flexible stance, especially when clear standards are maintained and individualization of care is ensured.[8]

In this context, humanized care is positioned as a fundamental pillar within the ICU, promoting an empathetic, supportive, and holistic attitude with the aim of not only improving the patient's experience but also contributing to their comprehensive recovery.[4,9]

Therefore, these areas represent complex spaces where life and death coexist, and where the approach focused solely on technology must give way to a more humane and comprehensive care; therefore, the inclusion of the family, the personalization of care, and the well-being of professionals must be considered key elements to achieve a truly humanized health system.[10,11]

Those, as mentioned above, visualized the need to explore how the open door model in critical care presents opportunities in care, as well as the challenges it presents in its implementation and the strategies used for its application.

METHOD

It is a qualitative approach, which allowed for the analysis and interpretation of pertinent data on the open door model in critical care, enabling an understanding of diverse perspectives within the context in which it was developed, and providing a deep and contextualized understanding of the analyzed information.[12]

Likewise, it is a descriptive design that is mainly oriented towards observing and detailing the characteristics of a phenomenon by conducting preliminary studies or, in specific cases, based on data collection, describing common characteristics or patterns.[12]

Likewise, it was a bibliographic review that sought to identify, evaluate, and rigorously specify the studies, applying clear criteria to select and evaluate the literature, highlighting key concepts and possible gaps in the research through an exhaustive analysis.[13]

Within the population, it refers to the total set of 83 articles on which we sought to collect relevant information in the indexed databases. On the other hand, a sampling method was employed to reflect the

characteristics of the population, focusing on the fulfillment of selection criteria. A sample of 30 studies that addressed the problem posed was obtained through convenience sampling. This refers to articles or relevant sources of information that meet specific inclusion and exclusion criteria.[13]

Inclusion criteria

- Original scientific articles.
- Articles in different languages: Spanish, English and Portuguese.
- Temporality within the last 5 years

Exclusion criteria

- Books
- Essays and theses

The technique used in this research involved data collection through a structured search in recognized academic and scientific databases, including PubMed, SciELO, Scopus, Dialnet, Google Scholar, and CINALH, as well as in books and technical reports related to the hospital and critical care fields. Keywords such as "open door model", "humanized ICU", "family participation in intensive care", "humanization of care," and "open door model in critical care" were used, combined with Boolean operators (AND, OR). The information collected was validated by another researcher, who verified compliance with the established criteria for selecting the studies.

An analytical reading of the selected texts was carried out in an Excel matrix for the registry, in which elements such as authorship, year of publication, summary, methodological approach, primary findings, conclusions and bibliographical references were recorded, which facilitated the analysis and interpretation of the data, contributing to a deep understanding of the phenomenon from a critical, contextual and humanized perspective, studies according to the questions posed.

To carry out the analysis, the CASPe method was used, as it enables the organization and evaluation of information compiled from different studies through reflexive reading, thereby determining both the quality and validity of the results obtained. This evaluation is based on a specific checklist.

DEVELOPMENT

Challenges in the implementation of the open-door model in critical care services

Family presence in the ICU is a determinant of patient recovery, improving emotional well-being, and strengthening the family bond; however, the lack of protocols that ensure a balance between family support and the quality of clinical care can cause interruptions in care and increase the workload of the healthcare team.[7]

It is worth noting that during the COVID-19 pandemic, critical care areas implemented limitations on family visits to reduce the risk of contagion, which impacted the interaction between patients and their families. These limitations led most ICUs to restrict visits, especially for patients with this condition. However, some restrictions were relaxed over time, and visits were never as open as they were before the pandemic. This situation highlighted the need to balance health security with emotional support for individuals.[14]

For this reason, visiting restrictions in Intensive Care Units had a negative emotional impact on both patients and their families, as companionship was limited. Despite attempts to adapt through strategies such as the use of video calls, it became evident that direct contact has an irreplaceable value; therefore, more humane and flexible policies should be designed to include families in the care process, guaranteeing biosecurity measures without neglecting emotional well-being.[15]

Similarly, a lack of resources, work overload, and conflicting information make it challenging to implement open-door policies; therefore, committed leadership and internal coordination are essential to managing changes in crisis contexts.[16,17]

On the other hand, the COVID-19 pandemic has created significant challenges in ICUs, profoundly affecting patients, families, and medical staff due to visitation restrictions. These limitations, although necessary to reduce virus transmission, have caused emotional harm, including distress and moral stress in staff who are unable to provide the essential emotional support to families. In response, many ICUs have adopted virtual visitation, using videoconferencing technology to connect patients with their loved ones. However, a lack of access, low demand, and technical problems hinder the delivery of humanized care.[18,19]

Similarly, the prioritization of business objectives and training focused on technical-scientific skills hinders this process, affecting both patients and professionals. Thus, humanizing care requires developing emotional and relational competencies, thereby promoting the dignity and autonomy of the person within an integral care framework.[20]

Likewise, pain and fear are the main difficulties in the ICU, where, despite technological advances and the

reduction of mortality, a distressing experience persists for patients, relatives, and professionals. Although academic training has focused on the biomedical model, the urgency of incorporating emotional competencies and a holistic approach that also addresses psychological suffering is now recognized. Thus, humanizing the ICU implies an ethical commitment that respects the patient's integral dignity, integrating the family and the healthcare team in a care based on empathy and scientific evidence.[21,22]

In addition, health safety is a constant challenge, especially in situations of contagion, as visits can increase the risk of infections. Cultural resistance within institutions, which still prioritize technical aspects of care, also hinders the integration of this model. Taken together, these factors demonstrate that, although the open-door model has the potential to humanize care, it necessitates a significant shift in structures and the way of thinking about intensive care.

Opportunities afforded by open-door models in critical care services

The intensive care unit was conceived to care for critically ill patients; however, its highly technical environment often neglects emotional needs, as a result, both patients and families experience anxiety and depersonalization. In response to this, the open-door model arises, where the continuous presence of family members represents an opportunity to humanize care.[23]

In this sense, although technological advances have transformed intensive care medicine, they have not always been accompanied by an improvement in humane treatment. Indeed, ICUs remain impersonalized environments that exacerbate emotional suffering. Moreover, restrictive visiting policies separate patients from their loved ones, intensifying their distress. Therefore, the aim is to balance the technical and the human, promoting a culture of care that respects the dignity, autonomy, and psychosocial needs of patients, including their families as part of the care, and placing humanization as the central axis of clinical work.[24]

It should be noted that families often face high levels of stress and anxiety. Therefore, the open visitation policy has been promoted as a strategy to mitigate this impact. In cultures such as the Jordanian one, where religion and family ties are deeply ingrained, this practice assumes a spiritual significance.[25]

On the other hand, family admission to ICUs has been limited, mainly due to biosafety concerns. However, from a patient-centered perspective, it has been proposed to make family access more flexible; in this context, the acceptance of the open model between patients, family members and professionals makes possible active participation in the follow-up of clinical evolution, as well as the strengthening of interpersonal relationships centered on empathy and trust, which improves their psychosocial well-being.[26]

At the same time, critical services are transitioning towards more flexible visiting models, reducing restrictions on both time and the number of visitors. While these policies can improve the patient experience and reduce family stress, they also present challenges. These include disorganization of care and staff burnout.[27]

Therefore, implementing an open-door model in the ICU can promote a more humane and patient-centered environment. This approach recognizes that the family provides not only emotional support but also facilitates communication with the clinical team. In addition, it can significantly reduce stress for patients and their loved ones. However, it requires an organizational transformation that includes staff training to manage this interaction adequately, as well as regulations and protocols for its implementation.[5]

Similarly, in pediatric ICUs, this open-door model has been promoted, allowing a constant presence of parents. This practice has been shown to enhance the emotional well-being of hospitalized children. Likewise, in the context of psychiatric ICUs, the implementation of open policies has shown promising results, specifically, a reduction in the use of forced isolation has been recorded, suggesting a positive impact on patient behavior. Thus, a less restrictive and more therapeutic environment is promoted.[28,29]

10 2 It should be emphasized that family members of ICU patients tend to positively value flexible visits, since they decrease their anxiety and improve their perception of care, making accompaniment possible, favoring family-centered care, as well as family participation in therapeutic decisions, as well as care support and alertness in emergencies.[30,31]

Therefore, open-door models in critical care services provide several opportunities that enhance the care process, facilitating better communication between staff and family members, which in turn contributes to reducing the anxiety and stress of loved ones, thereby improving their emotional well-being. They also facilitate family participation in the care process, strengthening the bond and ensuring that patients feel more supported. In addition, the implementation of this model fosters an opportunity to humanize intensive care, better integrating emotional and social needs.

Strategies implemented by healthcare institutions to ensure the use of the open-door model in critical services

The COVID-19 pandemic imposed restrictions on intensive care visits, affecting communication between medical staff and families, as well as the emotional well-being of patients. This problem highlighted the need to balance health safety with emotional support, making it necessary to consider more flexible visitation

policies in future emergencies to preserve the well-being of both patients and their families.[32,33]

Likewise, the prohibition of open visits in ICUs to prevent the spread of the virus hindered communication and patient- and family-centered care. Therefore, the use of virtual communication strategies improved visiting policies and maintained family connection, even in a pandemic scenario.[34,35]

In turn, the implementation of open-door ICU protocols fosters the humanization of care by allowing flexible visits and the active participation of family members in patient care. This approach helps reduce stress and anxiety, improves communication, facilitates emotional recovery, and decreases the complications of post-intensive care syndrome. Therefore, for its successful implementation, it is crucial to train healthcare personnel, sensitize them to the importance of family involvement, and adapt the hospital infrastructure to ensure the safety and well-being of all.[4,6]

Similarly, the implementation of this model facilitates recovery and promotes a family-centered hospital stay. For this reason, continuous training emerges as the primary tool for family intervention in critical care services, taking into account biosecurity, interpersonal relations, privacy, and the well-being of the healthcare team.[36,37]

It is worth noting that educational interventions for both healthcare personnel and family members make it possible to integrate them into intensive care areas, promoting quality and safety, which in turn avoids burnout and overload on the health professionals working there.[38,39]

Therefore, health institutions implement various strategies to ensure a humanized, open-door model in critical services, such as allowing flexible family visits, promoting their participation in the care process, and taking into account their education and that of the staff, to ensure patient-centered care, respect for their autonomy, dignity, and privacy.

CONCLUSIONS

The open-door model in Intensive Care Units (ICUs) represents a key tool towards a more humanized healthcare in highly complex contexts, where a technical and restrictive logic has prevailed. Therefore, the presence of family members, beyond being an emotional support, acts as a protective factor that can have a positive impact on clinical recovery, the patient's psychological well-being, and trust in the healthcare team. However, the scarce standardization of these practices, as well as the dominant biomedical vision in professional training that relegates the emotional dimensions of care, hinders the consolidation of a more comprehensive approach.

In this context, this model transforms care in these units, focusing on the humanization of care and the integral well-being of the patient. Therefore, it becomes necessary to develop concrete strategies that allow a safe and effective implementation, which can improve the experience of the patient and their environment; in addition, it is necessary to highlight the need for healthcare institutions to promote more inclusive and person-centered practices, fostering a cultural change that promotes quality and efficiency in critical care.

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