Open-door ICU Model and Humanized Care: A Systematic Review

Additional report

The manuscript pursues a clear objective: to identify the factors that facilitate or hinder humanized care when an open-door ICU model is implemented, integrating the perspectives of professionals, patients, and families. The assembled evidence converges along three axes. First, the perceptions of patients and families suggest that clear communication, empathy, and emotional support strengthen well-being and trust and translate into a safer experience of the critical-care process. Second, flexible visiting policies and technological mediation, including phone calls, video-based education, video calls, and ICU diaries, are associated with lower anxiety and higher satisfaction; nonetheless, staff resistance persists in certain contexts, particularly due to perceived workload, privacy, and workflow issues. Third, care centred on humanization requires safeguarding the patient's dignity and identity, providing spiritual and emotional support, and consolidating communication competencies across the entire interdisciplinary team.

Critical appraisal

1) Design and methods

Strengths. The study is grounded in a registered protocol and is reported in line with PRISMA 2020, which provides transparency and traceability. The multibase search strategy, using MeSH/DeCS terms and without restricting study design, is appropriate given the field's heterogeneity and allowed the inclusion of studies with diverse approaches. In addition, duplicate screening with Rayyan, resolved by consensus or with a third reviewer, reinforces consistency in evidence selection.

Areas for improvement. The PRISMA flow diagram should be reviewed, since in its current form it states "Reports sought for retrieval (n=0)"; the direction of the flow should be corrected so that it follows a logical process rather than continuing the arrow through the zero. Likewise, although a representative search equation is presented, full reproducibility would benefit from appending the complete strategies for each database together with the exact dates of the last search. Finally, although no effect measures were calculated, a reasonable decision given the heterogeneity, the manuscript would gain clarity by adding cleaner comparative tables that display the primary outcome for each intervention and setting, and by defining the outcomes of interest more precisely a priori.

2) Study selection, quality, and risk of bias

The use of JBI tools is adequately described, but the metrics employed should be unified. The text presents, in parallel, an average of 86% by study design and an overall average of 4.8/5, which could cause interpretive confusion. It is advisable to retain a single scale (or clearly explain the correspondence between them) and to report ranges by study design. The absence of meta-analysis is expected given the methodological diversity; in its place, the thematic synthesis is organized into three categories that align with the objective and the literature in the field.

3) Results and discussion

Most robust points. The results show clear convergence on the psychosocial benefits of flexible visiting and communication tools: reduced anxiety, better understanding of the clinical situation, and greater satisfaction. No signs of increased adverse events such as infections or delirium are identified when comparing flexible hours with strict restrictions in the studies summarized in the manuscript itself. Also noteworthy is the importance of respecting patient identity, through diaries, personal items, or "Get to Know Me" boards, and the explicit recognition of organizational tensions (perceived workload, structural and privacy constraints) that shape the adoption of open-door policies.

Areas requiring clarification. To enhance practical utility, it would be helpful to disaggregate heterogeneity by country or region, by population type (adult versus pediatric), and by health-system resource level, either via sub-analyses or separate tables. Additionally, when claiming benefits for length of stay, safety, or delirium, these statements should be traced to specific studies through precise citations in the main text and in Tables 3–5, thereby improving traceability between individual pieces of evidence and the conclusions drawn.

Presentation and writing

Tables 3–5 require careful editing. Results have also been placed under incorrect categories: for example, Table 4, which should focus on flexible visiting and technology, includes conclusions from post-ICU follow-up or family-satisfaction reviews that are not directly related to visiting/ICT, blurring the purpose of the table and hindering quick consultation by readers.

To address this, the tables should be reconstructed with a fixed column structure (Author–Year | Country | Design/Approach | Population/Setting | Intervention/Exposure | Primary outcome(s) | Key finding | Reference) and the rule "one row = one study" should be enforced. Each entry must be verified individually against the source to ensure that country, design, and finding truly correspond to the cited study. When a single article contributes to more than one category, it should be placed in the most pertinent table and mentioned only in the text of the other section with a cross-reference ("see also [ref]") to avoid duplication. It is also advisable to align each table's content with its category: Table 3 for patient/family perceptions; Table 4 for visiting policies and technological mediation; and Table 5 for broader humanization frameworks and interventions (for example, diaries, bundles, spirituality, and privacy). Finally, typographic breaks or mixed-language terms should be corrected, ensuring that "Trial" appears rather than "Tria" and avoiding Spanish labels such as "Cuantitativa" within English-language tables.

Practical relevance for nursing and ICU management

From an implementation standpoint, the manuscript supports several immediate actions. It is advisable to adopt flexible visiting policies with clear clinical criteria and standardized communication protocols, such as brief daily updates for families with verified information and defined time windows. Low-cost, high-impact interventions can be promoted, including ICU diaries, "Get to Know Me" boards, concise information leaflets, scheduled phone calls, and video-based education for caregivers and relatives. Team training in empathic communication, breaking bad news, and emotional support is essential and should be integrated into ongoing

professional development. Finally, environmental adjustments, controlling noise and lighting, strengthening privacy and modesty, and allowing meaningful personal items and mobile devices when safe, should be considered as part of a humanization culture that goes beyond visiting policies.

Limitations

The limitations should be presented succinctly. There is a possible publication bias toward positive findings and a language restriction to studies in English, Spanish, and Portuguese, which may have excluded relevant sources. Qualitative or descriptive designs predominate, and methodological heterogeneity is substantial, which limits generalizability and explains the absence of meta-analysis and of a formal certainty assessment. These constraints justify the choice of a thematic synthesis and underscore the need for more comparative studies and trials in the future.

Orthotypographic and style corrections

A final style pass is recommended to unify abbreviations, correct accents and word breaks, and resolve language mismatches within the tables. Ensuring consistent English terminology, for instance, using “Trial” instead of “Tria”, and removing Spanish terms embedded in English tables will substantially improve clarity and editorial readability “cuantitativa”.