Family Presence and Open Visiting Policies in Ontario Hospitals

A SUMMARY REPORT OF A RESEARCH PARTNERSHIP BETWEEN THE CHANGE FOUNDATION AND THE ONTARIO HOSPITAL ASSOCIATION

MAY 2019

THE CHANGE FOUNDATION
ENGAGE, EXPLORE, EVOLVE

OHA Ontario Hospital Association

ABOUT THE CHANGE FOUNDATION

The Change Foundation (the Foundation) is an independent health policy think-tank that works to inform positive change in Ontario's healthcare system. With a firm commitment to engaging the voices of patients, family caregivers, and health and community care providers, the Foundation explores contemporary healthcare issues through different projects and partnerships to evolve our healthcare system in Ontario and beyond. The Change Foundation was created in 1995 through an endowment from the Ontario Hospital Association and is dedicated to enhancing patient and caregiver experiences and the quality of Ontario's health care.

ABOUT THE ONTARIO HOSPITAL ASSOCIATION

The Ontario Hospital Association (OHA) is the voice of the province's public hospitals. The OHA serves hospitals through advocacy, learning and engagement, labour relations and data and analytics to build a better health system. We do this through thought leadership — by conducting evidence-based research, proposing ideas, convening members and partners, and encouraging responsible dialogue about system change.

ACKNOWLEDGEMENTS

We would like to acknowledge Bessie Cassidy, a summer student at The Change Foundation, who conducted most of the telephone interviews with staff from the participating hospitals, and Karim Suleman, an internship student, who helped with the analysis of the interviews.

The Change Foundation and the OHA would like to thank staff from the participating hospitals who took the time to participate in the interviews – their insights and reflections contributed to the richness of the research findings.

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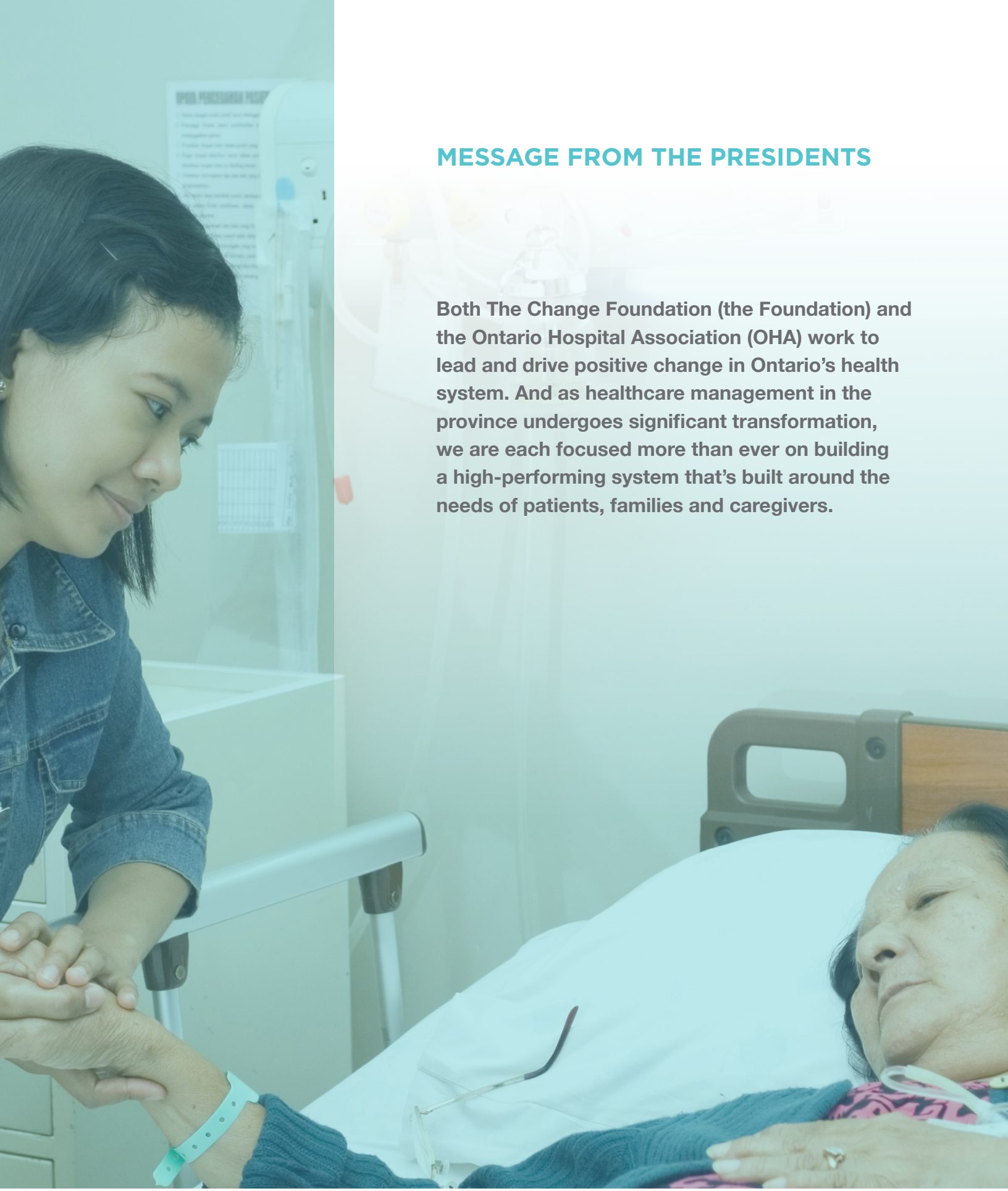


MESSAGE FROM THE PRESIDENTS

Both The Change Foundation (the Foundation) and the Ontario Hospital Association (OHA) work to lead and drive positive change in Ontario's health system. And as healthcare management in the province undergoes significant transformation, we are each focused more than ever on building a high-performing system that's built around the needs of patients, families and caregivers.

In 2015, the Foundation launched its strategic plan – *Out of the Shadows and Into the Circle* – which focused on improving the family caregiver experience in Ontario. The Foundation knew that listening to caregivers was a foundational, and crucial, element of this work. And so, in 2015-16, *The Caring Experience* initiative was born – a province-wide engagement with family caregivers, and health and community care providers.

And as a think-tank that does, the Foundation moved into action. In 2017, the Foundation identified four key partnerships from across Ontario to receive funding and support to improve the caregiver experience. All four Changing CARE partnerships were designed with caregivers in key design and decision-making roles. The partnerships are now leaders in caregiver recognition, support and integration in the Ontario healthcare system and are changing the way healthcare organizations, providers, patients and clients, and caregivers work together.

Recognizing that families and caregivers are an integral part of the collaborative care team, the Caregiver Identification (ID) initiative was co-designed with caregivers and providers in the Changing CARE projects. The purpose of Caregiver ID is to formally identify caregivers within care settings to facilitate their participation and role as members of the care team. It became evident that the Caregiver ID initiatives were very much aligned with a care setting's family presence policy.

Enter the OHA, whose strategic plan calls for assuring the sustainability of hospital services in the short-term, and advancing thought leadership to help identify the medium- and longer-term solutions that are needed in today's healthcare system.

We saw an opportunity for our two organizations to partner to drive positive change in Ontario's health system.

The OHA and the Foundation agreed to work together to interview a sample of hospitals with family presence policies to get a sense of how the policies were developed and implemented, and what has changed for patients, families and staff.

This report summarizes insights and reflections from hospital staff who we interviewed on their family presence policies. We hope these reflections and insights are helpful to those hospitals considering a move to family presence policies. We also hope that hospitals with family presence policies or those that want to shift to family presence will consider Caregiver ID initiatives as part of their family presence culture. Please reach out to us – we'd appreciate an opportunity to help launch Caregiver ID initiatives in your organizations.

Sincerely,

Cathy Fooks
President and CEO
The Change Foundation

Anthony Dale
President and CEO
Ontario Hospital Association

EXECUTIVE SUMMARY

Hospitals in Ontario have re-examined policies that govern the presence of family and friends at the patient's bedside as they receive care. The traditional model of firmly established visiting hours has given way to family presence and open visiting policies. This report presents the findings from a research partnership between The Change Foundation (the Foundation) and the Ontario Hospital Association (OHA). The OHA wanted to share learnings from hospitals' experience with family presence and open visiting policies. The Foundation was gaining more experience with Caregiver Identification (ID) initiatives in its Changing CARE projects and wanted to better understand hospital family presence policies as a potential receptor for the implementation of Caregiver ID initiatives.

Thirteen hospitals with family presence or open visiting policies participated in the project. Telephone interviews were conducted with staff who had key responsibility for the policy. Highlights of what we heard in the interviews include the following:

1. There was a great deal of **variability** in the family presence policies – how they were implemented and the actual content of the policies.
2. **Patients and families** were, in most cases, the instigator of the move to family presence policies – often through a Patient and Family Advisory Council.
3. Family presence policies often **formalized what was already happening** on units, what staff were already doing.
4. There were **pockets of concern** and varying levels of support across the hospital – generative discussions and problem-solving helped staff to be more comfortable with the change.
5. Family presence has required a **culture shift**, helping staff and physicians think differently – this is not just about visiting hours, rather, it is about collaborative care planning and working together to improve care processes.

Early results from the **Caregiver ID initiatives** in the Changing CARE projects include:

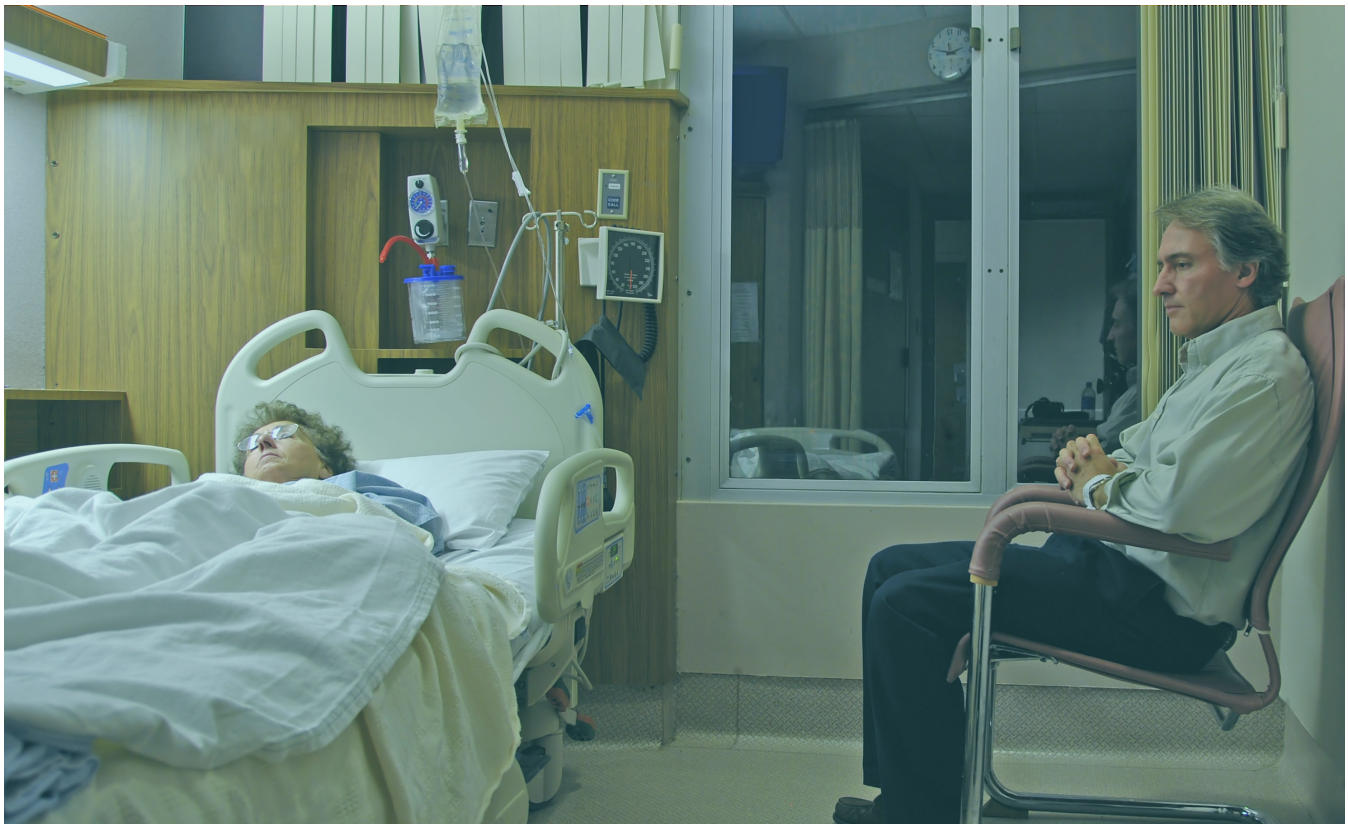
- Positive feedback from patients and families who feel acknowledged and recognized as part of the care team, and have easier and more convenient access in supporting the person they are caring for.

Family presence results in better patient outcomes, it is that simple. And no matter the barrier, you can figure it out. If there is will, then you can figure it out. And this kind of change has to come from the top.

- Positive feedback from staff who see how the ID badge addresses concerns about safety and facilitates caregiver involvement as a member of the care team.

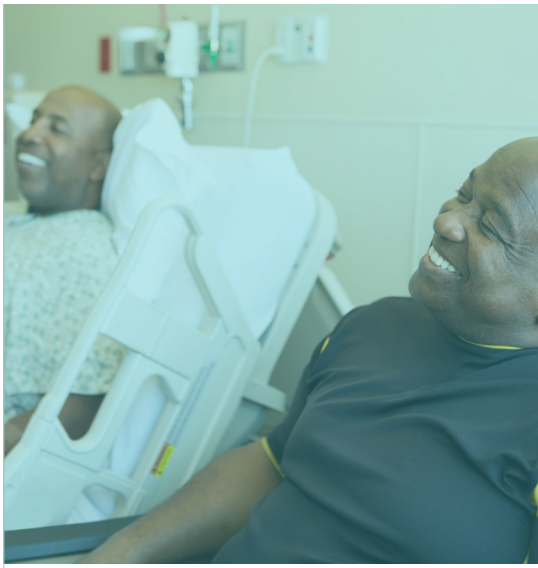
There is a strong receptivity between Caregiver ID initiatives and the introduction or expansion of family presence policies in hospitals. Offering an identification card, badge or lanyard is a concrete and visible way to recognize and validate caregivers and remove barriers to their participation as a member of the care team.

To make it easier for hospitals to introduce Caregiver ID initiatives to coincide with or enhance their family presence policies, the Foundation developed a set of tools and resources to draw on. Check out the *toolkit* online to access an implementation checklist, case studies and the Caregiver ID visual icon.



INTRODUCTION

Hospitals in Ontario have re-examined the policies which govern the presence of family and friends at the patient's bedside as they receive care. The traditional model of firmly established visiting hours started to give way to two new models: (i) a family presence policy, which ensures the ability of defined family members to stay with their loved one at any time of the day or night, and (ii) open or unrestricted visiting, which eliminates visiting hours and allows anyone to visit at any time.[1] Pediatric hospitals were forerunners of the family presence movement with some policies in place in the early 1990s. Some hospitals committed to the shift as part of the Canadian Foundation for Healthcare Improvement's (CFHI) *Better Together* campaign. *Better Together* was launched in 2016 and called on hospitals and healthcare delivery organizations to implement family presence policies as an important step toward delivering more patient- and family-centred care, where families are recognized as allies for quality and safety.[2]



1. Context

This report presents the findings from a research partnership between The Change Foundation (the Foundation) and the Ontario Hospital Association (OHA). The OHA was motivated to stay abreast of hospitals' experience with family presence and open visiting policies as more hospitals were moving away from standard visiting hours. The Foundation was gaining more experience with Caregiver ID initiatives in its Changing CARE projects and wanted to better understand hospital family presence policies as a potential receptor of the Caregiver ID initiatives.

The purpose of the joint project was to gain a deep understanding of:

- Current practices and experience with family presence or open visiting policies
- The challenges and impacts of making the policy shift away from visiting hours
- Insights for others to consider

[1]See the Ontario Hospital Association's *Principles for Family Presence Policies*.
[2]See Canadian Foundation for Healthcare Improvement's *Better Together* campaign.

2. Methodology

A sample of Ontario's 141 hospitals with a range of experience with family presence and open visiting policies were approached to participate in the project. The sample of 13 hospitals included pediatric hospitals, mental health hospitals, large urban academic health centres, and small rural and remote community hospitals.

4	+	7	+	2	=	13
HOSPITALS WITH LONGER EXPERIENCE – MORE THAN 5 YEARS		HOSPITALS WITH SHORTER EXPERIENCE – LESS THAN 5 YEARS		HOSPITALS CURRENTLY REVIEWING THEIR POLICIES		HOSPITALS IN TOTAL PARTICIPATING

An interview guide was developed with general and targeted questions. Telephone interviews were conducted with one or two staff from the participating hospitals who had key responsibility for the family presence or open visiting policy. We interviewed staff given that we were trying to understand the implementation of family presence policies in Ontario hospitals; we did not interview patients or families to get their perspectives of the shift to family presence policies. The interviews were conducted between July and October 2018. Participants consented to the interviews with the agreement that summary interview content, including quotations, would be anonymized to ensure confidentiality. The interviews were audio-recorded and transcribed. Themes from the transcripts were identified and the analysis undertaken by the lead reviewer, and independently verified by two additional reviewers.

INTERVIEW FINDINGS

The findings from the interviews are presented using the following organizing framework:

1. How were the policies described?

2. What were key features in developing and implementing the policies?

3. What changed for patients and families?

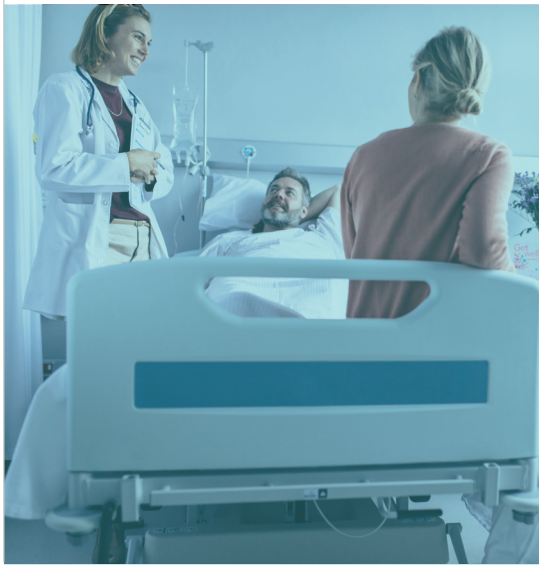
4. What changed for staff?

5. What were the main challenges in shifting to the new policy?

6. What was the overall advice to others?

The findings that follow reflect responses provided in the interviews – which were not validated through additional research. For example, the findings for "how were the policies described?" were not validated with a review of the actual hospital policies. Quotations from the interviews are included throughout to help illustrate the findings. Specific numbers of hospitals who reported on various findings are not reported, instead the reference is to some, most or all. This was done because the confirmation of a specific number was not always possible, and it was more instructive to report on the breadth of answers.

Quotes from the interviews are profiled in the side panels and in text boxes throughout this report.



1. How were the policies described?

There was a range of responses to the request to "please describe the policy in your organization." The responses demonstrated significant variability in the family presence or open visiting policies at the hospitals participating in this review, including variability in the terms used. On this page, excerpts of policies are profiled in text boxes.

> We recognize that family members, friends, and loved ones are an essential part of the healthcare team. Therefore, we have unrestricted visiting hours, provided that the visitor has been approved by the patient.

Some hospitals made a distinction between **care partners** or **designated family members** and other visitors (other family and friends). For other hospitals, this distinction between some family members and others was antithetical to the culture change that they were trying to achieve (i.e., a culture in which staff understood that families were not visitors). Some hospitals noted that the term *visitor* was still used, but they were working to move away from its use.

> Families are an integral part of the patient's care team because no one knows our patients better than their loved ones - that's why we welcome visitors 24 hours a day, 7 days a week.

> Visitors and visiting hours will ultimately be decided by the patient and healthcare team prior to any visit.

In those hospitals with policies that included a designated care partner or family member, patients were encouraged to **identify someone who was significant to their healing**, someone who was able to provide care and support. A patient usually identified one or two care partners who could be with the patient at any time (24/7 access).

> At our hospital, we are committed to enhancing the patient experience by fostering an environment and culture that embraces patient- and family-centred care. To support this commitment, patients may identify individual(s) as their care partners. Care partners are able to visit 24 hours a day, 7 days a week, with few exceptions.

We do very much encourage patients to identify one or two family members as partners in care, to be present and act as a spokesperson amongst family members and to support the patient through their care journey.

Families are there to support. But staff asked: what if the four-year-old sibling wants to stay overnight and we're saying family can be there 24/7? We clarified that the person staying overnight has to be able to serve a supportive role; they have to be old enough to provide care for the patient. We can't have nurses taking care of a sibling as well. We had some kids who wanted sleepovers – not appropriate since our nurses can't take responsibility for other kids. They could point to a policy.

Visitors or non-designated family members and friends have more limited access (i.e., they are encouraged to leave the hospital in the evenings so that patients can rest or sleep). Some hospitals noted that they have stipulated **quiet hours** – typically from 10 p.m. to 7 or 8 a.m. – when they encourage people who are not staying the night to leave, or for those who are staying, to remain quiet for the benefit of all patients.

Even though we don't have visiting hours, we do have designated quiet times from 10 p.m. to 7 a.m.

Across the participating hospitals, there was general support for family presence during **ambulatory visits, tests and procedures**. There were some caveats – support for family presence within safety-related limits (for example, not in the imaging rooms given the radiation risk) and, of course, with the patient's expressed wishes. Only some hospitals have formally codified this support for family presence during ambulatory visits and procedures in official policies.

A number of hospitals noted that their approach to family presence was part of a **broader philosophy of care** – part of a culture shift in understanding the role that families play in the care of patients and recognizing the expertise that family members bring to the table.

It's not just family presence, but how we support families and friends about their needs, preferences, how do we include them. They're an important role, how we are valuing them as part of the overall care, not only in the hospital but also beyond. Family presence is pushing us to think differently around collaborative care planning as well as how we think differently about our care processes.

We recognize the respective areas of expertise – clinical expertise, expertise of the patient in terms of how the condition lives within their body, and expertise of the family around the impact on the family.

2. What were key features in developing and implementing the policies?

The majority of participating hospitals specifically referred to the strong role their **Patient and Family Advisory Council (PFAC), or Patient and Family Advisors** played as either a catalyst for initiating the policy change or as active participants in designing and implementing their policy.

Most hospitals referred to **environmental scanning** and reaching out to other organizations with family presence policies already in place as key inputs to the development of their policy. They were very complimentary of how open other hospitals were in sharing their experiences – the successes, the pitfalls, what to watch out for, etc.

Most hospitals also referred to the importance of a **change management plan** or the use of more informal change management practices to guide the design and implementation of the family presence policy within their organization. Specific elements of change management that they described included:

- Senior executive team leadership to communicate the importance of family presence
- Extensive and thorough consultations with stakeholders
- Undertaking extensive scenario planning
- Ensuring there were multiple routes for nurses, physicians, and all staff to voice concerns
- Providing education and planning resources, as well as tools
- Enlisting unit champions or peer-to-peer coaches – work with areas of the hospital that are comfortable with the policy and ask them to be peer coaches to other areas that are struggling

We gave every manager on every in-patient unit different scenarios to go over with their staff to help them with those conversations.

Our PFAC was established in 2014. The #1 priority was looking at our visiting hours policy. That was the catalyst – it was very patient- and family-driven ... It was a nice entry point to showcase our PFAC and the type of work they could be involved in.

Other organizations were willing to share what their journeys were like, willing to share their learnings that gave us a heads up and provided direction on how to do it better in our organization.

We used senior leadership to help drive the message home, to say that this is important and why it's important.

We went to our PFAC, our Medical Advisory Committee, our Leadership Institute where our Patient Family Advisors presented the policy; our unions were apprised.

We did a lot of education tailored to different audiences in the hospital. We had continued follow-up and reinforcement; then we highlighted successful stories.

I offered myself as an escalation point if the nurses felt there were inappropriate behaviours on the unit. I gave them my number and told them they could page me off-hours.

We established an implementation team which included members from the PFAC, all clinical areas, security, human resources, physicians, volunteers. We looked at the current literature. We came up with a draft policy which we then socialized within the organization before we launched – we went to the larger PFAC, the Medical Advisory Committee, our leadership group. We had a leadership institute where patient and family advisors presented the policy. We opened it up on our website so community members could provide feedback. Our unions were apprised. We did a good job of consultation with stakeholders. Implementation was done unit by unit, with managers talking about the policy and responding to questions from staff. We applied the change management principles to implementing it – creating the burning platform, creating the vision, engaging the stakeholders, noting their concerns. It was a great change management plan that produced this successful roll-out.

Some hospitals stipulated that their family presence policy allowed for **flexible implementation**. Staff could consider the patient's condition, their care needs or their expressed wishes, or they could consider safety concerns. It was acknowledged by some hospitals that a significant challenge with flexible implementation is consistency. For example, given the same circumstance, some staff would allow family presence and some staff would not, which is not in the best interest of the patient and family.

Managers were going back as 'champions' of flexible hours, understanding how it was going to work.

"

One multi-site hospital that participated in the interviews pursued a **customized approach** (i.e., the family presence policy was not a hospital-wide policy, rather, specifics of the policy were developed at the unit and program level). They noted that there were advantages to this approach, mainly that customization provided an opportunity to be creative and focus on the needs of patients in specific units or programs.

We wanted a process across the organization to document who the partner in care was. But our processes and systems are so different program to program that we couldn't find a way to consistently document who the partner in care was so that from shift to shift, it would be easier.

"

However, they also reported some challenges, including the inability to take a strong stance to push areas that could have but were not making changes, and compromised consistency across the organization.

The **mental health hospitals and units** referred to examples of how the family presence policy was customized in specific circumstances:

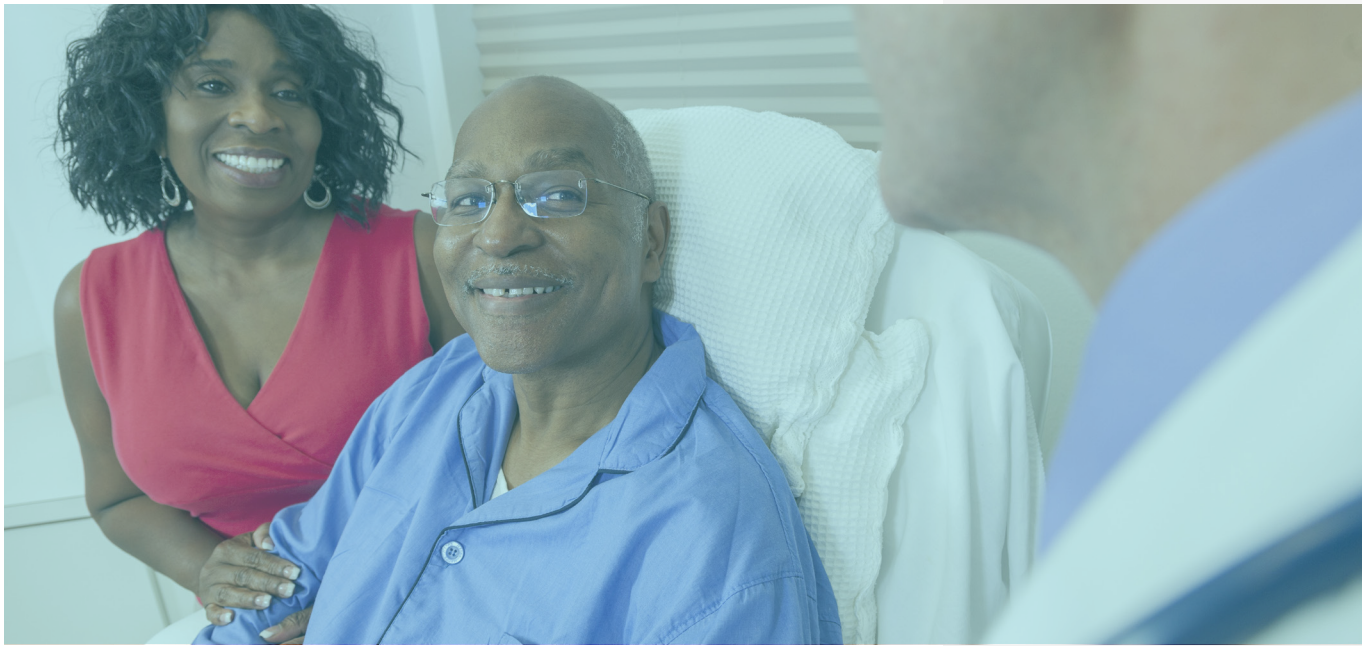
- Consideration of family presence based on the condition of the patient as well as their wishes
- Initiation of alternative visiting – pet- or animal-assisted visiting (in addition to pet therapy)
- Establishment of accommodation, even in circumstances of safety
- Establishment of new protocols to advance patient- and family-centred care

We tasked all of our managers prior to launch: here's the idea of family presence, look at how you're currently operating programs and think of ideas and opportunities to further enhance family presence. We had some amazing things happen. Mental health made some great changes in the in-patient area – they put in new protocols to invite family members for a meeting 24-hours after admission to discuss the care plan.

If they are in a crisis mode, a crisis that led to their admission, we need to recognize that.

Pet-or animal-assisted visiting has to be pre-arranged. There are some people who are attached to their animals and there are times when this is a form of support and therapeutic for them.

If something is going on in the unit with another patient and we don't want additional people in the environment, we try to take the patient to another area where they can be with their family.



3. What changed for patients and families?

The majority of hospitals noted that the policy change reflected what was essentially already happening in the hospital – the policy **formalized what was already being done in practice**.

> *I'm not sure a whole lot changed. Initially, staff were pushing back and saying, "we can't have people at all hours." So we asked some questions about the current practice: "What do you do if the family can't come between 9 a.m. and 9 p.m.?" Every single unit we spoke to were already going against the [visiting hours policy] and making changes so that the family member could stay. Although they were pushing back and saying "we can't do this," they were already doing it. Staff that thought terrible things would happen after hours have realized that, in fact, families don't want to visit while their loved one is sleeping. People, for the most part, are reasonable and respectful and that continues to be the case.*

Formalizing the general practice in a policy helped to clarify the expectation for all staff. For patients and families, the result was **more consistent treatment by all staff**.

Most hospitals noted that the move to a family presence policy resulted in **more convenience** for family members.

Hospitals also noted that there was **increased trust** between families and hospital staff. When family members are at the bedside 24/7, they can see that staff are caring and responsive.

Pediatric hospitals referred to both the positive changes for patients and families, as well as the potential that support for family presence can result in negative implications for the family – specifically, that parents may not get the rest they need.

This really just put pen to paper – it confirms practices we were doing anyway. Not a whole lot changed because a lot of areas were already practicing family presence.

Previously, 9 times out of 10, staff were fine with having family present. But occasionally, there would be a certain nurse who would say 'no, it's 8 p.m., our policy says no visiting.'

Family members have felt a bit of relief that it's more convenient – being able to walk in the building whenever they want.

We are establishing trust so they can see that their loved ones are being cared for.

Greater comfort for the child; less stress for the parents from the perspective of being able to care for their child and not being separated from their child.

We have a family room which provides space for parents to rest. It has high utilization. While parents tell us they don't want to sleep as they want to be by their child's bedside, when they do agree to take a nap they sleep for hours, which tells you they are stressed and sleep-deprived.

The unique circumstances in **mental health hospitals or on mental health units** and the impact of the policy shift on patients and families were also referenced:

- Many patients do not have visitors or support from family members
- Patients can be in a crisis situation that may not support a visitor
- Patients are often ambulatory and moving around even if they are in an in-patient unit
- There can be unique safety concerns for patients and families, particularly on forensic units
- There may be incongruencies between the wishes of the patient and those of the family
- The changing nature of consent can be a particular challenge[3]
- Staff can be genuinely concerned about what family members and other visitors might witness in a mental health unit/facility

A lot of our patients don't have loving family members or the support that you would have in an acute care facility.

The changing nature of consent can be really tough. When a client consents one day and then withdraws consent – it is very difficult for families.

The policy was one of the first things we started doing to shift the conversation around family engagement and families as partners in treatment. We do capacity building with staff about why we engage families and why family is important in recovery. This policy has really started a great conversation.

[3]See The Change Foundation's *privacy and consent resources*.

4. What changed for staff?

Hospitals noted that the shift to a family presence policy provided a **clear, standardized way to make decisions** – the policy gave staff something to point to for direction rather than feeling it was their duty to set limitations.

The new policy gives staff better direction and it's not ambiguous. Previously, I would like to have a family stay. However, I have a colleague saying visiting hours are over, you are not supposed to let them stay.

Hospitals acknowledged that the policy provided guidance on how to put patient needs first and reinforced **when they could set limits** on family presence. Hospitals referenced scenarios where staff felt empowered to limit family presence, including the following:

- When the patient, family or friends are sick, infectious or immuno-compromised
- When the family or friends are abusive to staff or with each other
- When family or friends are not able to provide support to the patient (i.e., a younger sibling or a frail partner can't be the designated family/care partner if they are not able to provide assistance through the night)

We're welcoming of family members 24/7, but there are caveats. For example, we had one parent who was not well, they looked like they were going to pass out from dehydration, they weren't able to care for the child, and they were putting other patients at risk. We had to ask that parent to leave. We've had families challenge us if we set behavioural standards – if a parent or another member of the family is abusive with our staff or with each other and we ask them to leave. That becomes more challenging when parents or other family members point to your policy that says "families are not visitors and are allowed 24/7." There's always the 'yes, but you're infectious,' or 'there's been a behavioural issue.' When people have the best of intentions of allowing for 24-hour presence, they need to also understand what the other issues are in terms of patient safety and a safe working environment.

Hospitals acknowledged that staff were keenly aware that family members were, in most cases, of great **assistance at the bedside** – providing support and helping out with their loved one.

> *The original view was that this would be disruptive – having people after hours when patients were trying to sleep. That perception has changed. Staff see how much of a benefit it is to have a family member there, family are quite helpful at the bedside. We have a lot of elderly patients who get restless and agitated at night – having the family present has helped the situation and has prevented falls and improved patient safety.*

Nursing staff appreciate family members being there just to do little things – blankets or pillow – and that family members play a great role because they know how to settle mom or dad.

Hospitals noted that the shift to family presence has required a **culture shift**, pushing staff and physicians to think differently – this was not just about visiting hours; it was about collaborative care planning, and working together to improve care processes.

I say with confidence that family presence has helped shape and advance our culture in terms of more openness, a shift in power, and the consideration for family and friends being part of decision-making.

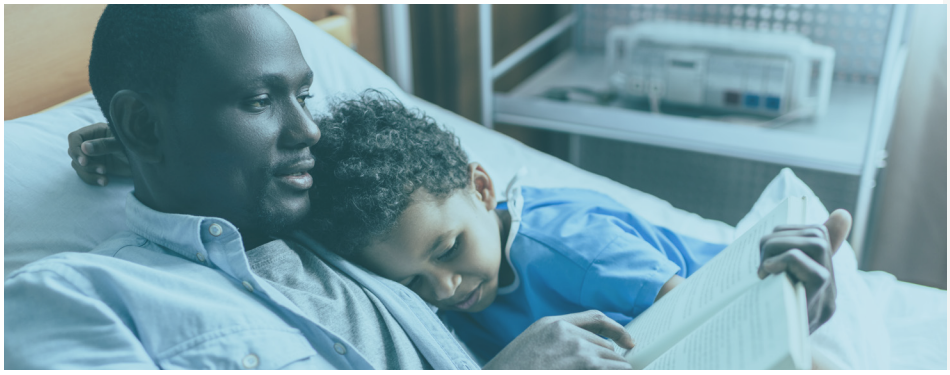
Hospitals noted that the shift also required a **different skill set**. Rather than depending on an established policy – the end of visiting hours – staff were being asked to draw on their judgement, negotiation and communication skills when they interacted with families.

There has been a shift towards more openness and problem-solving about how to work together to accommodate family. We are asking staff to dip into a different skill set – to make a decision about this.

Pediatric hospitals referred to specific changes for staff:

- Staff now have an expectation that parents will generally always be around their child(ren).
- Staff actually found it helpful to have parents present. Parents provided support (as other hospitals noted), they were looking after their child, and they were the constant set of extra eyes who knew the child better than anyone.

We've had this policy in place for 18 years and nobody's asking to go back. For staff, it is like 'thank goodness we have this in writing'- that consistency was super helpful.



5. What were the main challenges in shifting to the new policy?

All hospitals acknowledged there were **pockets of concern** during the planning and implementation of the family presence/open visiting policy in their organization.

- Staff who spent most of their time at the bedside often had the most concerns about the policy shift.

> *We had some older nurses really challenged over a youth defining their family – a teenager who says, "My boyfriend is my immediate family and I want him to stay over." Some older nurses were saying, "Not on my watch is a teenager getting pregnant." Whereas, we've had some great successes with youth. We had a diabetic youth who was non-compliant and routinely in ketoacidosis. With agreement of both families, his girlfriend was staying over and helping to reinforce teaching and getting him to monitor his sugar. She was the only person he would listen to; she was his motivator. He didn't care what his parents thought; he wasn't thinking long term. But pleasing his girlfriend was super high on his currency.*

- There was reference to concerns about the policy change from particular units.

- Some hospitals referred to concerns about the policy being applied to particular procedures.

> *Younger physicians are more open to parental presence during induction. Whereas those who have been practicing for many years, have been practicing in a certain way for many years, and they feel it is better for the child not to be distracted by parents.*

Hospitals also acknowledged that concerns about family presence could be resolved. For example, for units that were reluctant to move to family presence, it was important to try to understand what their concerns were, work with them to address those concerns, and provide more support in those units.

We still have an element of our staff who don't agree with this policy and think it is an example of patients and families coming first – getting what they want, when they want it. It is our biggest challenge.

Resistance from staff is usually based on the fact that they think that care is going to be negatively impacted. You just need to provide them the space to understand that this actually is going to be a good thing and let them live it out to see the benefit that it is going to bring.

Critical care wasn't a challenge because people are used to family coming in at all times – as well as pediatric and palliative care. But some of the other areas had challenges understanding why we would have a patient's family come in any time.

We tried to introduce parental presence during sedation pre-operatively and we found our anesthesiologists have not been as open to that.

We had quite a bit of discussion with our Medical Advisory Committee about family presence for bedside procedures, even somebody requiring resuscitation. We wouldn't be telling families that they had to leave if somebody really wanted to stay with their loved one. With resuscitation, 8 of 10 family members wouldn't want to be there. But if it meant their loved one might actually die and they could be there to hold their hand and there was room, we would make accommodation for that. Staff go above and beyond to try and accommodate a patient who might want to have a family member close by.

Hospitals spoke about concerns that staff had about **what potentially could go wrong** with the implementation of a family presence policy:

- There could be "a flood of people never wanting to leave the hospital."
- There could be unsafe situations for staff – "nurses not being aware that people are in the unit."
- There could be additional expenses because more chairs, blankets, mini-fridges would be required for family who stay overnight.

In spite of all the scenario planning, all hospitals reported that there were **actual challenges** when the policy was implemented.

- Units where there was not enough bedside **space** – to accommodate families especially for overnight stays.
- Efforts to accommodate family in wards where other patients want **privacy** and submit formal complaints to the hospital administration.
- Efforts to accommodate **cultural preferences** where the expressed wishes of one cultural group may have an impact on other patients or staff – for example, where there are large families with expectations to all be at the bedside, religious practices and rituals (e.g., prayers), and cultural traditions (e.g., smudging ceremony).
- There were **practical challenges**, like locked doors and elevators shutting down.

We anticipated every question or concern that staff might have had, and staff had all kinds of concerns. We did everything up front to try and mitigate their concerns, but we also said – if these materialize let us know right away. Very few of their concerns ever happened.

It's about nurses not being able to get to the IV pump. But we can work with families around those things.

We can work with families on what is their goal and how we can achieve their goal. Maybe off the unit where we've got more space to accommodate larger groups. Thinking about family presence, thinking outside the box – it doesn't have to be right at the bedside.

The biggest challenges were the actual practical stuff. At one of our sites, the elevators would shut down at a certain time. We can't say that we have flexible hours when people can't actually go up to the units where their loved one is. We had to do some problem-solving with security. But since we worked with security right from the start, they were open to working with us to support families.

The consistent guidance from all hospitals was the importance of **being flexible and problem-solving** as situations arise.

- Have **a process to address any anticipated staff concerns.** Most hospitals referred to various mechanisms that were established to get real-time feedback from staff about the implementation of the policy (e.g., setting up regular rounds on units or rounds with managers).

- Have a **point person** – an identified person that staff can go to if they have any concerns or if anything happens that they don't know how to handle.

- Show the **evidence and allow for individual preferences**. Provide staff with material that shows the evidence for improved patient care and outcomes as a result of family presence.

There is evidence that having family present during a code helps in terms of grieving – they see that every effort has been made. Where we, as staff, feel like we need to protect the family, you may have someone say 'that doesn't bother me, I want to stay" and we need to respect that.

- Be **responsive** to all concerns. For example, some hospitals referred to staff concerns about safety at night. Discussions with security staff resulted in changes to security processes and the introduction of identification badges.

Well, if that happens, let me know. And it never happened, or if it did, we just did problem-solving together.

Operationally, we have to figure it out. We don't have every room equipped with lounger, pillow and blanket. It is more like a logistical piece. We admit 35,000 patients a year ... I have had only two problems.

We've increased our security ... and developed a system to identify those patients that have visitors and where they are allowed to be.

6. What was the overall advice to others?

The following are the top six pieces of advice from the participating hospitals to others who are interested in shifting to family presence policies in their organization:

1. Take the time to **learn from other organizations** who have experience with family presence policies and other sources of guidance. The *Institute for Patient and Family Centered Care* (IPFCC) and the *Canadian Foundation for Healthcare Improvement* (CFHI) were flagged as organizations with useful resources, guidelines and recommendations; *Health Quality Ontario's Patient and Family Engagement Framework* was identified as a useful tool. Reaching out to other hospitals who have experience developing and implementing family presence policies was noted as particularly helpful.

2. **Anchor the change in "why?"** Make sure people are clear on why you're making the change, help people understand why change is needed.

3. **Involve key influencers and key stakeholders.** "Go far, wide and deep"; have them involved at the beginning to help design the policy and drive it forward. Engage your patients and families. Get them involved in every way you can.

   Also include:
   - Clinical managers who are key to understanding concerns on the unit
   - Leadership whose involvement is critical to driving home why the change is important
   - Security and housekeeping management and staff who will have insights into the practicalities of implementing the policy

4. **Think carefully about terminology** – people have different family structures, different relationships.

5. **Anticipate and address fears and concerns that staff may have.** There are practical issues that need to be worked out.

Most helpful was working with other hospitals – what worked well, didn't work so well; their plans, policies, communication strategies. That sharing really made us feel confident that we could do this. The partnerships with these hospitals was fantastic.

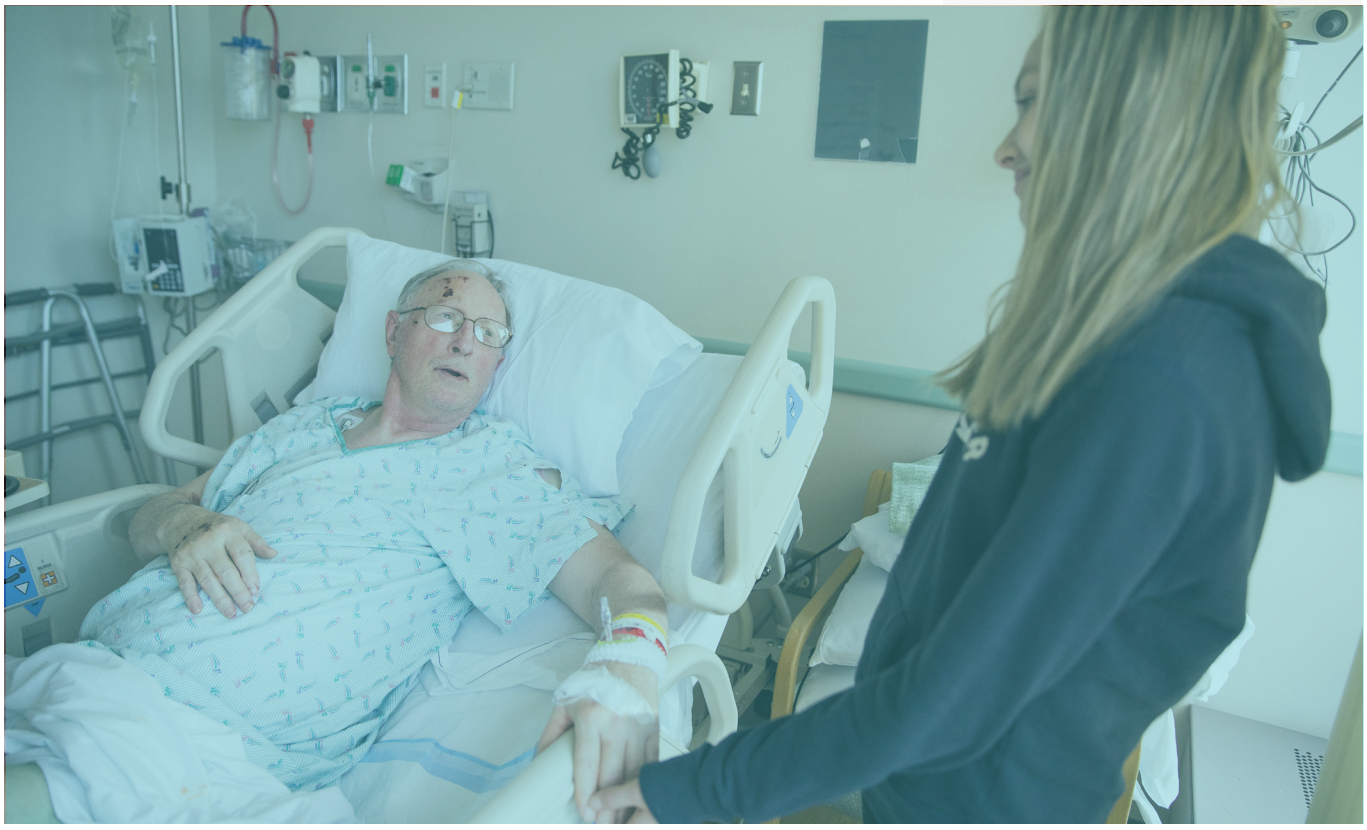
Engage your patients and families; use your patient and family advisors. Help them guide your policy. Get them involved in every way that you can. They are the ultimate result and they're the best people to help us make those decisions.

We didn't use family very intentionally, rather we use care-partner as somebody who the patient identifies as significant to their healing.

The things that we, as patient experience change agents, sometimes focus on when we're looking at these big initiatives is sometimes not what frontline team members might be thinking of. Try and anticipate some of the fears and concerns that team members are going to have and address that right off the bat in your communications. If you have Q & A packages or huddle packages for managers make sure all of that is addressed.

6. Make sure you have a **process or a mechanism for staff to go to with concerns**, and to problem-solve glitches or unanticipated situations along the way. There will be issues, situations or unique circumstances that need to be worked out as they present themselves.

Staff need to know that it's going to be reviewed on an ongoing basis, that they have a mechanism that, if they have any concerns, they have a way to bring them forward.



FAMILY PRESENCE AND CAREGIVER IDENTIFICATION

After collecting insights and reflections on their family presence policies, we asked the participating hospitals if they would be interested in learning more about Caregiver ID initiatives that align with family presence policies. The hospitals were unanimous in wanting to hear more.

The Change Foundation's Changing CARE teams have worked with caregivers and providers to co-design initiatives to improve the caregiver experience and the provider experience in working effectively with caregivers. One of the common themes was that caregivers and providers alike were interested in finding an easy way to visually identify caregivers within care settings to facilitate their participation as a partner on the care team. Both groups felt a form of caregiver identification would make it much easier to know who the family caregiver is for the patient, and it facilitates information sharing between providers and caregivers, especially as the patient transitions home.

The Foundation created a working group with caregivers and representation from each of the Changing CARE teams to map out a basic Caregiver ID process and identify considerations for implementation. The Foundation also designed a standard visual identification that could be adapted for use in a variety of healthcare settings and/or on particular units within hospitals or care facilities.

Offering a caregiver identification program is an important demonstration of the organization's commitment to caregivers. It's a concrete way to recognize caregivers and remove barriers to their participation as a member of the care team.

Within hospitals, Caregiver ID initiatives can be implemented on their own or in conjunction with another related initiative, such as a family presence policy. That was the case for one of our Changing CARE partnerships – the **Cultivating Change** project. At Bridgepoint Active Healthcare, part of the Sinai Health System in Toronto, the Caregiver ID was implemented to coincide with the roll-out of a site-wide family presence policy. By all accounts, the complementary implementation was successful.

I am a CAREGIVER

The Caregiver ID badge and the family presence poster provide examples of the visual materials used to implement the program at Bridgepoint Active Healthcare. Although Caregiver ID initiatives are still in their early days, there are some initial results and common themes coming out of the Changing CARE projects. Patients and families are consistently positive about the acknowledgement and recognition the identification provides, and staff understand how the identification can be beneficial to them as providers in facilitating the inclusion of caregivers on the healthcare team.

As it relates to family presence polices, the Caregiver ID can help address some of the common challenges associated with implementing a family presence policy. Specifically, it reduces staff concerns about safety because they can easily see the badge or ID indicating they are a family member, and the ID badge can double as an after-hour access card, making it much more convenient for family members.

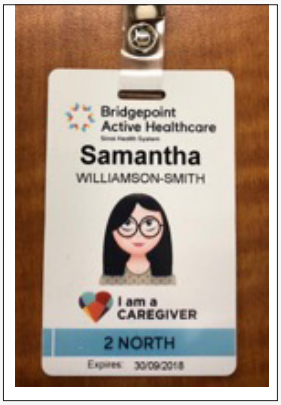
Overall, Caregiver ID initiatives support a culture shift to a broader philosophy of care where family caregivers are valued as important members of the care team.

For those hospitals that have introduced a family presence policy, there is already an organizational commitment to family caregivers. Within these hospitals, there may be a strong receptivity and alignment to introduce Caregiver ID initiatives.

For those hospitals that are going to introduce or even shift to family presence policies, consideration should be given to introducing a complementary Caregiver ID initiative as a further extension of their family presence culture.

The Change Foundation has tools and resources available to support organizations interested in Caregiver ID initiatives.

Contact info@changefoundation.com if you are interested in learning more about Caregiver ID initiatives.



I'll now be able to do some of my own errands – taking care of myself – and then come in for a visit without having to ask for permission.
— Caregiver at Bridgepoint

Engage your patients and families; use your patient and family advisors. Help them guide your policy. Get them involved in every way that you can. They are the ultimate result and they're the best people to help us make those decisions.

THE CHANGE FOUNDATION

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Ontario Hospital Association