



## Introduction

Corporate policies have been revised and continue to be revised with Patient- and Family-Centred Care in mind. The following 3 policies exemplify how language inclusive of patients, families and their needs and perspectives can begin to transform an organization's culture. Sometimes it's as easy as adding a few words. Other times the whole intent of the policy must change as in the case of the "Visitation Policy".

# KINGSTON GENERAL HOSPITAL

## ADMINISTRATIVE POLICY MANUAL

**Subject: Family Presence (formerly Visiting)**

**Number: 07-070**

**Prepared/Reviewed by:** Patient and Family Advisory Council, Professional Practice Council, Nursing Practice Council, Resuscitation Committee, Joint Program Council, Operations Committee

Page: 2 of 13  
 Original Issue: 1984.02  
 Revised: 2004.04  
 Revised: 2009.09  
 Revised: 2012.09

**Issued by:** President & Chief Executive Officer

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### Preamble

Kingston General Hospital is committed to creating an environment supportive of patient and family-centred care, positive health outcomes and the safety and security of patients, their families, guests, our staff and our community.

### Definition

Family – a group of individuals with a continuing legal, genetic, and/or emotional relationship. Patients define their 'family' and how they will be involved in care, care planning, and decision-making. Kingston General Hospital respects and values family as integral partners in providing excellent care.

Guest – visitor of the patient or family.

### Policy

1. Families are welcome 24 hours a day according to patient preference.
2. The number of people welcomed at the bedside at any one time will be determined in collaboration with the patient, family and interprofessional care team. In situations where there are shared rooms, this negotiation will include the other patient and his or her family. To ensure safety, considerations will also be given to the physical limitations of the space.
3. Between 2300 and 0600 hours, family members are encouraged to enter through the Davies main entrance. If family are expected between 2300 and 0600 hours, please contact the security desk at #4142, provide name(s) and estimated time of arrival. Security staff will issue a temporary ID.
4. Alternative guests (e.g. pets and/or animal-assisted therapy) must be pre-arranged with the interprofessional team.

5. Family and guests who are feeling unwell; have an infection; have symptoms of respiratory illness or flu-like illnesses should not come to the Hospital.
6. If an outbreak of infection requires some restrictions for public health, the staff will collaborate with the patient and family to enable and ensure that selected family members are still welcomed.
7. For the safety of our patients, families and guests are required to perform hand hygiene with soap and water or alcohol based hand rub upon entering and leaving the patient's room.
8. Children (i.e. < 14 years) supervised by an adult who is not the patient are welcomed.
9. There may be interruptions to family presence to protect the privacy rights of other patients or to maintain safety and security.
10. Individuals who have concerns regarding the application of this policy should refer the issue to a member of the unit based interprofessional care team. If the issue cannot be resolved at the unit level, it may be referred to the Patient Relations Program or the administrative coordinator in the absence of Patient Relations Specialist.

#### References

- American Academy of Family Physicians. (2009). *Definition of family* (policy statement). Leawood, KS: Author. Retrieved from <http://www.aafp.org/online/en/home/policy/policies/f/familydefinitionof.html>
- Institute for Patient and Family-Centered Care. (2011). *Changing Hospital Visiting Policies and Practices: Supporting Family Presence and Participation*. Bethesda, MD: Author.
- Johnson, B., Abraham, M., Conway, J., Simmons, L., Edgman-Levitan, S., Sodomka, P., Schlucter, J., & Ford, D. (2008). *Partnering with patients and families to design a patient and family-centered health care system: Recommendations and promising practices*. Bethesda, MD: Institute for Patient- and Family-Centered Care.
- Leape, L., Berwick, D., Clancy, C., Conway, J., Gluck, P., Guest, J., et al. (2009). Transforming healthcare: A safety imperative. *Quality and Safety in Health Care*, 18, 424-428.

#### Authorizing Signature

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Leslee J. Thompson  
President and Chief Executive Officer

## KINGSTON GENERAL HOSPITAL

### ADMINISTRATIVE POLICY MANUAL

|  |  |
|--|--|
| <b>Subject: Administrative Policy – Development / Review / Revision / Deletion</b> | <b>Number: 01-060</b>  |
| <b>Prepared by/Reviewed by: Risk Management /Operations Committee</b>              | Page: 4 of 13<br>Original Issue: 1985.02<br>Revised: 2012.05 |
| <b>Issued by: President &amp; Chief Executive Officer</b>                          |  |

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#### Introduction

Administrative policy reflects our guiding principles, strategic directions and is part of our integrated quality framework. It is the means by which rules and processes become documented and communicated. A standardized approach to Administrative policy defines, clarifies and provides direction for staff and leaders in the operations of the organization.

In order to ensure that the administrative policy manual serves as an authoritative guide to action for all staff, it is important that the manual be reviewed and updated on a regular basis. This goal is best accomplished when the responsibility for coordinating the process is vested in one person.

#### Policy

1. New, reviewed, revised and deleted administrative policies are endorsed by relevant stakeholders and approved by the Operations Committee (OC), +/- Medical Advisory Committee (MAC) +/- Hospital Board prior to signature and issuing by the President and Chief Executive Officer (CEO).
2. The Chief Operating Officer is responsible for coordinating the review and maintenance of administrative policies.
3. Administrative policies are reviewed at a minimum every three (3) years, or as required by legislation.

#### Definitions:

Administrative Policy: Includes policy that governs the conduct of more than one program or service in the organization with respect to, for example, operations, risk management, quality, safety, and staff conduct. Policy content is not generally patient related.

Executive Sponsor: A member of the Executive Management Committee: President and Chief Executive Officer (CEO), Chief Operating Officer (COO), Vice-president (VP) of Health Sciences Research, VP of People Services & Organizational Effectiveness, VP of Clinical Administration & Professional

Practice and Chief Nursing Executive, Chief of Staff and VP of Medical Administration, Chief Communications & Marketing Officer

**Stakeholders:** Staff & affiliates (physicians, learners volunteers), **patients and families**, committees, councils, groups, departments, services etc. who are directly or indirectly affected by the policy. Key stakeholders are those most impacted.

**Endorsement:** To express support for the policy being proposed

**Approval:** To give official sanction to the policy being proposed

**Minor Revision:** A policy revision that does not change the intent, process or practice of the policy

**Procedure** (See flow diagram Appendix A and refer to checklist Appendix D)

1. Need identified for new/reviewed/revised/deleted policy based on:
  - 1.1 change in practice
  - 1.2 new/changed legislation
  - 1.3 standardization of process(es)
  - 1.4 clarification of an issue
2. Individual identifying need for new/reviewed/revised/deleted policy seeks support from their Manager and/or Director and an Executive Sponsor
3. Most Responsible Person (MRP) appointed by Executive Sponsor
  - 3.1 In consultation with Executive Sponsor, required endorsement and approval process is established
  - 3.2 Endorsement/approval process may or may not include MAC and Board
4. MRP:
  - 4.1 Develops/reviews/revises/considers deletions of policy in consultation with stakeholders – see Policy & Procedures template (Appendix B)
  - 4.2 Initiates Tracking and Impact Form (Appendix C)
  - 4.3 Reviews and identifies other policies that may be duplicated and/or impacted by new/revised/deleted policies
5. MRP seeks endorsement from stakeholders and relevant committees as identified in consultation with Executive Sponsor
  - 5.1 For policies requiring minor revisions only, stakeholder endorsement is not required. MRP submits policy Tracking and Impact Form electronically to Executive Sponsor
  - 5.2 MAC and/Board endorsement is sought as applicable
6. Upon receiving stakeholder endorsement, MRP submits Tracking and Impact Form and policy electronically to Executive Sponsor

7. Executive Sponsor submits policy and Tracking and Impact Form to Operations Committee for approval
  - 7.1 MAC and/or Board approval is sought as applicable
8. Executive Sponsor communicates to MRP that policy has been approved
  - 8.1 If policy is not approved by Operations Committee, Executive Sponsor and MRP consult on establishing next steps
9. MRP:
  - 9.1 Communicates desired policy publication date to policy administrative support
  - 9.2 Sends updated Tracking and Impact form to policy administrative support
10. Policy administrative support:
  - 10.1 Has Operations committee Chair sign Tracking and Impact form
  - 10.2 Has President & CEO sign policy
  - 10.3 Files original signed policy
11. MRP implements communication and education plans that support new or revised policy. (Appendix E and F)
12. Policy administrative support:
  - 12.1 Publishes policies online
  - 12.2 Communicates manual updates to the organization
  - 12.3 Arranges for archiving of outdated and deleted policies

**References:**

London Health Sciences Centre Policy Administration Console. Corporate Policy Development, Approval and Maintenance  
 Hamilton Health Sciences, Policy and Procedure – Protocol  
 Hotel Dieu Hospital Administrative and Interprofessional Policy and Procedures (2010)

Authorizing Signature:

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Leslee J. Thompson  
 President and Chief Executive Officer

## **Policy Template**

### **Introduction**

An introduction can be used to provide the end-user with background information about the policy. Not all policies need an introduction.

### **Policy statement**

Broad, clear statement(s) that enable informed decision making prescribe limits, clearly outlines responsibilities and accountabilities within the organization, and provides direction for the organization secondary to i.e. Provincial Legislation and Hospital By-Laws. Policy statement(s) define the rule(s), to whom and when they apply, and when, applicable, why the policy exists. Policy statements contribute to the delivery of the Kingston General Hospital corporate strategy. **The patient perspective must be woven into every policy that materially influences the patient experience.**

### **Definitions:**

Provide definitions of terms used in the policy that may not be fully explained in the text of the policy.

### **Procedure**

The “how-to” for the policy. Provides the instructional/operational methods (i.e. sequence of steps) necessary to carry out a policy. Identifies the departments and/or people that are most responsible. Procedural steps are numbered using the following standardized format:

1. Recycling bins are available throughout the organization
  - 1.1 Blue bins are for cans and bottles
    - 1.1.1. Cans and bottles are placed loosely in the bins
  - 1.2 Grey bins are for paper
    - 1.2.1 Paper is bundles with string
  
2. Environmental Services empties the recycling bins at the end of the shift

### **References:**

References include resources that were used in the development of the policy. They may include legislation, textbooks, journal articles, and/or standards of practice.

### **Related Documents:**

List any Kingston General Hospital policies or other documents that the reader should refer to for further information. Include the type of document (e.g. Administrative Policy, Medical Directive), number and title as applicable.

## KINGSTON GENERAL HOSPITAL BRIEFING NOTE

|                         |  |
|-------------------------|--|
| <b>TOPIC OF REPORT:</b> | Position Description Language  |
| <b>SUBMITTED TO:</b>    | Operations Committee   |
| <b>SUBMITTED BY:</b>    | Eleanor Rivoire, Vice President, Clinical Administration and Professional Practice & CNE |
| <b>DATE:</b>            | January 20, 2012   |

|                                       |          |
|---------------------------------------|----------|
| <b>FOR INFORMATION AND DISCUSSION</b> | <b>x</b> |
| <b>CURRENT STATUS</b>                 |          |
| <b>RECOMMENDATION/ACTION</b>          | <b>x</b> |

### **BACKGROUND INFORMATION & CONTEXT:**

The KGH 2015 Strategy for achieving Outstanding Care, Always includes as its first Strategic Direction to “Transform patient experience through a relentless focus on quality, safety and service” and as its second direction to “Bring to life new models of interprofessional care and education”. In support of these directions, “people” are included as one of the six enablers to fulfilling the strategic directions.

As an outcome of the work with the strategic directions, there has been an explicit focus on promoting and understanding and support for Patient and Family Centred Care (PFCC). Staff who work in or are recruited to KGH now receive orientation/education about the concepts and practice that support PFCC. Increasingly, individuals who are being considered for employment at KGH are being interviewed by panels that include patient experience advisors who look for evidence of patient centred thinking and approach.

Progress with embedding PFCC continues as part of the way KGH staff practice, and provide care/services. Those supporting the PFCC workplan identified an additional opportunity to profile this fact at the point of hire,



and in doing so, ensure that any individual applying to work at KGH knows of the importance placed on this approach and the expectation that it will be supported.

To that end, it was suggested that all job descriptions be revised to include language that makes the expectations explicit. The following draft statement was developed for review:

*“As an employee, you must demonstrate an awareness of and be responsible for actively promoting and supporting patient and family centred engagement and care in all that you do. Within your role you are accountable for contributing to the delivery of the Kingston General Hospital corporate strategy.”*

The statement was presented to the Patient and Family Advisory Council on January 16, 2012 and was endorsed without change.

The statement was subsequently presented to the Professional Practice Council on January 19, 2012 and was endorsed with the suggestion of reversing the order of the two sentences, and encouraging/requiring all job postings to include the same language.

#### **RECOMMENDATION:**

The Operations Committee, which oversees implementation of the KGH Strategy is asked for support that all job descriptions be revised to include the following:

***“Within your role you are accountable for contributing to the delivery of the Kingston General Hospital corporate strategy. As an employee, you must demonstrate an awareness of and be responsible for actively promoting and supporting patient and family centred engagement and care in all that you do.”***

As well, there is request for support that all job postings, internal and external, include the same language.

# KINGSTON GENERAL HOSPITAL

## ADMINISTRATIVE POLICY MANUAL

|                 |  |                 |              |
|-----------------|--|-----------------|--------------|
| <b>Subject:</b> | <b>Hospital Identification</b>                         | <b>Number:</b>  | <b>02-01</b> |
| Prepared by:    | Director, Emergency Management, Security & Life Safety | Page:           | 10 of 4      |
| Issued by:      | President & Chief Executive Officer                    | Original Issue: | 1973.0       |
|                 |  | Revised:        | 2011.0       |
|                 |  | Revised:        | 2012.0       |

### Purpose

The purpose of this policy is the protection of patients, staff, physicians, volunteers, visitors, and hospital assets; including satellite sites, while giving staff and physicians the necessary access to administer patient care and to identify staff, physicians and volunteers during an emergency.

### Policy

Anyone employed by, or carrying out approved activity within the hospital must have approved photo identification issued by the Department of Emergency Management, Security & Life Safety.

Approved Hospital ID is to be worn at all times with the picture prominently displayed at chest level and visible at all times. The ID is not to be altered in any way from what was issued.

Identification badges are the property of Kingston General Hospital and must be returned by the holder to Security upon the termination of employment, contract, student status, or visit.

Badge holders are required to present their hospital identification and full name upon request by any patient, Security Officer, or staff person.

Identification badge requests comes from People Services for employees and affiliates, from Medical

Administration for Physicians, Volunteer Department for Volunteer Services, and Plant Services or the

Joint Planning Office for contractors and construction workers.

Three types of hospital identification are provided:

Employee/Affiliates/Credentialed Staff ID: reserved for employees, physicians, volunteers, and those who are authorized to work at KGH or at satellite sites such as Belleville Dialysis.

Non-Employee/Contractor ID: reserved for students, departmental assistants, observers, industry study monitors for REB approved studies, non-medical university members belonging to hospital-based research/educational groups,

non-medical university administrators and support staff with liaison duties requiring access to the hospital, community physicians regularly attending hospital-based CME, service, delivery and contract personnel who have an agreement with Education services, Research services, Medical Administration or Department Heads and Contractor/Construction workers.

Temporary ID: reserved for sales representatives and visitors. Temporary ID is disposable and will not have the photo.

Employee/Affiliate ID shall have the following identifiers:

First Name

Last Name

Role

Picture

KGH logo

Bar code where applicable

Non-employee ID shall have two additional identifiers on the ID:

A red border around the picture and

An expiry date printed in the middle of the ID.

Temporary ID will be identified by:

The ID is a self adhesive affixed to the chest area of an individual,

It shall have the KGH logo on it, and

It shall have an expiry date in the middle of the ID. Temporary ID shall only be issued for the day it was issued.

A replacement fee for lost ID badges, with the exception of temporary ID, is charged for and must be paid at the Cashiers Office. A receipt must be presented to the Security Office-Dietary 1.

ID cards are also proximity card readers that can allow access to certain areas in the Hospital dependant on an individual's responsibilities and duties approved by their Department Head. Under no circumstances can a hospital ID be used by anyone other than the person to whom the ID was issued to and whom the ID bears their picture nor can it be used to let another person into an area that they do not have authorization to access.

Card Access is tracked and may be monitored by Security through random audits to identify unauthorized use or in investigations.

KGHI recognizes that there may be times when specific unusual circumstances require us to evaluate the security and safety of an individual employee who demonstrates through supporting evidence (example could be a Police report or safety plan) that to have their last name on their ID would compromise their safety while at work. In these cases a pseudonym last name may be used. See “Procedure To Use a Pseudonym Last Name”. A pseudonym last name will be chosen by People Services and or Security.

Contractors must comply with requirements of the Contractor Health & Safety Program policy #02-195 and for Affiliates the Health & Safety Training for Employees and Affiliates policy #02-196 prior to being issued an I.D. badge.

#### Procedure to obtain Employee/Affiliate ID

Attend People Services on Watkins 4.

People Services will approve and provide the information to the Emergency Management, Security & Life Safety Department electronically.

Attend the security office on Dietary 1 to obtain Employee ID.

#### Procedure to obtain Credentialed Staff ID

From Medical Administration an “Appointment Letter” is sent to Security Office on Dietary 1 as authorization to issue ID.

Attend the security office on Dietary 1 to obtain ID.

#### Procedure to obtain Non-Employee ID

Appropriate authority provides a list of names to security with an authorization form attached.

Authorized persons attend security office on Dietary 1 and present student ID or drivers license to obtain non-employee ID. Non-employee ID will be identified with a red border around the photo and a red expiry date on the face of the badge.

For students, expiry dates will be based on the graduation date.

For departmental assistants, observers, industry study monitors, approved non-medical university members with research/educational affiliation, non-medical university administrators and support staff with liaison duties, and community physicians regularly attending hospital-based CME, expiry dates will be based on the term of the activity.

For contractors, expiry dates will be based on the term of the project.

For service personnel, expiry dates will be based on the term of the contract, or on an annual basis.

In instances where an authorized service company cannot provide a regular service employee, an ID badge without a Photo may be issued. In such cases, “service contract” will be placed in the photo area.

### Procedure to obtain Temporary ID

Staff or Physician notifies security with visitor name, date, time and location of appointment, at least 48 hours in advance.

Accessing the hospital:

Visitors report to security at the Davies main lobby.

Security will verify identity of visitor and scheduled appointment or visitation.

Security will issue a Temporary ID and ensure cell phones and non-compliant transmitters (e.g., personal digital assistants) are turned off prior to entry.

### Procedure to use Pseudonym Last Name

Fill out a “request to change last name form” at the Security Office on Dietary 1 indicating the specific circumstances for the request.

Security will forward a copy to People Services.

Security and Peoples Services shall evaluate the request.

If approved, Security will issue the ID with first name and a pseudonym last name.

Security shall notify the appropriate professional practice office, if any.

Nursing Professional Practice shall notify the College of Nurses, if a Nurse makes the request.

If a Registered Nurse, Registered Practical Nurse, or a Nurse Practioner shall notify the Chief Nursing Officer.

Other regulated/non-regulated health professionals shall notify their program Director.

Authorizing Signature

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Leslee Thompson

President and Chief Executive Officer