




BETTER TOGETHER:

**A Change Package to Support the
Adoption of Family Presence and
Participation in Acute Care Hospitals and
Accelerate Healthcare Improvement**



In Partnership with



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INTRODUCTION

ABOUT THE BETTER TOGETHER: PARTNERING WITH FAMILIES CAMPAIGN

Better Together: Partnering with Families is a campaign launched by the Institute for Patient- and Family-Centered Care (IPFCC) – a U.S. non-profit located in the United States with a mission to advance the understanding and practice of - and family-centred care. This three year campaign aims to change the concept of families as ‘visitors’ to families as partners in care in hospitals across North America.

In 2014, the Canadian Foundation for Healthcare Improvement (CFHI) partnered with IPFCC to spearhead the Better Together campaign in Canada. Building on our work in patient and family engagement for improvement and recognizing that family presence policies are an innovation at the level of service improvement and organizational design, CFHI endorses the Better Together campaign to promote patient and family engagement in healthcare improvement.

While 90 percent of health sector professionals and the general public are supportive of family presence,¹ less than a quarter of Canadian acute-care hospitals have accommodating visiting policies that foster family presence.² There is a real opportunity for improvement to better meet the needs of patients and families and to deliver patient- and family-centered care.

For more information about the Better Together campaign, please visit our [website](#).

ABOUT THE CHANGE PACKAGE

This Change Package is a guide for developing family presence policies that welcome and recognize families as partners in care. The recommendations and resources have been drawn from evidence-based patient- and family-centred care practices, improvement stories and research studies investigating the impacts of family presence and participation in healthcare. This document builds on the IPFCC Toolkit³ developed to support the Better Together campaign. The Change Package takes a broad approach to change from the development or adoption of new policies to their implementation, evaluation and spread. Several theories and models inform this Change Package:

- The Institute for Healthcare Improvement’s Model for Improvement⁴ allows organizations to accelerate improvements in ways of working with patients and families, and outcomes by testing changes and applying learning.
- The Kotter eight-step process for managing organizational change⁵ helps reduce the challenge of a large scale change by dividing it into manageable steps and actions.


1 Ipsos (2015) Hospital Visiting Hours: Canadian Foundation for Healthcare Improvement [Data set]

2 Canadian Foundation for Healthcare Improvement. (November 2015) Much More than Just a Visit: A Review of Visiting Policies in Select Canadian Acute Care Hospitals

3 IPFCC, Index of Toolkit: <http://www.ipfcc.org/advance/topics/better-together-index.html>

4 Institute for Healthcare Improvement: <http://www.ihl.org/education/WebTraining/OnDemand/ImprovementModelIntro/Pages/default.aspx>

5 Kotter J. (2012). Leading Change. Harvard Business Review Press, Boston, MA.

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- A recently developed concept of ‘health-literate organizations’⁶ is applied to identify priority action areas to help concentrate and structure the effort.

This Change Package provides a comprehensive change strategy that affirms a patient- and family-centred philosophy of care. Undertaking change of this magnitude requires commitment to continuous improvement, broad collaboration and inclusion of populations often not included in change management processes.

At CFHI we seek to better understand and support the most effective ways of promoting the implementation, adoption and spread of evidenced-based practices for the benefit of patients, their families and others. Any comments on this document are welcome. The most recent version of the Change Package can be found at: www.cfhi-fcass.ca/BetterTogether.

HOW TO USE THE CHANGE PACKAGE

The Change Package is divided in three phases and outlines a sequential process for achieving family presence and participation. Each phase (assessment and initial review; adoption and formulation of family presence policy and practice; implementation, sustainability and spread) includes priority areas for action, steps, change ideas, resources, examples and important tips.

Priority areas include leadership and management, workforce, meeting needs of patients and families, quality and safety, and communication. Each priority area typically includes a set of one to four steps outlining a concrete action facilitating the change in this priority area – the WHAT. Change ideas and priority actions outline specific tactics and techniques that can be used to deliver the concrete action - the HOW.

The timeline illustrates notable phases as your organization is advancing to achieve family presence. The timeline can help you focus on important milestones.

Implementation of family presence policies may look different in different contexts. We encourage you to use this document as a guide and choose steps and activities that best suit your needs and local context.

LANGUAGE

Family presence recognizes the right of the patient to define their partner(s) in care. Throughout the change package, the term ‘family’ refers to family members or other person(s) of significance in the life of the patient – as defined by the patient – who are designated partners in care.

⁶ Brach C, Dreyer B, Schyve P, Hernandez LM, Baur C, et al. (2010). Attributes of a Health Literate Organization. Workgroup on Attributes of a Health Literate Organization of the IOM Roundtable on Health Literacy, IOM. Available from: www.jointcommission.org/assets/1/6/10attributes.pdf

VISUAL TIMELINE

The following timeline provides an overview of phases and steps outlined in the change package to achieve family presence. **Aim:** Pursue, by the end of 2017, the review, development and implementation of policies and practices supporting presence and meaningful participation of family members in the process of care.

Phase 1: Assessment & Initial Review

Leadership and Management

Engage with patients and families to:

- Conduct self-assessment
- Form team or committee to champion the change
- Review existing policies and practices

0-3 Months

Phase 2: Formulation of Family Presence Policy & Practice

Leadership & Management

- Support patients' rights to identify family without discrimination
- Develop infrastructure required to support the change
- Support creation of educational programs for staff
- Model behaviour you expect to see in your organization

Workforce

- Develop proficiency standards for staff
- Educate staff to engage patients/families as part of care team

Meeting the Needs of Patients and Families

- Define broad definition of family and partner(s) in case
- Review and prepare to adopt the practice of four steps when working with families
- Clarify desired role of designated partner in care
- Support patients and families to engage in the care process and partnership with providers

Quality and Safety

- Teams test new guidelines and protocols using PDSA cycles
- Prepare to monitor and document the results
- Refine strategies, policies and other practice documents

Communication

- Create communications plan
- Review results of hospital tour (phase 1) to determine new signage, communications materials and physical environment requirements
- Review, standardize and update digital and print materials to reflect changes in visitation policies for new family presence and visitation policies

6-9 Months

Phase 3: Implementation & Monitoring of Impact, Sustainability & Spread

Leadership and Management

- Monitor infrastructure supporting implementation
- Assure that policies and protocols are in place and followed
- Build sustainability and plan for spread

Workforce

- Cultivate a healthy team in your unit department
- Incorporate family presence education into ongoing staff training and orientation for new hires

Meeting the Needs of Patients and Families

- Promote family presence as soon as the patient is admitted
- Practice assessment, planning, intervention and evaluation when working with families
- Clarify desired role of designated partner in care
- Advise all direct care providers that the family opts to be present and involved (verbally and in writing)

Quality and Safety

- Revise and modify measurement plan
- Build in longer-term resources for expansion of engagement activities

Communication

- Prioritize removal of old 'visitor' signage and communications materials
- Ensure front desk is aware of changes
- Share and celebrate early success

Ongoing






PHASE 1: ASSESSMENT & INITIAL REVIEW

In this phase, a team will define problems that need to be addressed by revising visiting policies, introducing or strengthening family presence in local context. This involves a self-assessment, audit of existing visiting policies and practices, and listening to the voice of the patients, families and staff. Fishbone analyses, '5 Whys' or a driver diagram can be used to analyze information. The problems that come to the forefront in this analysis will serve to focus the efforts of the team and guide implementation of next phases.

1. LEADERSHIP AND MANAGEMENT

1.1. Conduct an organizational self-assessment of current policies and practices¹

CHANGE IDEAS AND PRIORITY ACTIONS

-  • The self-assessment helps determine initial priorities and action steps to begin the process of improvement. Most importantly, it will help situate this work in the context of ongoing initiatives and patient- and family-centred related changes that have already taken place in your organization.
- Share assessment results with Chief Nursing Officer or VP responsible for patient relations, and other clinical leaders to build motivation for a change.
- To gain the buy-in and ensure sustainability over time, align this change with other ongoing initiatives aiming to improve the quality of care at your organization and identify specific challenges that might be helped through family presence. Assess and consider patient and family feedback.
- Having a solid patient- and family-centred care model in place can facilitate the implementation of a family presence policy. Alternatively, the process of reviewing, developing and implementing a family presence policy can catalyze a cultural shift toward patient- and family-centred care and patient and family engagement at large.

RESOURCES, EXAMPLES AND TIPS

Key Resources

1. Institute for Patient-and Family-Centered Care's [Organizational Self-Assessment](#)

Supplemental Reading

- Review IPFCC's presentation for Leadership ["A Call for Action"](#)

Important Tips

- The organizational assessment should be completed by anyone interested in the pursuit of family presence. During phase 1, step 1.2, a more formalized team structure will be established to lead the change, however, relationships can begin now. Encourage those interested pursuing family presence to reach out to others who may share this interest to complete



the assessment together. Building a broad coalition, comprised of patients, families, staff, administrators and leaders will help to sustain the change and offer different insight and ideas from early planning stages onward.

- Seek out existing data within your organization where feedback might already exist (e.g. satisfaction or experience surveys, patient complaints and suggestions cards, etc...).

1.2. Form a team to provide leadership for the change process

CHANGE IDEAS AND PRIORITY ACTIONS

- i** • Ensure that voices of those who will be affected by the policy change are captured and represented. Core team members needed to help lead this change include an executive leader, staff, patients and families. Members of your patient and family advisory council can be key team members. To complete the team, consider including personnel from a variety of disciplines:
 - Healthcare personnel who are responsible for initiating and monitoring policy changes and those who will be asked to adhere to the new policies and subsequently change their practice.
 - Staff from other departments that will be affected by changes to visiting policies, such as respiratory, emergency, radiology, phlebotomy, infection control, volunteer resources, housekeeping and security.

1.3. The team will review relevant existing policies and practices

CHANGE IDEAS AND PRIORITY ACTIONS

- i** • The purpose of the review is to collect information about current policies and practices affecting visitation, family presence and participation from the perspective of those affected by them (e.g. staff, patients, families, etc.). A variety of strategies can help gain insight into existing policies and practices and provide ideas for changes to visiting policies:
 - Tour the hospital or unit to examine signage and the physical environment for its potential impact on families;
 - Talk or hold focus group meetings with patients, families, Patient and Family Advisory Council, and other visitors. This may be a role for patient and family members from the team. Look for discrepancies between experiences of patients and families from the written policies.
 - Hold a special staff meeting or survey staff to determine their perceptions and knowledge of the needs of patients and families, concerns about visiting policies, their understanding of benefits and willingness to change practices.
 - If you identify examples of restrictive visitation or areas where partnerships with patients and families could be improved, get to the root of the problem to better understand why it is happening. Quality improvement tools such as a fishbone analysis, '5 Whys' or driver



diagram can help identify the root cause.

- Seek out existing champions for change from units who may already be instituting the change or are interested in supporting the initiative

RESOURCES, EXAMPLES AND TIPS

Key Resources

- Existing policies and practices can be reviewed against IPFCC's [Criteria for Exemplar Hospitals](#)
- Use the [Organizational Self-Assessment](#) to guide the reviews, to record the results, and to discuss priorities for change.
- IPFCC's [How to Conduct a "Walk-About"](#) from the patient and family perspective

Supplemental Reading

- IPFCC's [Strategies for Changing "Visiting" Policies](#) steps 2 to 5
- A [Quality Improvement Primer](#) from Health Quality Ontario

Important Tips

- Consider all areas where visiting policies may be communicated, including guidelines for practice, patient and family handbooks, information packets, website, etc.
- Keep staff and senior leaders informed about ideas for change by distributing regular briefs. See IPFCC's [Strategies for Changing "Visiting" Policies](#) steps 5-6.
- Use photos and videos to document observations while touring the unit(s) or facility.



PHASE 2: FORMULATION OF FAMILY PRESENCE POLICY AND PRACTICE

In this phase the team will lead the work of designing or adapting examples of guidelines and written policies, as well as making changes in practices (e.g. daily interdisciplinary rounds, shift changes, codes or other emergency situations) to accommodate patients and families. Concentrating your efforts on priority action areas (leadership and management, workforce, meeting the needs of patients and families, quality and safety, and communication) can help bring focus and structure to this work. Design and try different improvement ideas using Plan-Do-Study-Act (PDSA) cycles and communicate with staff members, patients and families to make sure that everyone is aware of the change.

1. LEADERSHIP AND MANAGEMENT

Senior executives can provide leadership and support adoption of family presence policies and practices:

- 1.1. Develop or adopt examples of policies and procedures that support patient's right to identify individuals as 'family' and/or 'partners in care,' without discrimination.**
- 1.2. Develop infrastructure to support this change and ensure that key stakeholders are included in the process from the start.**
- 1.3. Create educational programs for staff that increase awareness and knowledge about family presence and participation.**
- 1.4. Model behaviour you expect to see in your organization**

CHANGE IDEAS AND PRIORITY ACTIONS



- Evidence-based, patient- and family-centred tactics many organizations include in their new family presence policy include: 24/7 presence for 'family' and/or 'partners in care'; welcoming children accompanied by a non-patient responsible adult; accommodating family or designated support people who staying overnight; and encouraging the presence and participation of 'family' during all aspects of care delivery.
- Consider some circumstances when the safety, security or wellbeing of patients and staff would supplant family presence (e.g. combative or violent behaviours, uncontrolled emotional outbursts, behaviours consistent with an altered mental state from drugs or alcohol, suspicion of abuse, outbreaks of infection; visiting when ill, etc. . .). Existing policies on related subjects (e.g. security policies, infection control policies, etc. . .) may offer guidance on extenuating circumstances and potential case-specific exceptions that fall outside of family presence policies.
- Find and agree on an appropriate replacement for the term 'visitor' when referring to designated support person, for example, 'partners in care' or other easy to understand terminology.

- Begin a consultation process to gain early feedback on the content of proposed changes by circulating the draft family presence policy to all affected by it to encourage 'ownership' and acceptance of any changes.
- Engage the team, human resources, launch unit leaders and others to create an effective awareness program at both organization and unit-level. Assess and consider feedback from staff, patients, and families.
- Think about the best way to achieve family presence in your organization, including its sustainability and spread. Would incremental change be favourable to a large, radical single-step change, or vice versa?

RESOURCES, EXAMPLES AND TIPS

Key Resources

- Review IPFCC's [sample guidelines and policies](#) supporting family presence and participation
- Review IPFCC's [Family Presence Template](#)
- Consult IPFCC's [Strategies for Changing "Visiting" Policies](#) steps 6-7
- Hospital News' [Patient-centered Leadership: A Call to Action](#)
- Accreditation Canada's backgrounder on client- and family-centered care in the Qmentum program" and hyperlink to here: <http://www.cfhi-fcass.ca/sf-docs/default-source/patient-engagement/accreditation-canada.pdf>

Supplemental Reading

- AHRQ's [Supporting Patient and Family Engagement: Best Practices for Hospital Leaders](#)
- AACN's 2011 Practice Alert "[Family Presence: Visitation in the Adult ICU](#)"
- Northern Westchester Hospital's Family Presence Policy, p. 154 in IHI's [Patient-centered Improvement Guide](#)
- Kirchhoff KT, et al. Nurses' beliefs and attitudes toward visiting in adult critical care settings. Am J Crit Care, 1993;2:238-245

Important Tips

- Consider adapting examples of policy documents instead of developing new ones.
- Raising awareness of existing and complementary policies (e.g. security, infection control, etc...) can help reassure staff that many perceived barriers to adopting family presence are addressed when family presence operates in concert with other hospital policies. For example, infection control policies will continue to limit visitation of any visitor (including designated family members or other 'partners in care') who shows signs of infectious illness.



2. WORKFORCE

2.1. Develop or adopt examples of proficiency standards to reflect the change to family presence for all staff to ensure patient, 'family' and staff safety.

2.2. Consider additional education for staff focusing on various aspects of family presence and participation.

CHANGE IDEAS AND PRIORITY ACTIONS



- Consider adopting the following proficiency standards:
 - When possible, patients are asked to define designated 'family' members as partner(s) in care and indicate how they will be involved in care and decision-making. If the patient cannot designate their family, hospital staff makes decisions taking into account the broad definition of family as partners in care.
 - Presence and participation of families can be reevaluated and modified and such decisions will be documented in the patient's chart.
 - The number of people at the patient's bedside at any one time will be determined in collaboration with the patient and family. When patient rooms are shared, this negotiation will include other patients, their family and other partners in care.
 - Families are welcomed 24 hours a day according to patient preferences, which are documented and communicated to all involved in patient care. As outlined in the AACN proficiency standards¹, other policies that welcome families as partners in care and meet the needs and preferences as patients, may include: flexible visiting, visitation contract between patient, family and nurse, patient-controlled visitation, structured visitation, or inclusive visitation. Visitation by children may vary from no restrictions to supervision by an adult family member only.
 - Staff provides guidance to patients and families on how to partner with the staff, how to be involved in care and its planning, decision-making, how to support the patient during hospital stay and transition to home, and how to honour the privacy and confidentiality of other patients and families who share the same patient room.
- Use a variety of strategies to help staff develop the necessary competency, expertise, knowledge and skills, including orientation sessions, brown bag seminars, educational videos, hospital-wide campaigns, etc. Include the following components in educational programs:
 - Sharing of patient/family stories and the experience of staff (both as professionals and as patients or family members)
 - Benefits of family presence for the patient and family
 - Contraindications to family presence
 - Assessment and discussion with patients and families regarding their desired roles as in care

- Ethical aspects of family presence practice

RESOURCES, EXAMPLES & TIPS

Key Resources

- Proficiency standards by AACN in their 2011 Practice Alert “[Family Presence: Visitation in the Adult ICU](#)”
- RNAO’s [Person- and Family-Centered Care Clinical Practice Guidelines](#), p. 35,54
- [IPFCC](#) Strategies for Educating Staff and Educational [Activities](#) for Frontline Staff and Clinicians

Supplemental Reading

- [Pocket guide](#) to partnering with families for staff
- Example of family presence presentation from [AACN](#)
- Nurse competencies in [AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed
- [Roles for Security Personnel](#) in implementing family presence
- Visiting options in [AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed, p. 68
- Ethical analysis of family presence practice during resuscitation by [Dr. Simon Oczkowski](#)
- AACN’s [Practice Alert](#) for supporting evidence
- [Samuel Brown](#)’s We still lack patient-centered visitation in ICUs

Important Tips

- Find a way to capture in patients’ charts details about designated person, overnight stays etc. This data could be used for evaluation purposes.
- Consider establishing a new role of family presence facilitator and train nurses, social workers, chaplains, family therapists, or volunteers as facilitators.
- Family presence-related education can to be integrated into other clinical training simulation to provide an opportunity to embed family presence concepts into daily practice.




3. MEETING THE NEEDS AND PREFERENCES OF PATIENTS AND FAMILIES

- 3.1. Define a new, or revise an existing, broad definition of family and partner(s) in care.**
- 3.2. Review and prepare to adopt the practice of collaborative: 1) assessment, 2) planning, 3) intervention) and 4) evaluation when working in partnership with families**
- 3.3. Clarify with designated family or support person(s) their role as a partner in care**
- 3.4. Support patients and families to engage in the care process and partnership with healthcare providers by equipping them with the skills and authority to partner.**

CHANGE IDEAS AND PRIORITY ACTIONS



- Today's definition of nuclear family has changed and may include couples without children, single- parents, unmarried couples, reconstituted families, same sex couples and others.
- The practice of four steps offers a structured framework when working in partnership with families. Such an approach can help identify and prioritize family needs while the patient is hospitalized.
- Consider developing and testing a protocol to clarify designated family members' role(s):
 - Provide direct care to the patient if the family desires to do so (e.g. help with activities of daily living).
 - Explain all procedures to the family using plain language, use teach-back and encourage family to ask questions, share observations, or discuss treatment or any issues.
 - Establish the mechanism for family members' access to and communication with the patient (see examples of visitation policy options in common proficiency standards above).
 - Include family members in discharge planning, and/or end-of-life planning and implementation.
 - When possible, provide a comfortable environment for the family (e.g. quiet room, chairs, easy access to telephones, accommodations, etc. . .).
- Family engagement occurs along a continuum from emotional support to active care delivery. Because patients and families may have differing levels of interest – and ability – to engage in care, consider tailoring efforts to meet patients and families where they are to better know and address their needs and preferences, and facilitate their engagement. Note that sometimes families may need additional supports and resources. Get to



know these resources in the community and provide a list to the family when needed or requested.

RESOURCES, EXAMPLES AND TIPS

Key Resources

- 1) Review clinical recommendations for the four steps (assessment, planning, intervention, evaluation) in [AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed, pp. 35-40
- Review change strategies for patient and family preparation in [A ROADMAP FOR Patient + Family Engagement in Healthcare](#) and in [AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed, pp. 69, 74
- Review and consider adopting IPFCC's [Pocket guide](#) for families and an [Expanded pocket guide](#) for families
- Review IPFCC's [Guide for staff](#) about working with patients and families

Supplemental Reading

- Ethical considerations in [AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed, p.32 (connect care with family and patient's agreement with treatment)
- Review visiting options in [AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed, p. 68
- Review summary of research into family desires and readiness to be present and involved in the care process, and specifically in critical care [AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed, p.33

Important Tips


- If you work with cultural and/or linguistic minorities, consider making procedures flexible and make sure that information is easy to understand and available in languages other than English. Note that some cultures show their concern and feeling for each other by taking care of the patient's physical needs.
- Consider enabling both remote and in-person communication with the patient for the family, including email or hospital messaging services, text, telephone, etc.



4. QUALITY AND SAFETY

- 4.1. The team can begin testing various guidelines and protocols developed to support changes in visiting and family presence policies using multiple PDSA cycles.**
- 4.2. Prepare to monitor and document the results, measurements, challenges and unintended consequences.**
- 4.3. Based on lessons learned from tests, refine strategies, policies and other practice documents.**

CHANGE IDEAS AND PRIORITY ACTIONS

-  • Consider starting with small tests of change in a launch unit or with a small group of patients; small tests may help uncover undesirable effects of changes, allowing the taskforce to modify a change idea that has unintended consequences. Be sure to test new practices and protocols for each stage of the care journey: admission, engagement, discharge and flow through.
- Select a person or people (e.g. quality improvement specialist) from the team to manage the cycles and document learning).
- Look to existing quality measurement efforts within the organization when choosing indicators for this work. Choose only 1-3 meaningful measures for each improvement goal. This will keep data collection burden low and simplify information sharing.
- Consider focusing on process measures and outcomes at the start. If possible, take outcome measures several months before the new policy is implemented and six to 12 months into its implementation. Examples of measures include:
 - Process measures may focus on implementation of family presence practice and may include staff and other providers' awareness of the policy and knowledge of all components in the policy; adoption and consistent implementation of the policy; challenges to policy adherence and support of the policy.
 - Outcome measures may include: accelerated recovery time; improved patient experience, including increased reports of comfort and satisfaction; decreased duration of hospital stay (including ICU stay); reduced readmission rates; fewer falls; fewer medication incidents; and decreased number of complaints from patients and families.
- Use a variety of methods to evaluate patients' and family members' responses to interventions (e.g. feedback in support groups, family satisfaction surveys, family-to-staff communication books, multidisciplinary conferences with family members, interdisciplinary rounds, weekly discharge planning conferences and follow-up after discharge)
- Based on results from multiple PDSAs, the team should look into either adopting or abandoning some of the policy and practice elements.

RESOURCES, EXAMPLES AND TIPS

Key Resources

- Review PFCC dimensions suggested by the [PFCC Satisfaction Metrics Taskforce](#)
- See examples of measurement approaches in Gasparini R, Champagne M, Stephany A. (2015). [Policy to Practice, Increased Family Presence and the Impact on Patient- and Family-Centered Care Adoption](#). JONA, 45(1), pp. 28-34
- Review new and comprehensive [Canadian Patient Experience Survey - Inpatient Care Procedure Manual](#)

Supplemental Reading

- Evaluation in [AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed, pp.39-40
- [IPFCC series of Free Downloads](#): Other Tools to Foster the Practice of Patient-and Family-Centered Care and [Measuring and Monitoring Patient- and Family-Centered Program Outcomes](#) Bibliography
- IHI Open School's video tutorials about [The Model for Improvement](#) (Part 1 & 2) and [On Demand: An Introduction to the Model for Improvement](#). Consider adapting [PDSA Worksheet](#)
- Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. (2009). [The Improvement Guide: A Practical Approach to Enhancing Organizational Performance](#), 2nd Edition. San Francisco: Jossey-Bass, p. 23

Important Tips

- Review IHI's [tips for testing changes](#)
- Consider adapting the IPFCC Taskforce on PFCC Measurement's recommended top four dimensions to measure:
 - 1) Partners in care feel welcomed and supported, and are provided choices that respect their need- to-be-near preferences.
 - 2) They are informed of the plan of care and their preferences are included.
 - 3) They are given access to information to help them make decisions.
 - 4) They are clear about who is involved in care.

5. COMMUNICATION

5.1. Create a communication plan to support the change process.

5.2. Review results of the hospital or unit tour to examine signage and the physical environment for its potential impact on families conducted in Phase 1, Step 3.

5.3. Review and consider standardizing and updating all information sources (web site, patient leaflets, information packages, welcome packages, unit welcome/orientation script, volunteer patient orientation, expert peer support, etc..) to reflect the changes in new family presence and visiting policies.

CHANGE IDEAS AND PRIORITY ACTIONS



- Change management communication typically involves the following decisions and actions:
 - Decide on an optimum frequency (weekly vs. daily) and methods of communication for internal and external audiences.
 - Determine internal communications plan.
 - Determine external communication plan to reach the larger community.
 - Determine who should deliver messages (CEO/President vs. employee's supervisor).
 - Agree on messages to communicate: 1) messages about revising visiting policies and introduction/strengthening of family presence and participation, and 2) messages about how these changes will affect staff, patients and their families
 - Develop sustainable feedback mechanisms (e.g. establishing clear protocols for staff and/or families via email, help lines, team Q & A sessions, etc.).
- With policies and programs in place to encourage family involvement, it is essential that the physical environment and any and all communications to patients and families conveys that messaging to patients and their families.
- When updating the visiting policies posted on the hospital website, consider the following:
 - Make information easy to find and print (i.e. locate information under website sections such as 'Patients and Families' or 'Family Presence' or 'Visiting Hours').
 - Educate the public about welcoming families as partners in care by prioritizing information about family presence before general visitation.
 - Indicate the number of people allowed to visit a patient at the same time – and any flexibility to this rule.
 - Provide guidance for child visitors (e.g. age, supervision requirements, etc. . .) and any flexibility to this rule.

- List specific instructions for infection prevention, immunization and guidelines on when to avoid visits.
- Provide guidance for food, beverages and gift items for patients.
- Ways of maintaining contact with a patient via email, text messages, etc. for those now able to visit in person.
- Indicate whether the hospital will accommodate hours not prescribed in the existing policy upon request.

RESOURCES, EXAMPLES AND TIPS

Key Resources

- Review Prosci's tutorial for [Change Management Communications Planning](#)
- Review best practices in managing the change in communication from Prosci's [Communication Checklist](#)
- Review IHI's [Communication Strategies for Spreading Changes](#)
- IPFCC [Sample Press Release](#)

Supplemental Reading

- [Sick, Scared and Separated from Loved Ones](#): A report on New York State hospital visiting policies and how patient-centered approaches can promote wellness and safer healthcare
- [Sample communication document: Kingston General Hospital Communication matrix](#)
- [Sample communication document: Kingston General Hospital Memorandum to staff, volunteers and physicians](#)

Important Tips

- Note that elements of the communication plan can be tested in launch units (if an incremental approach to change has been selected).
- Consider joining an on-line community of organizations pursuing similar changes, or contacting organizations that have already implemented the change. This may give an opportunity to ask questions, explore solutions among colleagues, share learning and deepen your understanding of the changes you are making.
- Consider communication vehicles accessed by your internal and external stakeholders: use a combination of traditional and new media to deliver your message



PHASE 3: IMPLEMENTATION AND MONITORING OF IMPACT, SUSTAINABILITY AND SPREAD

The team can begin implementing tested changes. Revise the key measures to determine whether new practices and procedures remain effective. Continue to concentrate your efforts on priority action areas (leadership and management, workforce, meeting the needs of patients and families, quality and safety, and communication), share your improvement story and communicate how the changes made a positive impact on patient and family experience and outcomes. It is important to make the ‘what’s in it for me’ clear to help staff understand how they benefit from this change and ongoing improvement.

1. LEADERSHIP AND MANAGEMENT

- 1.1. Monitor that organizational infrastructure to support the implementation of new policies and practice is in place and functioning.**
- 1.2. Ensure that policies and protocols are followed to support a patient’s right to identify individuals as ‘family’ and ‘partners in care’ without discrimination.**
- 1.3. Build sustainability and begin planning for the spread of new policies and practices to all units, departments or sites.**

CHANGE IDEAS AND PRIORITY ACTIONS



- Managers at all levels work closely with staff to ensure that adequate supports are in place, and that changes/improvements are implemented into everyday practice.
- Determine an individual unit’s rate of compliance in implementing family presence. If compliance is lower than 90 percent, develop a plan to improve it. Examples of improvement strategies may include:
 - Forming a core group of staff, patients and families to discuss approaches to improve compliance with the new policy.
 - Re-educating staff about family presence and discussing the change as a component of patient- and family-centred care and evidence-based practice.
 - Incorporating content into annual competency verifications.
- The goal of sustainability is to lock in the progress already achieved and continue to build. Begin strengthening the following properties identified as essential to sustainability of improvements over time (See Key Resources, IHI Framework for Spread pg. 22):
 - Supportive management structure

- Structures to ‘foolproof’ change
- Robust, transparent feedback systems
- Shared sense of the systems to be improved
- Culture of improvement
- Ongoing partnerships between staff patients and families
- Formal capacity-building programs
- The goal of spread is to actively disseminate best practices and knowledge and implement them in every unit, department or site. It is never too early to plan for spread. Begin setting the groundwork for reaching all the units by taking the following steps to develop a spread plan:
 - Laying the foundation for spread
 - Developing an initial plan for spread
 - Refining the plan

RESOURCES, EXAMPLES AND TIPS

Key Resources

- Review best practices and examples of success in sustainability in hospital systems from [IHI's Framework for Spread: From local Improvements to System-Wide Changes](#), Part 1, pp. 1-15
- Consider using CFHI's tools to assess readiness to spread and to develop a spread plan, see both resources under 'Tools': <http://www.cfhi-fcass.ca/Elearning/improvement-workshops/spreading-healthcare-innovations-in-a-land-of-pilot-projects>
- Review Spreading Campaign Interventions to All Locations in [IHI's Framework for Spread: From Local Improvements to System-Wide Changes](#), Part 2, pp. 16-33

Important Tips

- Prioritize spread efforts where the greatest opportunity lies; this may be in a unit where champions exist, or where there is the greatest need for change based on phase 1 assessment inputs such as comment cards, patient experience measures, etc.



2. WORKFORCE

2.1. Cultivate a healthy team in individual units or departments.

2.2. Use a variety of strategies to help staff develop the necessary competency, expertise, knowledge and skills, including orientation sessions, brown bag seminars, educational videos, etc.

CHANGE IDEAS AND PRIORITY ACTIONS



- Unit managers are encouraged to engage in proactive team-building:
 - Use a strengths-based approach by gathering stories from patients, families and staff (both personal and professional) sharing positive news and problem solving common challenges.
 - Identify star staff and learn from them their engagement techniques. This will open up opportunities for staff to provide guidance and mentor their colleagues.
 - Create a culture of collaboration and support in the team. Consider having unit-based patient and family advisors to support improvement. Hold regular case conferences to share information, stories and practice problem-solving among the whole team; engage team members in the quality improvement work by being transparent about the change and its aims, and consistently share improvement data.
 - Continue to offer regular staff awareness or educational programs to educate staff about the benefits of family presence and help develop skills to work with patients and families. Incorporate family presence into orientation for new staff and learners and encourage existing staff to join when they can.

RESOURCES, EXAMPLES AND TIPS

Important Tips

- Strengthen partnership with front-line staff to meet the needs and enhance the strengths of your patient population. Team members should visit the launch unit regularly throughout the implementation phase to: learn about their work; explore the impact of changes on the daily work, stress level and scope of work of front-line staff; and outline specific next steps together.
- Engage your quality improvement team to learn about the collective impact of the changes and improvements.



3. MEETING THE NEEDS AND PREFERENCES OF PATIENTS AND FAMILIES

- 3.1. Front-line staff welcome family presence at the bedside as soon as the patient is admitted**
- 3.2. Practice assessment, planning, intervention and evaluation when working with families and clarify designated family members' role in patient care.**
- 3.3. Advise all direct care providers that the family opts to be present and involved both verbally and in writing.**

CHANGE IDEAS AND PRIORITY ACTIONS



- Establish the process for access to, and communication with, the patient by family members and others in a unit that has adopted family presence.
- Establish channels for direct communication with patients and family members.
- Recognize the important role families play in the lives of their loved ones, and discuss with family and caregivers the role they would like to play in helping to provide care to their loved one while in the hospital. Note that some family caregivers see hospitalization as a respite from their daily responsibilities, while others want to retain their active role.

RESOURCES, EXAMPLES AND TIPS

Key Resources

- [Clinical recommendations the assessment, planning, intervention, evaluation in AACN Protocols for Practice: Creating Healing Environments](#), 2nd Ed, pp. 35-40
- See Section VII.F., Environment of Care, p.170, for details on creating an environment that is welcoming of family members' presence and involvement. [IHI's Patient-centered Improvement Guide](#)

Supplemental Reading

- Patient and family preparation tactics in [A ROADMAP FOR Patient + Family Engagement in Healthcare](#)

4. QUALITY AND SAFETY

4.1. Revise and modify the measurement plan for monitoring of adoption and continual improvement in the practice of family presence and participation.

4.2. Build in longer-term resources for the expansion of patient and family engagement activities.

CHANGE IDEAS AND PRIORITY ACTIONS



- Together the team and the organization's quality improvement team need to refine the key measures that will help them determine whether new practices and procedures remain effective, be able to detect deviations and declines, and alert leaders, managers and staff if processes are not functioning as intended.
- Ensure that key details involving family presence are captured in patients' charts. This is not only required for safety but also helps data collection and evaluation purposes (e.g. what units or patient populations have more overnight stays, why supports are needed, etc. . .).
- Continue to monitor individual units' rate of compliance in offering families the option of family presence. If compliance is lower than 90 percent, apply the improvement plan.
- Although no major investments are needed to implement patient and family engagement strategies, the use of information technology may enhance, ease and improve the process. Consider creating a web site/forum or patient portals that support patient and family access to vital information about the hospital and their care (e.g., about facilities and services or clinical information), communicate with physicians and other patients, make appointments, view personal health information, or retrieve test results.

RESOURCES, EXAMPLES AND TIPS

Key Resources

- Review new and comprehensive [Canadian Patient Experience Survey - Inpatient Care Procedure Manual](#)
- Gasparini R, Champagne M, Stephany A. (2015). [Policy to Practice, Increased Family Presence and the Impact on Patient- and Family-Centered Care Adoption](#). JONA, 45(1), pp. 28-34

Supplemental Reading

- Elwyn et al. (2014) [Crowdsourcing health care—hope or hype?](#) BMJ blogs.
- Canada Health Infoway's "[Progress in Canada](#)"

Important Tips

- Offer a range of opportunities for staff to provide feedback and get involved in planning, implementation, and evaluation of new policies and practices.



5. COMMUNICATION

- 5.1. Prioritize removing ‘visitor’ signage and replacing informational materials that communicate restrictive visiting policies with an agreed upon terminology on family presence and participation.**
- 5.2. Ensure that switchboard operators/receptionists are aware about changes to visiting policies to convey accurate information about family presence and visitation to prospective family members, partners in care and visitors.**
- 5.3. Share and celebrate early successes of implementing family presence policy to maintain momentum and facilitate the spread.**

CHANGE IDEAS AND PRIORITY ACTIONS



- While signage and documentation is updated, it is also important to update your organization’s web site and other vehicles of communication to inform patients and families of family presence.
- Senior leaders can communicate and interact directly with patients and family members in ways that publicly emphasize two-way communication. This is a signal to the entire organization on the importance of listening to patients and families.
- Gather testimonials from patients and staff. Continue sharing your improvement story with staff, physicians, students/residents, families and volunteers and show how changes make positive impact on patient and family experience and outcomes. It is important to make the ‘what’s in it for me’ clear to help staff understand how they benefit from this ongoing improvement.
- Respond to media requests and, where possible, share patient stories and testimonials. Patient and family stories can help describe the type of care your hospital is striving to provide. This means telling stories, not just sharing statistics, when discussing successes and failures. The patient story establishes the tone for the meeting and reminds attendees to discuss issues with patients and families in mind.
- Celebrate and communicate success through internal channels. Recognize champions leading the initiative and also those who demonstrate support and adherence to the new policy.


RESOURCES, EXAMPLES AND TIPS

Key Resources

- [Sample Press Release](#)
- [Links to Media Coverage](#)

Important Tips

- Some organizations have created a policy whereby every meeting begins with a ‘mission



moment' during which a staff member shares a story about a particular patient or reads a patient letter.

- A CEO of the University of Colorado Hospital in Aurora, CO, started a program whereby patients and family members could send him feedback about their experiences via email.
- Track all media coverage and patient, family and staff comments to harness this momentum and continue to advance the practice of family presence



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