Patient Preferred Practices

Patient Directed Visitation

Module 2 of 5

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The Patient Voice

Planetree’s work to advance patient-centered care is grounded in the voices, stories and insights of patients and family members who serve as our guides in charting a course to a more patient-centered future for our industry. These voices are captured largely through focus groups facilitated by Planetree team members across the United States and internationally, in which we invite individuals with recent experiences in the healthcare system to weigh in on what went well and what could have been improved.

Patient-Preferred Practices

Over the past two decades of conducting these focus groups, consistent themes have emerged about how patients define a quality healthcare experience. These themes have informed the development of the Planetree methodology for patient-centered care implementation, the criteria for the Patient-Centered Designation Program®, and the identification of patient-preferred practices, i.e. field-tested practices that respond to how patients have expressed they want their care delivered.

Among these patient-preferred practices is patient-directed visiting.

Patient-Directed Visiting: the elimination of sweeping restrictions to visiting patients with any limitations imposed on a case-by-case basis and in collaboration with the patient, according to personal preferences and in consideration of their healthcare needs.

What Patients Have to Say about the Importance of Family’s Presence

In Planetree focus groups, the importance to patients of social support has been a consistent theme. Patients and family members understand intuitively that the presence of loved ones is healing. They express that the presence of family (however “family” is defined by the patient) brings comfort, reduces anxiety and offers reassurance that important information about the treatment plan, transition to the next care setting, and ongoing care management strategies is being received by those who will continue to support them in managing their health.

“The days went by quick because my family was here and I had so many people stop by and talk to me. They didn’t put any limitations on it. They came in anytime they wanted and stayed as long as they wanted. That was in the ICU as well. That’s a big deal to me.”

“Just to see the familiar faces is so reassuring and it takes the edge off of the visit.”
Despite these benefits of family’s presence, another reality is that for many patients, the company of family or too many well-wishers may be not be welcome. In focus groups, patients articulate that the ability to have control over who visits them and when is important. In addition, patients deeply appreciate staff’s support in helping them to manage visitors and to balance their desire for social support with their needs for rest, privacy and solitude.

“\emph{I have family who are very strong-willed and the nurses handled them really well. She told me, ‘If you need me to be the bad guy, let me know and I will kick them out.’ I really appreciated that.}"

“For those of us who don’t have family, I would have felt better if my friend could have been in the room while they got me ready for surgery. I didn’t care if she heard everything. I wanted her there.”

“They made it really easy for my family to be there without me feeling overwhelmed.”

Just as family members want to know that their loved one’s care and treatment is in the hands of kind, compassionate and nurturing caregivers, patients too appreciate staff’s efforts to meet their family’s needs — for information, for healthy, satisfying food, for a comfortable place to sit and perhaps even sleep, for positive diversion, and for simple acts of human kindness during difficult times.

“They thought about details that the family might need. Like you have a large family so here are more chairs. They cared for you as a person and as a family and what you are going through mentally. Not just the medical.”

“My family was well cared for. They got warm blankets. There was coffee for them.”
Ten Reasons to Liberalize Visiting Practices

1. **It’s good for patients.** Skeptics often fear that liberalizing visitation will be detrimental to patients. In fact, though, the exact opposite is true. Liberalizing visitation is good for patients’ health. It is associated with lower rates of severe cardiovascular complications (in the ICU setting) and lower stress hormones.\(^1\) The fact that the presence of family is associated with lower rates of anxiety among patients is not surprising. Family can bring a sense of normalcy to an otherwise very abnormal event. Having a loved one nearby also contributes to patients’ peace of mind by reassuring them that someone they trust is on hand to advocate for them, to help them remember questions they wanted to ask caregivers and to capture important information they may otherwise fail to absorb. Often the peace of mind that family’s presence brings also helps patients to rest better (not worse, as skeptics may fear).

2. **It’s good for families.** In a study that examined the benefits of unrestricted patient visitation, 88% of families stated it had a positive benefit to their overall experience and decreased their anxiety by 65%.\(^2\)

3. **It’s good for children.** The hospitalization of a loved one can be a particularly upsetting and disorienting event for children, particularly when they are restricted from seeing and spending time with their loved one. Evidence shows, though, that children who visit critically ill relatives show fewer negative changes in behavior and emotions and are more prepared for any loss than those not permitted to visit.\(^3\)

4. **Restrictive visiting policies put patients at risk.** Those who know the patient best are uniquely positioned to observe changes in their loved one’s condition, as well as to provide essential information about the patient to professional caregivers, such as allergies and medications. When they are invited to be present and involved as members of the healthcare team, family serves as an added set of eyes and ears who can alert caregivers to alarming changes, safety concerns, and possibly even prevent medical errors.

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\(^2\) Berwick, D, Kotagal, M. “Restricted visiting hours in ICUs: time to change.” *JAMA.* 2004; 292: 736-737

5. It promotes smoother transitions of care. Those who comprise the patient’s social system will likely be supporting them in managing their health well after hospital personnel have signed off on discharge paperwork. By welcoming the presence of family in a manner that best suits each patient and family unit’s individual circumstances, opportunities for educating family about post-discharge care and follow-up needs are maximized. This positions them to be more effective healthcare advocates—and in many cases, deliverers of hands-on care—for the patient moving forward.

6. Honoring patients’ and families’ wishes to be together is the compassionate thing to do. The hospitalization of a loved one is often a significant life event. Even under the best of circumstances, such as the birth of a healthy baby, anxieties run high, and patients and their loved ones are often fearful and overwhelmed. To be separated from those who know you best and who bring you comfort at just the time you need them most seems a cruel irony—especially in the absence of any evidence-based reasons for imposing the separation. This connection to a compassionate health care experience should not be trivialized as the “soft side” of medicine. A growing body of research demonstrates the importance of compassion as a dimension of high quality care.

7. It fosters trusting, collaborative partnerships between professional caregivers and family caregivers. A little good will goes a long way toward creating partnerships based on a shared concern for doing what is best for the patient. A visiting policy implemented from the point of view of maximizing the many ways that family’s presence is a good thing (versus traditional restriction-based visiting policies that emphasize risks, limitations and the potential challenges of family’s presence) fosters a sense of trust between all parties, which is an essential foundation of any patient and family engagement strategy. And when visiting policies and practices are implemented in this spirit of trust and partnership, necessary restrictions limiting patients’ access to their loved ones (made on an individualized basis in consideration of their preferences and clinical needs) will often be met with less contention and more cooperation by family members (for instance in cases when a visit is contraindicated due to the visitor’s cold, fever or flu).

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8. It facilitates more effective communication between patients, loved ones and providers. It is not uncommon for a family member to serve as their loved one’s record keeper, appointment scheduler, medication dispenser, and medical historian. They often possess critical information about the patient that clinicians should know. Likewise, it is vital that these family caregivers are kept informed about the patient’s condition and treatment plan, and are present when patient education occurs. The more access that those family historians/record-keepers/informal caregivers have to be with their hospitalized loved one, the more ample the opportunities for this important information to be exchanged between professional and informal caregivers. When family’s ability to be by their loved one’s side is restricted, opportunities for more effective communication are squandered. The importance of effective communication cannot be overstated. Indeed, it has been estimated that upwards of 80% of serious medical errors can be traced back to poor communication, and communication breakdowns continue to be a leading contributing factor in many different kinds of sentinel events. What’s more, when key support persons are welcomed as members of the care team, and when they feel informed, educated and adequately communicated with, redundant and inefficient communications can be reduced. Consider the example of one hospital in New Jersey that correlated implementation of patient-directed visiting with a reduction in the number of phone calls unit staff received for patient updates.

9. It enhances patient satisfaction. A 2013 study documenting one hospital’s implementation of patient-directed visiting reports that in the first eight months of the open visitation policy, patients’ ratings of their hospital experience on the HCAHPS survey went up.

10. “That’s the way it’s always been done” is no longer an acceptable rationale. Given the growing evidence base summarized here, conventional wisdom, habit and professional comfort-level are no longer acceptable reasons to cling to business as usual when it comes to visiting in hospitals. Admittedly, there will be circumstances that very appropriately justify the imposition of limitations to visiting. However, these isolated incidences should no longer dictate visiting practices for the critical masses of hospitalized patients who benefit in innumerable ways from the presence of those who comprise their support system. In the absence of any compelling evidence-based reasons for limiting visiting in hospitals, the time is now to lift these restrictions and welcome family not only as visitors, but as members of the patient’s care team.

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9 Ibid.
Components of a Patient-Directed Visiting Policy

✓ Permits 24-hour visiting for, at a minimum, those identified by the patient as their care partner, key support persons or priority visitors.

✓ Eliminates sweeping restrictions to visiting based on the time of day (or night), numbers of visitors and/or age of visitors.

✓ Explicitly states that the patient is the determiner of who is a “priority” visitor. (This determination can be made by a health care proxy in cases when the patient is unable to communicate their wishes). In other words, the policy does not delineate between visiting by immediate family and others, deferring to the patient to define who constitutes “family” for them.

✓ Promotes a flexible approach to visiting, with restrictions imposed on a case-by-case basis (as opposed to flexible accommodations being made on a case-by-case basis.)

✓ Includes provisions that enable staff to use professional judgment in imposing evidence-based restrictions to visiting on a case-by-case basis.

✓ Requires staff to exhaust all reasonable alternatives before imposing restrictions on visitation.

✓ Explicitly states that any restrictions to visitation and the rationale behind them will be clearly communicated to the patient and family.

✓ Should instruct visitors about responsible and safe visiting guidelines, including:
  • Visitors with a cold, the flu or other communicable disease should not visit the hospital
  • The importance of proper hand hygiene and appropriate infectious disease precautions before entering and after leaving the patient’s room
  • Guidance on bringing plants, food from home, etc. to the patient.

✓ May indicate special check-in procedures and/or a restricted number of access points to the hospital after hours to promote a safe and secure environment.
One measure of the quality of an organization’s patient-centered approach to visiting is the “every patient, every time” rule; in other words, to what extent are you confident that every patient who enters your facility is subject to the same attitudes, guidelines and accommodations related to visitation? Or conversely, how much is the degree to which visiting policies are enforced (or ignored) contingent on the time of day, the individual staff member providing care, or other special circumstances?

A philosophical or altruistic embrace of the principles of patient-directed visitation does not constitute quality. It leaves too much up to chance and provider choice. Quality execution requires meticulous alignment of policy, practice, staff training and communication.

This 13-question Quality Checking Tool was developed by Planetree to support organizations in assessing how patient-centered their approach to visiting really is, and to identify opportunities for better aligning structures, practices and culture around welcoming the presence of family and maximizing their potential as integral members of the patient’s care team.

To tabulate your rating:

- Give yourself 2 points for each “YES” statement.
- Give yourself 1 point for each “PARTIALLY IMPLEMENTED” statement

Use the scoring legend on page 10 to convert your score into a set of recommendations.
### Planetree Patient-Directed Visiting Quality Checking Tool

<table>
<thead>
<tr>
<th>Description</th>
<th>YES</th>
<th>Partially Implemented</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 24-hour flexible approach to visiting has been adopted hospital-wide and is formalized in a policy that states that restrictions to visiting are made on a case-by-case basis and in consideration of patient preferences and healthcare needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The visiting policy includes no sweeping restrictions on times visiting is permitted.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The visiting policy includes no sweeping restrictions on the number of visitors permitted.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The visiting policy includes no sweeping restrictions on the age of visitors.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The visiting policy does not delineate between “immediate family” and others, relying on the patient to determine who is considered a priority visitor.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The visiting policy requires staff to explore all reasonable alternatives to address a potential reason for restricting visiting before choosing to restrict the patient’s access to visitors.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Training is provided to staff on strategies for managing patient-directed visiting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The hospital’s web site explicitly communicates this flexible approach to visitation. Any suggested visiting hours are accompanied by a notification that visiting outside of these hours will be accommodated (within the parameters of patient-directed visiting).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All relevant signage within the hospital explicitly communicates this flexible approach to visitation. Any suggested visiting hours are accompanied by a notification that visiting outside of these hours will be accommodated (within the parameters of patient-directed visiting).</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Front-line staff were involved in the development of the visiting policy and the companion communication materials.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients and family members were involved in the development of the visiting policy, and the companion communication materials.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dedicated family spaces, equipped with positive diversions, are available throughout the facility for family to use.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Accommodations are made for overnight visiting.</td>
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</tbody>
</table>

**TABULATE YOUR SCORE:** 2 POINTS FOR EVERY “YES”; 1 POINT FOR EVERY “PARTIALLY IMPLEMENTED”
<table>
<thead>
<tr>
<th>If you scored</th>
<th>Is this your current state?</th>
<th>Next Steps</th>
<th>Recommended Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-26 points</td>
<td>Implementation of patient-directed visiting is consistent and cohesive.</td>
<td>Despite your strong performance in this area, now is not the time for complacency. Incorporate an assessment of staff’s understanding of the policy and how to execute it into regular competency checks. As the policy is reviewed and communication materials updated, seek out ways to partner with patients and families to ensure the practices outlined and language used are meaningful for them. Scrutinize those areas within the hospital where visiting guidelines are least flexible (for instance, on an inpatient behavioral health unit or the PACU) and identify strategies for maximizing flexibility. As part of this effort, consider implementing a family presence protocol that builds on your flexible approach to visiting by enabling loved ones to remain with a patient during bedside procedures and codes.</td>
<td>Strategies for Sustainability (pg. 19)</td>
</tr>
<tr>
<td>10-19 points</td>
<td>Implementation of patient-directed visiting is sporadic.</td>
<td>Identify those units and/or shifts when visiting practices are most flexible and draw on the experiences of patients, families and staff in those areas as the basis for developing a more inclusive and accommodating hospital-wide visiting policy and procedures. Educate all staff on the distinction between open visiting and patient-directed visiting, and coach frontline staff on strategies for managing difficult visiting scenarios, such as balancing patient needs in semi-private rooms, restricting visiting when it is clinically contraindicated, and addressing disruptive visitor behavior. Develop a system for capturing and communicating patients’ preferences around visiting. Conduct a signage and communications audit and remove or update any items that are not consistent with the new policy.</td>
<td>Sample Visiting Policies (pg. 12)</td>
</tr>
<tr>
<td>&lt; 10 points</td>
<td>Implementation of patient-directed visiting should be made a priority.</td>
<td>Apprehension over the potential risks of implementing patient-directed visiting, including security, infection and time management concerns, too often obscure the many benefits of doing so. In many ways, though, the risks associated with restricting patients from being with those who know them best are greater than the risks of lifting rigid visiting restrictions. Familiarize your team with the literature on the benefits of patient-directed visiting and with the policies and procedures of Planetree hospitals that have gone before you in executing this hallmark patient-preferred practice. Recruit some clinical champions to proactively address concerns and empanel a team to undertake the work of developing a policy and protocols.</td>
<td>Step by Step Implementation Plan (pg. 10)</td>
</tr>
</tbody>
</table>
# 10-Step Patient-Directed Visiting Implementation Plan

## STEP 1
**Do your research.**

Read up on other organizations’ efforts to implement patient-directed visiting. If you are a Planetree member, mine the sample policies available through My Planetree (myplanetree.org). Consult with your Patient and Family Partnership Council to explore your patients’ and family members’ experiences with visiting. Take the pulse of staff (through an informal focus group, quick home-grown survey, etc.) to gauge current attitudes and potential concerns about implementing patient-directed visiting.

## STEP 2
**Educate staff and physicians.**

Drawing on this primer and the research you completed in Step One, provide education to staff about why implementation of patient-directed visiting is an important component of a patient-centered approach to care. Reviewing the evidence-base may be helpful in establishing consensus. Be proactive about addressing any common concerns/fears that arose out of the pulse-taking exercise above.

## STEP 3
**Identify physician and nursing champions.**

These champions serve a vital role as credible subject matter experts and meet with departments to listen and respond to concerns with the ultimate goal of moving the institution toward adoption.

## STEP 4
**Form a multidisciplinary task force to lead the charge.**

Include not only your nursing and physician champions, but also representatives from security, infection control and your patient and family partnership council. Other key personnel whose involvement in operationalizing the policy may be important include communications and IT staff, facilities personnel, child life specialists and social workers.

## STEP 5
**Conduct a small scale test of change.**

Identify a specific area(s) that is willing to pilot patient-directed visiting for a specified period of time. *Before the pilot*, collect baseline data from the unit, including: the number of “after hours” visitors (those who visit after formal visiting hours have ended) patient satisfaction scores, number of security incidences and the number of phone calls to unit staff for patient updates. Roll out the pilot, testing processes for capturing patients’ preferences around visiting, communicating those preferences to the care team, managing access to the building after hours, and partnering with family members on “healthy” visiting practices, including ways to partner with staff to promote safety and quality of care, being respectful of other patients, and recognizing when visiting may not be appropriate. Use the *components of a patient-directed visiting policy* section of this workbook as a guide in the development of your policy and processes. During this time-limited pilot, continue collecting data on the same metrics identified above to measure the impact of the change.
### STEP 6
Establish a time frame for house-wide implementation and finalize the visiting policy.

Drawing on the experience of this pilot, the multidisciplinary task force refines the practice, develops appropriate policies, and educates other departments. Use newsletters, communication boards, etc. to share the results of the pilot and generate support for moving forward with hospital-wide implementation.

### STEP 7
Develop communication materials to notify patients and family members proactively of the flexible visiting practices.

Be sure that these materials, including the organization’s web site, in-house signage, patient information handbook, etc., not only emphasize the lifting of restrictions, but also how family can partner with staff to ensure safety and quality of care, as well as how they can be involved in care, preparing for discharge, etc. Partner with patients and families on the development of these materials.

### STEP 8
Ensure the environment of care is supportive of family’s presence.

Do a facility walk-through, with an eye on signage and family spaces. Are you providing an environment that is welcoming of family? Remove or revise any signage (wall mounted, virtual or auditory) that is a vestige of the now-retired visiting hours. Survey family lounge areas. Are there ample positive diversions for loved ones? Comfortable seating? Access to telephones, electrical outlets, nourishment?

### STEP 9
Publicly recognize your champions for their participation as change makers.

Recognition of staff who steps out on a limb to support these patient-centered practices is important for acknowledgment and empowerment of staff to embrace and lead other patient-centered initiatives.

### STEP 10
Monitor and measure to hardwire the practice.

Identify both process and outcomes measures you can use to monitor execution of patient-directed visiting. One approach for doing so is to round on patients and family members to ascertain their awareness of the visiting policy as well as whether they were ever kept from each other at times they wanted to remain together. Customized survey questions may also be added to an existing patient satisfaction survey. Check-in regularly with staff during the first year of implementation to proactively identify and address any challenges, and incorporate a review of the visiting policy and procedures into regular competency checks.

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**Looking for more support in implementing patient-directed visiting?**

Planetree offers a range of on-site coaching and training opportunities to support your organization in implementing patient and family engagement strategies. Our Experience Advisors will partner with you to develop and implement a customized implementation plan. For more information, contact Jim Kinsey, Planetree’s Director of Member Experience, at 203-732-1365 or jkinsey@planetree.org.
Sample Policy

(Reprinted with permission from Carolinas Medical Center-Mercy, Charlotte, North Carolina)

CAROLINAS MEDICAL CENTER- MERCY

Category: Patient Rights
Policy: Visitation
Number: PR 160.M1
Date of Issue: 06/13

PATIENT-CENTERED VISITATION POLICY

SUMMARY

This policy is consistent with CMC-Mercy’s Patient Centered Care/ Planetree initiatives. The goal of Patient-Centered Visitation is to create an environment of care that provides comfort, promotes healing and protects the privacy of all patients in the hospital. Visitation is valued as an important adjunct to patients’ care and comfort. The therapeutic environment, safety of the patient, and personal privacy will be maintained through the approved medical protocols and visitation procedures. Assessment of individual preferences, cultural, spiritual, and special circumstances of patients will be made to provide comfort to patients.

ENVIRONMENT OF CARE

Patient COMFORT

Patient SAFETY

Patient PRIVACY

PROCEDURE

I. General Guidelines

A. Visitor/family presence is encouraged as beneficial for patient safety, comfort and privacy.

B. Patients may designate a special “Care Partner” who is a participant in the patient’s non-clinical care, education, decision-making, and discharge planning.
   a. Care Partners have access to the patient 24hr/day in non-treatment areas.
   b. Care Partners receive a special identification badge.
   c. Care Partners receive a discount in the cafeteria.
   d. Care Partners receive orientation to the nursing area, including nutrition, linens, and designated Care Partner lounge areas.
   e. The Care Partner may or may not be the patient’s legal surrogate (Health Care Power of Attorney).
   f. Care Partners may rotate based upon the patient’s preference.

C. Assessment for comfort, safety, privacy and the maintenance of a therapeutic environment will be the responsibility of nursing.
a. Visitation Hours:
   i. 24 hours a day
   ii. Visitors present after 9:00 p.m. may be asked to obtain a visitor’s badge. This is to promote the safety of patients, visitors, and staff.

b. Children are allowed to visit without age restriction. However, children under 16 must be accompanied by another responsible adult other than the patient.
   i. The charge nurse may authorize exceptions.
   ii. In the event of childhood illnesses or other special circumstances, the charge nurse may use clinical judgment to determine whether or not visitation by children is appropriate or therapeutic. This decision is made by the nurse, the patient, and the Care Partner when possible.

c. Visiting Clergy.
   i. Patients have a right to spiritual comfort and clergy may visit patients at any time the patient prefers.
   ii. Visiting clergy will be encouraged to obtain a CHS Clergy badge.
   iii. Visiting clergy must present a valid CHS Clergy badge or visitor’s badge after 9p.m.
   iv. Visiting clergy will respect the privacy restrictions, therapeutic environment and safety precautions of the hospital.
   v. Visiting clergy are not allowed to proselytize or visit other patients without their expressed permission.

d. Isolation areas:
   i. For patients in isolation areas, all visitors (including children) will be educated on appropriate isolation precautions.
   ii. Visitors will be required to follow the guidelines for visitors as described in the Infection Control Policy for Transmission Based Precautions and will don appropriate PPE.
   iii. If a visitor refuses to cooperate with the enforcement of this policy, the nursing staff may contact Nursing Supervisor, Pastoral Care, Social Work, or the Security Department as appropriate.

3. All employees are to observe patient-visiting and privacy regulations when such visiting is for reasons that are personal or not job-related.

Special Considerations

A. Visitors will be educated to keep hallways unobstructed, to respect the privacy and comfort of all patients, to observe safety precautions, and maintain the nurses’ station as an active clinical space

B. In the event of medical emergencies, general public health or safety concerns, visitors may be asked to leave the unit temporarily to ensure the healing, comfort and privacy of their loved one or other patients.
Sample Policy: Behavioral Health
(Reprinted with permission)

**TITLE:** PATIENT VISITATION RIGHTS AND VISITOR VERIFICATION INPATIENT PSYCHIATRIC UNITS

**PURPOSE:**
To facilitate an environment where families and significant others are recognized as a supportive and integral part of patient care. To promote caring connections between patients and their support systems without interfering with patient care and treatment. To properly and accurately identify visitors to the inpatient psychiatric units in order to safeguard patient care and the milieu.

**POLICY:**
The organization is committed to providing all patients the opportunity to enjoy equal visitation privileges which are known to promote optimal well-being and healing.

The Hospital is also committed to providing a safe environment for patients and staff and therefore has established justified clinical restrictions/limitations to patient visitations which have been outlined in this policy.

The Institution’s policy on visiting hours is generally an open one; i.e. 24-hour access to patients for immediate family members. Given the unique clinical nature of psychiatry and the importance of appropriately scheduling multiple daily therapeutic activities for patients (i.e. group activities, individual sessions, family meetings, etc.) the Psychiatry Service Line believes that posting suggested hours facilitates treatment planning and unit programming. The goal is to maximize the benefits patients derive from the array of therapeutic interventions and activities which are offered, and to work collaboratively with patients and their support systems to provide for visitation when there is a need for visits outside posted hours.

The Hospital Patient Visitation policy does not restrict, limit or otherwise deny visitation privileges based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

**APPLICABILITY:**
All inpatient programs of the Psychiatry Service Line

**PROCEDURE:**
Visitors (e.g. family members, friends and significant others) are recognized as a supportive and integral part of patient care.

1. Every unit has a posted schedule of suggested visiting hours. See appendix.
2. In an effort to support patient focused care, arrangements for visits outside of suggested visiting hours may be made by request of patient and/or visitor to the clinical team or charge nurse.
3. Patients and family members are oriented to the visiting hours by nursing staff and are informed of how to arrange for visits outside of posted visiting hours.

4. Every effort is made by the staff to honor requests for visits outside of suggested visiting hours.

5. Each visitor is expected to observe the general rules and regulations of the unit including performing hand and respiratory hygiene, maintaining quiet and following any special care requirements or individual patient behavior plan.

6. Patients have the ability to restrict or limit visitors at any time during their hospitalization.

7. The hospital reserves the right to restrict and/or limit visitation based on clinically necessary or reasonable considerations. These include but are not limited to:
   a. Right of other patients: visitation may be limited in order to respect the rights of other patients, including other patient’s need for rest and privacy. Visitors are expected to keep noise levels low for the comfort and well-being of the patients and the milieu.
   b. Therapeutic needs of patients: Based on individual patient clinical needs and unit/milieu conditions, the treatment team may restrict or limit visit time. Decisions to limit or restrict visitation are reviewed daily by the treatment team. Decisions to restrict patient’s visitors will be fully explained to the patient and documented in the patient’s medical record. A physician order is required to restrict or limit a patient’s visitors. The decision to restrict or limit visit time will be evaluated daily in rounds by the treatment team. Patients have the right to appeal those decision which place limitations on visitors to the Unit Chief or designee, to the senior staff member on duty or to Patient Services. At the Organization, the Security Department staff members will be notified of restrictions.
   c. Infection Control: visitation may be limited if there are infection control concerns, with a risk of infection to the visitor or to the patient.
   d. Children: All visiting children (minors under the age of 18) are to be accompanied and supervised by a related adult visitor. Social Worker or Charge Nurse should be contacted by patient or family member to discuss plan for minor visitors under the age of 12.
   e. Behavior: visitors engaged in disruptive, threatening, violent, potentially destructive behavior (including bringing of contraband onto the unit and/or giving contraband items to patient) will have their visitation rights limited or withdrawn. Security will be notified of such behaviors.
   f. Court Order or Victim of Violence: when notified, the hospital will comply with the court order limiting or restricting contact with the patient (See Hospital Policy).
   g. Hospital Discretion: the healthcare professional responsible for the care of the patient may limit or extend visitation based on clinically
reasonable considerations. The health care professional will exercise their best clinical judgment in balancing the rights of the patient, other patients, the milieu and hospital priorities, taking into consideration the benefits of visitation on a patient’s care as well as the potential negative impacts that visitors may have on other patients, hospital staff and/or milieu. Staff may call Security to assist as necessary.

8. Number of Visitors: The staff may limit the number of visitors at a given time when the unit is assessed by the charge nurse to be at visitor capacity and additional visitors may interfere with a safe milieu. At these times, visitors will need to take turns visiting on the unit for an agreed upon period of time.

9. Overnight visitation is not allowed.

10. On entering a unit, visitors will be asked to identify all items which they are bringing for patients. A search of these items is conducted by staff.

11. Staff will follow the Visitor Verification procedure when allowing visitors on and off the inpatient unit.

Responsibilities of Security Department:

1. The Security Department reserves the right to search all persons entering or departing the hospital in possession of backpacks, duffel bags, sports bags or packages which may be subject to inspection.

2. The Security Department staff will assist Hospital staff when visitor(s) exhibit inappropriate behavior.

Responsibilities of Patient Services Department:

1. Act as a resource for Hospital personnel on issues pertaining to visiting hours.

2. Partner with clinical treatment team in working with patients, families and visitors when issues of conflict arise.

Responsibilities of Hospital Staff:

1. Promote caring connections between patients and their support systems without interfering with patient care and treatment.

2. Maintain patient’s safety, privacy and confidentiality.

3. Carry out the patient’s request to withdraw or deny visitation rights at any time.

4. Upon observation of visitors who are not complying with the policy, advise the visitors of the policy and request compliance.

5. Seek the assistance of Security in handing of designated visitors who fail to adhere to the policy or display inappropriate behavior and actions.

6. Properly and accurately identify visitors to the inpatient psychiatric units as outlined in the Visitor Verification Procedure.
Visitor Verification Procedure:

1) Upon arrival to the inpatient unit, a staff member will check-in all visitors. The staff member will issue each visitor a numbered visitor ID badge. Visitors are required to show a form of identification (preferably a photo ID).

2) Visitor Log:
   a. The staff member logs the number of the visitor ID badge given to the visitor into the visitor log.
   b. The staff member checks the visitor’s photo ID and writes down the visitor’s information (First Name, Last Name, Photo ID (Check if present)) into the visitor log.
   c. For those visitors who do not have photo ID:
      i. The visitor will verbally give his/her name and contact information for the staff member to write down in the visitor log.
      ii. The staff member will take note of distinguishing characteristic of the visitor and record this in the visitor log.

3) The visitor ID badge must be displayed above the waist and remain visible at all times during the visitation period.

4) Staff will let visitors off the unit after making accurate verification of the visitor by using the specified identifiers:
   a. Checking the returned number visitor ID badge against the visitor log. The number of the visitor ID badge returned must match the number of the visitor ID badge given which is logged in the visitor log.
   b. Verifying visitor information in the visitor log:
      i. For visitors with photo ID, upon visitor exit from the unit, photo ID will be checked and information in the visitor log will be verified.
      ii. For visitors who do not have photo ID, upon exit from the unit:
         A. The visitor must verbally give their name and contact information, and it must match the information on the visitor log.
         B. The staff member takes note of the distinguishing physical characteristic description written in the visitor log and matches it to the visitor requesting to leave the unit.

In the event that a person claiming to be a visitor tries to leave the unit without a visitor ID badge, unit staff need to verify that all patients are on the unit and accounted for before allowing the visitor to leave.

RESPONSIBILITY:
Psychiatry Service Line
Environmental Considerations in Support of Family’s Presence

*Conduct a facility walk-through using this audit tool as a guide for assessing how supportive your environment of care is of family’s presence.*

| Access Points | • Check all entrance ways – to the main building, as well as to individual units. Is there any signage that indicates that visitors are *not* welcome?  
• If certain entrances are closed after hours, are there clear instructions re-directing visitors to open entrances and/or instructions for how to gain access?  
• Are security personnel welcoming of visitors? |
|--------------|---------------------------------------------------------------------------------------------------------------|
| Signage      | • Review all signage related to visitation facility-wide. Remove or revise any signage that includes language inconsistent with the patient-directed visiting policy.  
• Check for appropriate placement of signage that instructs visitors to wash their hands before entering and after leaving patient rooms – as well as convenient placement of handwashing facilities to support adherence. |
| Patient Room | • Are there comfortable places for family to sit in the patient room?  
• Are there overnight accommodations available (for instance a reclining chair or a pull-out sofa)?  
• If such accommodations are not incorporated into the room design, are there instructions on how to request overnight accommodations (for instance a recliner brought in to the room)?  
• Is there a communication board where family can write notes to their loved one, as well as to the care providers? |
| Family Lounges/Waiting Areas | • Are there dedicated family spaces where family can congregate in relatively close proximity to their loved one?  
• Are there positive diversions available for family?  
• Do these diversions include child-appropriate activities?  
• Is Wi-Fi available, with instructions on how to access it readily available?  
• Are there family caregiver support resources available?  
• Are there facilities available to family for chilling and heating up food brought from home?  
• In the cases of family lounges in surgical and procedure areas, are there systems in place for providing regular updates to waiting family members on the progress and status of their loved one? |
Strategies for Sustainability

Monitoring for consistent practice is an essential component of any organization’s patient-directed visiting implementation plan. Doing so thwarts off complacency and promotes consistent practice unit-to-unit, shift-to-shift, caregiver-to-caregiver. Below are some suggestions to support you in hardwiring the practice.

Regular unit huddles
Routinely schedule a huddle with all unit staff to discuss their experiences with patient-directed visiting, and to share among colleagues how recent visiting scenarios were managed.

Leadership rounding question
Have leaders inquire of staff about their experiences with patient-directed visiting during leadership rounds. Ask about how they’ve seen the flexible approach benefit patients and families, what challenges they’ve encountered, and how implementation of the policy has affected their own work flow and care delivery processes. It is important to incorporate these types of questions into leadership rounds during the initial implementation process, but it is also important for organizations with established patient-directed visiting policies to use this strategy to ensure that practice remains in line with the written policy.

Patient rounding
When rounding on patients, ask them if there have been any times during the course of their hospitalization when they have been unable to have a key support person(s) with them when they would have liked. If the answer is yes, explore the reasons why and inquire of the patient why they would have preferred their loved one to be with them at that time. If the answer if no, ask them how they feel about the hospital’s open visiting policy. Share these stories in staff meetings, in newsletters, etc. to continually promote why the hospital adopted a patient-directed approach to visiting.

Staff competency checks
Incorporate content into initial and annual competency checks to keep practices around patient-directed visiting top of mind for all staff.

Customized patient experience survey questions
Work with your patient experience survey vendor to incorporate a customized survey question, such as:

How often were your choices respected to have family members/friends with you during your care? Always, usually, sometimes, never
Additional Resources:

Planetree Patient-Preferred Practice Primer Patient-Directed Visiting Webinar

- Available to Planetree members at no charge at: www.bit.ly/VisitingPPP

Additional Patient-Preferred Practice Primers available through Planetree:

- Shared Medical Records
- Bedside Shift Report
- Care Partners
- Patient and Family Partnership Councils and Beyond: Solutions for Making Good on the Promise of Partnering with Patients

Patient-Centered Care Improvement Guide

- A free download available at www.patient-centeredcare.org

Long-Term Care Improvement Guide

- A free download available at www.residentcenteredcare.org

The Putting Patients First Field Guide: Global Lessons in Designing and Implementing Patient-Centered Care

- Available to purchase at the Planetree Storefront at www.planetree.org
Reputation

Planetree, Inc. is a mission based not-for-profit organization that partners with healthcare organizations around the world and across the care continuum to transform how care is delivered. Powered by focus groups with more than 50,000 patients, families, and staff, and over 35 years of experience working with healthcare organizations, Planetree is uniquely positioned to represent the patient voice and advance how professional caregivers engage with patients and families. Guided by a foundation in 10 components of patient-centered care, Planetree informs policy at a national level, aligns strategies at a system level, guides implementation of care delivery practices at an organizational level, and facilitates compassionate human interactions at a deeply personal level. Our philosophical conviction that patient-centered care is the “right thing to do” is supported by a structured process that enables sustainable change.

Approach

A very common adage asserts that where there’s a will, there’s a way. If only good intentions were enough to achieve a patient-centered healthcare system, but experience has proven time and time again that desire alone does not generate change. Planetree provides the pathway to change, a structured methodology for

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<th>The Planetree Approach: A Roadmap to Patient-Centered Care</th>
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humanizing, personalizing and demystifying the patient experience, customized to your organization’s culture and needs. Informed by the stories and insights of patients, long-term care residents, family members and healthcare professionals, the Planetree approach guides organizations in making patient-centered care the centerpiece of a cohesive strategy that accelerates quality improvement and positions your organization to create change that will last through:

- Development of **infrastructures** to support change
- Implementation of patient-preferred **practices**
- Transformation of organizational **culture**.

**Solutions**

To achieve this, Planetree offers a range of solutions, including on-site assessments and staff development, virtual training, speaking engagements and immersion programs to steer organizations toward a patient-centered future. Fundamental to our approach is the belief that connecting staff with the purpose of their work, and educating them with new skills in a supportive, empowering environment unleashes their potential as effective change agents. Our menu of coaching, education and experiential offerings focuses on:

- Discovering the most powerful levers of change in an organization
- Activating caregivers to problem solve and create change
- Advancing these efforts in the spirit of continuous quality improvement, and
- Innovating to raise the bar for what patients, families and caregivers can expect from a patient-centered healthcare experience.

Planetree provides an unparalleled opportunity to tailor a set of solutions that will advance any organization’s culture change effort.

For more information on coaching and training available to support you in implementing patient-directed visiting or developing your patient-centered culture, visit [www.planetree.org](http://www.planetree.org) or contact Jim Kinsey, Planetree’s Director of Member Experience, at 203-732-1365 or jkinsey@planetree.org.