How to move from visiting to welcoming

There is growing recognition of the importance of encouraging and supporting people in hospital to stay connected to the people that matter most in their lives whilst they are in hospital or similar settings. This guide is designed to help teams move from traditional visiting hours towards more person-centred approaches focused on partnership and the needs of the individual and their family.

This improvement originated from within the NHS in Scotland and engagement on this issue initially took place with Nurse Directors as part of the Person-Centred Health and Care Collaborative in 2013. This guide brings together the experiences of teams and organisations who have already navigated this path and successfully made these improvements and also some change management techniques and tips. In Scotland we have set ourselves the bold ambition to have person-centred visiting in all our hospitals by 2020 and the Scottish Government has included this as a specific commitment in its Programme for Government 2019-20.

A list of FAQs is included at the end of the guide. Answers have been collated from staff with experience of implementing person-centred visiting as well as patients and their families who have experienced being in hospitals with this family-friendly culture.

Benefits of person-centred approaches to family involvement

What do we mean by “person-centred visiting”? We have chosen this term in Scotland to describe hospital (or similar) settings where each individual person is able to identify the people that matter most to them and how they would like them involved in their care. In practice, a person-centred culture would have (but not be limited to) the following characteristics:

- A conversation supported by a reliable process for the person to designate those people that matter most to them
- How they would like them involved in their care
- The absence of set visiting times

While there is a strong emphasis on removing time restrictions altogether, this does not mean that family presence is completely unmanaged. There are important considerations to bear in mind to protect the privacy and dignity of people in hospital and guidelines should be developed locally in partnership with patients and families to support this.
About this guide

It is designed to support organisations and teams develop, test and implement ways of working that promote family and carer presence, recognising them as essential partners in care. The guidance has been developed from evidence-based patient and family-centred practices, improvement stories, research studies and practice-based examples and evidence including examples from across NHS Scotland. It also draws on experience from other national improvement campaigns, in particular Better Together, run by the Canadian Foundation for Healthcare Improvement, and the campaign of the same name run by the Institute for Patient and Family Centered Care in the USA. Useful resources, evidence and case studies are available from both these sources.¹

How to use this guide

The guide provides a framework to help you develop, test, implement and spread person-centred visiting. It includes advice for senior leaders to support the development of strategy, communication and creating the conditions. There is also guidance for clinical teams on getting started and moving from testing to implementation. At each stage it is important to be able to describe the actions being taken against some core dimensions:

- Leadership and management
- Multidisciplinary teams
- The patient and family perspective and needs
- Quality and safety
- Communication

The framework is set out in three phases:

**Phase 1** – focuses on assessment review and preparation. This will help you understand the current system and create conditions to start developing change ideas in partnership with people who use the service and their families.

**Phase 2** – is about testing new guidelines, ideas and practices – making sure they are fit for purpose – and then starting to spread. Again, this should be done in partnership with people who use the service and their families.

**Phase 3** – focuses on moving to full implementation, further spread and sustainability. If starting from scratch most organisations should be able to move through the process in six to nine months. A visual summary of the framework can be seen on the page below (figure 1).

¹ CFHI [https://www.cfhi-fcass.ca/WhatWeDo/better-together](https://www.cfhi-fcass.ca/WhatWeDo/better-together)
IPFCC [http://www.ipfcc.org/bestpractices/better-together.html](http://www.ipfcc.org/bestpractices/better-together.html)
Person-Centred Visiting – How-to guide overview

**Phase 1:** understand your current system and set-up

**Leadership and management**
- Examine current organisational policies and processes
- Tour hospital and review signage and facilities
- Set up oversight and governance
- Allocate QI resource and support and develop high level QI aim statement
- Identify initial test teams

**MDT**
- Test teams dialogue and data to understand current system/culture
- Explore queries, questions, concerns

**Person-centred perspective**
- Engage with people with recent experience of your services

**Quality and safety**
- Identify existing indicators/metrics to support the work

**Communication**
- Create communication plan
- Communicate ambition formally and widely

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**Phase 2:** develop and test new ways of working

**Leadership and management**
- Support the rights of the individual to identify family without discrimination
- QI faculty support development of spread aim and spread plan

**MDT**
- Link with patient and family groups
- Develop team level aim, measures and change ideas in partnership with patients and families and test
- QI coaching and facilitation plus use of Model for Improvement (MfI) to support testing

**Person-centred perspective**
- Ensure broad definition of “family”
- Develop and test guidelines to manage person-centred visiting.
- Develop and test processes to identify people who matter and how to be involved (use MfI)

**Quality and safety**
- Monitor safety/quality of other processes whilst testing under way (balancing measures)
- Refine other policies and practices as required to fit with person-centred model

**Communication**
- Share stories and updates from test teams
- Maintain consistent messages and focus on person-centred visiting aim
- Ensure consistency for public across, web, print and signage

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**Phase 3:** Implement, spread, sustain

**Leadership and management**
- QI faculty/spread team begin process of spread and scale-up
- Identify resource and infrastructure required to sustain changes and support spread phase
- Incorporate person-centred ethos into staff induction processes and other training
- Ensure new guidelines and processes are stable and sustained before spreading
- Allow testing and adaptation as spread to different contexts whilst maintaining core principals of person-centred visiting

**MDT**
- Test teams are not responsible for spread to new teams but members from initial test sites can be used to share experiences with spread sites and help build will.

**Person-centred perspective**
- Families and patients from test sites share experiences

**Quality and safety**
- Monitor system metrics for signs of improvement and balancing measures.

**Communication**
- Share stories of impact from staff and patient/family perspective
- Prioritise removal of out-dated signage and ensure all other public information is consistent
Top-tips and links to helpful resources

Phase 1 top-tips – getting ready to start

• Carry out a hospital walk-round to review signage, especially around ward entrance areas. Things to look out for:
  • Unfriendly or unwelcoming messages
  • Messages which imply, or even state, a lack of flexibility
  • Inconsistencies
• Ensure all public-facing communications are consistent (web-page, Facebook and Twitter messaging, etc)
• The walk-round will be enhanced if it’s done by people who bring new perspective. Examples of who has carried these walk-rounds include:
  • Members of the public
  • Students
  • Staff members from different areas
• Connect with other organisations who have successfully implemented person-centred visiting.
• Ensure leadership messages on what person-centred visiting is, are clear and consistent across all departments.
• Identify champions and early adopters from within and without the organisation.
• Consider holding discussions with staff on this topic during patient safety/quality walk-rounds. The FAQs in this guide can be helpful to support these conversations.
• Include person-centred visiting ethos and policies in employee induction process.

Helpful resources

• Scottish Government programme for government 2018-19 pdf download
• Institute for Patient and Family Centred Care (IPFCC) organisational self-assessment tool pdf download
• Canadian Institute for Healthcare Improvement (CFHI) Better Together: a change package to support the adoption of family presence and participation in acute care hospitals and accelerate healthcare improvement pdf download

Phase 2 Top-Tips – testing and spreading

• Identify an initial group of wards or units to test these changes with. This will help to accelerate spread later on.
• Support each team to develop guidelines to help them manage person-centred visiting. Be clear about what the core principles are which cannot be changed (i.e. the bullet points in the box on page one), but allow variation and adaptation of how to implement these in practice – everywhere will be slightly different.
• Ensure a broad definition of what constitutes “family” – not limited to relatives or formal next of kin.
• Remember to take cultural and ethnic considerations on board and make sure any guidelines developed are able to flex around these needs.
• Develop and test processes to ensure every person admitted to hospital has the opportunity to designate the people that matter most to them and how they would like them involved in their care.

• Use a formal press release and communicate new approach through your existing communication channels. This can be very helpful in building pace and raising a positive awareness for public and staff.

• Consider publishing articles and case studies in the organisational newsletter.

• When it comes to spread make sure you have a clear spread plan with spread aims – your local quality improvement experts will be able to help with this.

• Make sure you have a way to measure the impact of the changes and how they are leading to improvement. Use qualitative and quantitative approaches.

Helpful resources
• NHS Grampian “Welcome Wards” video https://vimeo.com/220928919
• NHS Grampian “Welcome Wards” newsletter and press release
• Encourage people to share their experiences on Care Opinion to help you gauge impact, evaluate or improve
• How to spread improvements: The Spread Challenge (Health Foundation Sept 2018)

Phase 3 Top Tips – holding the gains
• Consider using outside observers to carry out walk-rounds or do observations of care to make sure the changes are embedded and working well.

• Keep an eye on stories on Care Opinion and formal complaints to see what lessons are emerging from people’s experiences of care in your organisation around this theme.

• Keep an eye on other safety and quality data in your system for signs of correlated improvements (falls, medication errors, rates of formal complaints, staff turnover).

• If some areas are struggling to implement or maintain this change, consider using forcefield analysis or Fishbone cause and effect to understand the root cause. Your local Quality Improvement experts will be able to help with this.

• Make sure each unit or ward has a reliable process for obtaining and recording the people who matter and how they should be involved.

• Consider gradually phasing out the term “visitor” form signage and policies.

• Gather stories of impact and celebrate successes in a high profile way.

• Work with your communications team to communicate new approach through your appropriate communication channels. This can be very helpful in building pace and raising a positive awareness for public and staff.
Case Studies

**Shona Sinkins, Lead Nurse at Royal Cornhill Hospital, Aberdeen**

**Introduced Person-Centred Visiting in Autumn 2017**

We were pushing against an open door because of the way our service is structured. We get patients from Aberdeen city and Aberdeenshire, so we have always been flexible with visiting times to allow relatives to see patients, given the distances some of them have to travel.

We introduced person-centred visiting by examining what we were doing already – bringing it in didn’t cause huge problems. Person-centred visiting isn’t about the specific times, but more about having a conversation about who really matters to the person and how they would like them involved. It is asking what’s important to that patient and discussing visiting arrangements after that.

We took our proposal to nursing staff forums where we gave some explanation around the terminology – what it is, what it isn’t. We talked to our operational groups within the hospital and debunked some of the myths and explained that there would still be a structure to the visiting. We do not have a lot of private space in the wards, so person-centred visiting challenged us to make the best use of the spaces we have available and a bit more user-friendly.

For staff, it’s about starting the conversation and asking patients who they want to visit them and when. It is about giving some of that responsibility back to patients and allowing that discussion to happen. We had previously completed Triangle of Care Self assessments that helped us address carer issues, and this really eased the way into person centred visiting for us. It gives people the language to have those conversations.
There are clear challenges around embedding person-centred visiting in a high secure, psychiatric, long-term care setting as a result of the need to balance safety with what matters to patients and visitors. Security ‘rules’ would make it very easy to adopt an inflexible approach to visiting. However, the question for us was ‘why would we not consider how we might introduce more flexibility?’

We understand that our patients and visitors are people who have a unique visiting experience. Therefore ‘visiting’ will hold a different meaning to other settings.

The Hospital is in a rural location with poor transport links and many visitors travelling a considerable distance to visit from throughout Scotland and Northern Ireland.

We regularly seek feedback from visitors and patients in an effort to identify learning opportunities which will result in an improved experience. The majority of visits take place in ward dining rooms because many patients are too unwell to leave the ward and require constant observation as they are considered high risk. Visitors likened the ward visiting experience to being in a ‘fish bowl’, with nursing staff supervising each visit in very close proximity, uncomfortable seating and patients peering through the internal windows, which visitors described as feeling ‘intimidating’ at times.

The Visit Experience Group has been formed to consider how the visiting experience can be enhanced e.g. introducing seat cushions, involving patients in developing ‘best visiting’ protocols, opening a side room to support visits and offering meals to visitors whose visit coincides with mealtimes.

Visits for patients who are settled in presentation, can take place in the “Botanical Garden” area, where visitors say staff are unobtrusive and have more time to speak to visitors and the environment is quiet and relaxed. Patients tell us that they consider access to this visiting area is as progress in the recovery journey and that they feel they can interact with visitors more ‘normally’ there.

We also have a Family Centre that is used to maintain family relationships, specifically with children. Outwith the ward environment, this space supports a more flexible visiting approach, meeting the needs of those who visit less frequently, who may wish to have a longer period of time together as a family unit, at a time to suit their travel needs.
We have also implemented the volunteer visitor programme as we have a number of patients who have no visitors. This initiative ensures that patients who may have no opportunity to engage with people out with their peer/staff group can also benefit from the visiting experience.

Implementing Person-centred Visiting requires a shift in the cultural mindset as well as a willingness to push boundaries and challenge perceived barriers. We use quality improvement methodology to understand what matters to visitors and patients, learn from their experience, test new ideas, evaluate outcomes and demonstrate positive outputs. Involving visitors and patients in service design around the visiting experience, in addition to sharing and celebrating success has been key to ongoing improvements.
What We Did…
In May 2015, I completed questionnaires for patients, visitors and staff asking opinions on the current restricted visiting (2-4pm and 6-8pm daily)

Patients and visitors were keen to have open access in the ward. Staff feelings were mixed but agreed to “test” the concept

How We Did It…
We had conversations with current and new patients and advised them we were no longer restricting access to the ward and would review daily.

We agreed to huddle at 2pm each day as a multi-disciplinary team and review the impact of the previous day’s arrangements. This continued for 8-9 months following the introduction.

Staff were anxious re increase risk of harm and error as a result of distractions. We monitored falls, violence and aggression, cardiac arrests, pressure ulcer rates and length of stay and discussed these at our daily huddles.

Benefits…
• Reduction in all harms
• Calmer ward environment
• Better discharge planning
• Better time management for staff
• Improved communication with carers and MDT
• Improved mealtime experience for patients
• Reduced feeling of isolation for patients
Frequently Asked Questions

Won’t this lead to people staying on the ward for hours on end?
Sometimes it might, but it very much depends on the circumstances and preferences of the individual. Often in the early stages of a hospital stay the patient might want their family close by, there is often a lot of anxiety at these times on the part of both family and patient and separating them often makes this worse. Often once things settle down and the situation becomes clearer, people will be more comfortable to spend time away from their loved ones.

On the other hand some people find hospital environments very stressful and intimidating and can only cope with shorter more frequent visits. It’s important to find out the needs of each individual and to be flexible.

Overall, teams who have developed a person-centred approach find that families visit in a pattern which is much more spread out over the day. They find this eases the big influx of people all at once which used to occur with set times and also provides more opportunity to communicate effectively.

What will I do if people want to come in the middle of the night?
This already happens in emergency situations and during end-of-life care. Most people don’t want to sleep in hospital and will want to go home at night and get some rest, especially once any critical phase is over. If a person does want their family member to stay, we should be accommodating and help them to make this happen. Sometimes hospital bays have multiple occupants, so it’s important to make sure everyone’s needs are considered equally in such situations.

A good example of a team personalising practice can be found in the Golden Jubilee National Hospital where people with dementia undergoing a major joint replacement are identified at pre-op assessment. Their family are then invited to make use of dementia friendly twin rooms and stay with their loved one for all or some of the time during the pre and post-operative period if they wish.

How will this affect private conversations with someone when other people are there?
We often need to have conversations about confidential matters and the same care and thoughtfulness we normally apply needs to be applied here. If the person is in a multiple occupancy room, we might consider taking them to a more private location or if that isn’t possible we might ask other people if they could leave the room to allow the conversation to take place more privately.

What about when I need to carry out treatment or deliver care while someone is there?
This is an area where professional judgement needs to be exercised based on the individual needs of the person and their family. This should be a collaborative decision made in partnership. Many minor care procedures won’t need the family member to leave, but again this very much depends on the personal needs and preferences of the patient and their family.

If there is something of highly personal nature that needs to be done (such as using a commode or bed-pan in a multiple occupancy room) then discretion should be used. It is perfectly reasonable to ask any other family members who might be in the room to leave in these circumstances.
Won’t this interrupt the flow of work and make it more difficult for healthcare teams to do their job?

In areas where there are no set visiting times, staff have not found any negative impact on their ability to do their job. Many report that having families around when care planning conversations, ward rounds and care transitions take place, contributes to the quality and efficiency of the care being delivered. Information can be gathered and shared in real-time without the need for separate meetings with families or finding additional time to meet for updates, etc.

What if someone has a large number of visitors at once?

Sometimes there may be cultural or personal reasons why a person wants to have a large number of people present. We should be sensitive and flexible in such circumstances. If the person is in a single room then there is little reason to object. If care needs to be carried out and there is limited room, then again, it is not unreasonable to ask for at least some of the people to leave to provide physical space to work.

If the person is in a multiple occupancy room and wishes to have a large number of people present then a negotiation needs to take place to make sure the comfort and dignity of other people in the room are taken into account and not compromised.

There isn’t enough space on my ward to implement this.

There is no reason why a general principle limiting the number of family present at any one time shouldn’t be created if space is limited, or simply to maintain a peaceful environment in the ward. Typically this has been 2 or 3 people per-bed at any one time. This is not unreasonable, but we should still be as flexible as we can.

What about protected mealtimes?

Protected mealtimes were originally intended to protect inpatients from unnecessary clinical interventions, not to protect them from their loved ones. A person-centred approach seeks to engage with the individual and their family and understand what matters most to them and what their needs are. A person-centred approach seeks to allow the person and their family to identify what their needs and preferences are. Typically mealtimes are important family times, so it makes a lot of sense to encourage rather than restrict family presence at mealtimes.

A nice example of this can be found at Hairmyres hospital where they designed an initiative in their Medicine for the Elderly wards called “Come Dine With Me” to encourage families to attend at mealtimes. They even offered to provide the family member with a meal so they could eat together.

I’m concerned that this will affect hygiene standards on the ward.

The available evidence indicates that nearly all hospital acquired infections are spread by healthcare professionals, not by family members visiting their loved ones.
I’m worried that this will compromise security.
Person-centred visiting is managed by staff, patients and their families and the security and safety of patients is of paramount importance.

A great example of a creative person-centred solution to this can be found in the Neonatal Intensive Care Unit (NICU) at The Royal Hospital for Children in Glasgow. The NICU needs to have a locked security entrance to maintain the safety of the infants inside, but this meant that anxious families had to ring a bell and sometimes wait some time to gain access to the unit and see their baby. This caused a lot of anxiety and distress to families and a lot of work for staff answering the buzzer and opening the door. They set up a group with families to look at this and other problems and the families came up with the idea of a fingerprint access system. This is now installed and the parents of babies in the NICU are now able to enter straight away and staff time has been released by no longer having to constantly answer the buzzer and open the door.

This won’t work in the clinical area I work in. There are too many seriously ill people.
The most seriously ill patients are usually in intensive care or high dependency units. These are the very places where a person-centred approach to family presence is most important. It is at these highly stressful times in peoples lives when they need the support of their loved ones most. There is a strong ethical and human rights imperative to make sure we do all we can to understand peoples needs at such challenging times in their lives.

The intensive care unit at Forth Valley Royal Hospital moved to person-centred visiting in 2009 and has now spread the same approach to the high dependency unit. They have been working in this way for ten years and it has enhanced the experience of care for patients and families. You can read about some of these experiences on the Care Opinion feedback website. There is also a good case and some evidence that supporting family presence at such times reduces anxiety and supports healing.

Won’t this place unrealistic expectations on relatives to provide care?
No. Person-centred visiting shifts most of the control over visiting to the patient and their immediate family, much like the culture in children’s settings. A genuine partnership approach between patient, family and clinical staff to ensure people stay connected, on their terms, to the people that matter most to them. Relatives are supported to be involved with care as much or as little as they need, as determined by the patient. Person-centred visiting does not put expectation on family to actually deliver care.
ANNEX A

Leading change

Two useful resources to consider when leading organisational change include:

- The Institute for Healthcare Improvement (IHI) Psychology of Change Framework
- The framework developed by John Kotter in his books “Leading Change” and “Accelerate”. There is a brief description of the two of the key messages from Kotter below.

Kotter identifies two key elements that are essential for success.

1. The first is Kotter’s 8 Step framework for leading organisational change. This identifies all the necessary steps required to support successful change. An important caveat is to note that the steps do not represent a predictable sequential progression and leaders often have to revisit steps, especially as you spread to new areas.

2. The second important element is to utilise your organisation’s dual operating system thus harnessing the creative power and innovation of social networks and informal leaders in your organisation, alongside the formal hierarchy. This will give your improvement work the best chance of success and accelerate spread. Networks are typically good at innovation and hierarchies at execution.

Practical examples of how to use this learning to promote and spread person-centred visiting can be found in the Top Tips section on pages 4 and 5.

“The greatest waste... is failure to use the abilities of people... to learn about their frustrations and about the contributions they are eager to make.”

W. Edwards Deming
Out of the Crisis p57
**Authors**

Shaun Maher, Strategic Advisor for Person-Centred Care, The Scottish Government and Principal Lead, Quality Improvement Team, NHS Education for Scotland.

Ruth Jays, Head of Person-Centred Team, The Scottish Government.

Alan Davidson, Policy Manager, Person-Centred Team, The Scottish Government.

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