Alberta Health Services

INTERIM CLINICAL DIRECTIVE

**TITLE**

# VISITATION AND FAMILY PRESENCE [INTERIM]

**SCOPE**
Provincial

**DOCUMENT #**
HCS-170

**APPROVAL LEVEL**
Alberta Health Services Executive

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March 31, 2016

**CATEGORY**
Health Care and Services

**REVISED**
Not applicable

[Directives reflect Alberta Health Services organizational goals and objectives by providing direction for a standardized approach to practices. Directives:

- support Alberta Health Services values and strategic directions;
- assist day-to-day operations by offering instruction and guidance for decisions and actions of managers and staff;
- encourage timely decision making in the interests of quality service and cost-effective operations; and
- may be time limited to fulfill short or long term operational and business goals and objectives.]

**NOTE:** The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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If you have any questions or comments regarding the information in this Directive, please contact the Policy & Forms Department at policy@ahs.ca. The Policy & Forms website is the official source of current approved policies, procedures, directives, and practice support documents.

## PURPOSE

- To articulate Alberta Health Services' (AHS) position on visitation and **family** presence within **Continuing Care Designated Living Options (Designated Living Options)**.
- To identify situations where **limitations** on visitation or family presence may need to occur.
- To outline processes of **resolution** and appeal should individuals disagree with imposed visitation or family presence limitations.

## DIRECTIVE STATEMENTS

Visitation and family presence are integral to **patient** safety, the healing process, the patient's medical and psychological well-being, comfort and quality of life.

Within Designated Living Options, patients and their families are welcomed as full partners in care. Families are essential members of the care team; they are not visitors in the lives of the patient. Families provide pertinent information essential to the patient's care plan and should be respected and recognized for their knowledge and expertise about the patient and his/her care needs and preferences.

Visitation and family presence shall be balanced in consideration of patient and **health care provider** safety, as well as the need to protect the confidentiality and privacy of all patients.

In select circumstances, limitations on visitation and family presence may be required. AHS will be transparent in communicating any such limits and the reasons. AHS shall follow a consistent and predictable process in terms of addressing and managing limitations on visitation and family presence.

## APPLICABILITY

Compliance with this directive is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

## DIRECTIVE ELEMENTS

### 1. Visitation and Family Presence

1.1 AHS welcomes and promotes visitation and family presence in all Designated Living Options.

1.2 AHS is committed to creating and fostering a welcoming, respectful and supportive environment that ensures the well-being, safety and security of all individuals – patients, family, visitors and health care providers.

1.3 Patients/**alternate decision makers** have the right to define who is to be identified as their family, as well as their desired level of family support and involvement. This decision may be re-visited at any time.

1.4 Designating a family spokesperson to facilitate effective communication among family, visitors and health care providers is recommended and encouraged.

1.5 The number of individuals welcomed to be present at one time will be decided upon with the patient, family or visitor, and care team. Consideration shall be given to the following factors (including but not limited to):

a) the patient's wishes;

b) the patient's health status;

c) the health care or **treatment/procedure** being provided;

d) space constraints;

e) time of day; and

f) the potential impact on others.

## 2. Expectations and Responsibilities – Health Care Providers

2.1 When family or visitors arrive in a Designated Living Option, health care providers shall:

a) acknowledge their presence and provide a welcome;

b) respond to requests, questions or concerns; and

c) share information in accordance with privacy laws.

## 3. Expectations and Responsibilities – Family and Visitors

3.1 Family and visitors to a Designated Living Option are expected to:

a) respect the dignity and privacy of all individuals, including health care providers, other patients, their family and visitors;

b) comply with any privacy legislation and applicable governance (e.g. policies, procedures and practice support documents) when taking photographs, video recordings or audio recordings of health care providers, other patients, their families or visitors;

c) supervise and monitor the behavior of children brought with them to visit;

d) be mindful and sensitive to the needs of other patients, their families and visitors by keeping noise and disturbances to a minimum;

e) respect quiet times designated by a Designated Living Option; and

f) comply with any site-specific requirements of imposed limitations, where applicable, for visitation or family presence.

## 4. Guiding Principles When Considering or Imposing Limitations to Visitation or Family Presence

4.1 The following principles shall be adhered to when consideration is being given, or action is being taken, to impose limitations on visitation or family presence:

a) Limitations to visitation or family presence shall be a last resort intervention and shall only be instituted after careful consideration of the situation and all potential alternatives.

b) The least restrictive approach shall be utilized initially, advancing through progressively more restrictive interventions as may be required by the situation. Limitations to visitation or family presence may include, but are not limited to:

(i) an action plan which may outline expectations of conduct for visitors or family attending a Designated Living Option;

(ii) partial restrictions (e.g. visitor or family requires supervision or may be limited to attend a Designated Living Option at designated times, etc.); or

(iii) complete restriction of visitation or family presence, in which there is no access to the Designated Living Option for a specified period of time.

c) AHS will not impose limitation on visitation or family presence based on age, race, ethnicity, religion, culture, language, physical or mental disability, socio-economic status, gender, sexual orientation and/or gender identity or expression.

d) Individuals subject to limitations on visitation or family presence shall be provided with the reason, duration and afforded opportunities to discuss and pursue any concerns pertaining to the limitation (refer to Section 6.2 and 6.3 for further detail).

e) Concerns about limitations to visitation or family presence may be voiced at any time to the manager of the Designated Living Option or alternatively, to the AHS **Patient Relations Department**.

f) Anyone who raises a concern about limitations to visitation or family presence shall be informed of the process for managing their concern. This shall include information about informal dispute resolution by the Designated Living Option, as well as the role of the AHS Patient Relations Department. The option of the Visitor Management Appeal Panel (VMAP) shall also be outlined.

g) All concerns shall be reviewed in a fair, respectful, and transparent manner. Efforts will be taken to resolve the concern in a timely manner.

h) Individuals, including patients, family or visitors who raise concerns about limitations to visitation or family presence shall not be subject to any negative repercussions.

## 5. Limitations to Visitation or Family Presence

5.1 Limitations to visitation or family presence may be implemented due to:

a) Wishes of the patient/alternate decision maker:

(i) AHS acknowledges that patients with capacity have the right to determine who is to be identified as their family or who may visit them.

(ii) Alternate decision makers, with the requisite legal authority, may specify parameters around visitation or family presence.

b) Clinically-based determinations of the care team:

(i) Visitation or family presence may be limited where the access to a patient is or would be, in the professional opinion of the interdisciplinary care team, detrimental to the patient's health or safety. The patient/alternate decision maker shall be consulted and the patient's needs and preferences shall be considered in the decision.

c) Need for privacy:

(i) Visitation or family presence may be limited in situations where a patient in a shared room requires a sensitive/private discussion or treatment/procedure, or immediate life saving measures (e.g. resuscitation).

d) Presence of an illness or a communicable disease:

(i) Family and visitors should not visit a patient, or they may be asked to refrain from visiting a patient if they:

- are feeling ill;
- are at risk of transmitting an infectious disease;
- have been exposed to a communicable disease for which they have no immunity; or
- have a diagnosis or symptoms of a communicable disease.

(ii) During a declared outbreak, family and visitors may be asked to refrain from visiting a patient.

e) Legal requirements (e.g. Court Order):

(i) Court orders may provide the requisite authority to limit family or visitor access to a patient.

f) Conduct of an individual visiting a Designated Living Option:

(i) Family or visitors may have limitations placed on them if their words or actions negatively impact:

- the ability of health care providers to carry out their duties;
- others within the Designated Living Option to feel safe and secure; and/or
- the well-being and safety of any patients, family, visitors or health care providers.

g) Urgent need to protect the well-being, safety and security of any person:

(i) If there are reasonable grounds to believe that limiting visitation or family presence is immediately necessary to protect the well-being or safety of any person, the relevant manager may impose an urgent limitation of that person to the Designated Living Option without first conducting any informal resolution as described in Section 7 of this Directive.

## 6. Issuing a Limitation to Visitation or Family Presence

6.1 The relevant manager at the Designated Living Option is to make a decision with respect to any necessary limitation to visitation or family presence. Decisions to impose a limitation to visitation or family presence shall be in alignment with the Guiding Principles outlined in Section 4 of this Directive.

6.2 With the exception of the circumstances outlined in Sections 5.1(c) and (d), any decision to limit visitation or family presence shall be communicated by the relevant manager to:

a) the family or visitor, and to the patient/alternate decision maker (done both verbally and in writing);

b) health care providers of the Designated Living Option; and

c) anyone else identified by the Designated Living Option as necessary to be informed.

6.3 The decision to limit visitation or family presence shall:

a) identify the reason and duration of the limitation;

b) identify when the matter will be next reviewed, including how to request a modification to the current limitation;

c) outline available resources and options to attempt to resolve the issue; and

d) be communicated within a timeframe that is appropriate to the situation.

## 7. Concerns Resolution

7.1 Whenever possible, concerns about limitations to visitation or family presence shall be addressed as close as possible in time and place to the concern by the Designated Living Option, with the patient/alternate decision maker being afforded an opportunity to participate.

7.2 If the concern remains unresolved following reasonable efforts by the Designated Living Option the relevant manager is to obtain permission from the individual

who lodged the concern to involve the AHS Patient Relations Department in the concerns resolution process.

7.3 Should the AHS Patient Relations Department be requested to provide assistance, dialogue on how best to resolve the concern shall take place with:

a) the relevant manager of the Designated Living Option;

b) the individual who lodged the concern; and

c) the patient/alternate decision maker.

7.4 VMAP may be requested by anyone identified in Section 7.3. Agreement by the patient/alternate decision maker is required in order to access the services of VMAP.

## 8. Visitor Management Appeal Panel (VMAP) Process

8.1 Should VMAP be utilized in resolving the concern (pursuant to Section 7.4), the scheduling and coordination will be provided by the AHS Patient Relations Department.

8.2 The VMAP process will, at minimum:

a) have a panel of three (3) individuals selected in accordance with Section 11 of this Directive;

b) have processes in place to ensure that information is disclosed in accordance with the *Health Information Act* [Alberta] and the *Freedom of Information and Protection of Privacy Act* [Alberta];

c) provide the opportunity for both the manager of the Designated Living Option, and the individual who lodged the concern to submit an exchange of relevant documentation in advance of the VMAP meeting; as well as an opportunity to present oral submissions at the VMAP meeting; and

d) allow the opportunity for both the manager of the Designated Living Option, and the individual who lodged the concern to attend the VMAP meeting and to be accompanied by others of their choosing such as an AHS Patient Concerns Consultant, a health care provider, legal counsel, or an agent, to support or represent them through the process. This is to be in accordance with the AHS *Interaction between Alberta Health Services and Third Party Advocates* Policy.

8.3 VMAP, in making its recommendation(s) shall consider the well-being and safety of all patients, family, visitors and health care providers. The recommendation(s) may

a) uphold the decision of the relevant manager of the Designated Living Option;

b) provide an alternate solution; or

c) delay a recommendation pending further information and provide an interim plan.

8.4 VMAP's recommendation(s) is to be in writing and shall include:

a) details of the recommendation, including the rationale;

b) any next steps, including timeframes; and

c) a listing of the VMAP members and all those present at the VMAP meeting.

8.5 VMAP's recommendation(s) shall be provided by the VMAP Chair to the AHS Patient Relations Department within a reasonable time following the last meeting with the individual who lodged the concern and manager of the Designated Living Option.

8.6 Within a reasonable time after receiving the VMAP recommendation(s) from the VMAP Chair, the AHS Patient Relations Department shall provide the VMAP recommendation(s) to:

a) the relevant AHS Chief Zone Officer;

b) AHS Senior Program Officer; Community, Seniors, Addiction & Mental Health; and

c) Chief Executive Officer (CEO) of the Contracted Service Provider, if applicable.

**NOTE**: A designate shall be appointed by the AHS Chief Zone Officer, the AHS Senior Program Officer; Community, Seniors, Addiction & Mental Health or the CEO of the Contracted Service Provider if he or she has had previous involvement in the matter. The designate shall perform all required duties outlined in Sections 8.7 to 8.12.

8.7 As soon as reasonably practical after the receipt of the recommendation(s) a decision shall be made. The decision shall be made by either:

a) the relevant AHS Chief Zone Officer in consultation with the AHS Senior Program Officer; Community, Seniors, Addiction & Mental Health; or

b) the CEO of the Contracted Service Provider in consultation with the relevant AHS Chief Zone Officer and the AHS Senior Program Officer; Community, Seniors, Addiction & Mental Health.

8.8 The decision may:

a) uphold the recommendation(s) of VMAP; or

b) provide an alternate solution.

8.9 The AHS Chief Zone Officer or the CEO of the Contracted Service Provider, as applicable, shall issue a written summary that shall include:

a) the recommendation(s) from VMAP;

b) the decision;

c) the rationale for the decision; and

d) any recommendation(s) or next steps, including timeframes.

8.10 The decision shall be communicated to the individual who lodged the concern, the patient/alternate decision maker, and health care providers of the Designated Living Option. A representative of the Designated Living Option who is able to share and explain the decision shall communicate the decision and provide a written copy of the decision to the individual who lodged the concern and to the affected patient/alternate decision maker. The decision will not be otherwise published or disseminated.

8.11 After issuing a decision, the AHS Chief Zone Officer or the CEO of the Contracted Service Provider, as applicable, may at any time correct a typographical error, an omission or any other similar error in its decision without prior notice to the parties. The AHS Chief Zone Officer or the CEO of the Contracted Service Provider, as applicable, will notify the parties of its correction to the decision.

8.12 The decision of the AHS Chief Zone Officer or the CEO of the Contracted Service Provider, as applicable, is final, subject only to any further avenues of appeal that the person who lodged the concern may wish to pursue.

8.13 If the person who lodged the concern issues a later concern to VMAP, then:

a) there is no requirement that the membership of subsequent VMAPs be identical to, or different from, one concern to the next; and

b) a VMAP member does not have a conflict of interest just because he/she had previously issued a recommendation(s) for an earlier VMAP concern that was adverse to the interests of the person who lodged the concern.

## 9. AHS Patient Relations and Patient Concerns Officer

9.1 The individual who lodged the concern may contact the AHS Patient Relations Department at any point in the process, as per the AHS *Patient Concerns Resolution* Policy and the AHS *Patient Concerns Resolution Process* Procedure.

9.2 If the individual who lodged the concern is not satisfied by the outcome of VMAP, or in situations where VMAP was not utilized, the AHS Patient Concerns Officer may review the decision.

## 10. External Options for Review

10.1 The **Alberta Ombudsman** may also conduct a review of the concern resolution process in accordance with the *Ombudsman Act* [Alberta], provided that a review has already been completed by the AHS Patient Concerns Officer.

10.2 In addition to raising a concern with AHS, individuals may without limitation and at any time raise their concerns with the:

a) Health Advocate;

b) Seniors Advocate; or

c) Mental Health Patient Advocate.

## 11. VMAP Membership

11.1 Each year, the AHS Executive Director; Provincial Seniors Health with support from the AHS Patient Relations Department Directors shall identify a pool of potential VMAP members. From this pool, individuals who will function as the Chair of VMAP shall be identified.

11.2 The VMAP shall be comprised of members who are knowledgeable about the AHS Patient Concerns Resolution Process and who have had no prior involvement with the affected patient/alternate decision maker or the concern.

11.3 The VMAP membership shall be chosen by the AHS Executive Director; Provincial Seniors Health with support from the applicable AHS Patient Relations Department Director, and shall be comprised of the following three (3) multi-disciplinary members from the available pool:

a) one (1) **Patient and Family Advisor**; and

b) two (2) additional members most suited to the nature of the concern from among the following list:

(i) health care provider from the AHS Provincial Seniors Health team;

(ii) health care provider employed in one of the Designated Living Options;

(iii) **medical staff** member or **physician of record**;

(iv) **health care professional**, either internal or external (e.g. Contracted Service Provider) to AHS; or

(v) representative from the AHS Clinical Ethics Department.

## 12. VMAP Procedural Authority

12.1 VMAP has the discretion to hold any VMAP meetings in person, teleconference and/or videoconference.

12.2 Any VMAP meetings to deliberate the concern and to arrive at VMAP's recommendation(s) shall be done in private, without the presence of either the individual who lodged the concern or the manager of the Designated Living Option.

12.3 If a procedural issue is not addressed in this Directive, then VMAP may provide whatever direction it feels is necessary to address the issue.

12.4 If it considers it appropriate in the circumstances, VMAP may depart from or vary the VMAP process outlined in this Directive.

12.5 If VMAP makes a procedural decision that conflicts with this Directive, then the procedural decision will prevail over this Directive.

## 13. Documentation

13.1 Health care providers shall document:

a) the wishes of the patient/alternate decision maker with respect to who may visit as well as individuals to be identified as family;

b) any limitation to visitation or family presence, including the grounds upon which the decision was made; and

c) communication and steps taken to resolve any concerns pertaining to any limitation to visitation or family presence.

13.2 The AHS Patient Relations Department shall retain all documentation related to the VMAP process in accordance with the AHS *Records Management* Policy and AHS *Records Retention Schedule* (1133-01).

## DEFINITIONS

**Alberta Ombudsman** means the Officer of the Legislative Assembly of Alberta with the authority to investigate complaints under the *Ombudsman Act* [Alberta].

**Alternate Decision Maker** means a person who is authorized to make decisions with or on behalf of the patient. These may include a specific decision maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act* [Alberta], an agent in accordance with a Personal Directive, or a person designated in accordance with the *Human Tissue and Organ Donation Act* [Alberta].

**Continuing Care Designated Living Option (Designated Living Option)** means residential accommodation that provides publicly-funded health and support services appropriate to meet the patient's assessed unmet needs. The level of care is accessed through a standardized assessment and single point of entry process and consists of Designated Supportive Living Level 3 (DSL3), Designated Supportive Living Level 4 (DSL4), Designated Supportive Living 4 Dementia (DSL4D), and Long Term Care (LTC).

**Family** means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

**Health care professional** means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* [Alberta] or the *Health Professions Act* [Alberta], and who practices within scope and role.

**Health care provider** means a person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

**Limitation (to visitation/family presence)** means the establishment of reasonable boundaries for accessing an AHS setting based upon circumstances, to include, but not limited to the wishes of a patient/alternate decision maker; the conduct of family/visitors; or site-specific circumstances such a declared outbreak. Limitations can range from visitation based on adherence to agreed-upon actions to a complete restriction in which access is denied.

**Medical staff** means physicians, dentists, oral & maxillofacial surgeons, podiatrists, or scientist leaders who have an Alberta Health Services Medical Staff appointment.

**Patient** means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients, and outpatients.

**Patient and Family Advisor** means a patient or family member from anywhere in Alberta with firsthand experience of the health care system who volunteers to help make a positive impact on the quality, safety and patient experience in Alberta's health care system. The role of the Patient and Family Advisor is to advise and work with the public, Alberta Health Services and its senior leaders, healthcare providers, staff and physicians on policies, practices, planning, delivery, and education of Patient and Family Centered Care. The Patient and Family Advisors encourage public participation between those receiving health services and leaders, staff, and healthcare providers by representing a strong patient voice in advancing Patient and Family Centered Care and patient engagement throughout the organization.

**Patient Relations Department** means the department of Alberta Health Services, led by the Patient Concerns Officer and Executive Director, who facilitates the patient concerns resolution process as guided by the *Patient Concerns Resolution Process Regulation 124/2006* and supports the patients and staff/management/medical staff involved in the process.

**Physician of record** means the one who has primary responsibility and authority for the medical care of a patient. In community settings, this will likely mean the family physician or general practitioner; in acute care settings, this may mean the admitting and/or following physician, or a hospitalist. As a patient flows through the continuum of care, the physician of record may change with the type of service provided.

**Resolution** means the point at which the review of the concern is concluded and where there is a level of mutual understanding of the outcome between parties involved. Resolution may differ with individual concerns and could mean that the complainant is:

a) satisfied with the review process and outcome;
b) satisfied with the review process and dissatisfied with the outcome;
c) dissatisfied with the review process and satisfied with the outcome;
d) dissatisfied with the review process and the outcome; or

the concern is dismissed as frivolous or vexatious, or it is found that no follow-up is possible.

**Treatment/procedure** means a specific treatment, investigative procedure(s), or series of treatments/procedures planned to manage a clinical condition.

## REFERENCES

- Alberta Health Services Governance Documents:
  - *Administrative Fairness* Guideline
  - *Appeal Panel Process* Policy
  - *Code of Conduct*
  - *Collection, Access, Use and Disclosure of Information* Policy
  - *Interaction Between Alberta Health Services And Third Party Advocates* Policy
  - *Patient Concerns Resolution* Policy
  - *Patient Concerns Resolution Process* Procedure
  - *Records Management* Policy
  - *Workplace Violence: Prevention and Response* Policy

- Alberta Health Service Resources:
  - *Ethics Framework*
  - *Records Retention Schedule (1133-01)*

- Non-Alberta Health Services Documents:
  - *Alberta's Health Charter* [Alberta Health Advocates – Health]
  - *Freedom of Information and Protection of Privacy Act* [Alberta]
  - *Health Information Act* [Alberta]
  - *Ombudsman Act* [Alberta]

## VERSION HISTORY

| Date | Action Taken |
|---|---|
| March 22, 2016 | Initial approval |
| March 31, 2016 | Initial effective |
| June 2017 | Scheduled for review |