COVID-19: REGIONAL PRINCIPLES FOR VISITING IN CARE SETTINGS IN NORTHERN IRELAND.

(REVISED FOLLOWING EXECUTIVE DECISION of 21.09.20)

Anyone showing or experiencing the symptoms of COVID-19 or any other infection should not visit, even if these symptoms are mild and unconfirmed. In these circumstances the individual should remain at home and follow the latest public health advice on self-isolation and testing

All people visiting/attending Health and Social Care Settings will be required to wear face coverings for the foreseeable future. Children under the age of 13 are exempt from wearing a face covering

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1.0 INTRODUCTION

1.1 During this COVID-19 pandemic, normal hospital, hospice and care home visiting arrangements were suspended with key exceptions. This document follows a review of the restrictions and outlines the principles for visiting which applies to the following; Health and Social Care (HSC) Trust and Independent hospital inpatient and outpatient services, Maternity Services, Hospices, Care Homes, Mental Health and Learning Disability Hospital Inpatient Services, Children's Hospital Services, for the duration for the COVID-19 pandemic

1.2 The Surge Grid at **Appendix 1** is aligned to the pandemic surge levels/R value based on the best scientific advice available at any given time.

1.3 Additional guidance may be developed for specific settings where this is deemed necessary, at any time.

1.4 The revised guidance recognises the right of next of kin, partners, children, parents and carers to visit their loved ones while in health and social care facilities and independent care sector facilities in Northern Ireland.

2.0 BACKGROUND

2.1 In response to the Government restriction of movement and to protect patients, their families and all staff, on 9 April 2020 the HSC temporarily restricted the number of visitors across hospitals[1]. With immediate effect all intensive care and hospital visiting across Northern Ireland was stopped. There were also significant changes to the provision of Hospital Chaplaincy services[2].

2.2 COVID-19: Guidance for nursing and residential care homes in Northern Ireland[3] was issued to care homes on 17 March 2020 and an updated version

[1] https://www.health-ni.gov.uk/sites/default/files/publications/health/COVID-19%20%20Visiting%20Update%20HSC.pdf

[2] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-chaplaincy-services.pdf

[3] https://www.health-ni.gov.uk/publications/covid-19-guidance-nursing-and-residential-care-homes-northern-ireland

issued on 26 April 2020 which detailed further information for the care home sector regarding visiting restrictions and included advice about visiting at end of life.

2.3 Further modifications to the visiting arrangements were made on 11 May 2020. These modifications relaxed restrictions, allowing family, friends or loved ones to be facilitated to safely visit dying patients; treating dying patients with dignity and compassion. The modifications applied equally to care home settings and other community settings as well as hospitals.

2.4 Following publication by the Northern Ireland Executive on 12 May 2020 of the five-step approach to relaxing lockdown restrictions, it is timely to review exceptions to visiting across all care settings[4].

2.5 In particular, there has been a significant number of queries raised regarding patients being unaccompanied for appointments and the visiting restrictions across all care settings.

2.6 The Strategic Clinical Advisory Cell (SCAC), Department of Health (DoH), undertook a review of the evidence relating to coronavirus infection and the impact of hospital visitors on disease transmission. A summary of the evidence is given in Appendix 2.

2.7 This resulted in the publication of the first version of these regional principles on 30 June 2020, taking effect from 6 July 2020.

2.8 As a result of the Executive's decision to invoke limited additional restrictions, initially in specific areas across Northern Ireland but with effect from 22 September 2020 across the entire region, arrangements do have to be further limited.

[4]https://www.nidirect.gov.uk/sites/default/files/publications/OUR_APPROACH_DOCUMENT_SUMMARY_12-05-2020.pdf

3.0 DEFINITIONS AND SCOPE

3.1 For the purpose of this guidance a visitor is defined as:

- A person visiting an inpatient or resident.
- A person accompanying a patient attending for an outpatient appointment, day procedure, or attendance at an Emergency Department.

3.2 This guidance is aimed at all HSC Trust inpatient services including Mental Health and Learning Disability Inpatient Services, Maternity Services, Children's Hospital Services, Care Homes and Hospices for the duration for the COVID-19 response.

3.3 In addition, there are also important messages for relatives and friends of patients and residents in hospitals, nursing and residential homes.

4.0 ROLES/RESPONSIBILITIES

4.1 It is the responsibility for organisations to consider how they will implement this guidance within their organisations in the provision of their local services.

4.2 Specific guidance is available for Maternity services (Appendix 3), and Care Homes (Appendix 5).

5.0 KEY POLICY CONSIDERATIONS

General Considerations

5.1 The review of the suspension of visiting takes account of Article 8 of the European Convention on Human Rights (ECHR), which provides a right to respect for private and family life. The ECHR asserts that blanket visiting bans are contrary to the rights of both patients and their families and that failure to adopt an individualised approach to the safety of visits will breach the Article 8 rights of both the patients and their families[5].

[5] https://www.echr.coe.int/Documents/Guide_Art_8_ENG.pdf

5.2 The revised guidance recognises the right of next of kin, partners, children, parents and carers to visit their loved ones while in health and social care facilities and independent care sector facilities in Northern Ireland.

5.3 However, given the serious consequences of the spread of COVID-19, particularly in already sick and/or frail people, organisations will be expected to provide explanations should they decide to vary from this guidance. In addition to following this guidance, local knowledge will inform the decision to permit visitors into facilities on a day to day basis, will lie with the person in charge (i.e. nurse in charge/manager, in hospital settings, and the care home manager in care home settings). This will be based on a risk assessment and rely on the ability to ensure social distancing and safety of both patients/residents and the visitor.

5.4 Any decision to deny visiting rights must be made following a risk assessment and must be communicated clearly with the patient/resident and their family/next of kin/carer. This is particularly relevant to those patients who are on immunotherapy treatment and those following organ transplantation. NICE guidance COVID-19 rapid guideline – NG164: Haematopoietic Stem Cell Transplantation (published 01 April 2020 and updated 29th July 2020) should be followed for all patients who have received stem cell or bone marrow transplantation and should be considered in a risk assessment for all other patients who have received an organ transplant - https://www.nice.org.uk/guidance/ng164 .

5.5 It is also recognised that some individuals may have specific support and assistance requirements to ensure that their communication or other health and social care needs are met due to a pre-existing condition. To meet the needs of the individual this may necessitate the presence of a carer or family member from a small pool of carers/family members to support and assist the patient whilst in hospital. In these circumstances the person in charge will discuss the individual's needs with the patient and their carer/family, and as far as possible facilitate their needs. It may be helpful to include other people who know the person well but this will not always be necessary. The patient needs to be

central to decision making in each case. This support from carer/family will be in addition to visitors to the patient and therefore all other guidance around visiting in this document will apply.[6]

Hospital Chaplains

5.6 Hospital Chaplains are members of the multi-disciplinary teams providing pastoral support to patients/residents and are not counted in the number of nominated visitors. Therefore, attendance by Chaplains/Ministers of Faith as part of the care a patient receives will be facilitated.

5.7 However, it is recognised that in an effort to reduce the footfall through health and social care settings, there may be times in high surge when Chaplains access may be limited. In these circumstances, Chaplains will be required to liaise with the person in charge of the ward or facility to agree how the religious and pastoral needs of patients can be met. At such times the provisions within the Hospital Chaplaincy Guidance will apply[7].

Specific Considerations

5.8 Specific guidance for different areas of care are available on the attached Grid (Appendix 1) which outlines visiting guidance aligned to the pandemic surge levels/R value. The grid is based on the best scientific advice available at any given time and should be read in the context of the full text of this guidance.

5.9 The visiting guidance principles will be applied as the surge level and the Northern Ireland Executive five step approach[4] permits.

5.10 The surge level may vary in a particular geographical area or facility due to a cluster of cases. In this situation local guidance relevant to the level of surge will apply.

[6] Families Involved NI (FINI)
[7] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-chaplaincy-services.pdf

5.11 The application of these principles may be influenced by local facilities, such as the availability of single rooms or room space, to allow adequate social distancing. This will form part of the risk assessment.

5.12 Where it is difficult to maintain/adhere to social distancing rules, due to the layout of facilities, organisations must have a local directive for use of PPE by visitors.

5.13 It is important that where organisations are unable to facilitate visitors in line with this guidance, that they have a clear record of their decision-making. This will assure the public they have considered all reasonable adjustments.

5.14 Adoption of any change to the visiting arrangements requires an evaluation of the risks and benefits of the change, bearing in mind there is a need for a reasonable proportionality between these two factors.

5.15 Whilst the hospital environment is a source of virus spread, including among healthcare workers, patients, and visitors. The risk of spread of infection in facilities can be mitigated using appropriate PPE, good hand hygiene, and good respiratory hygiene and maintaining social distancing as per guidance.

6.0 Principles for Visiting

6.1 Where possible, effective virtual visiting remains the preferred option as this reduces the risk of spread of COVID-19. To support this all areas will continue to facilitate virtual visiting.

6.2 All people visiting/attending to Health and Social Care Settings and Care Home Settings will be required to wear face coverings for the foreseeable future.

6.3 People will be required to supply their own face covering and will not be permitted to enter the facility without it.

6.4 Anyone showing or experiencing the symptoms of COVID-19 or any other infection should not visit, even if these symptoms are mild and unconfirmed. In

these circumstances the individual should remain at home and follow the latest public health advice on self-isolation and testing.

6.5 Members of the public who are shielding are strongly discouraged from visiting hospitals/care homes and other community healthcare settings.

6.6 Visiting and visitor numbers will be restricted as the defined surge levels permit (Appendix 2). Individuals who require specific support and assistance to ensure that their communication or other health and social care needs are met due to a pre-existing condition will be considered.

6.7 Additionally there may be occasions to ensure reduced footfall in any particular area at a particular time. In this scenario the parent or carer may be asked to temporarily leave the patient/resident to permit a visit from a named individual. It is anticipated this would be the exception rather than the norm.

6.8 As far as possible, patients/residents will be asked to nominate a maximum of two people to visit. In the main, only these two people will be permitted to visit throughout the patient's stay in hospital. Specific guidance for care home residents will be provided.

6.9 In the event a nominated person becomes unwell another individual can be nominated. Where the patient/resident are unable to nominate individuals the next of kin will be asked to provide nominees.

6.10 Children under the age of 16 will not be permitted to visit. In the event of exceptional circumstances, this can be discussed with the person in charge.

6.11 Visitors should stay with the patient/resident throughout visiting, minimising movement around the hospital/care home, maintaining social distancing from other patients/residents and staff to reduce risks of infection spread.

6.12 Visitors will be required to wear face coverings for the foreseeable future and where this guidance changes or additional PPE is required, organisations will have systems in place to ensure guidance related to visitors and PPE is followed.

6.13 Visitors will be required to sanitise their hands on entering and leaving the hospital/care home/facility and again on entering and leaving the ward or area where the visit is taking place.

6.14 In hospitals, all lockers and bedside tables and surroundings should be left as clear as possible to facilitate cleaning; therefore visitors are discouraged from bringing anything other than essential items for the patient/resident. In particular flowers will not be accepted into wards/departments.

6.15 Further guidance on specific areas can be viewed in the following appendices:

- **Appendix 3 Maternity Services**
- **Appendix 5 Care Homes**
- **Appendix 6 Paediatric and Neonatal**

7.0 CONSULTATION PROCESS

7.1 The Strategic Clinical Advisory Cell (SCAC) at the DoH were consulted during the guidance development process.

7.2 Advice was additionally sought from the Chief Scientific Officer for Northern Ireland, Infection Prevention and Control and Executive Directors of Nursing.

7.3 The guidance was shared with Commissioner for Older People, Mental Health Advocacy Organisations, and Commissioner for Children and Young People.

7.4 Guidance was also sought from Families Involved Northern Ireland (FINI).

7.5 Guidance from other UK nations and the Republic of Ireland was also reviewed and included in the deliberations.

8.0 IMPLEMENTATION

8.1 Public-facing links to this guidance advising service users and the wider public of the current visiting arrangements will be made available via the Department of Health Website.

8.2 Dissemination to HSC Trusts, Public Health Agency, HSC Board, Regulation Quality Improvement Authority and Executive Directors of Nursing will be via the Chief Nursing Officer's (CNO) Department.

8.3 This regional guidance will be available on DoH, PHA and HSC Trusts website and will be updated. The regional surge level position is subject to change and will be reviewed frequently. Local outbreaks in HSC Trust areas and care homes may occur which will require a specific local response aligned to this guidance, but reflecting the pandemic surge level in that area

Appendix 1

The Surge Grid outlines the restrictions which apply in line with Regional Surge Level Position - this is subject to change and will be reviewed frequently.

Local outbreaks in HSC Trust areas and Care Homes may occur which will require an additional specific local response.

Surge Level	**High/Extreme Surge Level 5**	**Medium Surge Level 4**	**Pre/Low Surge Level 3**
Description of Surge	**A material risk of healthcare services being overwhelmed"- extremely strict social distancing**	**A high or rising level of transmission - enforced social distancing**	**The virus is in general circulation - social distancing relaxed**
Area Of Care	**Visiting and accompanying of visitors will be limited as follows**	**Visiting and accompanying of visitors will be limited as follows**	**Visiting and accompanying of visitors will be limited as follows**
General Hospital(including ICU)	No face to face visiting – however following a risk assessment and ensuring a COVID free environment end of life visiting only may be considered.	Only one family member or carer to be permitted access to visit. Where the person visiting requires assistance and is accompanied by a carer and this can be accommodated within social distancing guidance then a second person may be admitted (prior arrangement with ward staff is essential). Visits for up to one hour once a week	One visitor only per patient at any one time. In specific circumstances where the visitor requires assistance then no more than 2 people will be permitted access to visit at any one time where this can be accommodated within social distancing guidance.

Hospice Facilities	No face to face visiting – however following a risk assessment and ensuring a COVID free environment end of life visiting only may be considered. .	One family member or carer to be permitted access to visit where the environment is COVID secure.(* see definition) for up to one hour daily Where the person visiting requires assistance and is accompanied by a carer and this can be accommodated within social distancing guidance then a second person may be admitted (prior arrangement with ward staff is essential).	One family member or carer to be permitted access to visit where the environment is COVID secure.(* see definition) In specific circumstances where the visitor requires assistance then no more than 2 people will be permitted access to visit at any one time where this can be accommodated within social distancing guidance.
Emergency Departments	One person only to accompany the patient where the patient is unable to understand or communicate with staff.	One person only to accompany the patient where the patient is unable to understand or communicate with staff.	One person only to accompany the patient where the patient is unable to understand or communicate with staff.
Out Patient Departments	Not applicable – OPD appointments will be cancelled.	Where necessary for the patient to attend face to face appointment only one person to accompany where patient is unable to understand or communicate with staff.	Where necessary for the patient to attend face to face appointment only one person to accompany where the patient is unable to understand or communicate with staff.
Paediatric/neonatal hospital settings	Any child admitted can be be accompanied by one of two nominated parents	**Neonatal unit:** One nominated parent/caregiver can be accommodated at any given time	**Neonatal unit:** Two nominated parents/caregivers can be accommodated at any given time

	/caregivers at any given time for the duration of the stay (paediatric and neonatal units)	**Paediatrics** - Any child admitted can be accompanied by one of two nominated parents/caregivers at any given time for the duration of the stay	**Paediatrics** - Any child admitted can be accompanied by two nominated parents/caregivers at any given time for the duration of the stay
X Ray	One person only to accompany the patient where the patient is unable to understand or communicate with staff.	One person only to accompany the patient where the patient is unable to understand or communicate with staff.	One person only to accompany the patient where the patient is unable to understand or communicate with staff.
Cancer/Burns/Renal Units	End of Life Visiting only.	One visitor to be permitted to visit where the environment is COVID secure (* see definition) for up to one hour per week. Where the person visiting requires assistance and is accompanied by a carer and this can be accommodated within social distancing guidance then a second person may be admitted (prior arrangement with ward staff is essential).	One visitor only per patient at any one time where the environment is COVID secure (*see definition). Where the person visiting requires assistance and is accompanied by a carer and this can be accommodated within social distancing guidance then a second person may be admitted (prior arrangement with ward staff is essential).
Day Procedure Units	One person only to accompany the patient where the patient is unable to understand or communicate with staff.	One person only to accompany the patient where the patient is unable to understand or communicate with staff.	One person only to accompany the patient where the patient is unable to understand or communicate with staff.

Care Homes*	Arrangements for end of life visiting only	Indoor visiting in residents' rooms – one person for one hour once weekly will be permitted where this can be accommodated within social distancing. This does not apply to care partner arrangements.	Two people will be permitted access to visit indoors at any one time where this can be accommodated within social distancing.
***Please refer to Section 4 in Appendix 5 for the specific guidance around facilitating care partners.**	Alternatives to face-to-face visiting for all others should be provided	Alternatives in line with Care Homes' visiting policies, e.g. outdoor visiting, virtual visits, designated visiting rooms etc. should be provided.	Care partner arrangements in place. Alternatives in line with Care Homes' visiting policies, e.g. outdoor visiting, virtual visits, etc. should be provided.
Maternity Units	Birth partner will be facilitated to accompany the pregnant woman to labour ward for active labour (to be determined by midwife) and birth only.	Birth partner will be facilitated to accompany the pregnant woman to dating scan, early pregnancy clinic, anomaly scan, Fetal Medicine Department, when admitted to individual room for active labour (to be determined by midwife) and birth and, to visit in antenatal and postnatal wards for up to one hour once a week.	Birth partner will be facilitated to accompany the pregnant woman to dating scan, early pregnancy clinic, anomaly scan, and Fetal Medicine Department, for induction of labour, duration of labour and birth and, to visit in antenatal and postnatal wards for up to one hour once a week.
Mental Health Wards	One person only to visit where deemed necessary to support the mental health and wellbeing of the patient. Alternatives to face-to-face visiting for all others	One person to visit for up to one hour once a week, or more where deemed necessary to support the mental health and wellbeing of the patient. Alternatives in line with visiting policies, e.g. outdoor visiting,	Two people will be permitted access to visit at any one time where this can be accommodated within social distancing. Alternatives in line with visiting policies, e.g. outdoor visiting, virtual visits, etc.

		virtual visits, designated visiting rooms etc.	
Learning Disability Wards	One person only to visit where deemed necessary to support the mental health and wellbeing of the patient. Alternatives to face-to-face visiting for all others	One person to visit for up to one hour once a week, or more where deemed necessary to support the mental health and wellbeing of the patient. Alternatives in line with visiting policies, e.g. outdoor visiting, virtual visits, designated visiting rooms etc.	Two people will be permitted access to visit at any one time where this can be accommodated within social distancing. Alternatives in line with visiting policies, e.g. outdoor visiting, virtual visits, etc.

***Covid Secure**: To maintain

- a social distance of 2 metres when possible
- Optimal hand hygiene and personal hygiene measures
- Good ventilation
- Use of PPE when required
- Face Coverings

Appendix 2

Evidence Review Summary (1/6/2020)
A rapid evidence review was performed by Strategic Clinical Advisory Cell (SCAC) to identify and summarise published evidence relating to coronavirus infection and the impact of hospital visitors on disease transmission.

Results
Studies of 'visitors' and nosocomial infection documented 'whole hospital' nosocomial infections or specific department infections. The hospital has been shown to become frequently contaminated when providing care to COVID-19 patients. In one study, the most contaminated objects were self-service printers (20.0%), desktop/keyboards (16.8%) and doorknobs (16.0%), with hand sanitizer dispensers (20.3%) and gloves (15.4%) being the most contaminated Personal Protective Equipment (PPE) [1]. The hospital environment could thus be a source of virus spread, including among HCWs, patients, and visitors.

COVID-19
One retrospective cohort study in China documented a visitor infection rate with Covid-19 of 9.8%[2], however, 'visitors' were grouped with patients who had attended outpatient departments as well as hospitalised patients who had went home and then developed symptoms.
The other studies looking at nosocomial infections were in relation to SARS (n=1)[3] and MERS (n=1)[4].

SARS
A zero-level nosocomial infection rate (Healthcare Workers (HCWs) and visitors) was reported in one paediatric hospital during a SARS outbreak in 2003 where either parent was allowed to visit SARS-positive children on compassionate grounds for 2 hours daily[3]. This department deployed a strict Infection Prevention and Control (IPC) regime which included: stratifying wards into 3 areas: 1. Ultra high risk area, 2. High risk area and 3. Moderate risk area according to different risk levels of nosocomial SARS transmission, registering visitors on arrival at the wards in case future contact tracing was necessary and visitor PPE use according to different

levels of risk stratification. Designated places in the paediatric wards were provided for putting on and removing PPE. Routine thorough cleaning and disinfection of the floor, tables, computers and medical equipment in all wards were carried out at least three times per day using sodium hypochlorite solution at 1000 ppm[3].

MERS

The MERS outbreak in South Korea in 2015, was almost entirely (99.4%) nosocomial[5]. The reasons were thought largely attributable to infection management and policy failures, rather than biomedical factors. In a 2014 retrospective cohort study defined a nosocomial MERS case as RT-PCR positive in a symptomatic person, exposed to hospital as a HCW, patient, or visitor with symptom onset 2-14 days after hospital contact[4]. 11.5% of nosocomial infections were visitors to hospital. Infection control deficiencies included limited separation of suspected MERS patients, patient crowding, and inconsistent use of infection control precautions; aggressive improvements in these deficiencies preceded a decline in cases[4].

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Appendix 3

COVID-19: REGIONAL PRINCIPLES FOR VISITING MATERNITY SERVICES IN NORTHERN IRELAND

Revised 22 September 2020

1.0 INTRODUCTION

1.1 This guidance for visiting requirements in Maternity areas **MUST** be read alongside *COVID-19: Regional principles for visiting in care settings in Northern Ireland (Date of Publication: 22 September 2020)* **AND** the Grid at Appendix 1, which is aligned to the pandemic surge levels/R value based on the best scientific advice available at any given time.

2.0 BACKGROUND

2.1 Since the onset of the COVID-19 surge period, guidance on visiting to maternity hospital settings has been that a woman could be accompanied by one birthing partner and only during active labour and at birth. This position was revised in the guidance principles issued on 30 June 2020.

2.2 However, evidence not only supports the presence of birth partners in labour and birth in improving outcomes for women and infants but also highlights that infant bonding and attachment with parents, increases in the first few days after birth and restricting visiting reduces the opportunity for bonding.

2.3 Also, there has been a significant public pressure regarding women being unaccompanied for antenatal ultrasound scans and induction of labour, as well as during the postnatal period.

2.4 Therefore, the Strategic Clinical Advisory Cell (SCAC) at the Department of Health undertook a review of the emerging global evidence relating to coronavirus infection and the impact of hospital visitors on disease transmission, as well as the impact of reduced involvement of birth partners in hospital maternity care (see Appendix 4).

3.0 DEFINITIONS AND SCOPE

3.1 This paper outlines guidance for pregnant women attending hospital settings for specific pre-planned antenatal appointments.

3.2 The guidance outlines situations where the woman can be accompanied by her partner or nominated other.

3.3 The revised guidance is applicable to women either, while they are an inpatient on antenatal or postnatal wards, or when attending the maternity hospital for the following reasons:

- pregnancy dating scan (approximately 10-12 weeks);
- early pregnancy clinic;
- anomaly scan (approximately 19- 20 weeks);
- attendance at Fetal Medicine Department;
- pregnancy loss and bereavement; and
- duration of labour and birth.

4.0 KEY POLICY PRINCIPLES

4.1 Women can be accompanied by their partner or nominated other to any of the above except in high/extreme surge (see Grid on page 14 above).

4.2 There may occasions in individual HSC Trusts that visiting, for specific reasons, may be limited further than outlined in this guidance. This will most likely be to reduce the number of people in any one area to comply with social distancing rules. In this scenario, clear explanations will be given to women and their partner/nominated other.

4.3 **Members of the public who are experiencing the symptoms associated with COVID-19 <u>should not</u> visit maternity hospitals**.

4.4 Specifically the following will apply to visiting on antenatal and postnatal wards:

a. Visitor numbers in maternity services will be restricted to one visitor per woman at any specific time;

b. Women will be asked to nominate a maximum of two people (one will be the nominated birth partner) to be permitted access to visit throughout the duration of the hospital stay;

c. In the event a nominated person becomes unwell another individual can be nominated;

d. Where the patient is unable to nominate individuals, the next of kin will be asked to provide nominees;

e. Visits will be for a maximum duration of one hour. Any exception to this must be agreed with the midwife in charge;

f. The time of this visit should be agreed with the nominated visitor and the midwife in charge.

Appendix 4

Evidence Review Summary: Birth partners visiting maternity units

(1/6/2020)

A rapid evidence review was performed by Strategic Clinical Advisory Cell (SCAC) to identify and summarise published evidence relating to coronavirus infection and the impact of hospital visitors on disease transmission, as well as the impact of reduced involvement of birth partners in hospital maternity care.

Results

There were no articles pertaining to 'birth partners' and coronavirus nosocomial infections. Studies of 'visitors' and nosocomial infection documented 'whole hospital' nosocomial infections or specific department infections (e.g. Paediatrics) that were not maternity.

The hospital has been shown to become frequently contaminated when providing care to COVID-19 patients. In one study, the most contaminated objects were self-service printers (20.0%), desktop/keyboards (16.8%) and doorknobs (16.0%); with hand sanitizer dispensers (20.3%) and gloves (15.4%) being the most contaminated Personal Protective Equipment (PPE) [1]. The hospital environment could thus be a source of virus spread, including among Healthcare Workers (HCWs), patients, and visitors.

Role of visitors in Nosocomial Infection during coronavirus outbreaks

COVID-19

One retrospective cohort study in China documented a visitor infection rate with COVID-19 of 9.8%[2], however, 'visitors' were grouped with patients who had attended outpatient departments as well as hospitalised patients who had went home and then developed symptoms.

The other studies looking at nosocomial infections were in relation to SARS (n=1)[3] and MERS (n=1)[4].

SARS

A zero-level nosocomial infection rate (Healthcare Workers (HCWs) and visitors) was reported in one paediatric hospital during a SARS outbreak in 2003 where either parent was allowed to visit SARS-positive children on compassionate grounds for 2 hours daily[3]. This department deployed a strict Infection Prevention and Control (IPC) regime which included: stratifying wards into 3 areas: 1. Ultra high risk area, 2. High-risk area, and 3. Moderate risk area according to different risk levels of nosocomial SARS transmission, registering visitors on arrival at the wards in case future contact tracing was necessary and visitor PPE use according to different levels of risk stratification. Designated places in the paediatric wards were provided for putting on and removing PPE. Routine thorough cleaning and disinfection of the floor, tables, computers and medical equipment in all wards were carried out at least three times per day using sodium hypochlorite solution at 1000 ppm[3].

MERS

The MERS outbreak in South Korea in 2015 was almost entirely (99.4%) nosocomial[5]. The reasons were thought largely attributable to infection management and policy failures, rather than biomedical factors. In a 2014 retrospective cohort study defined a nosocomial MERS case as RT-PCR positive in a symptomatic person, exposed to hospital as a HCW, patient, or visitor with symptom onset 2-14 days after hospital contact[4]. 11.5% of nosocomial infections were visitors to hospital. Infection control deficiencies included limited separation of suspected MERS patients, patient crowding, and inconsistent use of infection control precautions; aggressive improvements in these deficiencies preceded a decline in cases[4].

Birth Partners in Maternity Care

Regarding the benefits of birth partners in maternity care low quality evidence supports their presence in labour and birth in improving outcomes for women and infants[6]. Emotional support can increase control in labour and give positive birth experiences for both parents. Infant bonding and attachment with parents increases in the first few days after birth[7]; restricting visiting reduces the opportunity for

bonding which may be particularly relevant where infants are admitted to the neonatal unit.

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Appendix 5

COVID-19: REGIONAL PRINCIPLES FOR NURSING & RESIDENTIAL CARE HOMES IN NORTHERN IRELAND

Publication date: 22nd September 2020

Implementation Date: 23rd September 2020

1.0 INTRODUCTION

1.1 The first priority continues to be to reduce the risk of COVID-19 transmission in care homes and prevent future outbreaks, to ensure the health and safety of both residents and staff. There are challenges which care homes, as distinct from other health and care settings, face in safeguarding residents from infection, and the particular risks of outbreaks of infection in care homes.

1.2 This guidance **MUST** be read alongside COVID-19: REGIONAL PRINCIPLES FOR VISITING CARE SETTINGS IN NORTHERN IRELAND (Updated version published: 23rd September 2020).

1.3 In the first instance care homes should consider regional surge level status as per directives from DoH/NI Executive and as defined in Appendix 1 - Covid-19: Regional Principles for visiting care settings in Northern Ireland.

1.4 Care homes who **do not have a current outbreak of infection** should facilitate a variety of visiting arrangements that:

- take account of individual resident personal health and care needs (e.g. those who may be hearing impaired, visually impaired, cognitively impaired etc.;), which should be set out in an individualised visiting plan;
- operate in accordance with the care home's dynamic risk assessment and visiting policy;
- align with the detail set out in Appendix 1 relevant to the current surge level.

1.5 Care homes which **are experiencing an outbreak of infection** must follow the directions of the Public Health Agency in managing the outbreak.
    - "**Outbreak**" is defined as **two or more confirmed or suspected cases in either residents or staff;**

- visiting will be permitted at this time in exceptional circumstances only (e.g. for residents approaching end of life) under strict IPC and PPE measures;
- the care home will remain in “outbreak until the terminal clean is completed;
- at conclusion of the outbreak, the care home should revert to the regional surge level status as per directives from DoH/NI Executive and as defined in Appendix 1 - Covid-19: Regional Principles for visiting care settings in Northern Ireland, and recommence visiting arrangements accordingly.

2.0 DYNAMIC RISK ASSESSMENT & VISITING POLICY

2.1 Care homes should conduct a suitable risk assessment using dynamic risk assessment principles to determine the measures required to facilitate a variety of visiting arrangements and develop a visiting policy. Dynamic risk assessment is a process of assessing risk in developing and changing situations, where it is not always possible to know the exact level of risk ahead of time.

2.2 DYNAMIC RISK ASSESSMENT

The dynamic risk assessment should consider relevant factors including:

- a balance of the measures required to minimise infection transmission into and within the care home (including public health protective measures such as footfall through the care homes premises, cohorting and isolation) with the rights of residents to family life and relationships, friendships and companionships with other residents and their mental health and emotional well-being;
- the measures required in a particular setting to put in place practical measures to mitigate any risks arising from visits, for example:
    - signing in and out arrangements;
    - appropriate signage;
    - virtual visiting arrangements;

    - outdoor visiting arrangements;
    - situation of a designated visiting room in easily accessible areas with reduced passing footfall;
    - one way walking system;
    - access to hand washing facilities;
    - allocation of any required PPE for visitors with safe donning and doffing facilities where required;
- the health and wellbeing risks arising from the needs of the residents in that setting. This will include both whether their needs make them particularly vulnerable to COVID-19 and whether their needs make visits particularly important;
- if any resident requires an individualised assessment of their circumstances in order to safely facilitate visits that are meaningful and of benefit to both the resident and their visitor, for example:
    - those who may be hearing impaired, visually impaired, cognitively impaired etc.);
    - where there might be specific challenges for an individual resident in adhering to social distancing requirements for visiting;
    - provisions for those who cannot access outside visiting or internal visiting areas due to the complexity of their current condition;
    - consideration of mitigation and management strategies for any unintended consequences of changes to visiting arrangements, such as a distressed reaction, that may require additional emotional/psychological support for individual residents;
    - those who may have to take cognisance of shielding advice, when applicable.
- advice from the Public Health Agency (PHA), Health and Social Care Trust local Infection Prevention and Control Teams, and the PHA Health Protection Team (in the event of an outbreak).

2.3 VISITING POLICY

2.3.1 Care homes should develop a visiting policy that can respond to local and regional changes in surge levels and outbreaks of infection.

2.3.3 Care home policies and associated procedures should be developed in collaboration with resident and relatives and include details of:

- the range of visiting arrangements that safely and holistically meet the needs of residents;
- the requirement for each resident to have an individualised visiting plan. Plans may require bespoke arrangements that address the complexity of their needs;
- the mechanisms for ongoing review of residents' individual visiting arrangements;
- how visiting will be managed for those residents who are approaching the end of their life;
- a robust method of continuing engagement and communication with residents and families;
- the arrangements for those designated as "care partners" (see section 4 below);
- details of support for staff in enabling visits safely, holistically and in line with all the relevant guidance;
- the agility of the arrangements to respond to local and regional changes in surge levels and outbreaks of infection.

3.0 IMPLEMENTATION

3.1 Extant social distancing requirements, IPC measures and any recommended or required use of PPE, including face coverings/masks must be adhered to at all times. Visitors to a care home must wear face coverings that they should bring with them and have in place before the visit commences.

3.2 Visits can only be facilitated if arranged by appointment – ad hoc visits cannot be facilitated. *Visits will need to be booked in advance for a specific day and an agreed time. Visitors must check in with the care home in sufficient time in advance of the agreed visit, just in case the situation in the care home has changed.* This is to protect other care home residents, staff, and families and to ensure equity of access to visits.

3.3 Care homes may wish to implement screening questions before the visit takes place, asking visitors about specific symptoms indicative of a possible COVID-19 infection. Where any visitor indicates presence of a symptom, the visit should not take place.

3.4 Subject to the care home's risk assessment, number of residents and other environmental considerations, visits may have to be limited to maximum number per week per resident. This is to allow opportunity for every resident to avail of a visit where they wish to do so, assist the facilitation of an appointment system, facilitate visits, and implement appropriate enhanced cleaning measures between visits (see https://www.niinfectioncontrolmanual.net/cleaning-disinfection).

3.5 One hour should be allocated for each visit, although it is recognised that not all residents will wish to use the full visiting hour.

3.6 **Virtually supported visiting** is a key method of maintaining family connections and, dependent on the surge level at a particular point in time, or the outbreak status of the care home, may be the preferred option in terms of reducing and managing infection and footfall to care homes. Whilst it is important virtual visiting should continue to be supported and facilitated, the limitations of this approach for some residents must be considered.

3.7 **Outdoor facilitated visiting**, where environmentally possible, can involve a range of options to include garden visiting, specially constructed marquees etc. Whilst outdoor visits must be booked in advance and follow the principles for safe visiting as set out in the care home's visiting policy (social distancing, PPE, IPC requirements etc), the number of visitors permitted to visit an individual resident should align with advice for the general public.

3.8 Children may visit where agreed with the home manager. Children should be able to fully understand and comply with safe visiting requirements – social distancing, limiting movement through the area/room/premises, IPC, PPE etc.

Any child visiting will be included in total number of visitors for the arranged visit.

3.9 Where care homes have been able to facilitate outdoor visiting arrangements, inclement and adverse weather contingencies will have to be considered, especially as autumn/wintertime approaches.

3.10 Other care homes may not have been able to introduce outdoor visiting arrangements for number of reasons, including lack of a suitably safe space to do so.

3.11 Therefore indoor visiting arrangements are required.

3.12 **Indoor visiting** arrangements may involve a designated visiting room/area, or a visiting “pod”. This room should be situated where it requires as limited as possible travel by visitors to the room and limited footfall past the room. All of the extant social distancing and IPC requirements must be safely implemented and managed.

3.13 Indoor visiting may necessitate the use of glass/plastic barriers between the resident and their visitor. Any such use will require advice and instruction from IPC colleagues to ensure that any such barriers can be effectively decontaminated between uses with a suitable disinfectant. Advice on decontamination can also be found in the Northern Ireland Infection Prevention and Control Manual (see https://www.niinfectioncontrolmanual.net/basic-principles).

3.14 The number of visitors permitted at any one time will be in accordance with Appendix 1 of the Covid-19: Regional Principles for visiting care settings in Northern Ireland.

3.15 Facilities for safe storage of visitor personal belongings that should not be brought through the care homes premises (handbags, keys, phones, coats etc) should be provided.

3.16 **Visiting residents in their own rooms** should only happen in exceptional circumstances where the resident is unable to avail of outdoor/indoor arrangements due to the complexity of their current condition, and under strict IPC measures. These residents are likely to be considered particularly vulnerable with regards to Covid-19. Arrangements for visits in a resident's room should be guided by individual risk assessments and management plans that include the details of requirement for use of appropriate PPE. Any such visitors should limit movement and interactions inside the care home, going straight to the resident's room, trying not to unnecessarily touch surfaces etc and leaving directly after the visit.

3.17 Should a resident wish to have a visit from a Minister of Faith, an agreed and pre-arranged visit can be accommodated. This visit will not be counted as or replace a resident's scheduled visit with family/friends. Visiting Ministers of Faith must adhere to the detail of the care home's visiting policy with regards to IPC, PPE, requirements for social distancing etc.

4.0 CARE PARTNERS

4.1 Care partners are more than visitors. Care partners will have previously played a role in supporting and attending to their relative's physical and mental health, and/or provided specific support and assistance to ensure that communication or other health and social care needs are met due to a pre-existing condition. Without this input a resident is likely to experience significant and/or continued distress.

4.2 Care homes should identify residents who will physically, mentally and/or emotionally benefit from input from a care partner and who they would like to be their care partner. This does not have to be a family member. In many circumstances a close friend may have previously acted in the care partner role. In addition, consideration should be given in individual risk assessments to:

- the safety of all of the residents, the staff and other visitors in relation to Covid-19;

- whether a proposed care partner needs to consider their specific health condition specific to Covid-19);
- how the care partner was involved in supporting the resident prior to the Covid-19 pandemic period.

4.3 Care home policy should include details of how the care partner arrangements will be agreed and facilitated with individual care partners. Agreement should be reached with residents and care partners with regards to:

- who will be the designated care partner(s) – up to two individuals may be designated as a care partner, providing the required support over the course of a week, one care partner at any one time;
- the frequency, time and duration of the visit and what type of support might be needed/provided. This could include assistance with physical needs, washing, dressing, eating, drinking, supervised physical activity, as well as support with communication or emotional support;
- not visiting if they have, or are in contact with anyone has had symptoms or tested positive for Covid-19 within the 14 days previous to the visit;
- not visiting if they are coming from an area where local restrictions are in place;
- adherence to all the required visiting policy and procedural requirements including the booking system, PPE and IPC measures and any outbreak situation.

4.5 A care partner visit is not considered the resident's "booked" visitor. Any additionally requested visit should be accommodated in line with this guidance.

5.0 END OF LIFE VISITS

5.1 A resident may have indicated in their Advance Care Plan who they would like to visit as they approach end of life. If this has not been recorded, a resident approaching end of life should be asked where possible who they would like

to visit. Family, next of kin and/or appropriate others may be able to advise where a resident is unable to provide this information themselves.

5.2 An individualised risk assessment should be undertaken with regards to accommodating visiting for a resident who is approaching the end of their life.

5.3 The DoH Covid-19 Guidance: Ethical Advice and Support Framework (2020) states that only in extreme cases should family members/ loved ones next of kin be denied the possibility to be with a resident as they approach the end of their life. Where this is the case the reasons should be clearly outlined to the resident and his/her family members and/or loved ones.

5.4 All requirements in terms of the care home's visiting policy, which includes IPC measures, use of PPE etc. must be adhered to. Infection prevention and control requirements in these circumstances should not be so rigid as to prevent family members/loved ones from saying goodbye in as humanely a way as possible- this includes the ability for them to hold hands and touch the dying person.

6.0 COMMUNICATION AND ENGAGEMENT WITH RESIDENTS, FAMILIES AND OTHER VISITORS

6.1 Clear and regular communication with residents and families will be key in the successful implementation of visiting policies.

6.2 Care home providers should develop a communication strategy in collaboration with residents and relatives to ensure that all official information and guidance is cascaded directly to residents and relatives. This strategy should detail a robust method of continued engagement and communication with residents and families.

6.3 This strategy should include plans to provide regular and detailed updates to relatives about their loved one's well-being in between organised visits where

residents are unable to personally update their relative and particularly in circumstances when visiting is subject to additional restrictions.

6.4 Residents and relatives should be involved in the development of care home policy, and in the decision making regarding the risks and benefits in facilitating visiting. This will facilitate an understanding that the arrangements required to safely manage visits to care homes must be aligned with the specifics of their relative's needs, the detail of this guidance and in particular dictated by local and regional surge levels.

6.5 The care home policy should recognise that residents and/or their representatives should be involved in the individual discussions and decision-making about their own tolerance of risk and their own judgements about the balance of risks, coming to an agreement regarding an individualised visiting plan.

7.0 SUPPORT FROM HSCT CARE MANAGERS/SOCIAL WORKERS

7.1 HSCTs should assure themselves that care homes that accommodate their clients are operating in accordance with the most up to date guidance for visiting care homes, and that they are implementing a dynamic risk assessed approach to visiting at their premises. This may include:

- providing support and advice where there are difficult to navigate situations relevant to a particular HSCT client;
- considering if the arrangements in place for individual clients recognises the balance in managing infection transmission with protecting the mental health and emotional well-being of residents and family relationships;
- considering if the arrangements in place for individual clients take account of each client's personal health and care needs (e.g. those who may be hearing impaired, visually impaired, cognitively impaired etc.);
- considering if the arrangements in place recognise and facilitate the role of care partners, support may required in identifying the care partner or managing the process;

- ensuring that individual clients and their relatives have been involved in agreeing visiting arrangements, recognising that residents and/or their representatives should be involved in the individual discussions and decision-making about their own tolerance of risk and their own judgements about the balance of risks; and,
- ensuring that there are mechanisms for ongoing review of clients' individual visiting arrangements.

Appendix 6

COVID-19: REGIONAL PRINCIPLES FOR VISITING FOR PARENTS/CAREGIVERS IN PAEDIATRIC AND NEONATAL INPATIENT/OUTPATIENT SETTINGS, DAY PROCEDURES AND EMERGENCY DEPARTMENTS

Publication date: 22nd September 2020

Implementation Date: 23rd September 2020

1.0 INTRODUCTION

1.1 This guidance for visiting requirements for parent/caregiver in Paediatric and Neonatal inpatients, outpatients, day procedures and emergency departments **MUST** be read alongside COVID-19: *Regional principles for visiting in care settings in Northern Ireland (Date of Publication: 30th June 2020)* **AND** the Grid at Appendix 1, which is aligned to the pandemic surge levels/R value based on the best scientific advice available at any given time.

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2.0 BACKGROUND

2.1 Evidence supports that Parents/Caregivers are an integral part of the baby or child's care team, and should not be considered visitors in the traditional sense. This is in line with the principles for family integrated care. It facilitates parent child bonding for neonates and supports the psychosocial needs of babies, parents and children and young people.

2.2 Since the onset of the COVID-19 surge period, guidance on visiting has stated that:

- any child admitted to an inpatient ward/neonatal ward or paediatric ICU can have one parent/caregiver at a time and
- the duration of the visit must be agreed with the Ward Sister/Charge Nurse

3.0 DEFINITIONS AND SCOPE

3.1 This paper outlines revised guidance in relation to visiting for parents/caregivers in paediatric and neonatal inpatient settings, outpatient settings, day procedure settings and emergency departments as the pandemic surge levels change.

3.2 This guidance is applicable to all Health and Social Care Trusts, children and young people receiving health care and families/care givers visiting children and young people in healthcare settings, including mental health and learning disability inpatient services for children and young people, across Northern Ireland.

3.3 Separate guidance is available for visiting children in social care settings.

4.0 KEY POLICY PRINCIPLES

4.1 A parent/caregiver should be facilitated to accompany their children where possible throughout their duration in hospital during the pandemic, except in high/extreme surge (**see Grid Appendix 1, page 12-13 above**)

4.2 In Paediatric inpatients, Outpatients, Day Procedure Units and Emergency Departments

- Families will be asked to nominate a maximum of two parents/caregivers who will be permitted separate access throughout the baby/child/young person's stay

4.3 In Neonatal Units,

- Families will be asked to nominate a maximum of two parents/caregivers who will be permitted access together throughout the baby's stay

4.4 In All Areas

- The parent/caregiver should agree the time and duration of visiting with the Ward sister/nurse in charge
- In the event a nominated parent/caregiver becomes unwell another person can be nominated to take their place for the duration of the stay or until the parent/caregiver can resume access.
- There may be occasions in individual inpatient settings that it will be necessary to further restrict visiting. In this event a risk assessment should be conducted aimed at reducing the number of people in any one area to comply with social distancing rules. Should this scenario occur, clear explanations must be given to parents and caregivers and services should

attempt to mitigate the impact of separation through the use of video technology.

- Parents/Caregivers will be given clear information about how they will be supported to remain involved in care (e.g, feeding) and decision making.
- In exceptional circumstances only, e.g. palliative care/critical illness, consideration will be given to allowing additional family/caregivers access. The ward sister/nurse in discussion with the nominated parent/caregiver must agree the planned arrangements such as: frequency and duration of additional family/caregiver access.
- Parents/caregivers in all settings will be required to wear face coverings upon entry to the care setting. They will be required to use their own face coverings, except in the Neonatal settings where masks, specific to Neonatal settings, will be provided by the hospital. Potential exemptions to wearing face coverings should be discussed with the ward sister/nurse in charge.
- Virtual visiting will be facilitated where possible for siblings and grandparents.
- The cooperation of all provided access to the setting is essential to ensure the safety of infants, children, young people, families and staff.