

# COVID-19 Guidance on visitations to Inpatient Areas of Acute Hospitals including Children’s Hospitals, rehabilitation services and other healthcare settings providing a similar intensity of care

V1.1 23.12.2020

Version	Date	Key changes from previous version
1.1	21/12/2021	Redefinition of critical and compassionate grounds to include some visiting in particular for longer stay patients  Additional information on an approach to managing patient requests to visit home during periods of major cultural or religious significance
1.0	11/10/2020	Initial guidance published

## Scope

This document is relevant to inpatient areas of acute hospitals including children’s hospitals, rehabilitation units, specialist palliative care inpatient units and maternity services. It should be considered in the context of the current overall guidance for control of spread of COVID-19 in acute and children’s hospitals and the Interim Guidance on Infection Prevention and Control for the HSE (see [www.hpsc.ie](http://www.hpsc.ie)).

Services provided by maternity hospitals and hospital services for children differ from general hospital services. Sections 1.4 and 1.5 of this document address issues specific to those settings.

Version 1.1 of this document represents an update to align, where appropriate, with updated guidance on long-term residential care facilities including a redefinition of critical and compassionate grounds.

## 1. Family and friends visiting

On September 11, the Government issued a Five Level Framework –Table of Public Health Restrictive Measures that includes visiting to long term residential care facilities. The document specifies the following:

The following summarises the measures at each level of the framework:

Framework Level	Visiting Policy*
Level 1	Open with protective measures
Level 2	Open with enhanced protective measures
Levels 3,4 and 5	Suspended other than in critical and compassionate circumstances*

\*Note this is intended to apply to indoor visiting. "Window visiting" where a person stands outside and speaks to a person at safe distance through an open window or by telephone is acceptable at any Framework Level and during Outbreaks. Window visiting is often not practical in many multi-story hospital buildings or where access to a window at ground level is not practical. It is acknowledged that window visiting can be challenging for some patients with hearing difficulties but visitors should be encouraged to maintain distance. Likewise, outdoor visiting where safe distance can be maintained at all times need not be restricted at any Framework Level or during Outbreaks where it is appropriate for the patient, it is arranged in advance and there are suitable facilities and capacity to accommodate and support the visit. If suspension of "window visiting" and outdoor visiting are considered this should be in the context of a documented risk assessment. If window visiting or outdoor visiting is suspended, the reasons for the suspension and the expected duration of the suspension should be communicated clearly to patients and relevant other persons.

### Communication

Restrictions on visiting are of themselves a source of stress for patients their friends and families. Any lack of clarity regarding the visiting arrangements and the reasons for them exaggerates the stress and is avoidable. It is essential that hospitals engage with patients, where possible involve them in decision making and communicate clearly with each patient and relevant others regarding visiting policy including any restrictions and the reasons for those restrictions. The communication should make it clear that only a very limited number of visitors can be in the hospital at one time and that to achieve this it will frequently only be possible to facilitate visitors during very specific times.

## Visitors

For the purpose of this guidance visitors may be taken to include people, typically family members or friends, who come to the hospital for a social visit. It is important that visitors are clear that they must accept personal responsibility with respect to the risk that they may inadvertently be exposed to infection during the visit and that their safety depends in a large measure on their behaviour during the visit. Particularly in the context of an outbreak a signed acceptance of personal responsibility may be appropriate.

The term visitor does not encompass a parent, guardian or carer accompanying a child or a person with a disability for whom the presence of this **accompanying person** is essential to support care.

It does not include **essential service providers** (ESPs). ESPs are people who provide professional services including healthcare, legal, financial and regulatory. Key examples include those who come from other sites to provide healthcare services such as medical, nursing, dental, physiotherapy, occupational therapy or podiatry services and those who provide legal services, chaplaincy services, advocacy services, or inspection of the hospital for monitoring or regulatory purposes. Access for ESPs cannot be denied and should only be limited in the most exceptional circumstances and for defined periods in the context of specific public health advice. ESPs should ensure that they have, at a minimum, taken on-line training in hand hygiene and in the donning and doffing of relevant personal protective equipment available on the [HSEland](#) website and that their organisation has appropriate supports to document and manage adverse incidents.

A third distinct category are **important service Providers** (ISPs) who provide services that are important to peoples sense of self and wellbeing but that are not strictly necessary. Examples of ISPs include those who provide personal care (for example hairdressers). A hospital should, where possible, have a list of important service providers with whom there is an established relationship and clarity around infection prevention and control requirements. ISPs should ensure that they have, at a minimum, taken on-line training in hand hygiene and in the donning and doffing of relevant personal protective equipment available on the [HSEland](#) website.

**Critical and compassionate circumstances** are difficult to define and of necessity require judgement. The term should not be interpreted as limited to circumstances when the death of a patient is imminent. A compassionate approach to care is relevant in all settings but has particular relevance to specialist palliative care inpatient units.

Subject to a risk assessment in each case, examples of critical and compassionate circumstances may include:

- At framework levels 3 and 4 up to one visit per week by one person should be facilitated on compassionate grounds in the absence of any other specific critical or compassionate circumstances
- At framework level 5 up to one visit every two weeks by one person should be facilitated on compassionate grounds in the absence of any other specific critical or compassionate circumstances
- This is not intended to define any maximum limit on the number of visits that should be facilitated where other critical or compassionate circumstances apply, in particular end of life circumstances. In those circumstances patient's wishes should be accommodated to the greatest extent possible consistent with the need to protect other patients and staff.
- Circumstances in which a patient is significantly distressed or disturbed and although unable to express the desire for a visit there is reason to believe that a visit from a significant person may relieve distress.
- When there is an exceptionally important life event for the patient (for example death of a spouse or birthday).
- When the visitor may not have another opportunity to visit for many months or years or never (for example because they are leaving the country or are themselves approaching end of life).
- Increased visiting is recommended by their doctor as a non-pharmacological therapeutic alternative to an increased dose of an existing agent or introduction of a new anxiolytic or sedative agent.
- A patient expresses a strong sense of need to see someone whether for personal reasons, to make financial or other arrangements or to advocate on their behalf.

- A person nominated by the patient expresses concern that a prolonged absence is causing upset or harm to a patient.
- Other circumstances in which the judgement of the medical or nursing staff or other staff member caring for the patient is that a visit is important for the person's health or sense of wellbeing.

## **Introduction**

Infection Prevention and Control (IPC) practice is critical to the safe operation of acute hospital services including the children's hospitals. The focus on the rigorous application of IPC measures is increased in the context of a public health emergency such as the current pandemic in particular given the impact of COVID-19 on older people.

There is persuasive experience during the current pandemic that visitors can, unintentionally and through no fault or omission on their part, be the means of introducing COVID-19 into an acute or children's hospital with significant consequences for the person they are visiting, for other patients and for hospital staff. While there is considerable scope to use technology to facilitate social contacts for patients and the engagement of family members or friends in supporting decision making these solutions cannot entirely replace visiting.

Visiting restrictions can play a role in preventing such accidental introduction of COVID-19 into a hospital; however visiting can also be very important for the health, wellbeing, recovery and rehabilitation of patients. Therefore, the hospital should do all that is practical to support safe visiting. The hospital should have the capacity and relevant skill sets within its staffing complement to manage this appropriately. In some instances, suitably trained volunteers may be able to guide and support visitors to hospitals to adhere to guidance.

Many patients are in acute hospitals for a short period for a specific treatment and or procedure and may be able to manage very well without visitors during that period of time. Where it is acceptable to patients to go without social visits; reduced visiting helps to protect them and everyone in the hospital.

However, some patients may become very anxious even in a short period of time without contact with people who are important in their lives. Many people who are in

hospital for extended periods or have specific needs may suffer greatly from a lack of contact with family and friends. This guidance document recognises the importance for patients of contact with family members. It aims to support hospital staff in fulfilling their responsibility by giving guidance to management, staff, patients and relatives to balance the risk of COVID-19 while facilitating visiting where practical during these exceptional times. As part of this person-centred approach, timely communication in a manner appropriate to the individual patient will include an overview of the proposed visiting arrangements and any updates or changes that may occur in accordance with Public Health/Infection Prevention and Control advice.

Visitors who do not adhere to guidance will be asked to leave and may be declined access subsequently if there is a pattern of non-adherence. Consultation with local Public Health teams and Infection Prevention and Control expertise will assist the hospital to review their plans and risk mitigation in order to facilitate visiting where necessary and practical. Restrictions should be applied on the basis of a documented risk assessment that is reviewed regularly in view of the evolving public health situation and new guidance.

## **1.1 Visiting in a hospital with no ongoing COVID-19 outbreak**

### **1.1.1. During periods of Framework Level 1**

Indoor visiting for patients in hospitals where there is no ongoing COVID-19 should be facilitated particularly for patients who are hospitalised for longer periods. Patients who are expected to have short inpatient stays (2 to 4 days) may be encouraged to forgo social visits if they are able to tolerate this without significant personal upset.

The duration of the visit may generally be limited to an hour however some flexibility is required on compassionate grounds in exceptional circumstances. In particular for people approaching end of life the greatest possible flexibility is required.

The number of visits per patient per week should generally be limited to 2 visits with up to two people at each visit. Where possible, limiting visiting to 1 person at each visit should be encouraged.

This is subject to the capacity of the hospital to schedule the visits safely. Visits should only take place when there is sufficient staff on duty to manage visiting. Visits should generally occur away from mealtimes however if a patient is taking a meal in their room and would like a visitor to assist them that can be facilitated.

Each patient should have nominated visitors for whom the hospital has contact details.

In general visits should be arranged in advance.

Visits should be scheduled to avoid heavy footfall in the hospital at any time. It is expected that each ward/unit will consider the number of visitors they can accommodate and to discuss these plans with IPC who can then seek Public Health advice if required.

Visitors should be made aware of the visiting processes that apply which are symptom checking, determination of previous known exposure to COVID-19, and use of correct hand hygiene techniques. In addition, they should be made aware that any visitors with fever or respiratory symptoms will not be admitted.

Visitors should be asked if they have COVID-19 or had close contact with a person with COVID-19 / suspected COVID-19 symptoms within the time period as determined by national guidance. Visitors should declare that they have no symptoms before entering the hospital. People who have had COVID-19 but for whom the infectious period has passed may visit as for other people.

Visitors are required to sign in on entry to the hospital or the ward. Visitors should be advised to bring their own pen and be guided in performing hand hygiene when they arrive and before signing in. The sign in may be in the format of an acceptance of personal responsibility for their behaviour and for unavoidable risk.

Visitors are required to wear a cloth-face covering or a surgical mask during the visit. Even when the visitor and patient (if over 13 years old or as clinically indicated) are alone together and at a safe distance from others continued use of the face covering or mask is preferred but it may be appropriate to remove the mask in some circumstances where it is an impediment to communication, impedes recognition or disturbs the patient. The hospital should provide any necessary personal protective equipment. It is not appropriate nor is it practical to seek to

prevent all physical contact (for example an embrace, hug or holding hands) where the visitor and the patient wish to express themselves in this way.

Visits should occur either in the patient's room if the room is a single room. In the case of a multi-occupancy room it is preferable for visiting to take place in a room away from other people where distance can be maintained. However, if there is adequate space between beds in a multi-occupancy room and if a visitor complies with all IPC guidance the risk of visiting in a multi-bed room is low.

Visits by a child may be facilitated if the child is accompanied by an adult who takes responsibility for ensuring appropriate conduct and the child is able to comply with the general requirements for visiting.

There are no restrictions on Accompanying Persons, Essential Service Providers or Important Service Providers in Framework Level 1 other than adherence to good infection prevention and control practice.

The patient's right to decline a visitor shall be respected.

### **1.1.2 During Periods of Framework Level 2**

The following modifications apply to guidance during Framework Level 2.

The number of people participating in each visit should be reduced to 1 unless there are compassionate or critical circumstances that require that visitor should be accompanied by an additional person needed to support them.

Visits should be strictly arranged in advance with the hospital.

Visitors are required to wear a surgical mask throughout the visit unless there is a specific difficulty that prevents wearing a mask. If a mask cannot be tolerated they should wear a visor that extends from above the eyes to below the chin and from ear to ear. PPE should be provided by the hospital.

Visits by children should be avoided except in compassionate or critical circumstances.

Services from Important Service Providers should be suspended.

### **1.1.3 Visiting during Framework Levels 3, 4 and 5**

Visiting is suspended aside from critical, child-centred and compassionate circumstances.

At framework levels 3 and 4, up to one visit by one person per week should be facilitated on compassionate grounds in particular for patients with long hospital stays if this is at all possible.

At framework level 5, up to one visit by one person every two weeks should be facilitated on compassionate grounds in particular for patients with long hospital stays if this is at all possible.

Visitors are required to wear a surgical mask throughout the visit unless there is a specific difficulty that prevents wearing a mask. If a mask cannot be tolerated they should wear a visor that extends from above the eyes to below the chin and from ear to ear.

Services from Important Service Providers should be suspended.

Arrangements for virtual visiting (telephone or video-link) and window or out-door visiting should be reviewed to ensure that they are as supportive as possible.

### **1.1.4 Issues specific to maternity services**

Although most hospital inpatient stays in maternity services are of short duration it is generally appropriate to facilitate visiting by a partner through this period.

In the context of maternity services an accompanying person (partner) should generally be facilitated in accompanying a woman in labour and childbirth.

Parents should generally be facilitated in visiting an infant who is in the neonatal intensive care unit (NICU) with due regard for the need to manage the risk to all infants in the NICU.

If restrictions on partner visiting, accompanying persons in labour or parents visiting NICU are considered essential this should be based on a documented risk assessment that is reviewed regularly. The risk assessment may consider infrastructure, staffing levels, the current Framework Level and the potential adverse impact of restrictions on patients, infants and their families.

### **1.1.5 Issues specific to children's hospitals**

Hospitals services for children and adolescents (up to 16 years old) encompass services for many children with special and complex care needs. Although most children's inpatient stays are short, a child-centred approach to care requires that visiting and stays by parents/guardians are facilitated throughout this period in order to provide a sense of security and comfort to their child through their presence during their hospital stay. Therefore, the management of visiting in this context requires a different approach factoring these considerations into the risk assessment.

One parent, guardian, or carer (**accompanying person**) is supported to be with their child during their hospital admission in the children's hospitals and hospital units caring specifically for children. Parents/Guardians/Carers can alternate who stays with their child. The accompanying person must not have suspected or confirmed infectious COVID-19 and should not be a COVID-19 Contact and access should be effectively controlled. Visiting by siblings is generally not possible at this time.

### **1.2 Visiting in the context of an outbreak of COVID-19**

The risks of the virus introduction associated with visiting during an outbreak are different from those in a ward/ hospital without an outbreak of COVID-19 because in the former case the virus is already in the ward/hospital. The risk to visitors is a much more significant concern during an outbreak. The following approach applies to acute hospital visits during an ongoing outbreak of COVID-19.

Visiting and access for within the ward/unit/hospital will generally be suspended in the first instance with the exception of critical and compassionate circumstances. Access for important service providers will generally be suspended during the early phase of an outbreak. When the situation has been evaluated and control measures are in place the extent to which visiting can be managed should be reviewed regularly.

Significant considerations in the risk assessment include the outbreak related care workload for staff and the number of staff available which may limit capacity to manage visiting. If the outbreak is confined to one wing or one ward or unit in a hospital there may be less requirement for visiting restrictions in other wards or units.

All visits during an outbreak are subject to the visitor accepting that all visiting during an outbreak is associated with a risk of infection for the visitor and that they choose to accept that risk. The hospital should request visitors to confirm that they have been advised of the risk to them, that they accept that risk and will comply fully with any measures they are asked to follow for their own protection or the protection of staff or patients. All visitors should be provided with any necessary personal protective equipment.

Arrangements for virtual visiting (telephone or video-link) and window or out-door visiting should be reviewed to ensure that they are as supportive as possible.

The messages around visiting during an outbreak should be communicated clearly to patients and the public and reinforced by placing signage at all entry points to the hospital and by any other practical means of communication with families and friends.

### **1.3 Patients requests to visit home while inpatient in an acute hospital**

In some circumstances visits home may be an essential part of the therapeutic or discharge process. Where this is essential for clinical care the risk must be accepted and managed.

It is also important to acknowledge that patients who are able to do so have the right to leave hospital at any time if they choose to do so.

The following relates to those situations in which a patient is seeking to agree on a plan for a social visit home. This may arise in particular in the context of a time of major religious or cultural significance such as Christmas. Other periods that are equally important to people of other traditions require the same consideration.

In general, at Framework levels 1 and 2 patient requests to visit home for a brief period can generally be facilitated with a low risk of introduction of the virus into the hospital as a result of the subsequent return of the patient provided good infection prevention and control measures are followed.

Framework levels 3, 4 and 5 reflect an assessment at national level that community transmission of COVID-19 is at a relatively high level. In that context the risk of a patient being exposed to and acquiring COVID-19 during a visit to a private home or similar setting outside of the hospital where they are likely to interact with multiple people over an extended period in a relaxed family/social context is significant. On

that basis visits out of the hospital generally not recommended at Framework Levels 3 and higher.

**At level 3 or higher of the Government Framework of Public Health Restrictive Measures patients are generally advised against visits to a private home or similar setting outside of the hospital because of the risk to them of acquiring COVID-19 during the visit and the risk to other patients that they may bring COVID-19 infection into the hospital when they return from the visit.**

However, it is recognised that there may be exceptional circumstances in which a visit outside of the hospital may be essential on critical or compassionate grounds and should be facilitated if at all possible without undue risk to other residents and staff. This may be particularly the case if there are specific reasons to expect that there may not be the opportunity to meet at this time in future years.

In that context it is appropriate to have approach to assessing and managing the risk associated with such a visit outside of the hospital. This is important to ensure that the patient and relevant other people are fully informed of the risk to them and to others associated with the proposed visit and to support the hospital in managing the risk to all residents and staff associated with the proposed visit.

### **Risk Assessment**

Assessing Risk Associated with a Resident Visit outside of the hospital	
Note 1 The following is intended to apply to hospital inpatients that have not had COVID-19 in the previous 12 weeks. If the person had COVID-19 confirmed in the previous 12 weeks the risk of them acquiring COVID-19 is extremely low and the risk of a visit to a private home or similar is extremely low. Visits by such patients can generally be facilitated. Although the risk of re-infection is extremely low it is prudent to advise avoiding contact with people who are symptomatic or known to be COVID-19 contacts.	
Characteristic	Comment
Level of independent function of the patient	Risk generally lower for patients who are very functionally independent

Vulnerability of the patients	Risk is generally lower with younger patients and those without long-term disease or immunocompromised
Accommodation of the patient in the hospital	Risk is generally lower if the resident has their own room in the hospital
Behaviour of the patient	Risk is generally lower if the patient copes well with staying in their own room most of the time
Travel to and from the hospital	Risk is generally lower if transport is to and from the hospital in a vehicle driven one of the people from the house they will be visiting
The number of people they will be in contact with	Risk is generally lower, the lower the number of people the person will be in contact with during the visit. For example, visit to with a spouse or other individual is low risk whereas a visit to an extended family is much higher risk Consider if the host is able to give an undertaking regarding the number of people who will enter the house while the patient is there
The people they will be in contact with	Risk is generally lower if the people they intend to be in contact with can give an undertaking that they are exercising a high level of precaution in relation to their own possible exposure in the two weeks before the visit  If the host is able to give an undertaking regarding minimising the risk that no one who is currently infectious for COVID-19 or is a COVID-19 contact or who has travelled from Great Britain in

	the previous 14 days will be in the household
The hosts assessment of the ability of others present to accept measures to reduce risk of infection (staying away if symptomatic, hand hygiene, distancing and mask use when appropriate)	Risk is generally lower if the host is able to give an undertaking that the people present are able to accept and follow measures to protect the patient during the visit
The duration of visit	Risk is generally lower if the visit is shorter (1-2 hours is much safer than 8-10 hours).

### Managing the assessed risk

If the risk is assessed as low and there is a need on critical or compassionate grounds to facilitate the visit it is appropriate to facilitate the visit.

The following are characteristics of a low risk visit:

1. The patient is relatively independent in activities of daily living and of lower vulnerability
2. The patient has their own room and copes well with staying in their own room much of the time
3. The patient will travel in a car driven by one of the people they intend to visit
4. The patient is going to visit one or two people who have no symptoms and can undertake to adhere to measures to reduce risk of infection
5. The duration of the visit is no more than 4 to 6 hours

If it is confirmed on return that the visit went as planned then no additional IPC precautions are required when patient returns. However, they should be monitored carefully for symptoms suggestive of COVID-19 for 14 days after their return.

If the risk is assessed as medium to high the patient and relevant person as appropriate should be advised that the visit poses such a risk to them and to other patients that the hospital advises against the visit. The risk should generally be assessed as medium to high if the characteristics of a low risk visit as outlined above are not met.

If the visit is assessed as medium to high risk but the patient considers it as absolutely essential to them the visit should be planned to minimise risk. When the patient returns they should be managed in a single room and should be tested for COVID-19 between day 5 and day 7 after return even if asymptomatic. This should be explained to the patient and relevant person(s) in advance of the visit as part of the risk assessment process.

ENDS