

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

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

Date of Publication: 30th June 2020

Date of Implementation 6th July 2020

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 inpatient services, Maternity Services, Care Homes, Mental Health and Learning Disability Hospital Inpatient Services, Children's Hospital Services, for the duration for the COVID-19 pandemic.
- 1.2 Additional guidance may be developed for specific settings where this is deemed necessary, at any time.
- 1.3 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 hospitals¹. With immediate effect all intensive care and hospital visiting across Northern Ireland was stopped.

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

There were also significant changes to the provision of Hospital Chaplaincy services².

- 2.2 COVID-19: Guidance for nursing and residential care homes in Northern Ireland³ was issued to care homes on 17 March 2020 and an updated version 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 settings⁴.
- 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 <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>

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 nominated 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 important to note that it is the responsibility for organisations to consider how they will implement these principles to 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 families⁵.

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, the decision to permit visitors into facilities will, on a day to day basis, lie with the nurse in charge, in hospital settings, and the care home manager in care home settings. This will depend 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.
- 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 ward sister or charge nurse 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 or required. 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.

⁶ Families Involved NI (FINI)

- 5.7 However, it is recognised that in an effort to reduce the footfall through health and social care settings, there may be times 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 apply⁷.

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. This is based on the best scientific advice available at any given time.
- 5.9 The visiting guidance principles will be applied as the surge level and the Northern Ireland Executive five step approach⁴ 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.
- 5.11 The application of these principles may be influenced by local facilities, such as availability of single rooms or room space, to allow adequate social distancing.
- 5.12 Where it is difficult to maintain/adhere to social distancing rules, due to the layout of facilities, organisations may 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.

⁷ <https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-chaplaincy-services.pdf>

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 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.

6.6 Visiting and visitor numbers will be restricted as the defined surge levels permit (Appendix 2).

6.7 Only one visitor is permitted to visit at a time.

- 6.8 Visits will be for a maximum duration of one hour. The time of this should be agreed with the nominated visitor and the nurse/person in charge.
- 6.9 It is expected that all patients/residents will have no more than one person visiting them at any one time.
- 6.9.1 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 facilitated.
- 6.9.2 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.
- 6.10 Each patient/resident will be asked to nominate a maximum of two people to visit. As far as possible 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.
- 6.11 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.
- 6.12 Children under the age of 16 will not be permitted to visit. In the event of exceptional circumstances, this can be discussed with the nurse/person in charge.
- 6.13 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.

- 6.14 Visitors will be required to wear face coverings for the foreseeable future and where this guidance changes or other PPE is required, organisations will have systems in place to ensure guidance related to visitors and PPE is followed.
- 6.15 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.
- 6.16 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.
- 6.17 Further guidance on specific areas can be viewed in the following appendices:
- **Appendix 3 Maternity Services**
 - **Appendix 5 Care Homes**

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 Examination of guidance from other nations revealed the following:

7.5.1 Visiting guidance in England was modified on 11 May 2020 to facilitate visiting at the end of life across a range of settings⁸.

7.5.2 Additionally, the restrictions of general visiting in healthcare inpatient settings during the COVID-19 pandemic has also been lifted in England (as of the 5 June 2020). The advice is that visiting shall instead be subject to local discretion by Trusts and other NHS bodies⁹.

7.5.3 Visiting guidance in the Republic of Ireland was also reviewed. As of 12th June 2020 advice was hospital specific but largely allows visiting by exception, similar to NI visiting restrictions¹⁰. Visiting arrangements for care homes in the Republic of Ireland changed on the 15 June 2020¹¹.

8.0 IMPLEMENTATION

8.1 Public-facing links to this guidance advising service users and the wider public of the visiting changes 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

⁸ <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0393-clinical-guide-for-supporting-compassionate-visiting-arrangements-11-may-2020.pdf>

⁹ <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0524-visiting-healthcare-inpatient-settings-5-June-2020.pdf>

¹⁰ <https://www2.hse.ie/services/hospital-service-disruptions/hospital-service-disruptions-covid19>

¹¹ <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/COVID-19%20Guidance%20on%20visiting%20residential%20care.pdf>

and care homes may occur which will require a specific local response out with the regional pandemic surge level.

Appendix 1

The Surge Grid outlines the Regional Surge Level Position using Critical Care capacity as the defining Surge Factor - this 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 out with the regional pandemic surge level.

Surge Level	High/Extreme Surge	Medium Surge	Pre/Low Surge
Description of Surge	<p>All health and social care systems significantly affected.</p> <p>ICUs operating at 100% and above capacity.</p>	<p>Community spread impacting on health and social care delivery mechanisms.</p> <p>ICUs operating at 50% above steady state capacity.</p>	<p>Evidence of community spread and increasing numbers of hospital admissions.</p> <p>All ICU beds converted to level 3 and working up to 25% above steady state capacity.</p>
Area Of Care			
General Hospital/ Hospice Wards (Covid-19 and Non Covid-19)	<p>NO FACE TO FACE VISITING</p>	<p>End of Life Visiting Only.</p> <p>Only one designated family member or carer to be permitted access to visit.</p> <p>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</p>	<p>Visiting and accompanying of visitors will be limited as follows:</p> <p>One visitor only per patient at any one time.</p> <p>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</p>

		(prior arrangement with ward staff is essential).	this can be accommodated within social distancing guidance.
Intensive Care Units	NO FACE TO FACE VISITING	<p>End of Life Visiting only.</p> <p>Only one designated family member or carer to be permitted access to visit.</p> <p>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).</p>	<p>Face to face visiting will be accommodated as far as reasonably possible.</p> <p>One visitor only per patient at any one time.</p> <p>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).</p>
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.
X Ray	One person only to accompany the patient where the patient is	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

	unable to understand or communicate with staff.		understand or communicate with staff.
Cancer/Burns/Renal Units	NO FACE TO FACE VISITING	<p>End of Life Visiting only.</p> <p>Only one designated family member or carer to be permitted access to visit.</p> <p>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).</p>	<p>Visiting and accompanying of visitors will be limited as follows:</p> <p>One visitor only per patient at any one time.</p> <p>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).</p>
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	NO FACE TO FACE VISITING	End of Life Visiting only.	<p>Visiting and accompanying of visitors will be limited as follows:</p> <p>No more than 2 people will be permitted access to visit at any one time where this can be accommodated within social distancing.</p>

Maternity Units	Birth partner will be facilitated to accompany the pregnant woman to labour ward for active labour and birth ONLY.	Birth partner will be facilitated to accompany the pregnant woman to dating scan, anomaly scan and for active labour and birth.	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 as appropriate.
Mental Health Units	One person only to visit where deemed necessary to support the mental health and wellbeing of the patient.	One person only to visit where deemed necessary to support the mental health and wellbeing of the patient.	<p>Visiting and accompanying of visitors will be limited as follows:</p> <p>No more than 2 people will be permitted access to visit at any one time where this can be accommodated within social distancing.</p>
Learning Disability Units	One person only to visit where deemed necessary to support the mental health and wellbeing of the patient.	One person only to visit where deemed necessary to support the mental health and wellbeing of the patient.	<p>Visiting and accompanying of visitors will be limited as follows:</p> <p>No more than 2 people will be permitted access to visit at any one time where this can be accommodated within social distancing.</p>

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 daily³. 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 ppm³.

MERS

The MERS outbreak in South Korea in 2015, was almost entirely (99.4%) nosocomial⁵. 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 contact⁴. 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 cases⁴.

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1. Ye G; Lin H; Chen S; Wang S; Zeng Z; Wang W; Zhang S; Rebmann T; Li Y; Pan Z; Yang Z; Wang Y; Wang F; Qian Z; Wang X. Environmental contamination of SARS-CoV-2 in healthcare premises. *Journal of Infection*. 2020 Apr 30.
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5. Kim KH; Tandl TE; Choi JW; Moon JM; Kim MS. Middle East respiratory syndrome coronavirus (MERS-CoV) outbreak in South Korea, 2015: epidemiology, characteristics and public health implications. *Journal of Hospital Infection*. 95(2):207-213, 2017 Feb

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

All people visiting Health and Social Care Settings will be required to wear face coverings for the foreseeable future

Date of Publication: 30th June 2020

Date of Implementation 6th July 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: 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.

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.
- 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:
- 12-week pregnancy dating scan;
 - early pregnancy clinic;
 - anomaly scan;
 - attendance at Fetal Medicine Department; 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 page 19).
- 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 should not 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.

The Surge Grid outlines the Regional Surge Level Position using Critical Care capacity as the defining Surge Factor - this 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 out with the regional pandemic surge level.

Surge Level	High/Extreme Surge	Medium Surge	Pre/Low Surge
Maternity Units	Birth partner will be facilitated to accompany the pregnant woman to labour ward for active labour and birth ONLY.	Birth partner will be facilitated to accompany the pregnant woman to dating scan, anomaly scan and for active labour and birth.	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 as appropriate.

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 daily³. 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 ppm³.

MERS

The MERS outbreak in South Korea in 2015 was almost entirely (99.4%) nosocomial⁵. 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 contact⁴. 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 cases⁴.

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 infants⁶. 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 birth⁷; restricting visiting reduces the opportunity for bonding which may be particularly relevant where infants are admitted to the neonatal unit.

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

Date of Issue: 30th June 2020

Date of Implementation: July 2020

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

**ANYONE WHO IS EXPERIENCING SYMPTOMS ASSOCIATED WITH
CORONAVIRUS SHOULD NOT VISIT A NURSING OR RESIDENTIAL CARE
HOME.**

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 (Date of Publication: 30th June 2020)
- 1.3 Nursing and residential care home managers must first consider the regional surge level position visiting guideline details in Appendix 1 of the above guidance, and apply these guidelines in the first instance. The regional surge level position is aligned to the pandemic surge levels/R value based on the best scientific advice available at any given time.
- 1.4 Where the regional surge level indicates that it may be possible to facilitate controlled visiting arrangements at pre/low surge level, care homes should then consider their own particular circumstances at that time in relation to an outbreak of infection in the home, and apply the following guidelines:

Status	Overarching visiting guidelines
<p>Outbreak of infection in the care home.</p> <ul style="list-style-type: none"> • “Outbreak” is defined as two or more confirmed or suspected cases in either residents or staff. • The care home remains in “outbreak” until terminal clean is completed. 	<p>Visiting in exceptional circumstances only (e.g. for residents approaching end of life) under strict IPC and PPE measures.</p>
<p>Care home has no outbreak of infection; there is continued evidence of community spread of infection.</p>	<p>Restricted visiting with adherence to IPC precautions.</p>

This could mean that, for example, the regional surge level position indicates the pre/low level surge visiting arrangement applies *regionally*, but the *status of an individual home* at that time may dictate *different visiting arrangements apply*.

2.0 RISK ASSESSMENT

2.1 Prior to any reintroduction of visiting, care homes should conduct a suitable risk assessment to determine if visiting can resume and under what circumstances, and develop a visiting policy to reflect this.

2.2 The assessment should consider relevant factors including:

2.2.1 a balance of the benefits to the residents, against the risk of visitors introducing infection into the care home, or spreading infection from the care home to the community;

2.2.2 the ability of a particular setting to put in place practical measures to mitigate any risks arising from visits, e.g. signing in and out

- arrangements, appropriate signage, one way walking system, access to hand washing facilities;
- 2.2.3 the health and wellbeing risks arising from the needs of the cohort of 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;
 - 2.2.4 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);
 - 2.2.5 discussions with staff to address any anxieties and provide appropriate support, policies and procedures to enable staff to facilitate visits safely and in line with all the relevant guidance;
 - 2.2.6 whether, and to what extent, the environment of the care home is conducive to a visit with adjustments to minimise risk, for example whether a visit could be facilitated in an open-air setting, such as a communal garden;
 - 2.2.7 the likely practical effectiveness of social distancing measures between the visitor and the residents, having regard to the cognitive levels of the resident and their communication needs;
 - 2.2.8 if any resident requires an individualised assessment of their circumstances in order to safely facilitate visits, for example, those who may have to take cognisance of shielding advice, or where there might be specific challenges for an individual resident in adhering to social distancing requirements for visiting, and whether sufficient infection prevention and control measures could be put in place to safeguard the residents, staff and visitors to allow the visit to take place;
 - 2.2.9 consideration of mitigation and management strategies for any unintended consequences of reintroducing visiting, such as a distressed reaction, that may require additional emotional/psychological support for individual residents.

3.0 IMPLEMENTATION

- 3.1 Virtually supported visiting remains the preferred option in terms of reducing and managing footfall to care homes and should continue to be supported and facilitated.
- 3.2 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.
- 3.3 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.
- 3.4 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.
- 3.5 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, implement appropriate enhanced cleaning measures between visits (see <https://www.niinfectioncontrolmanual.net/cleaning-disinfection>) and assess the impact of the reintroduction of visiting to staff, residents and relatives.

- 3.6 At the discretion of the Home Manager and if it can be managed safely outdoors, up to a maximum of six visitors may be permitted to visit a resident. All social distancing, IPC and PPE requirements must be adhered to.
- 3.7 Children may **only** visit in exceptional circumstances, agreed with the home manager on a case by case basis.
- 3.8 The length of time for each visit will be determined by the individual care home's risk assessment and visiting policy, and where necessary an assessment of an individual resident's situation, with maximum duration of one hour.
- 3.9 Where face to face visiting can be safely arranged subsequent to completion of the risk assessment by the care home, **outdoor visiting** is preferred and should be facilitated if environmentally possible, in suitable, safe locations within the grounds of the care home, adhering to all required and recommended IPC measures.
- 3.10 **Indoor** visiting may be necessary in specific circumstances, and where weather conditions are not suitable for outdoor visiting arrangements.
- 3.11 If indoor face to face visiting is being considered as part of a care home's visiting policy, the care home should identify a visiting room or area within the home where all of the extant social distancing and IPC requirements can be safely implemented and managed.
- 3.12 It is recommended that one person visits at a time. However in some cases the visitor themselves may need assistance and in this case a maximum number of two people are permitted to visit a resident indoors at any one time.
- 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 Visiting residents in their own rooms should only happen in exceptional circumstances and under strict IPC measures. This 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 and leaving directly after the visit.
- 3.15 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 END OF LIFE VISITS

- 4.1 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. All requirements in terms of the care home's visiting policy, which includes IPC measures, use of PPE etc. must be adhered to.

5.0 COMMUNICATION WITH FAMILIES AND OTHER VISITORS

- 5.1 The care home should communicate the detail of its visiting policy to residents, family and other visitors.
- 5.2 Friends and family should be advised that their ability to visit care homes is still being controlled in accordance with regional guidance and the care

home's risk assessment, and is subject to the specific circumstances of the care home and those living and working within it.

- 5.3 Where care homes are proposing to take a bespoke approach to a specific resident, it should seek to engage family and other likely visitors, as well as the resident where appropriate, in this decision.