COVID-19 Guidance on Access to Acute Hospitals for Nominated Support Partners, Accompanying Persons, Visitors and External Service Providers

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Version	Date	Key changes from previous version
1.4	09.02.2022	Key message on the need to ensure reasonable access Removal of requirement for the COVID-19 vaccination pass Testing of asymptomatic parents staying overnight in multi-bed rooms is now based on assessed risk at institutional level Clarified that total withdrawal of access, in particular for a nominated support person, is not required in the context of an outbreak Clarification regarding access for community midwifes accompanying a woman who transfers to hospital for delivery Clarification regarding access for people other than community midwifes who may accompany a woman in labour Revision to guidance on nominated support partners attending antenatal care appointments Change to guidance regarding asymptomatic parents staying overnight with children Change to guidance on nominated support person in general hospital during an outbreak Removal of reference to temperature checking of visitors and others accessing the hospital
1.3	22/12/2021	Reference to Omicron variant Increased emphasis on booster vaccination & updated information on vaccination programme Reference to recent advice from the Chief Medical Officer on self-testing for antigen Recognition that testing of asymptomatic adults accompanying children may not be essential if an institutional risk assessment indicates the risk is effectively managed otherwise Addition of Appendix 3
1.2	18/11/2021	Updated to include a requirement for COVID-19 vaccination pass for visitors Recommendation on testing of asymptomatic adults accompanying children and staying overnight in multi-bed areas with other children and adults Clear statement that essential service providers and important service providers should be vaccinated Guidance on access for home birth midwife and doula
1.1	21/10/2021	Additional material on the rationale for controlling access to hospitals and the need for the controls to be proportionate Change in terminology form restrictions to limitations on access Removal of section on equity of access as the same level of access now applies from 8am to 9pm to single rooms and multi-

		bed areas Nominated support partner access in maternity services from 8am to 9pm Guidance regarding the need to facilitate appropriate access for children to parents and others Extension of the model of nominated support partner access from maternity services to all hospital inpatients
1.0	02/09/2021	This document replaces "*COVID-19 Guidance on visitations to Acute Hospitals including Children's Hospitals, rehabilitation services and other healthcare settings providing a similar intensity of care*"

Note: If you have any queries on this guidance please contact the AMRIC team at hcai.amrteam@hse.ie

Key message

Hospitals must strike a balance between the need to manage the risk of introduction of COVID-19 by people accessing the hospital while ensuring that patients who need the support of a partner, a member of their family or a friend has reasonable access to that person. The hospital should have the capacity and relevant skill sets within its staffing complement to manage this essential access appropriately

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Scope

This document is applicable to 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).

Introduction

Infection Prevention and Control (IPC) practice is critical to the safe operation of acute hospital services including the maternity and 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, but must be balanced with regard for the needs of patients for access to people who are important to them. Vaccination of the majority of the population was associated with a striking reduction in the risk of severe COVID-19 in patients and staff resulting from exposure to the SARS-CoV-2 virus in the healthcare setting. Booster vaccination, when eligible for booster vaccination, is essential to preserve the benefit of vaccination in particular in the context of the Omicron variant. Even with booster vaccination, there are significant risks in particular for many of those who use acute hospital services. The risks are greater for those who are not vaccinated, including booster vaccination, and for those who have conditions associated with a high risk of severe disease or compromised immune function.

COVID-19 is spread primarily when susceptible people share an indoor space with an infectious person for a period of time. People with symptoms are generally more infectious but people can spread the virus to others before symptoms develop. In the context of an acute hospital setting any patient, staff or other person who enters the space may introduce infection.

In the course of the COVID-19 pandemic, there is persuasive experience of the introduction of COVID-19 and resulting outbreaks in acute hospitals and similar settings because of patients, staff and other people. Outbreaks of hospital-acquired infection continue to occur in acute general hospital settings even in the context of a very high proportion of

vaccinated staff and patients. Although the overall impact of such outbreaks in hospital in terms of severe disease and death are much less in those who are vaccinated, some patients who acquire COVID-19 in hospital, including some vaccinated patients, continue to experience very serious disease.

The risk of spread of infection to a large number of people in the acute hospital is greater in settings where relatively large numbers of people share a common space such as multi-bed inpatient areas, multi-chair day care facilities and waiting areas in outpatients and similar settings. The risk is greater in settings where people are closer together and where ventilation is poor. There is therefore, a continuing need for caution in relation to the risk of infectious people entering a hospital. The management of risks associated with infectious patients and staff are addressed elsewhere. This document relates to the management of risk associated with people other than patients and staff who access the hospital.

Managing the risk must take account of both how likely it is that people will catch infection in the hospital setting and how likely it is that those who catch infection will suffer serious harm. The risk of serious harm because of hospital acquired COVID-19 is greater than the risk of harm in most other places where people meet. This is because many people in hospital are at very high risk of severe disease if they become infected. People at high risk of severe disease expect that hospitals will do all that is practical to keep them safe when they are in the hospital. For these reasons, there needs to be more caution in hospitals than in places where people meet for social or recreational purposes. This requires that hospitals need to control access to a greater degree than is the case in society more generally.

While there is considerable scope to use technology to facilitate social contacts between patients and those who are important to them, hospital policies on access have to recognise that these solutions cannot entirely replace face-to-face contact for everyone in every situation. Hospitals must strike a balance between the need to manage the risk of introduction of COVID-19 by people accessing the hospital while ensuring that patients who need the support of a partner, a member of their family or a friend have reasonable access to that person. The hospital should have the capacity and relevant skill sets within its staffing complement to manage this essential access appropriately. In some instances, suitably

trained volunteers may be able to guide and support those who access hospitals to adhere to guidance.

Reducing the risk of introducing COVID-19 to an acute hospital or similar setting

Since any person who accesses an acute hospital or similar setting may unintentionally introduce the virus, the number of people who access acute hospitals should be limited as much as is reasonably practical, but with regard for the obligation to meet the needs of patients for companionship and support as outlined above.

Those patients who feel able to manage without being accompanied or visited during their time in hospital should be encouraged to do so, particularly if they are spending a short time in hospital. However, some patients may find it very difficult to manage without personal contact with others who are important to them even for a short period. People should be accompanied when they are expecting to receive new information that has a major consequence for their life and health if they wish to have that support. 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. It is not appropriate to impose extended periods of lack of contact on patients.

As the risk of spread of infection is greater with closer and more prolonged contact, people who access acute hospitals should limit their interaction with others within the building to the least possible number of people (staff and patients) necessary to fulfil their purpose.

Other than as a patient in need of essential care, no one should access an acute hospital if the person has symptoms of COVID-19, has been advised to self-isolate or restrict movements because of COVID-19 or is required to restrict movements in line with government guidance for travel outside of Ireland. Very rare exceptions to this may need to be considered on compassionate grounds. In that case, very careful risk assessment and planning is required.

Vaccination is offered to everyone aged 5 years and older. Booster vaccination is recommended for people as soon as people are eligible for booster vaccination based on current National Immunisation Advisory Committee guidance. Availing of primary

vaccination and recommended boosters is especially important for people who need to access an acute hospital as this helps to reduce risk of introduction and spread of COVID-19.

This guidance recommends that the risk of inadvertent introduction and spread of SARS-CoV-2 into the acute hospital setting should be managed primarily by assessing people for symptoms, checking that people accessing the hospital are adhering to public health guidance on restricted-movements and to good infection prevention and control practice.

A practice of requiring routine testing of all asymptomatic people before accessing the hospital is likely to be a barrier for some people and to result in delays and practical challenges for implementation. Hospitals are not generally required to organise, provide or seek evidence of testing of asymptomatic people for SARS-CoV-2 in advance of access to the hospital as nominated support partners, accompanying person or visitors. However it is appropriate to note that the Chief Medical Officer has advised that "*those who are meeting regularly with people from other households should regard this as high risk and should therefore consider using antigen tests twice weekly & before they socialise with others (including immediately prior to gatherings over the Christmas and New Year Period)*". This advice is relevant to visitors and others accessing acute hospitals and it is appropriate to bring to their attention.

There is an exception with respect to testing of asymptomatic adults accompanying children and staying overnight in multi-bed areas with other children and adults. Testing of asymptomatic parents or guardians accompanying children and staying overnight in multi-bed areas should be considered. This should take account of recent percentage positive in parents tested and any association with hospital acquired infection. Testing of asymptomatic parents or guardians accompanying children is not generally required if they are not staying overnight in multi-bed areas. The hospital should have a clear process for implementing testing of accompanying persons and for managing communication of results. Appendix 3 of this document includes suggested approaches to managing this. In addition to the testing of adults accompanying children as outlined, hospitals may consider providing or organising testing of asymptomatic people as an option for specific periods or in certain settings based on their hospital risk assessment.

Hospitals should do everything practical to dissuade patients and relevant others from meetings at the hospital door or gate that are not planned with the hospital staff. Such meetings are potentially high risk because there are no health checks on the person they are meeting and IPC precautions are often neglected. An important part of dissuading patients from this type of meeting is ensuring they have reasonable access to people they need to see in a structured and controlled manner.

Everyone who accesses an acute hospital must adhere to directions on essential infection prevention and control practices including maintaining physical distance (in so far as appropriate to their purpose), mask use, respiratory hygiene and cough etiquette and hand hygiene.

All those who regularly access the acute hospital setting in the role of Essential Service Provider or Important Service Provider should have a basic training in, and should consistently apply basic infection prevention and control measures necessary to protect themselves and others and should have availed of vaccination.

Policy on Access

A hospital policy on access should be based on this HSE-AMRIC guidance. If limitations on access that are greater than outlined in this guidance are considered necessary this should be based on a risk assessment that is reviewed regularly in view of the evolving public health situation. The risk associated with access is generally greatest when the incidence of infection in the population served by the hospital is higher. The risk may be greater also during periods of high community transmission, high hospital occupancy, in wards providing care for patients at particularly high risk of severe disease and in wards where patients are accommodated in multi-bed areas. Providing access in busy general Emergency Departments is particularly challenging. In all circumstances, however it is necessary to retain flexibility to take the needs of the person into account in application of limitations on access.

Refusal of Access

A total refusal of access should be very exceptional, however hospitals will generally refuse access to people who show evidence of infection unless there are extraordinary circumstances such as expected imminent end of life or other compassionate circumstances and the risk can be managed with specific additional measures. Hospitals may be obliged to refuse access to a person who is unwilling or unable to comply with reasonable measures to protect themselves and all patients and staff or if the person has not complied with reasonable measures during previous access.

Communication

Limitations on access are a cause of distress and disappointment to patients, their friends and families. Information that is clear, up to date and consistent across website, leaflets and when talking to staff helps people to accept limitations. This communication should make it clear how access is facilitated, any limitations that apply, the reasons for those limitations and the expected duration of limitations. Patients and others should be provided with a clearly defined pathway to appeal against limitations on access that they consider as being unreasonable. This process should provide access to a person other than the staff providing direct care to the patient (such as a duty manager or ADON) and be capable of responding to appeals in a reasonable period. Patients and others should be clearly informed as to how to use the hospital's complaints process if they wish to complain about access at any time during or after their attendance at the hospital.

General Guidance on Access

Reasonable access should be facilitated to the greatest degree practical for those patients who ask to receive people. Access may be very limited for a period of time in the early stages of dealing with an outbreak but a total withdrawal of access is not appropriate. This should not be limited exclusively to end of life care but should recognise other circumstances in which people need this support.

All patients in inpatient areas of a hospital should be allowed to nominate one support person. Access for that support person should be as flexible as possible, including some access to patients in critical care areas, within reasonable hours defined by the hospital.

Even in the early stages of an outbreak, total withdrawal of access for a nominated support person is not necessary.

The nominated support person should normally attend alone but some people need someone to accompany them. Access for nominated support persons to high intensity areas including Emergency Departments and Acute Medical and Surgical Assessment Units may need to be much more limited than in general inpatient areas.

In addition to access for a support person, patients who have children, particularly younger children, and who are in hospital for more than a week should generally be facilitated in seeing each child for some time at least once per week.

Access for visitors (that is people other than the nominated support person and children of patients as above) may be limited as appropriate to manage heavy footfall in the hospital and in the ward/unit/multi-bed room. It is expected that each hospital will consider the number of visitors who can have access at one time and discuss these plans with their infection prevention and control advisors. This is particularly challenging when multi-bed rooms represent the majority of the bed capacity and when rooms or waiting areas are small or poorly ventilated. At times of high community transmission visitors (as defined above) may be need to be limited to exceptional circumstances (for example approaching end of life).

Anyone accessing the hospital should declare that they have no symptoms of COVID-19 and are not required to quarantine, self-isolate or restrict their movements for any reason before entry.

People accessing the hospital are required to sign in on entry to the hospital. They should be guided in performing hand hygiene when they arrive. The sign in may be in the format of an acceptance of personal responsibility for their behaviour and for unavoidable risk.

People accessing the hospital are required to perform hand hygiene regularly and should wear a surgical mask during the visit. If wearing a mask is not practical, they should wear a visor that extends from above the eyes to below the chin and from ear to ear. However, if both the person accessing the hospital and the patient are alone together in a room the patient should be able to decide whether masks are worn or not. The risk associated with not wearing masks is lower if both people are vaccinated, including booster.

It is generally not appropriate to ask people accessing the hospital to wear gloves, apron, gown or eye-protection during access unless the person they are seeing has a specific confirmed or suspected infectious disease that requires this.

The hospital should provide any necessary personal protective equipment to all those accessing the hospital. In most cases, this will mean a surgical mask.

While physical contact (for example an embrace, hug or holding hands) between the patient and other people may increase the risk of transmission of infection it is for the patient to decide what is appropriate for them but they should have access to advice on the risks based on their vaccination status and immune function.

Access should occur in the patient's room. People should be asked to confine themselves to the room or to the bed space of the person that they have come to see. They should avoid interaction with anyone other than that person and the staff with whom they need to interact. To the greatest extent that is practical, having regard to weather conditions and patient comfort, there should be adequate ventilation of rooms during visiting.

The duration of the access should be appropriate to the needs of the patient. Nominated support people may be asked to keep the time they spend as short as is practical, however, the nominated support person and the patient can be expected to manage how long they need to spend together.

Gifts of baked goods whether homemade or commercially produced are most unlikely to pose a significant risk and should not be restricted on infection prevention and control grounds.

Patients' right to receiving items such as books, magazines, confectionery, keepsakes or objects of religious or personal significance should not be limited on infection prevention and control grounds.

The patient's preference with respect to seeing people or not seeing people should be respected.

In addition to access by children to a parent experiencing a long hospitalisation (as above), there is a need for sensitivity to the need for children and other people to meet (for example children to see grandparents) in particular at a time of great personal significance including approaching end of life. The child must be able to comply with the general requirements

for visiting or be accompanied by a person who can support them in complying with those requirements.

Essential Service Providers (Defined in appendix 1)

Controls on access for ESPs should be the minimum required to manage infection prevention and control risks and should be limited to the most exceptional circumstances and for defined periods in the context of specific Infection Prevention and Control (IPC) or Public Health advice. Essential service providers should be vaccinated and should avail of booster vaccination if they are eligible for booster vaccination and should comply with all required infection prevention and control precautions.

Important Service Providers (Defined in Appendix 1)

Important Service Providers (for example hair dressing) should be facilitated in providing services in the hospital to the greatest extent practical at times when those services are open to the general public. Important service providers should be vaccinated and should avail of booster vaccination if they are eligible for booster vaccination and should comply with all required infection prevention and control precautions.

Nominated Support Partner Access in Maternity Services (Defined in Appendix 1)

A nominated support partner plays a central part in supporting a person using maternity services. The support person also has a right to be present and to participate in the care process to the greatest practical degree. Limitations on access for nominated support partners should be the minimum required to manage infection prevention and control risks, must be clearly explained and should be applied with consideration for individual circumstances and needs.

Labour and delivery;

On arrival in labour or for induction of labour a nominated support partner should be facilitated in accompanying the woman through the admission and initial assessment process and on the pathway.

When the woman reaches her bed space or room, the nominated support partner should have open access between 8 am and 9pm subject to occasional requests to step outside to facilitate specific clinical activities such as ward rounds and also housekeeping and meals.

As with all aspects of this guidance, it is important to apply the time cut offs with consideration for the needs of the patient and their nominated support partner in particular when people are anxious or distressed and the clinical situation is changing rapidly.

In circumstances where there is a need for a nominated support partner to be present between 9 pm and 8 am every effort should be made to ensure that the woman is accommodated in a single room, both to provide privacy and to facilitate 24 hour access for a nominated support partner. This may arise because delivery is anticipated or because the woman has a specific need for the support of her partner for other reasons.

The COVID-19 related risks do not differ materially between vaginal delivery and delivery by Caesarean Section therefore COVID-19 related concerns do not require that a partner be excluded from attending a delivery by Caesarean Section if attendance would otherwise be appropriate.

When a woman who was planning a home birth transfers to hospital care and is admitted to a single patient room, access for the home birth midwife (Self Employed Community Midwife/SECM), in addition to her nominated support partner, should be facilitated on the same basis as applied in the hospital prior to the pandemic. As with hospital staff, the home birth midwife/SECM should be vaccinated, including booster and not be subject to any requirement for self-isolation or restricted movement.

Access for an additional person, other than a home birth midwife/SECM, including a person in the role of a doula, should reflect the hospital practice prior to the pandemic subject to the requirement for vaccination including booster, and the person should not be subject to any requirement for self-isolation or restricted movement.

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

infants in the NICU. Managing access may be necessary in NICU setting where there are many infants in an open area and space is very limited.
As in all other hospital services, in circumstances where a women has a long length of stay, the hospital should provide reasonable access for her children to visit her.

Antenatal Care;
The goal of hospitals should be to provide unrestricted access for nominated support partners to antenatal care as soon as this is safe to do so. To the greatest extent practical, a distance of 1m should be maintained between patients/couples in waiting areas and at any rate, patients/couples should have sufficient space to avoid direct contact. Maintaining reasonable distance may require staggered scheduling of in hospital appointments. Limitations on space in waiting areas in many maternity services mean that it is very helpful if those who feel able to attend unaccompanied can do so. Where hospitals are otherwise unable to maintain reasonable distance (of about 1m) between couples, limitations on access for nominated support partners are still necessary at this time.

When access of nominated support partners must be restricted to maintain reasonable distance between couples a nominated support partner should nevertheless be welcome to attend at the following

1) 12-week and 20-week scans,
2) early pregnancy assessment unit attendances,
3) unscheduled attendance including attendance at emergency services
4) first visit for first pregnancies
5) other antenatal appointments or attendances if there is reason to anticipate that the attendance is likely to be associated with particular stress or to involve communication of particular emotional significance.

It is important to take a person-centred approach to recognising contexts in which the presence of a nominated support person is required. Hospitals should put in place an arrangement (for example an email address or telephone number) whereby a woman who feels a specific need to be accompanied at an antenatal visit can contact the hospital in

advance of a scheduled attendance to request that a nominated support partner be facilitated in accompanying the woman at that visit. Such requests should generally be facilitated.

Any limitations on nominated support partners in excess of those outlined above should be based on a documented risk assessment, that is reviewed regularly and that is readily available to women and their partners (for example on the hospital website). Such risk assessments may consider if there is an ongoing outbreak of COVID-19 in the facility, the infrastructure, staffing levels, the current level of cases in the community and the potential adverse impact of limitations on access on patients, infants and their families. A template for such risk assessment is available.

Accompanying Person (Parent/Guardian/Carer) in Children's Services

Hospital 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 parents/guardians have access and can stay with the child throughout this period. This is to provide a sense of security and comfort to their child through their presence during their hospital stay. Therefore, the management of access in this context requires a different approach factoring these considerations into the risk assessment. Similar issues may arise for adults notably for some adults with special needs.

1. One **accompanying person** should be supported to be with a child during their hospital admission or other hospital attendance. Parents/Guardians/Carers may rotate the role of accompanying person.
2. Testing of asymptomatic parents or guardians accompanying children and staying overnight in multi-bed areas should be considered. This should take account of recent percentage positive in parents tested and any association with hospital acquired infection. Testing of asymptomatic parents or guardians accompanying children is not generally required if they are not staying overnight in multi-bed areas. The hospital should have a clear process for implementing testing of accompanying persons and for managing communication of results. Appendix 3 of this document includes suggested

approaches to testing accompanying adults.

Visitors (that is people other than Nominated Support Person, children of parents and accompanying persons)

Routine visiting when there is no Outbreak

Hospitals should make reasonable provision for general visiting (other than access for nominated support partners) and should make the policy readily available to patients on admission.

The number of people participating in each visit should normally be one person unless there are specific circumstances that require that an additional person support the visitor.

Visiting on Compassionate Grounds (Definition in Appendix 1)

There is no upper limit on the frequency or duration of visiting that is acceptable where critical and compassionate grounds (as set out in Appendix 1) apply, subject to the ability of the hospital to manage the visiting safely.

Access and Visiting in the context of an outbreak of COVID-19

In the general hospital setting, access for nominated support persons may need to be limited in the early stages of an outbreak but this should always be for the shortest period of time possible. Access for a nominated support person should rarely, if ever, be completely withdrawn.

General visiting and access within the ward/unit/hospital will often 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 access. If the outbreak is confined to one wing or one ward or unit in a hospital there may be fewer requirements for limiting access in other wards or units. Continuing access of a nominated

support person may support staff in many cases by providing company and emotional support.

All access during an outbreak is subject to the person accepting that all access 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 those accessing the hospital 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.

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.

In some cases, patients may seek to plan a social visit to their home or another house while an inpatient. Visiting to a residence outside of the hospital should comply with public health guidance that applies to visiting private houses by the public at the time. The risk associated with such planned visiting should be assessed and discussed with the patient. The risk can generally be managed with appropriate planning and precautions particularly if the patient is vaccinated, including booster vaccination, and is not immunocompromised. An approach to risk assessment is presented as appendix 2 to this document.

If a patient is absent from the hospital for less than 12 hours and in the absence of any reported unintended exposure there is generally no requirement for the patient to be subject to any additional testing or IPC measures other than those that apply to all patients on their ward on their return.

If the patient in question is vaccinated, including booster vaccination there is generally no requirement for the patient to be subject to any additional testing or IPC measures other than those that apply to all patients on their ward on their return even if they are away overnight.

In the context of a patient who is not vaccinated with booster and who has been away for more than 12 hours (typically an overnight stay), the IPC precautions applied to the patient should be those that apply to a new admission on their return.

Appendix 1 Definition of Terms

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. The term visitor is not intended to include the following categories of people who require access to the acute hospital setting.

Nominated Support Partner

For the purpose of this guidance, a nominated support partner is the person nominated by a woman accessing maternity services to accompany her to provide support and to act as an advocate as appropriate.

Hospitals should apply a similar model of nominated support partner with levels of access as outlined above for other groups of patients who are likely to experience frequent and prolonged hospitalisation for life threatening illness.

Accompanying Person (Parent/Guardian/Carer)

For the purpose of this guidance, an accompanying person is a parent or guardian accompanying a child or a carer accompanying a person with special needs in the acute hospital setting.

Essential Service Providers (ESPs)

For the purpose of this guidance, Essential Service Providers are people who provide professional services including healthcare, legal, financial and regulatory services. Key examples include those who attend the hospital to provide healthcare services such as medical, nursing, social work, safeguarding, 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.

Important Service Providers (ISPs)

For the purpose of this guidance, Important Service Providers are people who provide services that are important to a patient's 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 consider if it is possible to have a list of important service providers with whom there is an established relationship and clarity around infection prevention and control requirements.

Vaccinated

Individuals are considered to have completed primary vaccination as set out below:

1. 15 days after the second dose of AstraZeneca (Vaxzevria);
2. 7 days after the second Pfizer-BioNTech dose (Comirnaty);
3. 14 days after the second Moderna dose (Spikevax);
4. 14 days after Janssen (one dose vaccination course).

People who are immunocompromised require a third dose to complete extended primary vaccination.

An additional dose given after completion of primary vaccination is a booster dose.

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. Where critical and compassionate grounds (see examples set out below) apply the duration and frequency of visiting should be as flexible as possible subject to the ability of the hospital to manage the visiting safely.

The following are examples of critical and compassionate circumstances:

1. Circumstances in which end of life is imminent;
2. Miscarriage, stillbirth or other adverse pregnancy outcome;
3. 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;
4. When there is an exceptionally important life event for the patient (for example death of a spouse or birthday);
5. 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);

6. 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;
7. 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;
8. A person nominated by the patient expresses concern that a prolonged absence is causing upset or harm to a patient;
9. Other circumstances in which the judgement of the medical or nursing staff, registered health or social care professional, spiritual advisor or advocate acting for that the patient is that a visit is important for the person's health or sense of well-being.

Appendix 2

Assessing Risks Associated With a Visit to a Residence or Similar Setting Outside of the Hospital

It is appropriate to have an approach to assessing and managing the risk associated with visits 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 ward manager in managing the risk to all patients and staff associated with the proposed visit. This document is intended to support the patient, relevant other people and the ward manager in dealing with these issues arising from proposed visits outside the hospital when such visits are consistent with general public health guidance in force at the time.

Patients who are able to do so may choose to leave the hospital in the absence of an agreed plan with the ward manager or clinical team. If that patient subsequently requests to return to the hospital, this poses a significant challenge for the ward manager and clinical team. However, it is expected that a patient who wishes to return in such circumstances would normally be accommodated as appropriate to their clinical condition and in a manner that manages that risk to other patients and staff.

Strong and supportive communications between patients, family and staff should be in place. For all circumstances, the patient and/or family member should be advised of any requirements in advance of leaving the hospital in order that they can make an informed decision regarding any external visits. Communication plans and risk assessments should be documented.

Risk Assessment

Assessing Risk Associated with a Patient Visit outside of a Hospital
It is not possible for the clinical team/ward manager to seek verification or documentation regarding the information provided by the patient or the person hosting the visit. The risk assessment and advice provided to the patient is based on accepting the good faith of the person providing the information

Characteristic	**Comment**
Vaccination status of the patient intending to visit	The risk is much lower if the person is vaccinated including booster vaccination if eligible
Vaccination status of the person(s) the patient intends to visit	The risk is much lower if the person is vaccinated including booster vaccination if eligible
Vaccination status of other patients who share space with the patient	The risk is much lower if most other patients in a multi-bed area/ward are vaccinated including booster vaccination if eligible
Level of independent function of the patient	Risk generally lower for patients who are very functionally independent
Medical condition of the patient with respect to risk of severe COVID-19	Risk is generally lower with younger patients and those with underlying illness that does not represent a high risk for severe COVID-19
Accommodation of the patient in the hospital	Risk is generally lower if the patient has their own room in the hospital
Behaviour of the patient in the hospital	Risk is generally lower if the patient copes well with staying in their own room most of the time if this is necessary for any reason after their return
Travel to and from the hospital	Risk is generally lower if transport is to and from the hospital in a vehicle driven by one of the people from the house they will be visiting and particularly if that person is vaccinated including booster vaccination if eligible
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 a spouse or other individual is low risk whereas a visit to an extended family is much higher risk Consider if the host can 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 vaccinated, including booster vaccination if eligible, and exercising a high level of precaution in relation to

Characteristic	Comment
	their own possible exposure in the two weeks before the visit Risk is generally lower if the host is able to give an undertaking regarding minimising the risk that any person who is currently infectious for COVID-19 or is a COVID-19 contact will not be in the household
The host's 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 can 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 that 8-10 hours). See guidance in text related to duration of visit.

Managing the assessed risk

If the risk is assessed as low, it is appropriate to advise the patient and relevant others accordingly.

The following are characteristics of a low risk visit:

1. The patient is vaccinated, including booster vaccination if eligible, is relatively independent in activities of daily living and does not have medical conditions that place them at high risk of severe COVID-19;
2. The patient has their own room and copes well with staying in their own room much of the time if this is necessary for any reason after their return;
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 are vaccinated, including booster vaccination if eligible, have no symptoms and can undertake to adhere to measures to reduce risk of infection;
5. The duration of the visit is short (less than 12 hours).

If it is confirmed on return that the visit went as planned, then no additional IPC precautions are required with that patient on return. However, they should be monitored carefully for symptoms suggestive of COVID-19 for 14 days after their return, particularly if they are not vaccinated, including booster vaccination if eligible.

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 clinical team/ward manager 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 is essential, the patient should generally be managed as for a new admission on their return to the hospital. It may arise that a patient leaves the hospital in the absence of an agreed plan to minimise risk to exposure to COVID-19. In most circumstances the patient should be managed as for a new admission on their return (see text of guidance).

Appendix 3

Approaches to testing of adults staying overnight with children during inpatient paediatric admission

This guidance is applicable to asymptomatic adults. Adults who have symptoms or other clinical features of acute viral infection of any kind should not stay in multi-bed areas with other parents and children.

Adults who present credible evidence of a test reported as not detected in the previous 3 days do not require re-testing.

It may be relevant to a hospital considering how to address the issue that at the present time a member of the public may access testing for SARS-CoV-2 by attending a walk-in test centre or by self-testing. They do not need to be referred by a medical practitioner and do not need to provide the name of a medical practitioner to whom the test can be sent. In those circumstances the person receives the result directly from the testing service on their mobile phone.

Sample collection

In general, sample collection by a healthcare worker can be expected to have a higher yield of positives than a self-collected sample but a self-collected sample is acceptable. If using self-collected samples it is important to provided clear instructions on sample collection. Where practical to do so a healthcare worker observing self-sampling is likely to improve sample quality.

Test method

The hospital may use the test method most appropriate to its service needs.

Laboratory-based testing approach

Sample collection may be self-collection or collection by a health care worker. If self-collection is used, observation by a healthcare worker may be expected to improve sample quality.

Laboratory-based testing PCR testing is more likely to detect infection than antigen testing but is also more likely to detect residual viral RNA that is no longer of clinical significance.

If a hospital is using PCR based testing, it should have a defined process for managing test results that are likely to represent detection of residual viral RNA. There is national guidance on interpretation of high Ct values that is relevant.

Where the test method is a laboratory-based method options include one or more of the following:

(1) Provide the result directly to the person tested with an explanatory note that advises them to self-isolate if positive and to seek medical advice from their usual provider if they become unwell or have any other concerns regarding the implications of the result for their health. As above this is analogous to the way that walk-in testing is managed for many people although the context if very different.
(2) Report the result to a doctor associated with the hospital who is satisfied to receive the result in the context of an agreed process for managing the communication and management of the result.
(3) Subject to agreement with the relevant GP community, ask the person for the details of their GP and report the result to the persons GP [note the GP cannot be responsible for managing immediate communication with the person or the infection prevention and control implications for the hospital service. The result may be useful however if the person subsequently seeks care from their GP]

Notification to the Department of Public Health should follow standard requirements.

Self-testing Approach

If a hospital uses self-performed antigen testing it is important to provide a good quality test kit, clear instructions and an appropriate space for the person to perform the test and dispose of the materials. The accompanying person should confirm to hospital staff that they have performed the test and of the result.

If this approach is taken, a repeat sample and test after an interval (for example after 24 or 48 hours) may reduce the impact of the difference in sensitivity of this approach compared to laboratory-based PCR based testing.

Communication

The hospital needs to have a process to have a clear communication process in relation to what is required and what the results (detected or not-detected) means for the person.

Refusal to accept testing

If people refuse to accept testing the first step is for a senior staff member to discuss with them why they object to testing and to assess if there is way to address concerns and resolve the issue by agreement. If a child is seriously ill and the adult is upset or distressed it may be necessary to defer that discussion for a time. If the adult is resolved not to comply with this requirement or with other infection prevention and control requirement it is reasonable to decline access to the hospital in the interests of other patients. In this context adults who decline to comply with the testing requirement should generally be declined access to stay overnight in a multi-bed area. In some circumstances, in the interests of the child, accommodation in a single room may be a solution if a room is available

ENDS