GUIDANCE

Hospital visiting during the coronavirus outbreak guidance: July 2021

How the NHS can support hospital visiting in a safe and planned way during the coronavirus pandemic.

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Visiting with a purpose

The Health Protection (Coronavirus Restrictions) (No. 5) (Wales) Regulations 2020 as amended set out the number of persons who are permitted to gather together in regulated premises, which is defined to include hospital premises and hospices. This Guidance does not change those Regulations but provides advice in the context of what is considered to be appropriate in terms of visitor numbers to maintain infection prevention and control in hospital and hospice settings during the pandemic.

This guidance supersedes NHS Wales visiting guidance of 25 March, 20 April, 20 July and 30 November.

The following is a summary of the changes made to the 30 November guidance:

- The Health Protection (Coronavirus Restrictions) (No. 4) (Wales) Regulations 2020 as amended have been repealed and replaced by the No 5 Regulations.
- Reference to the All Wales Standards for Accessible Communication and Information for People with Sensory Loss added.
- Up to two parents, guardians, or carers at the bedside at a time for paediatric inpatients and neonates subject to local determination, and following a risk assessment including the ability to maintain **social distancing**.
- Link to guidance on **extended households** updated.
- Lateral flow testing for hospices added to **Annex 3**.
- Principles organisations to consider regarding hospital visiting added as **Annex 4.**

Summary

- To ensure the health and safety of patients/service users and staff our first priority is the prevention and control of infection in healthcare settings.
- In order to comply with the 2 metres social/physical distancing measure it is still necessary to restrict the number of visitors.
- Virtual visiting should be encouraged and supported where possible.
- Face-to-face visiting needs to be agreed in advance and outdoor visits may

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be offered if appropriate.
- Visiting should be with a clear purpose and agreement for visiting based on the best interests of the patient/service user or the well-being of the visitor.

Guidance

The Welsh Government supports a person-centred, flexible approach to visiting. However, Wales is still in a phase of sustained community transmission of COVID-19 and our first priority is the prevention and control of infection in our healthcare settings. This is to ensure the health, safety and well-being of patients/service users, staff and visitors themselves.

Welsh Government guidance currently states that 2 metres social/physical distance needs to be maintained as one of the key measures to help prevent the transmission of COVID-19. Insofar as possible, this measure needs to be maintained in a healthcare setting. To adhere to the social distancing measure, it is still necessary to restrict the number of visitors in healthcare settings.

The importance of continuing to support the well-being both of patients/service users and their families and loved ones during this difficult time is fully appreciated. It is recognised health boards and trusts have been innovative in finding alternative ways to enable patients/services users to maintain contact with their relatives and friends through virtual visiting using mobile phones, tablets etc and this should continue where possible. There is immense value in cards, phone calls, e-mails, social media as well as video calls.

Therefore, this updated guidance aims to assist health boards and trusts to strike a balance in terms of the visiting principles between allowing visiting with a purpose and the clear need to maintain robust infection prevention and control strategies at this stage in the pandemic, for the safety of patients, visitors and staff.

This guidance is being kept under review and will change as the pandemic status alters.

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The guidance remains that health boards and trusts should not return to "business as usual" in relation to visiting.

Some people may require essential support assistants for specific additional support, for example a support worker or **British Sign language or foreign language interpreter**. Essential support assistants are not to be classed as visitors in the traditional sense. In some circumstances, where people receive care and support from a family member or partner they may nominate this person as their essential support assistant.

All visitors aged 11 or over are required to wear a face covering in indoor public areas unless they have a reasonable excuse not to wear a face covering, for example if you have a health or disability reason for not wearing one. **Read further guidance on face coverings and exemptions.** In so far as possible, visitors should also maintain 2 metres physical distancing whilst on the hospital premises.

Visiting, with agreement from the ward sister/charge nurse/nurse in charge or via the health board's arrangements for visiting, can be facilitated as follows; as long as visitors:

- do not have any symptoms of COVID-19 and are awaiting the outcome of a test
- have not tested positive for COVID-19 and are still within the **self-isolation period** and are therefore still recovering from COVID-19
- have not been told to self-isolate by **NHS TTP (Test, Trace, Protect) Service**
- have not been knowingly exposed to someone with COVID-19 in the past 10 days
- do not live with any household members who currently have COVID-19 symptoms and are awaiting the outcome of a test, or have been tested positive and are currently self-isolating, or have been told to self-isolate by NHS TTP Service
- have not returned from overseas travel in the last 10 days from a non-exempt country and are required to be in quarantine

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Within non-COVID-19 areas and services:

- Up to two parents, guardians, or carers at the bedside at a time for paediatric inpatients and neonates subject to local determination, and following a risk assessment including the ability to maintain social distancing.

- Patients who are in the last days of their life - this can be up to two visitors at a time, for a specified amount of time, from the same household or part of an **extended household.** If not from same household or not part of an extended household they should visit the bedside separately and maintain distance outside of the clinical area. See **current guidance from 7 June 2021 for extended households**. You will also need to check our Alert levels page for the latest information.

- Essential support assistants and partner support visitors may support women in a maternity unit/hospital setting in accordance with the defined risk assessed levels of restrictions, in accordance with **Annex 2.**

- In general, one visitor at a time for a patient with mental health needs, dementia, learning disability or cognitive impairment, where lack of visiting would cause distress or it is required as a reasonable adjustment to support access to health assessment or intervention. However the number and frequency of visitors should be considered on an individual basis in light of the patient's/service user's needs, care plan and in consultation with their support staff or carer.

- Children and young people may visit a parent/guardian/carer or sibling in a healthcare setting and should be accompanied by one appropriate adult.

- People with long term conditions which necessitate increased length of stay in a healthcare setting or people with specific care and well-being needs that the visitor/carer actively contributes to, for example, feeding, supporting communication needs and supporting rehabilitation. The health and wellbeing of these patients may benefit from seeing appropriate visitors, as their length of stay is over many weeks. This should be documented in their

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care plan.

COVID-19 confirmed and possible infectious areas (assessment areas)

- Infection Prevention and Control (IP&C) procedures in these areas must be clear and any visitors must be made aware of the risks and advised of IP&C measures in place including the use of any PPE required during their visit.
- End of life COVID-19 patients may receive visitors during their last days of life, if permission is sought in advance from the ward sister/charge nurse/ nurse in charge. This may be up to two visitors, one at the bedside at a time, for a specified amount of time, preferably from the same household or part of an extended household. Currently guidance from 7 June 2021 for extended households can be found **here**, you will need to check our **Alert levels** page for the latest information.
- **People who were formerly shielding** or who are otherwise **at increased risk from the virus** should avoid hospital visits wherever possible. Where a hospital visit is deemed essential, for example to visit a loved one in the last days of life, hospitals should provide medical masks. All permitted visitors must adhere to hand hygiene and infection control precautions on arriving and leaving the area.

Exceptionality

It is recognised that guidance cannot foresee all requests for visiting nor all patient circumstances. Therefore, health boards and trusts do have the discretion, when operating the guidance, to agree to visiting requests that are not outlined in any of the categories set out above where they are satisfied the benefits to the wellbeing of the patient or visitor in agreeing a visit outweigh the infection control risks and any other practical difficulties in facilitating access.

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Agreeing visits

It is important that all visitors have agreement from the ward sister/charge nurse/nurse in charge before travelling for each visit. It may not be possible for visitors to see their loved ones every day and agreement for one visit should not be taken as agreement for further visits. This should be made clear to the visitor.

Staff should treat all requests from visitors with compassion and empathy whilst ensuring the patient's best interests are met. Face-to-face visiting should be with a purpose and not just a social occasion. It is to improve the well-being and aid the recovery of a patient or benefit the well-being of a visitor, for example a visit from a young person who is distressed at not being able to see their parent, guardian or carer. All visitors aged 11 or over are required to wear a face covering in indoor public areas unless they have a reasonable excuse not to wear a face covering. For example, if you have a health or disability reason for not wearing one. **Read further guidance on face coverings and exemptions.**

If the ward sister/charge nurse/nurse in charge is unsure, advice can be sought from the Infection Prevention and Control team if required. All visits need to be risk assessed and **Annex 1** provides a checklist of questions to aid decision-making for visits.

Outdoor visits for patients not known to be infected with COVID-19

Scientific evidence suggests that the virus survives less well in sunlight. This means that the risk of transmission is thought to be greatly reduced when outdoors.

If health boards and trusts are in a position to support outdoor visits, for example in the grounds or gardens of the healthcare setting, such visits should be made in accordance with **Welsh Government guidance**. Visitors should maintain the 2 metres distance from patients/service users, staff and other visitors at all times.

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Health boards and trusts may offer outdoor visits if they feel in certain circumstances that such visiting arrangements would be appropriate and possible to arrange. **Annex 1** provides a checklist to aid staff in considering visits.

Accompanying patients to scheduled healthcare appointments

It may be necessary for visitors to accompany patients/service users to scheduled appointments in a healthcare setting.

This may be in the following situations, which are by no means exhaustive:

- Individuals with a mental health issue, dementia, a learning disability or autism, where not being accompanied would cause the patient/service user to be distressed. Where possible, visits for such service users should be considered on an individual basis in light of the patient's/service user's needs, care plan and in consultation with their support staff or carer.

- Individuals with cognitive impairment who may be unable to recall health advice provided.

- Some people may require essential support assistants for specific additional support, for example a support worker or British Sign language or foreign language interpreter. Essential support assistants are not to be classed as visitors in the traditional sense. In some circumstances, where people receive care and support from a family member or partner they may nominate this person as their essential support assistant

- Where the treatment/procedure is likely to cause the patient distress and the visitor can provide support.

Appointment letters and websites should provide advice and contact details for visitors to request approval to accompany patients (where appropriate). The

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letters may include advice on:

- The need to adhere to **social/physical distancing** as well as **hand hygiene** and infection control precautions on arriving and leaving the appointment.

- **people who were formerly shielding** or **who are otherwise at increased risk from the virus** should avoid hospital visits wherever possible. Where a hospital visit is deemed essential, for example to visit a loved one in the last days of life or to attend as an outpatient, hospitals should provide medical masks

- all visitors aged 11 or over are required to wear a face covering in indoor public areas unless they have a reasonable excuse not to wear a face covering. For example if you have a health or disability reason for not wearing one. **Read further guidance on face coverings and exemptions**.

All requests to accompany patients need to be risk assessed and **Annex 1** provides a checklist of questions to aid decision-making for visits. Guidance on accompanying pregnant women to pre-planned antenatal appointments is provided at **Annex 2** and **Annex 4** on lateral flow testing principles.

Accompanying patients to unscheduled healthcare appointments

It may also be necessary for visitors to accompany patients/service users to unscheduled appointments, for example to Emergency Departments. If via ambulance this will need to be at the discretion of ambulance/emergency department staff and requests should consider the individual patient's/service user's needs and the support which can be provided by the visitor to help them understand their treatment and/or alleviate their distress.

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Annex 1: Considerations for visiting in non-COVID-19 healthcare settings

Staff should treat all requests for face-to-face visits with patients compassionately and with empathy whilst ensuring the patient's best interests are met. Indoor visiting should always be by appointment for a limited time period unless the patient/service user is in the last days of their life

Consideration should be given as to whether or not outdoor visiting is an option for the patients. If it is, an offer should be made for outdoor visiting in accordance with **Welsh Government guidance**.

All requests and offers for visits need to be risk assessed and the following considerations will aid decision making:

- Does the patient/service user meet the exceptions to visiting for patients not infected with COVID-19?

If not:

- Is the request for visiting with a purpose? That means it is not a social occasion but to improve the well-being and aid the recovery of a patient or benefit the wellbeing of a visitor?

- Would the patient's/service user's health and well-being benefit from seeing an appropriate visitor?

- Is the patient/service user COVID-19 free and placed on a COVID-19 free ward

- What is the COVID-19 situation in the healthcare setting? Visiting will need to be suspended if an outbreak or increased numbers of patients with symptoms of COVID-19 (or other infection) occurs in the healthcare setting.

- Has the patient/service user already received a face-to-face visit from another relative? Visits should preferably be with people from the same

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household or part of an extended household and ideally be limited to one household/extended household in any given week, however visiting arrangements should take into account individual circumstances - multiple adult children may each be living in separate households for example. The aim here is to limit the number of contacts as far as possible whilst ensuring compassionate arrangements for visiting. Currently guidance from 7 June 2021 for extended households can be found **here**, you will need to check our Alert levels page for the latest information.

Practicalities and location of visit

- Has provision been made to ensure all chairs and equipment are cleaned between visits?
- Can hand sanitiser be provided for the visitor at a fixed point?
- The expectation is that visitors would provide their own face coverings, but in the event a visitor arrives without one, they should be provided with one.
- Can the visit be facilitated outdoors, such as a garden?
- Do staffing levels support outdoor visiting?
- If the visit cannot be facilitated outdoors, is there a separate side room in the healthcare setting which can be used?
- How will the visitor safely journey from the car park through the building to and from the patient's/service user's location?
- For outdoor visiting, consider how the visitor will safely journey from the car park to the outdoor location.
- Is there sufficient signage to the patient's/service user's indoor or outdoor location as well as social distancing reminders?

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- Will the visitor need to be escorted to the patient's/service user's indoor or outdoor location?

- Have any other visits been arranged at the same time in the side room or outdoor location?

- Is there facility for a designated, well sign-posted "visitor toilet" near to the visiting location?

- How will visitors of different patients/service users be managed to prevent too many visitors at one time in a location?

Essential messages to convey to all visitors

- Remind the visitor of the option of other methods by which they can maintain regular contact with their loved one, for example, phone calls, e-mails, social media and video calls.

- Ensure the visitor is made fully aware of what is required with regard to their present health and COVID-19. If they have COVID-19 symptoms they should be self-isolating. All visitors should be made aware that they must stay at home and are not permitted to visit if:
    - they personally have COVID-19 symptoms, are awaiting the outcome of a COVID-19 test, are required to self-isolate (including as an identified contact of a positive case under the NHS Test, Trace and Protect Strategy):
    - or, if they live with any household members who have COVID-19 symptoms (and who are therefore self-isolating), or have COVID-19 symptoms, are self-isolating and are awaiting the outcome of a COVID-19 test.
    - or, they have returned from overseas travel in the last 10 days from a non-exempt country and are required to be in quarantine

- Ensure the visitor understands that if they arrive and are displaying any symptoms consistent with COVID-19 they will be asked to leave

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immediately.

- Ensure the visitor understand that visiting may have to be suspended if an outbreak or increased numbers of patients with symptoms of COVID-19 (or other infection) occurs in the healthcare setting.

- Ensure the visitor understands that agreement for this visit does not mean they may see their loved one every day. Agreement will need to be sought for subsequent visits.

- Ensure the visitor is made aware it is their responsibility to arrange their own travel to the healthcare setting.

- Ensure the visitor understands the need to maintain the 2 metre social distance from patients/service users, staff and other visitors at all times in the healthcare setting or outdoor location.

- Ensure the visitor understands that they will need to listen and adhere to staff advice on hand hygiene and infection control precautions on arriving and leaving the area and the consequences of not doing so.

- Ensure the visitor is discouraged from bringing a young child or toddler along to the visit due to the difficulty of maintaining social distancing.

- Ensure the visitor understands that if they were formerly shielding or are otherwise clinically vulnerable, they should avoid hospital visits. Where a hospital visit is deemed essential, for example to visit a loved one in the last days of life, hospitals should provide medical masks.

- Ensure the visitor understand that all visitors aged 11 or over are required to wear a face covering in indoor public areas unless they have a reasonable excuse not to wear a face covering. **Read further guidance on face coverings and exemptions**. Ensure the visitor been made aware of the need to bring their own face covering with them and the consequences of not doing so (visit unable to go ahead).

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- Ensure the visitor understands that food and drink must not be shared and gifts/flowers are discouraged.
- Ensure the visitor to the outdoor location understands that they may not enter the healthcare setting unless they wish to use the designated “visitor toilet”.
- Ensure the visitor understands that outdoor visits are weather dependent and may be cancelled at relatively short notice if there is no alternative visiting area.

Annex 2: Framework to assist NHS health boards to assess visitor access for partners, visitors and other supporters of pregnant women in Welsh maternity services during the COVID-19 pandemic

Visiting guidance for maternity and neonatal settings

This guidance is designed to support local services when planning and implementing their visiting / access arrangements for maternity and neonatal services. It has been co-produced, with discussion and consultation across health boards, Maternity Services Liaison Committees and service users, coordinated by the Wales Maternity and Neonatal Network and is in line with current Public Health Wales and Welsh Government policy.

The health, safety and wellbeing of pregnant women, birthing people and their babies and the staff in maternity and neonatal units and in the community is crucial and remains our absolute priority. The importance of nominated partner support and parents as partners in care is truly understood and forms the basis of the decision making within this guidance. The positive steps outlined within this guidance will be subject to regular review, and dependent of the levels of COVID within the community.

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With the ethos of partnership working to ensure delivery of safe, effective care, it is expected that all nominated partners and parents will follow required infection prevention and control measures including hand washing, mask wearing and providing honest response to triage of symptoms when in clinical settings.

No more than one nominated partner / parent will be able to visit at any one time, with appointment systems in place to promote fair and equitable access. The individual views and needs of each patient and, in the case of someone who lacks capacity, the views of the Power of Attorney or Guardian, should be central to the decision about who provides support in the clinical setting.

Individual healthcare professionals and clinical teams should feel empowered to make the right decision to meet the needs of the individual patient and their family in any given circumstance. If in doubt, the default position should be to err on the side of compassion and facilitate family contact.

A nominated partner supporting a woman during hospital visits and parents/ primary care givers are partners in care, including neonatal settings, and as such should never be considered as visitors, but continue to be categorised as essential visitors.

In addition, in line with national visiting guidance, a carer or interpreter – or someone else fulfilling a similar necessary function – should also be considered as an essential visitor.

Key principles

Where possible consistency of approach across Wales should be taken to ensure equity of experience.

- All nominated partners, parents and visitors must be provided with information through health board websites on local access arrangements and infection prevention control policies. They should be supported to work within any constraints prior to attending a clinical area and discussions on mask exemption should be held at this point.
- All nominated partners, parents and visitors when visiting (including those

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categorised as ‘essential’) must not have symptoms of COVID-19 and must not attend if they are self-isolating for suspected or confirmed COVID-19.
- Screening health checks should be maintained at the point of entry to a healthcare setting.
- Nominated partners, parents and visitors must wear face coverings or any other personal protective equipment (PPE), and must adhere to strict hand and respiratory hygiene.
- All appointments and visits as detailed in this document are subject to local risk assessments and current physical distancing measures.

Key responsibilities

It is essential that service users and health boards understand their responsibilities in maintaining a safe environment for continued support.

Visitors should:

- Maintain the required physical distancing requirements under health board policy.
- Always wear face masks, with additional PPE measures for visiting a COVID-red area or as a birth partner to a COVID positive woman.
- Have access to and use hand hygiene facilities.
- Respond honestly to any screening or pre-visiting questionnaires.
- Not visit other areas of the hospital unless a requirement of care pathway.
- Follow all local guidance.
- Engage with staff, sharing concerns and finding resolution.

Health Boards should

- Recognise the importance of nominated partner / parent support across the whole care pathway, empowering staff to make decisions based on the needs of individuals.
- Provide access to hand and respiratory hygiene facilities.
- Undertake weekly reviews of local risk assessments to consider how many visitors can be accommodated in clinical areas across the whole care pathway, giving consideration to each clinical setting.

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- Risk assessments should be shared with staff and information published on health board websites.
- Consider staggered visiting through appointment systems to maintain appropriate physical distancing and avoid crowding of communal areas.
- Ensure consistency of approach to ensure equity of access and experience of maternity and neonatal care.
- Clinicians are supported to use their judgement to take a flexible and compassionate approach in the context of essential visits.

These are minimum standards subject to local risk assessments. Individual needs can be assessed locally with particular consideration in the cases of severe illness or end of life care.

Minimum Standards for visiting guidance for maternity and neonatal units

Care setting	Minimum standard	Managing an active outbreak
Early pregnancy units	Nominated person to attend all early pregnancy appointments including scanning and consultations	Consideration to maintain partner presence
Antenatal care	Nominated partner to attend all antenatal appointments and scans, subject to risk assessment of physical environment Plan for person centred access as soon as the risk allows	Maintain access to dating and anomaly scan appointments
Labour and birth	Nominated partner present for labour assessment Nominated partner present for active labour and birth	Birth partner present for active labour

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Care setting	Minimum standard	Managing an active outbreak
	Local assessment of ability to have nominated partner throughout induction of labour Plan for person centred access as soon as the risk allows	
Inpatient wards	Nominated partner present for specified times, maintaining an appointment system whilst social distancing is required. Plan for person centred access as soon as the risk allows	Visiting according to local risk assessment
Neonatal care	Both parents have unrestricted access as primary care givers Any additional visitors to be determined by risk assessment and condition of the baby Parents to remove face masks when baby is skin to skin, where possible	Both parents subject to local risk assessments and physical distancing

In maternity care:

- Midwives / Obstetricians should discuss visiting with women at the earliest opportunity and discussion should include options for an alternative essential visitor should the nominated birth partner have symptoms of COVID-19, be in self-isolation for suspected or confirmed COVID-19.

In neonatal care:

- Both parents/primary care givers must be supported to have unrestricted access to their baby together, subject to the need to maintain physical distancing in neonatal units.

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- Where space makes maintaining physical distancing challenging, neonatal units should undertake and document risk assessments, including an assessment of the impact on babies and families if access is limited. They should maximise all possible opportunities for parents to be with their babies. For babies who are critically ill or receiving end of life care, there should be no limitation to access
- Parents should continue to have access to local facilities such as parent accommodation, parent rooms and kitchens, recognising the need to maintain physical distancing within them.
- Consideration should be given to access for wider immediate family on an individualised patient basis.
- Plans must be in place to return to full access for wider family members (especially siblings).

Annex 3: Considerations for visiting in non COVID-19 hospice settings

This guidance should be read in conjunction with **Annex 1** above: Considerations for visiting in non-COVID-19 healthcare settings.

Hospices place family and carers care at the heart of good palliative care. Being able to share time with friends and family at the end of life contributes, not only to the wellbeing of the patient, but also to their loved ones. All visiting requests should be met with sensitivity and understanding and accommodated where possible particularly during the last days of life.

As a result of the numbers of people affected by coronavirus pandemic, hospices are having to do things a little differently.

Hospices want to provide families and loved ones with the opportunity to visit COVID-19 positive patients and others receiving end of life care, wherever possible. In order to do this, they must consider that prevention and control of infection, is supported by detailed risk assessment and careful planning, to ensure the health and safety of patients, visitors and staff. Hospices will need to continue restricting the number of visitors if this is necessary, to comply with

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social distancing measures.

Revised guidance on hospital visiting during the coronavirus outbreak (effective from (June 2021), is, where relevant, also applicable to hospices. The guidance sets out that, where patients are in the last days of their life, up to two visitors may be allowed at a time, for a specified amount of time, from the same household or part of an extended household. If not from the same household or not part of an extended household, they should visit the bedside separately and maintain social distancing outside of the clinical area. See **guidance from 7 June 2021 for extended households**. You will also need to check our Alert levels page for the latest information.

Agreement, in advance of any visit to a hospice, should be sought from the Hospice manager, before a visit is made.

- Virtual visiting is encouraged and supported where possible, but in the case of face-to-face visiting, this needs to be agreed in advance and outdoor visits may be offered if appropriate. Hospices should consider local situations, including COVID-19 outbreak status and the unique structure of each hospice.

- Lateral flow asymptomatic testing is available for visitors and visiting professionals in hospice inpatient unit settings. Further details are available from the hospice when arranging visiting.

- All visitors to health and care facilities must wear face coverings. See **guidance in relation to the new measures**, including reasonable excuses for not wearing face coverings.

- Risk should be balanced against:
  - the benefits to individual well-being of having visitors;
  - the extent of harm experienced by a patient or by a visitor from a lack of visitation, particularly for people in the final hours or days of life;
  - the provisions and needs outlined in an individual’s care plan.

- Hospices have discretion to meet the individual needs of patients and to deliver family centric care, at a time when the presence of family or friends

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will be particularly important.

- This individualised and flexible approach must take into consideration a patient's wishes, proximity to death, rights, family needs and any cultural or religious needs. Patients should be involved in this approach as far as possible. These discussions should be documented within the patient's notes so that there is a written record.

- Hospices may apply different rules for different patients, in particular for people in the final hours or days of life. Planning should be done in advance in cases where this is possible. Information and decisions should be shared quickly with patients, families and staff.

- The approach to making decisions on visiting, including factors taken into consideration for a decision and the decision making process, should be outlined in a visiting policy, which is distributed to patients and families.

- For hospices with an In-Patient Unit (IPU), it is important to provide clarity and gain consensus with the IPU team on its visiting policy.

- It is recommended hospices enable pre-booking and recording of visits, avoiding ad-hoc visits where possible.

- Supporting children to visit loved ones can be a key part of their bereavement support.

- In the event of an outbreak in a hospice and/or evidence of community hotspots or outbreaks, hospices may rapidly impose visiting restrictions to protect patients, staff and visitors. In this situation, hospices should set out alternative options to maintain social contact and keep families updated.

- This guidance is being kept under review and is likely to change as the pandemic status alters.

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Annex 4: Principles for organisations to consider regarding hospital visiting

The guidance suggests 'that Health Boards (HBs) undertake a risk assessed approach, following a meaningful and documented assessment, making any necessary changes according to local transmission of the virus to either relax or reinstate previous degrees of restrictions.'

The guidance also identifies that visiting for individuals may be assessed and facilitated by the relevant ward manager on a case by case basis within the framework.

Whilst the importance of visiting to maintain wellbeing for individuals, especially those with a mental health issue, dementia, a learning disability or chronic illness is well understood and accepted, it must be remembered that a large proportion of transmission of COVID-19 within hospitals has been nosocomial and has occurred when the community rate of transmission is high.

It is therefore recognised that HBs will need to tailor protocols on visiting within specific hospitals and care settings according to local variables such as community transmission rate and the existence of highly transmissible Variants of Concern (VoC).

This annex sets out some principles for organisations to consider to assist with making decisions as part of this risk assessed approach within a national framework.

Hierarchy of controls

The primary consideration for HBs in excluding COVID-19 infection from hospital sites should always be the implementation and maintenance of the 'Hierarchy of Controls'; these being in order of priority - elimination, substitution, engineering controls, administrative controls and **personal protective equipment (PPE).**

Therefore Health Boards should work to develop reliable systems for the

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exclusion of symptomatic individuals and to ensure that environmental modifications and signage are in place to enable **social distancing** and to manage the risk of queues and pinch points.

There should be sufficient **hand-washing/hand sanitiser** stations and cleaning products to ensure good and frequent hand and respiratory hygiene opportunities and, if necessary, the provision of appropriate **face coverings** and PPE.

Patient vaccination guidance

There is growing evidence of the efficacy of the vaccination programme in preventing the hospitalisation and death of patents with COVID-19. The vaccination of elderly and clinically vulnerable people is well advanced and data presented on the Public Health Wales Tableau database for 8 June 2021 indicate that 95.4% of Health Care Workers have also received at least the first dose of vaccine.

On 3 March 2021 the joint CMO/CNO letter ‘Consideration of vaccinating patients in eligible priority cohorts at or around admission and for inpatients’ recommended vaccination for elective, emergency and admitted hospital patients within eligible cohorts. Most of these cohorts will now have received both doses.

The letter gave examples of how HBs were asked toput arrangements in place to enhance deployment of the COVID-19 vaccination programme including:

1. Offering at least one COVID vaccination, where practical, to elective admissions who are in the eligible cohorts, preferably more than two weeks prior to admission.
2. Offer COVID vaccination to emergency admissions who test negative at admission and who are in the eligible cohorts currently being offered vaccination, if they are deemed clinically suitable/fit for vaccination.
3. Offer COVID-19 vaccination to current inpatients who are in the priority groups being immunised, where practical.
4. For those who have received the first dose of the vaccine, which may have

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been given in the community or in hospital, if their second dose is due while they are in hospital, this needs to be facilitated if they are deemed clinically suitable/fit for vaccination.

Considerations on the use of testing

Testing is being used to screen visitors to other closed settings with vulnerable residents and so can be considered for hospitals.

There are two perceived benefits from the introduction of testing for hospital visitors:

- the exclusion of infectious visitors if the test is positive
- the provision of reassurance if the test is negative

There are a range of different testing technologies that may be employed, including lateral flow tests (LFTs) and point of care (POC) devices. Each of these has different characteristics and costs.

In making decisions about testing in the suite of measures to promote safer hospital visiting, it is important that Health Boards understand the context within which testing takes place. To take the case of LFTs:

- For the week of 23 to 29 May 2021, the **COVID-19 infection survey** estimates that community COVID-19 infection rates in Wales were around **1 person in 1,050** (95% credible interval: 1 in 2,910 to 1 in 520), or an estimated 2,900 people during this period.
- It is now understood that at this low prevalence the vast majority of positive LFTs will be false results. This would mean that an individual who tests positive with an LFT might still only have a less than 5% chance of actually being infectious. The reliability is likely to be further reduced when the test is self-administered without supervision.
- At low prevalence, there is a high chance of inappropriately excluding individuals with positive LFT results from visiting, with potentially distressing and harmful consequences where the person they planned to visit is critically ill or at the end of life. Also visiting is denied to those that do not take a test.

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- The reliability of a positive test increases as community prevalence increases, suggesting a more useful role for lateral flow testing if community rates are high.
- It should also be noted that LFTs are not 100% sensitive, so may miss around 30% of those that are truly infectious. This is further justification for continuing the other measures in the hierarchy of controls.
- It is recognised that there will be circumstances when a local risk assessment is thought to suggest a benefit to lateral flow testing of visitors, perhaps for immuno-compromised patient cohorts.

The latest guidance **Visits to care homes: guidance for providers** (updated 6 August 2021) advises that all indoor care visitors are tested, via supervised testing, prior to entry. The care home guidance document is also clear in stating that 'The expectation is that risk assessed visits, including indoor visits, will be supported' and that the emphasis for providers should be on 'how' rather than 'whether' visits should take place.

In comparison, the document 'Hospital visiting during the coronavirus outbreak: guidance' (November 2020) frequently reiterates that 'visiting should be with a clear purpose and agreement for visiting based on the best interests of the patient/service user or the well-being of the visitor.'

As restrictions are relaxed and hospital visiting ceases to be only 'visiting with a purpose' Health boards may consider whether the implementation of LFT or POC testing, supplemented by Polymerase Chain Reaction Rt-PCR lab based testing to confirm positives, is required in addition to the 'Hierarchy of Controls' to assist in the initiation of more routine hospital visiting.

The main options through which Health Boards could utilise testing if they make it a requirement are:

- supervised testing in-situ at the hospital site
- self-testing at home.

There are practical considerations that should be taken into account when choosing the most appropriate channel:

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- For supervised testing in-situ: Do hospitals have staffing and estate capacity to ensure supervised testing for all visitors on the same day as the visit and to provide sufficient room for social distancing whilst awaiting results?
- For self-test at home prior to visiting: questions about the accuracy of unsupervised tests have been raised, Health Boards will also want to consider validation of the process and the ability to record the results of all tests. Ideally, visitors should be engaging in regular testing and will have had at least two negative tests before visiting. Visitors will also need clear guidance on how and where they can access LFTs.

There are also potentially large financial and ecological costs associated with widespread deployment of further testing which should be taken into consideration.

Parents and partners

The hospital visiting guidance does recognise the special circumstances of partners of women in maternity services to attend pregnancy appointments and inpatient admissions and allows up to two parents, guardians or carers at the bedside at a time for paediatric inpatients and neonates subject to local determination, and following a risk assessment including the ability to maintain social distancing. The principle of local risk assessment still applies as outlined, but it is recognised that there may be a useful role for regular lateral flow testing to facilitate access to partner/parent support throughout pregnancy/birth/postnatal and in provision of support to children. There could also be opportunities to utilise Point Of Care devices to test parents and partners.

Parents of children in hospital and pregnant women and their identified support partner in maternity services are now able to access LFT packs by collecting test kits from their closest **community collection point** or by **ordering test kits direct to their home.**

Conclusion

Implementation of the hierarchy of controls remains the primary means of

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preventing the entry and spread of COVID-19 to hospital. Protocols and procedures for social distancing, environmental cleaning and IPC, including thorough and frequent hand-hygiene by visitors and wearing of face coverings and use of PPE, where appropriate, must be reviewed and evaluated on a regular basis.

Health Boards and Trusts should consider how vaccination for emergency, elective and in-patients can be deployed to enhance the safety of hospital visiting, and if the benefit outweighs the disadvantage.

The role of visitor testing as part of a risk assessed approach must be considered in the context of current community transmission rate, the local presence of VoC, the vulnerability of particular patient groups and the circumstances and purpose of the visit.

Footnotes: Principles for organisations to consider regarding hospital visiting

[1] early pregnancy assessment unit scan (EPAU)/early pregnancy dating scan (11 weeks + 2 days to 14 weeks + 1 day)/fetal anomaly scan (18 to 20 weeks + 6 days)/attendance at Fetal Medicine Department.

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