



Enabling Family Support for People in Hospital Consolidated Guidance

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Version History

Version	Date	Summary of changes
1.0	23/12/21	First version of document

1. Introduction

The importance of support from family members and those who matter to people in hospital cannot be overstated, bringing comfort to both the person in hospital and the people they consider their family or carers.

To protect against the risk of COVID-19, it has unfortunately been necessary to restrict family and carer presence to various extents since March 2020. As progress is made, steps have been taken to carefully re-introduce family support in hospitals more broadly.

However, as the presence of COVID-19 in our hospitals fluctuates, and new variants are found, it is sometimes necessary to temporarily reintroduce visiting restrictions.

This guidance document provides guiding person centred and safety principles for staff to support them to safely manage visiting through different levels of restriction, to enable family presence as much as possible.

For up to date information about current visiting restrictions in NHSGGC, please visit the [NHSGGC website](#).

1.1 National guidance

This consolidated guidance is intended to support the local application of [national guidance](#) from Scottish Government for hospital visiting and is aligned to [The Scottish Winter 2021/22 Respiratory Infections in Health and Care settings - Infection Prevention and Control \(IPC\) Addendum](#).

Where further information or detail is required, this is signposted in this guidance.

1.2 What do we mean by ‘Family support’?

The term family is interpreted in its broadest possible sense, recognising that the person an individual might want to support them in hospital could be a friend, carer or neighbour, and may not always be a relative. We recognise that the support provided from such people is vital to the wellbeing and recovery of a person in hospital. Wherever the term ‘family’ is used throughout this guidance the same broad interpretation is intended, also recognising that family and friends are not ‘visitors’ in a person’s life, even in hospital.

2. Core Principles

The following core principles are to be applied as flexibly and compassionately as possible, with each patient's needs considered on their own merits and taking account of the local context, recognising the need to be person-centred at all times and to ensure the safety of patients, family members and staff.

2.1 Welcoming

- We welcome and encourage the involvement of the people who matter to patients.
- Patients are able to have family support wherever possible, e.g. mealtimes, rehabilitation sessions, discharge planning and Multi-Disciplinary Team conversations. We will provide family members with [necessary PPE](#) to undertake these activities as required.

2.2 Patient led

- We are guided by patients whenever possible: when the people who matter will visit, how they would like them involved in their care, and when they want to rest.
- For people without the capacity to provide this information, see [Adults with Incapacity \(Scotland\) Act 2000: principles](#) for further information.
- On admission and on transfer into the ward we will ask the patient who matters to them and who they would like to be their family support while in hospital.
- We will take care to determine whether the individual patient wishes to receive visitors and who they want to see. The patient is under no obligation to have a visitor if they don't want one. We will respect their wishes.

2.3 Partnership

- We will work in partnership with the people who matter to patients.
- We will have conversations with the patient and their family on admission and throughout the hospital stay to advise of visiting arrangements and expectations to embed this as part of routine care conversations.
- When family contact the ward to discuss local arrangements, we will discuss what time suits all. We will approach this compassionately, handle in a manner which is sensitive to individual needs, and document appropriately.

2.4 Flexibility

- We have no set visiting times.
- We will be person centred and maximise the length of visits, as far as patients and family members wish and is practically possible.
- In some cases, the family members chosen to visit may need to be accompanied by another person, for example a child visiting a parent or sibling, or a frail elderly person who cannot attend independently. We will facilitate the presence of this additional person, and discuss with them how the visit will be managed.
- There may be instances where time slots for visiting may be required - in particular shared room accommodation and open ward environments - to ensure physical distancing and maximum room occupancy can be adhered to. This should be included in local risk assessments where required. Otherwise, visiting arrangements should be as flexible as possible and visiting times should not be imposed unnecessarily.
- 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.

2.5 Respect

- We respect peoples' individual needs and act on an individual basis to ensure the safety, privacy and dignity of all patients.
- This means there may be times when we need to ask people to leave a clinical area temporarily.
- If a patient is particularly concerned about other patients' visitors, this should be taken into account and where possible they should be placed in an area where they are more distanced or separated from other patients who are having visitors.

3. Safety Mitigations

COVID-19 is still with us and can be transmitted easily. In order for transmission risk to remain low in our healthcare settings, Infection Prevention and Control (IPC) measures around family support remain.

All visitors must be informed on arrival of IPC measures and adhere to these at all times. The following measures should be put in place to minimise risk:

3.1 Covid-19 measures

- **Information and support** should be available to prepare the family or carers attending the hospital, so they are prepared for the extra measures in place.
- All visitors should be asked if they have [**symptoms of COVID-19 or**](#) if they have symptoms of another viral infection e.g. respiratory symptoms, GI symptoms. They must not visit if they are feeling unwell, have suspected or confirmed COVID-19 or other viral illness, or if they have been advised to self-isolate unless prior agreement with clinical teams during specific circumstances. The [ward door poster](#) should be displayed prominently at the ward entrance.
- **2 metres physical distancing** must be observed in all areas wherever possible, unless risk assessed to be otherwise. Visitors may have **touch contact** (hug/kiss) however are reminded that maintaining physical distancing outwith direct contact wherever possible will reduce the risk of transmission of COVID-19 and other respiratory pathogens to them, the person they are visiting and others in the health and care setting.
- With appropriate IPC measures in place we expect families to be able to have close contact, such as holding hands, when they are with the person they are visiting. Current IPC measures taken by staff are deemed acceptable to reduce risk associated with close contact, and the same evidence-based assessment approach to this risk should be applied for the family member providing support. A risk assessed approach should be taken as required.
- Visitors are asked to **avoid circulating around clinical areas, remain seated** at the bed/chair side wherever possible, and avoid visiting other patients in the ward.
- Avoid **sharing mobile phones** with the individual unnecessarily – if mobiles are shared to enable communications with others, the phone should be cleaned between uses using manufacturer's instructions.

3.1.1 Fluid Resistant Surgical Masks (FRSM)

Family must wear a FRSM for the duration of their visit in a hospital building, unless medically exempt, and avoid touching their face or face mask once in place.

If the family member is unable to wear a mask for a medical reason, please discuss this with the local IPC team. They will risk assess the situation on an individual basis and advise how to proceed.

If the family member refuses to wear a mask, and is not exempt for medical reasons, they should not be allowed into the ward/ department. They should be asked politely to leave.

3.2 Good IPC practice

- Family members should be provided with **appropriate PPE** when required for individual circumstance and given assistance to don and doff PPE as required.
- **Hand hygiene** measures must be adhered to by using hand washing facilities or alcohol hand rub on entering and leaving the ward/ department, following any personal contact, prior to putting on PPE and after removing PPE
- **Respiratory hygiene** also remains important, covering the nose and mouth with a disposable tissue when sneezing, coughing, wiping or blowing the nose. These should be disposed of immediately in the bin and hand washing performed immediately afterwards. The principles of respiratory and cough hygiene can be found in section 1.3 of SICPs.
- Family should use the **toilet facilities provided for members of the public** only, not patient and staff toilets, unless there is no other option available, and must be made aware in advance of this policy before attending the hospital.

3.3 Lateral Flow Device (LFD) Testing

Anyone who wants to visit a patient in hospital should carry out a LFD Test before every visit, and must not visit if the test is positive but self-isolate immediately and organise a PCR test via the NHS Inform website. Other safety measures above still have to remain in place.

Information about how to order kits is on the Scottish Government's website.

Staff are not being asked to verify negative results on a family member's arrival, but should make these expectations clear to every family member in advance, alongside existing protections detailed above.

3.4 Test and Protect

It is **no longer necessary** to collect visitor contact details for Test and Protect in most circumstances.

There may be some circumstances or environments (for example as the outcome of local risk assessments or as part of an outbreak management process) where collecting this information will be appropriate, however this will be by exception.

[Trace and Protect templates](#) can be found on the staff visiting pages, if they are required to support local risk management or outbreaks.

3.5 Risk Assessment

All areas should have a risk assessment process in place, tailored to specific local environmental or clinical needs. In NHSGGC, there is a wide variety of accommodation including single rooms, shared rooms and open wards where there is variation to risks, control measures and mitigations which are required.

The risk assessment should clearly describe the process from entry to the hospital to the end of the visit and how safety measures will be achieved to maintain physical distancing, infection control and health and safety requirements to assess how many people can safely be present in all accommodation areas at one time. The maximum room occupancy should be displayed on the door and should not be breached.

The social distance risk assessment details the maximum number of people permitted in a room at any one time to ensure we can all follow physical distancing measures. The maximum occupancy of a room or ward should be used to guide how many family visiting can be present at any one time.

An example of a risk assessment for local adaptation and a risk assessment checklist can be found on NHSGGC's [social distancing in the workplace pages](#).

3.5.1 Risk Assessment for high-risk situations

Individual risk assessment for high-risk patients or high-risk cohorts of patients in inpatient or outpatient settings should be completed separately adhering to the same principles of assessment and inclusive of the individual circumstance.

3.5.2 Risk Assessment for outpatient settings

Outpatient settings for low-risk patients that identify the need to reduce physical distancing in line with [Scottish Government guidance](#) are required to undertake a robust [risk assessment](#) in partnership with staff to determine feasibility. The outcome of this risk assessment must be recorded, retained and communicated in line with [current guidance](#).

4. Variation

4.1 High risk and vulnerable patients

There are many vulnerable patients in our wards and particular clinical pathways where we need to proceed with extreme caution and ensure a risk assessment is undertaken appropriately and reassessed as circumstances change for these patients.

If assessed to be safe, the advice for their chosen visitor will be to undertake LFT as a minimum twice per week and this should be explained to them clearly. If the test is positive or the visitor is symptomatic they must not visit.

High-risk patients and pathways may include:

- Some surgical patients
- Patients who are immunocompromised
- Organ Transplant patients
- Bone Marrow Transplant patients
- Oncology patients
- Cohorts of COVID-19 patients
- Areas undertaking Aerosol Generating Procedures (AGP), such as ICU.

A consultant led multi-disciplinary team, individual risk assessment is advised for high-risk patients to aid decision making to determine whether visits can be safely supported or not. Patients advised against receiving family support must be provided with an explanation and this should be reviewed as the patient's condition changes, including why it is not possible for the person providing family support to continue to visit taking the same IPC precautions as staff attending the patient. This should be reviewed regularly as the patient's condition changes.

With surgical patients the pre-op discussion with patients should explore the wishes of the patient and explanation of the need to risk assess their visiting options.

4.1.2 High risk pathway AGP areas

In high risk pathway AGP areas only, family members should not visit whilst the patient is undergoing an AGP or during the Post AGP fallow time that follows the procedure. Where a unit has unit wide airborne precautions in place, family members may be allowed to enter the room but must be informed that there is a higher degree of risk due to the potential exposure to infectious aerosols. The following additional mitigation measures should be in place;

- Family member should not enter whilst the individual they are visiting is undergoing an AGP or during the post AGP fallow time.

- Ask family member to remain 2 metres from all other patients
- Provide the family member with [appropriate PPE](#)
- Guide and supervise family member when donning and doffing PPE and remind them of the appropriate times when hand hygiene should be undertaken.
- Ensure family member performs hand hygiene on leaving the ward.

The below guidance should be applied when considering whether family members require to self-isolate after visiting AGP environments:

- If visiting a high AGP environment (e.g. respiratory ICU), without the specified PPE they may need to self-isolate after the exposure in line with current guidance.
- If visiting a medium risk (cohort) AGP area, or is passing through an AGP area, but the person they are visiting is not on an AGP, a local decision should be taken as to whether the family member needs to self-isolate, based on; the individual case, ability to take the necessary risk mitigation steps above, and the local environment. It is important to explain to the family member the nature of the environment they are passing through and associated risks and mitigations
- If a patient is receiving continuous AGP in a single room, and they are medium risk (negative test and low clinical suspicion), the family member does not need to self-isolate. Family members should still be encouraged to take standard IPC precautions
- If a patient is requiring continuous AGPs in the medium risk pathway with regular testing, it's important to inform family members wishing to visit of this risk, and that if the patient is to test positive in the 48hrs following their visit, the family member will be contacted and assessed as a close contact and required to self-isolate.
- It is not expected that family visiting will be routinely fitted with FFP3 masks. However, if a visitor did have an FFP3 mask they would not be required to isolate. Where patients who are COVID-19 positive are in an AGP area (e.g. ICU), and the family member is not face-fit tested with an FFP3 mask, then they would be required to isolate for the quarantine after the visit.

4.1.3 Patients who have tested positive for COVID-19 or other respiratory pathogens

All patients should be able to have support from the people who matter to them, including individual cases where a patient may have COVID-19 or other respiratory pathogens. The visit should be managed in accordance with local IPC advice, as for other infectious agents with a similar risk profile to COVID-19.

The exception to this is where there is a local outbreak or when the numbers of patients with COVID-19 or other respiratory pathogens reach a point where they require to be cohorted. In these situations the situation should be managed by the local Infection Management Team and a return to essential visiting for those specific areas may be required. See section 6 of this document for further information.

4.2 Hospital Outpatient Areas

In line with the remobilisation of PCV, patients in outpatient clinics in NHSGGC should be able to have support in hospital from the people who matter to them. However, it may sometimes be necessary to limit the numbers of people who can be present in outpatient clinics at any one time, so physical distancing can be followed.

NHSGGC principles for family support in outpatient settings is available on the [staff visiting page](#).

4.3 Mental Health, Learning Disability, Neurodevelopment and Addictions

The European Convention on Human Rights, in particular Article 8, which provides a right to respect for private and family life, is of particular relevance for people accessing mental health, learning disability, neurodevelopmental, addictions services where their stay in hospital is often lengthy. Given this, the ward is deemed their home during this period.

Therefore, the ward team must take account of evidence about the harm posed from the virus, carefully balancing this with evidence about the positive impact on health and wellbeing from seeing family on the individual's treatment and recovery plan.

4.4 Maternity and Neonatal Visiting

Specific [national guidance](#) is available which sets out how this hospital visiting guidance should be applied in these contexts.

4.5 End of Life Care

As has been the case throughout the pandemic, there are no restrictions on time or the number of people who can provide support for people at the end of life.

It can often be difficult to identify when someone may be nearing the end of life and interpretations of 'end of life' may differ across clinical settings. As such, it is not appropriate to define a set time-period for 'end of life' care in this context and instead clinical teams should adopt as compassionate and broad an approach as possible.

If someone is identified as at the end of their life and then rallies, support from family should not be stopped suddenly, but should be carefully and sensitively transitioned

so that support can still continue as described elsewhere in this guidance.

More detailed and specific guidance is available on the [NHSGGC website](#), and is supported by the principles set out by the [Scottish Academy of Medical Royal Colleges](#).

4.5.1 International Travel and End of Life

People travelling from countries on the red list are permitted to leave quarantine after international travel to visit a loved one at end of life. This should be managed carefully by the hospital to minimise risk. Further guidance is available on the [Scottish Government's website](#).

4.5.2 Can a family member visit if they are self-isolating because of their hospital contact with the patient?

If a family member has to self-isolate because of a hospital visit, and the patient's status deteriorated and they were in an end-of-life situation, further visits can take place within the isolation period, as long as the family member returns to isolation thereafter.

If the family member has entered a high risk AGP area without a FFP3 mask, then they would need to isolate and not visit again within the period of isolation (unless in an end-of-life situation as detailed above).

4.6 Children Visiting

Children are able to visit adults in hospital and every effort should be made for a child or young person to be able to visit who matters to them in hospital safely.

A child in hospital is entitled to have one or both parents or carers present to support them. A child in hospital should be allowed visits from siblings or other children.

There will be rare and specific clinical circumstances where visits are not possible. For example, when an individual is severely immunocompromised following organ donation or bone marrow transplantation, visits will be restricted as they would be in normal circumstances.

In principle, children can visit intensive care, but the detail of how this is managed will need to be determined by the particular circumstances in each case based on risk assessment.

Each situation should be approached in a person-centred, compassionate way with the benefits of visiting being given equal priority and balanced against the harm caused by separation or the risk of cross-infection.

4.7 People who have sensory loss

Consideration will also need to be given to the communication needs of patients or family members.

Staff communication with patients and families will be more challenging with the requirement for face coverings and physical distancing. Hearing aids work best within 1m but decrease in effectiveness by 50% at 2m and masks impact on the hearing aid's frequency. Please see the additional [guidance on communicating with people who have sensory loss](#).

Transparent face masks have been approved for use in health and social care settings. The new transparent masks, which feature a clear front panel to enable lip reading, will make communication easier and help reduce the challenges the pandemic has created for those with communication needs. These should be made available to family members who may require this to facilitate a successful visit.

5. Outbreak Management

In the event of an outbreak, standard outbreak management policies will be applied by the local Incident Management Team. This may include limiting family and carer support to essential visits only.

5.1 General Principles

In a situation where an individual patient on the respiratory pathway is being cared for outwith an outbreak situation, it may still be possible to safely manage support from at least one person as would be the case with other infectious diseases with a similar risk profile to COVID-19.

Decisions should be made based on each individual case by the clinical team at local level in discussion with the local Infection Prevention and Control Team.

If a decision is taken to prevent family support in this situation the reasons why should be clearly communicated to the family and patient, including why it is not possible for the person providing family support to continue to visit taking the same IPC precautions as staff attending the patient.

As is standard infection prevention and control practice, wards with a **current active outbreak** are required to temporarily restrict visiting to **essential visits** only, for the duration of the active outbreak.

PPE in accordance with Table 10 of the Scottish COVID-19 IPC [Addendum](#) should be worn when visiting in respiratory pathways, in particular a Type IIR FRSM.

Consideration should be taken to assess each patient's needs on an individual basis. In situations where support from another person is essential for advocacy and wellbeing, family support should be facilitated.

5.2 Essential visits only

Where it is risk assessed as necessary to restrict visiting, **essential visits will continue**. Staff should take as flexible, person centred, and compassionate an approach as possible in applying this guidance. The examples of the type of situations where 'essential visiting' should be supported are included below:

- A birth partner supporting a woman during hospital visits
- A person receiving end-of-life care – we expect this to be defined as flexibly and compassionately as possible, to support patients at the end of life spending

meaningful time with their loved ones in their final days, weeks or months

- To support someone with a mental health issue, or dementia, or a learning disability or autism, where not being present would cause the patient to be distressed
- To accompany a child in hospital
- A child in hospital is entitled to have one or both parents or carers present to support them. A child in hospital should be allowed visits from siblings or other children
- In general situations when someone is receiving information about life-changing illness or treatments
- In these and other similar situations where support from another person is essential for advocacy and wellbeing
- Carers, those providing essential care or emotional support, or spiritual care, and those providing essential care or emotional support are not considered to be visitors and will be permitted.

It should be noted these examples are intended to be illustrative rather than exhaustive. A flexible, compassionate approach is encouraged - family support should be facilitated in any situation where you assess that it is important to involve family or carers for ethical, safety, or other reasons.

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.

Further guidance about [essential visits](#) is available on the NHSGGC website. A patient information leaflet about essential visits is also available on the [NHSGGC website](#).

5.3 One or two named visitors

In some instances, the Visiting Review Group may agree to temporarily restrict visiting to one or two named visitors, as part of a gradual phased resumption of Person Centred Visiting. In these situations, additional guidance applies as follows:

- The people providing support can change to meet the needs of patient or family.
- This may be particularly relevant for example if a person in hospital needs support from a different person for a variety of reasons, or if the person who has been providing support becomes unwell, needs a rest or is unable to visit. It is important to make sure that patients and their families are aware of the flexibility to change those visiting if required. This can help to reduce the emotional trauma some people may experience if they feel they are having to choose *between* family members.

- Changes to the person providing support should be reasonable, but in order to reduce the risk of transmission, for example changing the people providing support multiple times (for instance daily) would not be expected in normal circumstances.

5.4 Visiting in wards adjacent to outbreaks

In some situations, the Visiting Review Team may agree to apply a purposeful and targeted approach to visiting restrictions based on underlying risk assessments, and further restrict visiting on wards not directly involved in an outbreak, but in close proximity to them.

In these situations, the Visiting Review Team will agree what specific visiting restrictions apply, in which wards, and when these shall be reviewed.

5.5 Give and Go

If visiting is temporarily restricted across NHSGGC, the successful [Give and Go service](#) available earlier in the pandemic will be remobilised, for family to drop off essential personal items, and to pick up laundry etc. Further information can be found on the [Give and Go webpage](#).

Where Give and Go is not available, local arrangements will be recommenced in all other sites. Ward staff will require to advise patients and families of local arrangements for dropping off and collecting belongings.

5.6 Person Centred Visiting

The default visiting position in NHSGGC, unless advised otherwise, is that PCV is in place in all inpatient wards, with some important mitigations to ensure safety for all in the context of COVID-19.

This means that patients are able to have support in hospital from the people who matter to them. The maximum occupancy of a room or ward should be used to guide how many people visiting can be present at any one time.

As was the case before the COVID-19 pandemic, a full person-centred approach to family support does not mean an unmanaged approach to family support. It is necessary to work with patients and families to develop processes and a culture that maximises the full benefits of family support and recognises the vital role this plays in high quality safe, effective, person-centred care. The main difference is that

this needs to be balanced with the risks that COVID-19 still presents and needs to be cognisant of the safety measures which still be in place.

6. Person Centred Virtual Visiting

Virtual Visiting is an integral part of our person centred approach to visiting. Where in-person support is not possible for any reason, a patient should be supported to use the hospital iPad or their own personal mobile or tablet to maintain contact with the people who matter to them.

However, it is important to bear in mind that this virtual approach will not be appropriate for some people and it should not be used to replace in-person support. The virtual option is available for circumstances where in-person support is prevented either for clinical reasons or by geographical distance or because the visitor is isolating. Our first option should always be to aim to facilitate in-person support from family.

Further information about Person Centred Virtual Visiting is available on the [NHSGGC website](#).

Person Centred Visiting

Consolidated Hospital Visiting Guidance
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