# Enabling Family Support for People in Hospital
## Local Toolkit for Hospital Visiting – COVID-19
### From 27 August 2021

## Contents

1. Introduction .......................................................................................................................... 2
2. Background .......................................................................................................................... 2
3. Key Principles ..................................................................................................................... 3
4. Minimum Standard for Visiting ....................................................................................... 4
5. Lateral Flow Testing for Visitors ..................................................................................... 4
6. Risk Assessment ................................................................................................................. 5
7. Green Pathway, Extremely Vulnerable and High Risk ...................................................... 5
8. Mental Health, Learning Disability, Neurodevelopment and Addictions ....................... 6
9. Maternity and Neonatal Visiting ..................................................................................... 7
10. End of Life Care ............................................................................................................... 7
10.1 International Travel and End-of-Life .......................................................................... 7
11. Children Visiting ............................................................................................................. 8
12. Outbreak Management ................................................................................................... 8
13. Virtual Visiting ............................................................................................................... 9
14. Safety Measures ............................................................................................................. 9
15. Other Practical Considerations .................................................................................... 10
16. Test and protect information requirements .................................................................. 11
17. Security Arrangements .................................................................................................. 11

## Appendix 1: Visiting Toolkit of Documents and Templates .................................................. 12
## Appendix 2: Asymptomatic Test Centres in NHS GGC Area ..............................................
## Appendix 3: Enabling Family Support – Checklist ............................................................ 13
1. Introduction
From Monday 9 August 2021 the following changes will take place in all NHSGGC hospitals:

- Patients will be able to have support in hospital from the people who matter to them. This no longer needs to be limited to the same two people visiting. The maximum occupancy of a room or ward should be used to guide how many people visiting can be present at any one time.
- Conversations with the patient and family should take place on admission and throughout the hospital stay to advise of visiting arrangements and expectations to embed this as part of routine care conversations.
- Inclusion of family support at times when patients wish the presence, help and support of the people who matter to them i.e. mealtimes, rehabilitation sessions, discharge planning and MDT conversations etc.

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 will be 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 need to be in place.

This guidance is intended to support the local application of national guidance from Scottish Government for visiting in all hospital in NHSGGC to enable family support for people in hospital during the Covid-19 pandemic.

This guidance should be read alongside the Scottish Government Visiting Guidance for Hospitals in Scotland (26 April 2021) which is aligned with the corresponding levels in Scotland’s Strategic Framework.

In the event of an outbreak, standard outbreak management policies will be applied by the local Incident Management Team (IMT). In these instances, this may include limiting family and carer support to ‘essential visits only’, as detailed further in Section 12 of this toolkit.

2. Background
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 who they consider their family or carers.

The pandemic has created an unprecedented situation, which at times has necessitated some restriction of families’, and carers’ freedom to support people in hospital. This has had a significant impact on patients, families and staff alike. Studies on the positive benefits of family presence in hospital have shown improvements in healing and recovery, patient safety, patient and family experience and staff experience. In addition to these clinical considerations, there is also a fundamental human right to family life. Therefore, we need to balance these risks and basic rights.

The impact on people with dementia and others with cognitive and communication difficulties, and people experiencing momentous changes in their lives such as childbirth, life-changing illness and end-of-life situations, has been significant. This situation makes it imperative that we now focus on facilitating the vital support for people in hospital provided by families and carers.
**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.

At various stages throughout the COVID-19 pandemic, visiting has been reduced to “essential visits”, permitting visits only where not seeing a family member would cause particular distress or suffering. This was necessary to minimise the spread of COVID-19 and to keep patients, families and staff safe. However, we recognise that the absence of vital family support and information causes social isolation, emotional distress and can result in negative impacts for patients, families and staff. Therefore, we need to balance these risks appropriately and ensure a person-centred approach to family and carer support. Family and carer presence was only restricted because it was necessary to do so to protect against the risk of COVID-19. Given progress that has now been made, the time is now right to take steps to carefully re-introduce family support in hospitals more broadly.

### 3. Key Principles

The following key principles are expected to be applied flexibly and compassionately, taking account of the local context, recognising the need to be person-centred at all times, and especially in areas such as ICU, learning disabilities, autism, mental health, frail elderly, dementia and maternity, and in general situations when someone is receiving information about life-changing illness or treatments. In addition there will be other similar situations where support from another person is essential for advocacy and wellbeing, where family support should be facilitated.

- Helping people in hospital to get the vital support they need from family, carers or friends is of paramount importance. This should be done in a way that recognises the balance of risks proportionately and has the wellbeing and safety of all concerned at its heart.
- A person-centred focus should be adopted. The individual views and needs of each patient and, in the case of someone with incapacity, the views of the Power of Attorney or Guardian, should be central to the decision about who provides this support. If an individual lacks capacity, the principles of the Adults with Incapacity (AWI) Act make it clear that attempts should be made to involve the person in whatever way possible, considering past and present views.
- “Blanket” policies for all hospitals, or all patients with particular characteristics, **should not be applied**.
- Implementation of this guidance should be based on the current evidence, on incidence and prevalence of COVID-19 available at the time. This evidence should be balanced with the needs and circumstances of the patient and their family.
- A staged approach to the reintroduction of family support will be adopted – progression will be as fast as possible while fully taking into account the risks at key stages.
- Flexibility will be required; for example, in the event of an outbreak in a hospital and/or evidence of rapidly increasing community transmission or outbreaks.
- In the event of an outbreak, the local Incident Management Team (IMT) may need to reinstate some restrictions for short periods to protect patients, families and staff, as is normal practice in outbreak situations.
- For example, if COVID-19 cases are so numerous that they are being cohorted within a specific area of a hospital then previous guidance on limiting support to “essential visits” may need to apply for this specific group of patients.
- However, if frequency of COVID-19 cases is lower and limited to an individual patient in a ward or ICU, for example, then local infection control policies should be applied as would be the case for other infectious diseases with a similar risk profile to COVID-19. In these circumstances, support from at least one person may still be possible.
• In some cases, the person providing family support visits 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 the hospital independently. The presence of the additional person should be facilitated and should not prevent a support visit taking place.

• Family, carers or friends attending the hospital to provide support should continue to wear face coverings and follow existing infection control requirements.

• Physical distancing should be adhered to in communal areas of the hospital wherever possible, with appropriate Infection Prevention Control (IPC) measures in place.

• Ability to touch the person’s hand without wearing gloves to provide comfort and reassurance when stressed or distressed should be permitted with discretion following strict hand hygiene measures before and after contact between the family and the patient.

4. Minimum Standard for Visiting

A person-centred, flexible approach to visiting should be taken where possible to ensure people have meaningful contact with their family and those who matter to them in accordance with the minimum standard for visiting at each of the strategic tiers.

During each of the tiers, the following visiting arrangements (where possible) should be in place in accordance with national guidance and aligned with the context of the hospital visit.

<table>
<thead>
<tr>
<th>TIER</th>
<th>VISITING ARRANGEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 4, 3 and 2</td>
<td>Support from at least one person (where possible) &lt;br&gt; In some cases, the person providing family support visits 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 the hospital independently. The presence of the additional person should be facilitated and should not prevent a support visit taking place.</td>
</tr>
<tr>
<td>Level 1</td>
<td>Support from at least two people from the same household at the same time (where possible), (or from separate households, as long as physical distancing can still be maintained).&lt;br&gt; If not from the same household and physical distancing cannot be maintained, visits can take place separately</td>
</tr>
<tr>
<td>Level 0</td>
<td>Full person-centred visiting subject to local health protection advice &lt;br&gt; It is important to note that, as before the COVID-19 pandemic, a fully person-centred approach to family support does not mean an unmanaged approach to family support. It will be 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.</td>
</tr>
</tbody>
</table>

In the event of an outbreak, standard outbreak management policies will be applied by the local Incident Management Team (IMT). This may include limiting family and carer support to ‘essential visits only’. 
5. Lateral Flow Testing for Visitors

**ALL visitors** should be strongly encouraged to have a voluntary lateral flow test (LFT) prior to visiting. Universal lateral flow testing will be available for anyone in Scotland from April 26.

As the named family visitor(s), lateral flow testing is encouraged twice weekly, in line with other screening strategies.

Alongside face coverings, distancing and hand hygiene, voluntary lateral flow testing can be an important part of a multi-layer approach to protecting patients, staff and visitors. When family members arrange to visit, voluntary testing should be strongly recommended as a valuable way to promote safety.

However, there are two important factors to bear in mind. Testing is not mandatory and boards are not able to insist that visitors undergo a test before visiting. Not wishing or not being able to test **will not be** an obstacle to a visit. It is also important to note that if visitors choose to test then this must be considered an additional mitigation as part of a suite of protections including face coverings/mask, distancing and hand hygiene – and that it will be important to protect visitors as well as patients and staff to the best of our ability. Even if a test is done, these other measures will still have to remain in place.

Family should only visit if the test is negative and/or if they are asymptomatic.

Explanation and written Information should be shared with patients and families. This is included in the Patient and Visitor Information Leaflet available on the NHSGGC website.

Information on how to order Lateral Flow Tests is on the **Scottish Government’s website** or tests can be collected from COVID testing centres in the afternoon or early evening.

You can also book/arrange a test at the **asymptomatic test facilities** across NHSGGC. These can also be found on the NHSGGC Website.

6. Risk Assessment

Every hospital 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 types including single rooms, shared rooms and open wards. The risk assessment should describe in plain and accessible terms 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 a shared room at any one time. The maximum occupancy of rooms should be displayed on the door and should not be breached.

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

An example of a risk assessment for local adaptation and a risk assessment checklist can be found in **Appendix 1B**.

7. Green Pathway, Extremely Vulnerable and High Risk

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

A consultant led multi-disciplinary team (MDT), 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 a visitor must be provided with an explanation and this should be reviewed as the patient’s condition changes. If assessed to be safe, the advice for their chosen visitor will be to undertake community lateral flow test twice per week and this should be explained to them clearly. If the test is positive or the visitor is symptomatic they should not visit.
High-risk patients may include:

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

With surgical patients the pre-op discussion with patients should explore the wishes of the patient and explanation of the need to risk assess the possibility for them to receive a visitor during their hospital stay. If assessed to be safe the requirement for their chosen visitor to undertake community LFT prior to initial visit followed by a test twice per week should be strongly recommended. If COVID-19 positive or symptomatic they should not visit.

Patients assessed as extremely high risk, on risk assessment may not be able to receive a visitor. Patients and their family must be provided with an explanation if this is the outcome of the risk assessment. 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 Infection Prevention Control (IPC) precautions as staff attending the patient. This should be reviewed regularly as the patient’s condition changes.

In high risk pathway AGP or red/ COVID 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.

8. Mental Health, Learning Disability, Neurodevelopment and Addictions

The European Convention on Human Rights (ECHR), and 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.

In addition, many people with mental health issues may have fewer family members and friends that they are in regular contact with and can often feel socially isolated and disconnected from their local communities. It is therefore crucial that connections with their friends and family is supported to aid their recovery and to support their transition from being cared for in a hospital to managing their mental health condition after discharge. Family and friends should be seen as partners in care, and crucial to the individual’s treatment and recovery. Therefore, the ward clinical team must take account of the evolving evidence about the harm posed from the virus, carefully balancing this with the evidence about the positive impact on health and wellbeing from seeing family and loved ones on the individual’s treatment and recovery plan.
9. Maternity and Neonatal Visiting
Specific guidance for attendance or visits in maternity or neonatal settings is available which sets out how this hospital visiting guidance should be applied in these contexts.

A person-centred, flexible approach to visiting should be taken where possible to ensure women have meaningful contact with their birth partner and those who matter to them in accordance with the minimum standard for visiting at each of the strategic tiers. Local guidance for visiting maternity wards can be found on NHSGGC’s Website.

10. End of Life Care
When patients are judged to be dying within days, weeks or months, the presence of family at their side for short visits, or longer stays, is vital to palliative and end of life care and a timeless part of the human experience of life and death. It provides comfort not only to the dying patient, but also to those present, and the inability to be present is a source of anxiety, distress and moral injury that may be long-lasting.

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 those who matter most to them. Where possible all visiting requests should be met with compassion, sensitivity and understanding, particularly during the last days and hours of life.

It is important to note that, as was the case at the start of 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 from either one or two individuals as described elsewhere in this guidance. This guidance is intended to ensure that people nearing the end of life can spend meaningful time with the people who matter to them in the final days, weeks and months of their life.

This updated guidance should therefore not be viewed as a direction to limit the number of visitors for those nearing the end of life. The Scottish Government endorses the principles set out by the Scottish Academy of Medical Royal Colleges and clinicians may find these helpful when considering how best to support visiting for patients nearing the end of life.

Further local guidance on end of life visiting arrangements can be found in Appendix 1D.

10.1 International Travel and End-of-Life
It is important to note that visiting someone in hospital in an end-of-life circumstance is listed as an exemption to the Health Protection (Coronavirus) (International Travel) (Scotland) Regulations 2020. This means that someone is 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, as follows:

The individual must:

- contact the hospital to arrange a visit in advance
- wear full PPE equipment as advised by the hospital
- observe physical distancing from others, but not from the individual being visited
- not visit any other area of the hospital or use facilities such as toilets
- observe any other risk measures as required by the hospital
The hospital must:

- carry out a risk assessment to determine whether a visit can safely take place make every effort to prevent other staff, visitors or patients from being in the same area as the person being visited.
- support the individual to don and doff PPE
- enhance cleaning measures in the area visited
- safely escort the visitor in and out of the hospital

11. 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 – for example at end-of-life, when a parent or grandparent is a long-stay patient or has suffered a life-changing or traumatic event.

For the purposes of this toolkit, a child or young person means every person below the age of 18 years of age as defined in the UN Convention of the Rights of the Child. This guidance covers all young people under the age of 18 regardless of whether they are in children or adult wards.

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.

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.

While in nearly all circumstances it should be possible for a child or young person to visit a member of their family, 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.

It will be beneficial to a child’s recovery and for the wellbeing of their siblings for them to have a visit from a brother or sister in many circumstances. Every effort should be made to accommodate visits by other children where that child has a significant relationship to the child in hospital and it is safe to visit.

12. Outbreak Management

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

In a situation where an individual patient with COVID-19 is being cared for out with 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 (IPCT).

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 Infection Prevention Control (IPC) precautions as staff attending the patient.

Where it is risk assessed as necessary to restrict visiting, essential visits will continue.
The essential visiting arrangements should be applied flexibly and compassionately and each patient’s needs considered on their own merits. Carers, those providing essential care or emotional support, or spiritual care are not considered to be visitors and should continue to be permitted to attend a patient in hospital.

The essential visiting criteria is set out below. However, it is important to note that these examples are intended to be illustrative rather than exhaustive:

- 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
- Other situations where clinical staff assess that it is essential to involve family or carers for ethical or patient safety reasons.

All patients and their family should be offered daily virtual visits as a minimum to ensure they can see and talk to those people who matter most to them.

13. 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, carers or friends.

14. Safety Measures

COVID-19 is still with us and can be transmitted easily. To reduce risks careful attention to IPC measures around family support still need to be maintained.

The following measures should be put in place to manage visiting safely and minimise risk:

- **Physical distancing** must be observed in all communal areas wherever possible.
- **Face coverings** must be worn.
- **Hand hygiene** measures must be adhered to by using hand washing facilities or alcohol hand rub on entering and leaving the ward/department or following any personal contact.
- **Movement around other areas must be limited** as much as is reasonably possible and communal gatherings in public areas of the hospital must be avoided.
- No visits should take place if the visitor has symptoms of COVID-19. **However, people are permitted to leave quarantine to visit a family or friend at end-of-life.**
- **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.
- **Other PPE requirements** should be based on local risk assessment for individual circumstances or environment of care. If a patient has suspected or confirmed COVID-19, those providing essential support should be
provided with the appropriate PPE as is the case for staff who have close contact with COVID-19 patients. The person providing family support in these situations should not be required to self-isolate following visits if they have followed the IPC and PPE procedures.

- 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.
- Family and carers should use 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.
- Ability to touch the person’s hand without wearing gloves to provide comfort and reassurance when stressed or distressed should be permitted with discretion following strict hand hygiene measures before and after contact between the family and the patient.

15. Other Practical Considerations

Individual wards and hospitals are best placed to decide how to manage family presence based on patient need, physical environment and local incidence and prevalence of COVID-19. Examples of ways this can be managed include:

- Discussion with patients and their family/guardian/power of attorney on admission and as circumstances change, to explain visiting arrangements and identify the preferred family support - care should be taken first to determine the individual patient wishes to receive support in this way and who they want to see.
- Communication process at ward level to discuss arrangements for family support to arrange a visit in advance to suit the needs of the individual patient, family and staff.
- Family and friends should be seen as partners in care.
- Consider the use of an individual visiting plan – commonly used in mental health and learning disabilities (see Appendix 1E).
- It may be beneficial for a family member or a carer to undertake some personal care such as supporting nutritional intake at meal times, or other personal care. Where they have been used to working with the person and not having their input would cause them distress not to involve them in the care and support of the individual. The clinical team should work with the family / carer to enable this to occur. In these instances, the family/carer should be provided with necessary PPE to undertake this activity.
- Introducing of one-way systems (where possible) - directional signage should be reviewed and clearly displayed.
- Local visiting arrangements should be as flexible as possible to accommodate everyone’s needs - set visiting time restrictions should not be imposed as this would make physical distancing harder to maintain in communal and clinical areas by concentrating groups of people into one area at the same time.
- Setting maximum occupancy levels for single rooms, shared rooms and open wards to ensure appropriate social distancing measures can be maintained.
- A visit to a patient by a faith representative from out with the hospital’s spiritual care team should not be counted as one of the individuals supporting them – such support is in addition to that outlined above.
- 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.
16. Test and protect information requirements

From Monday 9 August, 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.

It is very important for the health and wellbeing of patients, family and staff that people do not visit if they are feeling unwell in any way or have symptoms of Covid-19.

On all visits, all visitors should be asked the following questions:

- Are you feeling unwell?
- Do you have new/continuous cough?
- Have you had any sickness or diarrhoea within the last 48 hours?
- Have you noticed a change in your temperature?
- Have you noticed a change in your normal sense of taste or smell?
- Are you self-isolating because you have been in contact with anyone suspected as having, or has tested positive for COVID-19, in the past 14 days?

People should not be allowed to visit if they do not pass this safety check.

Where a child or young person is a young carer over 12 they do not have to be accompanied by an adult, and this should not be a barrier to visiting.

Trace and Protect templates can be found in Appendix 1F, if they are required to support local risk management or outbreaks.

17. Security Arrangements

Security arrangements are in place at the entrance to most of our hospital. Family members identified for visiting should be advised, security staff will stop them at the entrance to enquire where they are going and the safety measures required before entering the building.

All visitors should be asked to take the stairs to the ward or department where possible. This is to avoid lift areas becoming over-crowded.
## Appendix 1: Visiting Toolkit of Documents and Templates

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Document Icon</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Risk Assessment (Draft) and optional Risk Assessment Checklist (for local adaptation as appropriate)</td>
<td><strong>ITEM 1:</strong> &lt;br&gt;202108 Risk Assessment COVID Vi &lt;br&gt;202107 Risk Assessment COVID Vi</td>
</tr>
<tr>
<td><strong>ITEM 1:</strong> Risk Assessment for all other hospitals</td>
<td></td>
</tr>
<tr>
<td><strong>ITEM 2:</strong> Risk Assessment Checklist</td>
<td></td>
</tr>
<tr>
<td><strong>B.</strong> NHSGGC End of Life (EoL) Visiting Guidance during Covid-19 – Version 8</td>
<td>![PDF](202012 NHSGGC EoL Visiting Guidance During Covid 19 V8.pdf)</td>
</tr>
<tr>
<td><strong>C.</strong> Visiting Plan Template</td>
<td>![My visiting plan.docx]</td>
</tr>
<tr>
<td><strong>D.</strong> NHSGGC Visitor Trace and Protect Record – Version 7 &amp; 8</td>
<td>![PDF](NHSGGC Visitor Trace Protect Record.jpg)</td>
</tr>
</tbody>
</table>
## Appendix 2: Enabling Family Support – Checklist

### Enabling Family Support: checklist

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 1 | No Outbreak | ✓ No active outbreak in the department amongst staff or patients  
   ✓ No one with Covid symptoms providing family support | ☐ |
| 2 | IPC Compliance | ✓ IPC precautions in place including hand-washing facilities and face masks  
   ✓ Physical distancing in communal areas and no gatherings  
   ✓ No one with Covid symptoms or in quarantine providing support | ☐ |
| 3 | PPE | ✓ Adequate supplies of PPE in place  
   ✓ Families helped with PPE if required  
   ✓ Additional measures in place for Covid positive patients | ☐ |
| 4 | Family identified | ✓ Conversation with patient to understand who they need to support them  
   ✓ People such as interpreters or personal assistants should not be counted as the support person. | ☐ |
| 5 | Risks Assessed | ✓ General assessment of physical environment  
   ✓ Special consideration in multiple occupancy areas  
   ✓ Individualised plans may be required for some people. | ☐ |
| 6 | Monitoring | ✓ Local infection incidence and prevalence monitored in ongoing basis.  
   ✓ Outbreaks managed by local IMT | ☐ |
| 7 | Other factors | ✓ Any specific local issues that need to be considered  
   ✓ The needs and rights of the patient should be given equal consideration to any other factors identified.  
   ✓ Anything else? | ☐ |