Visiting Guidance for Hospitals in Scotland

Enabling Family Support for People in Hospital in Scotland

April 2021

Version History

Version	Date	Summary of changes
1.4	26/4/21	First version of document

Introduction

The importance of support from family members and loved ones to people in hospital cannot be overstated, bringing comfort to both the person in hospital and the people whom they consider to be their family or carers. For example, people with dementia may have limited understanding of events, including the COVID-19 pandemic. They may experience distress and confusion – which can be eased by the presence of familiar faces of family and friends who visit. There are many other situations where we know that support from family, friends or a carer has a positive effect on quality of care including nutrition, healing, recovery and overall quality of care. Given this, family support should be a fundamental part of the care of a person in hospital and not optional.

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 absolutely necessary to do so to protect against the risk of COVID-19. Given progress that has been made, the time is now right to take steps to carefully re-introduce family support in hospitals more broadly.

Key principles

This visiting guidance, which updates our earlier guidance of June 30, 2020, has been designed with the following principles in mind:

- All people in hospital will be able to have support from *at least* one person of their choosing during their hospital stay.
- This will apply in all levels of the Strategic Framework.
- 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 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.
- The person providing support can be changed if required.
- 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, but 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 supporting
- This guidance has been reviewed in conjunction with Health Protection Scotland and Public Health Scotland and aligns with policies and recommendations in terms of Infection Prevention and Control (IPC).

The impacts of isolation

The pandemic has created an unprecedented situation which at times has necessitated some restriction of families' and carers' freedom to support people in hospital and 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 also 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, and indeed other person-centred improvement work, as important elements of the NHS Scotland recovery plan.

Staged approach to the reintroduction of visiting

From April 26, 2021, every patient in hospital in Scotland will be able to benefit from support and contact with at least one person, regardless of which level in the strategic framework the hospital is in.

Clinical advice is that this is a proportionate measure that will help to significantly reduce emotional harm and promote wellbeing, if implemented with all current safeguards as described or linked to elsewhere in this guidance. We are also mindful of seeking to balance the objectives of population level public health measures, with a holistic view of a person's care needs at the individual level and their right to family life.

However, 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. Key among these will continue to be frequent handwashing and the use of alcohol-based hand rub, wearing face coverings, and adherence to physical distancing in communal areas. As noted above, we expect family members to be able to have close contact, such as holding hands, with the person they are supporting. Current IPC measures taken by staff are deemed acceptable to reduce risk associated with close contact and the same approach to this risk should be applied for the family member providing support.

In the event of an outbreak, standard outbreak management policies will be applied by the local IMT which 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 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. These decisions should be made based on each individual case by the clinical team at local level.

We understand that increasing the numbers of visitors to hospital will carry with it the risk of increasing transmission, but this is being done in the context of a downward trajectory in incidence and prevalence of COVID-19 in the general population. This situation can of course change and will be monitored by the health board IPC teams as well as local and national public health bodies.

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, and existing hand hygiene measures will continue.
- 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, or is quarantining because they have had contact with a person with COVID-19 or for some other reason.

The person providing support can be changed. 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 for some reason. In normal circumstances we would expect such changes to the named person to be reasonable both in respect of limiting transmission risk and administrative burden on staff. For example, changing the named person multiple times in a day or perhaps daily, would not be expected in normal circumstances.

Policies should not restrict the presence of children and if children need to be accompanied this should not prevent a visit. More detail about how this guidance applies to children is included on page 13 of this document.

Areas with COVID-19

As stated above, in the event of an outbreak, standard outbreak management policies will be applied by the local IMT which may include limiting family and carer support to essential visits only in the department or area concerned. In a situation where an individual patient with COVID-19 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. 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.

If it does become necessary to restrict visiting, the examples of the type of situations where "essential visiting" was supported earlier in the pandemic may be helpful and 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.

These examples are intended to be illustrative rather than exhaustive. A flexible, compassionate approach is encouraged, and healthcare staff should be supported to facilitate family support in any situation where they assess that it is important to involve family or carers for ethical, safety, or other reasons.

Further relaxing visiting restrictions

Assuming continued falling incidence and prevalence of COVID-19, we propose moving to support from two people per patient in Level One of the Strategic Framework. As described above, this should be the default position and considered a minimum standard for all patients with exceptions noted as above. Again, all current safeguards contained within the guidance would be maintained and any necessary modifications introduced.

This will operate as follows:

Strategic Framework Level	Level Zero	Level One	Level Two	Level Three	Level Four
Visiting	Full person-centred visiting subject to local health protection advice	Support from at least two people from the same household at the same time *If not from the same household and physical distancing cannot be maintained, visits can take place separately* Preparations put in place for return to	Support from at least one person	Support from at least one person	Support from at least one person

		full person-centred visiting			
Required	People providing support must: • maintain physical distancing in the communal areas of the hospital wherever possible • wear face coverings • have access to hand hygiene facilities • not move around other areas of the hospital unless as part of care for the patient – i.e. birth partner attending scan, parent accompanying child or other similar situation • Must not gather in communal areas of the hospital with other people				
Settings	Hospitals/ wards with no COVID-19 outbreak. Family support can still take place in COVID-19 areas (now known as red pathways)if deemed necessary and essential, in accordance with local standard outbreak management policies.				

- **Level one**: support from two people per patient at the same time, or visiting at different times, if from different households. Preparation of plans to return to full person-centred visiting subject to local health protection advice.
- **Level Zero**: return to full person-centred visiting, subject to local health protection advice and acceptable incidence and prevalence data.
- We will continue to work with boards to return to a full person-centred approach to family and carer support in hospitals when it is safe to do so.

Managing visitors in practice – further guidance for staff

In Levels four, three and two – support from at least one person

A relaxation of restrictions does not mean that there are no risks, therefore in levels four, three and two support will be limited to one person, wearing a face covering, as well as any further PPE that the area being attended considers necessary and observing physical distancing wherever possible in all communal areas of the hospital. This person can be changed if required. Hand hygiene will remain crucial to protect families and patients alike.

Patients should be asked to identify a person to provide family support while they are in hospital to facilitate trace and protect if required.

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 has been managed include introducing one-way systems, signing in and out, and arranging visits in advance. These and other considerations will be especially necessary in multiple occupancy patient areas.

If a visitor is required to arrange a visit in advance, this must be clearly communicated to patients and visitors.

No one should attend the hospital if they have any symptoms of COVID-19 or are self-isolating following contact with someone with COVID-19 and instead should remain at home and follow advice on NHS Inform. Staff should make every effort to remind patients and those providing essential support of the importance of this. Anyone who arrives at the ward/department with symptoms should be asked politely to leave and return home directly to follow advice on NHS Inform.

NHS Boards should not impose set time restrictions 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.

Risk assessments should be carried out where required and these may need to be tailored to specific environmental or clinical requirements locally. Clinical teams and managers may find the family support checklist provided in the appendices of this guidance helpful in assisting with this process.

The number of people able to be accommodated in a clinical area at any one time will vary depending on the setting. For example, hospitals with single rooms will be able to accommodate more people at any one time than multiple occupancy areas. Individual settings should consider how many people it is possible to accommodate at any one time. This should be done in the context of overall footfall throughout the hospital.

Anyone attending a hospital should wear face coverings or any other PPE as indicated by the clinical team and must adhere to strict hand hygiene by using hand washing facilities or alcohol hand rub on entering and leaving the ward/department or following any contact with their loved one. 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.

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.

In areas designated as AGP generating, such as ICU, if the family member is not face-fit tested with an FFP3 mask, then they would be required to isolate for the quarantine period after the visit. This should be clearly explained to the family member along with the risks of transmission. However, this should also be balanced with the unique circumstances of any such situation, for example a sudden deterioration or if someone is at the end of their life. In such circumstances every effort should be made to make the right decision for the patient and their family.

Physical distancing must be maintained in the communal areas of the hospital where possible.

<u>We expect these principles to be applied flexibly and compassionately</u>, 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. 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, family support should be facilitated.

"Virtual Visiting"

Where in-person support is not possible for any reason, a patient can be supported by other alternatives such as person-centred "virtual visiting" using tablets or mobiles. 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.

In Level One - support visits from at least two people

When local authority areas are in Level One we expect hospitals to begin the phased introduction of support visits from two people per patient. This must continue to be done in a careful way that takes all necessary precautions to help prevent the spread of COVID-19. Where a hospital is in an area that is designated Level One from April 26^{th} 2021, it would be reasonable to develop a phased approach over a period of a few weeks to move from the current restrictions to support from two family members.

Patients will be asked to name two people who will support them in hospital during their stay. These individuals are not fixed and can be changed if a patient needs to see another person other than those originally identified as described above. Local managers and clinical teams will still need to manage the safe operation of the clinical environment and some of the following points may help with this. Some of the following considerations may be helpful:

- Two people from the same household may visit at the same time.
- If those providing support are from different households then they may need to visit at separate times if physical distancing cannot be maintained in the clinical area. It should be possible in most cases to accommodate reasonable requests for support from the patient or those supporting them, with appropriate risk assessment and mitigation in place.
- Current requirements around wearing face coverings, provision of contact details hand washing or the use of alcohol-based hand rub, will remain in place.
- Physical distancing should be maintained where possible in the communal areas of the hospital, along with additional risk mitigation measures such as face coverings.

- People must continue to refrain from gathering in groups in the communal areas of the hospital.
- Hospitals and health boards should ensure they are as flexible and compassionate as possible and do all they can to operationalise this guidance and facilitate support from two people per patient as quickly and safely as they can.

We expect hospitals to be as accommodating as possible given the constraints of individual environments. For example, a particular ward or area with single rooms or a large space may mean that a greater number of visits – or visits by two people at the same time – may be possible. whereas in smaller areas the flow of people in and out may need to be managed more carefully.

The maximum possible interaction between patients and family, carers or friends should be accommodated and the specific reasons for any limitations should be explained clearly.

Specific examples of application include: Two parents can accompany a child in hospital, or a parent and sibling. Adult patients can now be visited by two different people, allowing the benefits of more frequent visiting for both patient and visitors. Where family members own schedules mean they may not be able to visit frequently, there is now the ability for another person to be able to visit hospital. As is currently the case, visits for someone with learning disabilities or mental health problems should be tailored and flexible to meet the needs of the individual. For example, visits could take place once a day or several times a day and could include a carer or family member to participate in care, reducing the stress and distress experienced by the individual.

In Level One, health boards should start to prepare for a return to a fully person-centred approach to visiting, and will be asked to submit plans for how they plan to achieve this.

In Level Zero – a return to full person-centred visiting, subject to local health protection advice.

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.

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 to be 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.

Contact with family and friends

All patients will be able to have support from one person as a minimum, and follow the staged approach outlined in this guidance. A flexible approach must be maintained to meet patients' individualised needs to maintain connection to family and friends and to manage the stress and distress to both the individual and their loved ones which may result from being separated. Examples of this are below. Please note this is not exhaustive and other flexible, person-centred approaches should be considered.

- Visits several times per day if required
- More than one person visiting in the same day at the discretion of the clinical team where beneficial to the individual's mental health and wellbeing.
- Ability to go for a walk around the hospital grounds with their loved ones
- Ability to touch the person's hand without wearing gloves to provide comfort and reassurance

Individualised approach

An individual visiting plan should be discussed with the person, their next of kin and the ward clinical team. This could include a combination of both in person and virtual visiting. This will ensure:

- The needs of the person are met,
- No blanket timelines for the duration of a visit.
- The family have been involved in thinking through how they can best arrange their day to meet the agreed visiting plan and to keep the rest of their family and friends connected to the person. This may include the use of virtual visiting approaches for wider family members and friends unable to visit in person.
- Enables the clinical team to manage the number of people in the clinical area at any one time to enable COVID safe precautions to be maintained

The plan should be reviewed on a regular basis to ensure the individual's needs are continuing to be met and that their family and friends are being supported to see their loved ones.

Family and Carers involved in the provision of care

It may be beneficial for a family member or a carer to undertake some personal care such as supporting nutritional intake at meal times, bathing etc. where they have been used to working with the person and not having their input would cause them distress 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 they should not be deemed as a visitor to the ward and be provided with then necessary PPE to undertake this activity.

End of life care

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 loved ones at the end of life**. The flexibility and compassion of clinical staff in supporting this throughout the pandemic has been appreciated and this should continue as flexibly as possible.

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 we would encourage clinical teams to adopt as compassionate and broad an approach as possible. "End of life" is *not* expected to be defined only as the last hours of a patient's life or when someone has become unconscious. Likewise, as is not infrequently the case, if someone is identified as at the end of their life and then rallies, support from family or carers 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 patients nearing the end of life can spend meaningful time with their loved ones 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.

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

Children

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 their loved one 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 guidance, 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.

There are many circumstances in which it will be beneficial to a child in hospital's recovery and for the wellbeing of their siblings for them to have a visit from a brother or sister. 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.

Test and protect details

A child accompanied by an adult will not need to have their details stored for test and protect as long as the details of the accompanying adult are obtained and it is noted that a child was with them.

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. In these circumstances test and protect details will need to be obtained and stored as for an adult visitor.

Maternity and Neonatal guidance

Specific guidance for attendance or visits in maternity or neonatal settings is available and you can find it here. It sets out how this hospital visiting guidance should be applied in these contexts.

Spiritual Care

It is important to clarify the principles around patient access to spiritual care and how this links with family presence.

A visit to a patient by a faith representative from outwith 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. Further principles about managing visits by faith representatives are included at Appendix Three.

Planning for changes to enable family support

We suggest approaching any change in practice resulting from this guidance from three perspectives – that of the individual patient and their characteristics; the individual providing support and their characteristics; and the specific environment of the hospital in question.

Where changes in guidance are anticipated it is expected that patients, staff and their family and carers will be given as much notice as is reasonably possible.

It is important that any changes in visiting are handled in a manner that is supportive and sensitive. Patients should be asked who they want their support person/s to be.

Care should be taken first of all to determine whether the individual patient wishes to receive support in this way and who they want to see.

The family or friend providing the support and contact may have specific concerns and expectations about the person in hospital they are supporting and the conditions in place to minimise risk, which could be discussed in advance. Some patients may find the conditions associated with recommencement of visits difficult and emotional and may require help to understand the processes in place to keep them safe. 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.

Staff may be fearful about the risks of harm associated with expanded numbers of people in their wards and departments and how they will manage the conditions which will make this possible and safe. They are also likely to be concerned about the reactions of patients and their families and how they can best support emotionally challenging situations. It is important to note however, that these risks are relative compared to existing sources of risk in a hospital setting and that there are also many benefits in respect of staff workload and quality of care when patients are able to be supported in this way.

Staff, families and carers providing essential support would benefit from being supported to anticipate different responses and prepared with some potential coping strategies in the context of some form of restrictions continuing for the foreseeable future. There is much to be learned from care teams who have been especially successful in adopting a range of methods to maintain connections between families, patients and themselves. Continuing to develop augmented channels of communication such as virtual visiting will be important.

It will be particularly important when guidance allows support from two people, with the extra demands placed on areas to accommodate physical distancing where possible, that there is an appropriate risk assessment process. This may be in respect of the environment or the ability of the family or carer providing support to adhere to specific measures to manage risk accordingly, or both.

The patient

Consideration will need to be given to the specific needs of the patient involved, and what matters most to them. The main goal of family and carer involvement in care is to support emotional wellbeing, advocacy and to promote recovery for the patient. The patient should be involved in all decision-making and supported to be able to make a decision as to which person or persons they may wish to see.

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. Guidance on communicating with people who have sensory loss is available here.

How will the support happen?

Consideration needs to be given to how frequently a patient may wish to see their family member, carer or friend. Practical steps will need to be put in place locally that take into consideration local conditions, the needs of the patient and their family and the risk mitigation required.

All of these requirements will need to be clearly explained to patients and family members.

Family, friends or carers providing wellbeing support and contact

As with identifying one person described above, the family of a patient may require to be supported in making the decision as to who is to be the second person. It will also be helpful to remind them of the potential to change this person as required to meet the need of the patient or to facilitate a rest for the person providing wellbeing support. This is especially the case if a patient has been in hospital for a long period of time. In normal circumstances we would expect such changes to the named person to be reasonable both in respect of limiting transmission risk and administrative burden on staff.. For example, changing the named person multiple times in a day or perhaps daily, would not be expected in normal circumstances. Staff should be prepared to support both anxiety and upset should it occur. Awareness of the factors that prevent someone from attending a hospital should also be noted as outlined earlier in this guidance.

The hospital
Every hospital should be encouraged to risk assess and where required develop due process. Local protocols should describe in plain and accessible terms the process from entry to the hospital to the end of the visit. Every hospital should have a risk assessment process in place, tailored to specific environmental or clinical needs locally. An example risk assessment form is provided at Appendix One.

All visits
Over the past year Health Boards have established robust processes to manage the practicalities of family and carer presence in hospitals. These include measures such as one-way systems, physical distancing signs, extra hand-hygiene stations, and so on. These should remain in place or be enhanced if required in keeping with local risk assessments.

Toilet facilities
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.

Feedback on the guidance
If you have feedback on this guidance please email: Annalena.Winslow@gov.scot.

Appendix one: "Enabling Family Support" checklist

Enabling Family Support: checklist		
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?	☐

ID:

Appendix two: Sample Risk Assessment Form

Use this form for any detailed risk assessment unless a specific form is provided. Refer to your Summary of Hazards/Risks and complete forms as required, including those that are adequately controlled but could be serious in the absence of active management. The Action Plan and reply section is to help you pursue those requiring action.

Name of Assessor:		**Post Held:**	
Department:		**Date:**	
Subject of Assessment: E.g.: hazard, task, equipment, location, people			
Hazards (Describe the harmful agent(s) and the adverse consequences they could cause)			
Description of Risk Describe the work that causes exposure to the hazard, and the relevant circumstances. Who is at risk? Highlight significant factors: what makes the risk more or less serious – e.g.: the time taken, how often the work is done, who does it, the work environment, anything else relevant.			
<u>Additional Local Units Description of Risk</u>			

Existing Precautions

Summarise current controls In place	**Describe how they might fail to prevent adverse outcomes.**
Bed Spacing **Current General Precautions**	

Level of Risk - Is the control of this risk adequate?

Give more than one risk level if the assessment covers a range of circumstances. You can use the ‘matrix’ to show how ‘likelihood’ and ‘consequences’ combine to give a conclusion. Also, be critical of existing measures: if you can think how they might fail, or how they could be improved, these are indications of a red or orange risk.

Risk Matrix

Likelihood	Impact/Consequences				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	**Medium**	**High**	**High**	**V High**	**V High**
Likely	**Medium**	**Medium**	**High**	**High**	**V High**
Possible	**Low**	**Medium**	**Medium**	**High**	**High**
Unlikely	**Low**	**Medium**	**Medium**	**Medium**	**High**
Rare	**Low**	**Low**	**Low**	**Medium**	**Medium**

Very High **High** **Medium** **Low**

Current risk level

Given the current precautions, and how effective and reliable they are, what is the current level of risk? **Green** is the target – you have thought it through critically and you have no serious worries. Devise ways of making the risk green wherever you can. **Yellow** is acceptable but with some reservations. You can achieve these levels by reducing the inherent risk and or by effective and reliable precautions.

High (Orange) or Very High (Red) risks are unacceptable and must be acted on: use the Action Plan section to summarise and communicate the problems and actions required.

Action Plan (if risk level is **High (Orange) or Very High (Red)**)

Use this part of the form for risks that require action. Use it to communicate, with your Line Manager or Risk Coordinator or others if required. If using a copy of this form to notify others, they should reply on the form and return to you. Check that you do receive replies.

Describe the measures required to make the work safe. Include hardware – engineering controls, and procedures. Say what you intend to change. If proposed actions are out with your remit, identify them on the plan below but do not say who or by when; leave this to the manager with the authority to decide this and allocate the resources required.

Proposed actions to control the issue List the actions required. If action by others is required, you must send them a copy	**By Whom**	**Start date**	**Action due date**

Action by Others Required - Complete as appropriate: (please tick or enter YES, name and date where appropriate)

Report up management chain for action	
Report to Estates for action	
Contact advisers/specialists	
Alert your staff to problem, new working practice, interim solutions, etc	

Reply

If you receive this form as a manager from someone in your department, you must decide how the risk is to be managed. Update the action plan and reply with a copy to others who need to know. If appropriate, you should note additions to the Directorate / Service Risk Register.

If you receive this as an adviser or other specialist, reply to the sender and investigate further as required.

Assessment completed - date:		**Review date:**	

Appendix Three: Spiritual Care guidelines

The Spiritual Care Service in each health board area exists for the delivery of safe and effective, person-centred spiritual care to all patients, family/carers and members of staff.

When particular spiritual care needs are identified that are associated with a patient's faith/belief community, the Spiritual Care Team should be informed. This will usually involve the Healthcare Chaplain responsible for the patient's ward, or, in an emergency, the Healthcare Chaplain on call.

After full consultation with the patient, the Chaplain will either address the need arising, or, and at the patient's request, engage with the patient's own faith/belief community.

If the patient needs to be supported by a representative from the patient's own faith/belief community, the Spiritual Care Team should arrange for this to happen.

Pastoral support is part of the person-centred spiritual care being given to the patient while in hospital. Therefore, a faith representative should not be classed as a patient's designated visitor.

In some health board areas, requests for spiritual care from a specific faith/belief community are so common that separate arrangements have already been made for contacting and accessing support from that community, so that the board's own Spiritual Care Team is not involved in the continual delegating of this aspect of their work. Where such arrangements are in place (and have, perhaps, been suspended during lockdown) such faith/belief community support can now be accessed as previously, according to local protocols.

When a patient's faith/belief community representative is supporting that patient, the ward's standard infection control measures should be observed. A faith/belief community representative may only support a number of patients in the hospital if it is safe to do so and standard infection control measures are observed at every stage.

Physical distancing should still be observed and physical touch restricted to that which is absolutely necessary for spiritual care, observing strict hand hygiene protocols while doing so.

Where spiritual care involves the sharing of objects (e.g. printed material, food and drink associated with rites, anointing oils) the same procedures should be in place as in local faith/belief community gatherings, to ensure effective infection control.