**Visiting Guidance for all care homes**

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11. **Definitions**
	1. **Resident:** An individual that lives in a 24-hour CQC registered care service either whole or part time.
	2. **Essential Family/Friend Carer (EFC):** Essential Family/Friend Carer (EFC) is anyone whom a resident sees as important to their daily mental health and wellbeing and this will include; Family members, friends, Lasting Power of Attorneys (LPAs), Court Appointed Deputies, informal advocates and any other people not currently covered under other government guidance as “essential Visitors”. MHA (the UK's largest charity care provider) have defined “A resident’s family member or friend whose care for a resident is an essential element of maintaining their mental or physical health. Without this input a resident is likely to experience significant distress or continued distress.”[[1]](#footnote-1)
	3. **Visitors:** Where this guidance refers to visitors, it does so with the intention of meaning EFCs only and does not include other essential visitors (e.g. hair dressers) or health professionals.
	4. **COVID:** COVID is a highly infectious respiratory disease which is spread from person to person through small droplets when an infected person sneezes, coughs or exhales. Infected persons may be asymptomatic, mildly ill or chronically ill as with the older population or those with underlying medical conditions such as high blood pressure, heart or lung problems, cancer or diabetes ( WHO (2020) Q & A on Coronavirus (COVID-19))
	5. **Outbreak:** “An outbreak is defined as two or more confirmed cases of COVID-19 or clinically suspected cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days. An incident is defined as less than 2 people with suspected Covid-19 regardless of whether staff or residents”
	6. **Support Bubble:** A support bubble is a close support network between a household with only one adult in the home (known as a single-adult household) and one other household of any size.
	7. **School Bubble:** School Bubbles are loosely defined as small groups and may be defined by individual schools and therefore vary.[[2]](#footnote-2)
12. **Introduction**
	1. This guidance has been created to support all CQC registered care homes, which include residential without nursing, nursing, EMI etc to facilitate safe visiting for the people they support. All care homes must make every effort to facilitate face to face visits for all people who have a genuine want or need to promote people’s wellbeing by maintaining meaningful contacts with EFCs. Reduced contact may have significant consequences, with respect to an individual’s mental health and general well-being, especially if such restrictions continue over an extended period[[3]](#footnote-3). Providers must not impose blanket policies on their settings and all risk assessments, care plans, and visiting arrangements, must be person centred to each individual, as set out in Government Guidance[[4]](#footnote-4) and Case Law[[5]](#footnote-5). All visiting arrangements must promote the mental health and wellbeing of all those supported in each setting as well as work to mitigate the risk of COVID.
	2. Providers should check with their insurance providers whether their policy covers local guidance.
13. **Residents**
	1. Residents must be consulted throughout all decision-making regarding visiting. Mental capacity assessments must be completed with best interests decisions clearly documented. Where the individual lacks capacity, providers must consider historic visiting wishes and needs and consult with their LPA’s, advocates, EFCs, and medical professionals where necessary. The priority must be in the best interests of the resident and if the resident does not wish to receive visits or would not benefit from visits due to emotional distress, visits should not be implemented due to relative request, and this must be backed up with risk assessment and mental capacity assessment[[6]](#footnote-6). EFCs do not need to be limited to one person, however the number of EFCs must be defined through person centred risks assessment and prioritised.
	2. **Dynamic Risk Assessments**
		1. Risk assessments should be completed in a person-centred way. They should account for:
			1. If a resident wishes to receive face to face visits
			2. People whom a resident deems as meaningful to them
			3. People whom a resident does not wish to receive visits from
			4. Emotional wellbeing and the impact of reduced face to face contact with EFCs
			5. Risk of health effects due to COVID (consider using the BMA risk tool[[7]](#footnote-7))
			6. Outcomes of mental capacity assessment and best interests discussions
			7. Concerns of safety of residents not receiving or wishing to receive visits
			8. Considerations of COVID status of the resident
			9. Overall health of the resident
			10. Ability to understand and adhere to social distancing
			11. Consideration for supervised visits based on social distancing comprehension
				1. Visits may not need to be supervised but regular comfort checks are recommended to ensure procedures are being adhered to
14. **EFC Visits**
	1. Visits if appropriate will be facilitated according to the resident's wishes or in their best interests if they lack capacity and not of the EFC.
	2. EFCs should be communicated to with all visiting decisions made by or in the best interests of the resident.
	3. All EFCs must be reminded of the mantra: Hands Face Space, be provided with adequate hand washing and/or hand sanitising facilities and be briefed (either verbally or in writing) about general IPC and how viruses and other communicable diseases are spread.[[8]](#footnote-8)
	4. EFCs should be offered the opportunity to receive COVID tests as part of the providers regular testing if they are signed up to whole home testing. However tests should only be offered weekly to agreed EFCs who visit weekly or more. Tests should be arranged prior to visits of EFCs who visit less frequently and must allow time for the result to be returned (at least 72 hours).
	5. **Risk Assessments (Visitors)**
		1. Screening questionnaire must be completed at point of booking a visit should include
			1. COVID symptoms
			2. Social distancing procedures (including PPE use)
		2. Impact risk assessments of EFCs to assess safety when visiting. Impact risk assessments should be reviewed every 3 months or sooner if there are any changes.
		3. Risk assessment on day of visit including checklist. Risk assessment must include
			1. Temperature Check (and consent to record)
			2. COVID symptoms
			3. Willingness to adhere to and their understanding of Social distancing and PPE procedures
			4. Potential COVID contacts including NHS track and trace communicated to the visitor
			5. Confirm all EFCs are from the same household or support bubble[[9]](#footnote-9)
			6. Education establishment COVID risk including school bubbles
			7. Consideration for supervised visits based on social distancing comprehension
			8. Return from travel abroad within last 14 days (Advise all visitors that visiting is not possible until after 14 days return)
			9. COVID test results
			10. Signed declaration of adherence to local and national COVID rules during the last 14 days
15. **Special Considerations (including End of Life Care and close contact)**
	1. There will be certain circumstances where socially distanced visits will not be beneficial for the resident or suitable for their current health needs. The below considerations could be applied to residents who are receiving end of life care, have sensory impairments, learning disabilities, or for those people who are living with a disability which would hinder their ability to adhere to a socially distanced visit.
	2. This could include:
		1. Extended visiting times
		2. Physical contact
		3. Provision to live in (adhering to 14-day isolation periods)
		4. Ability to doff facemask in the resident’s bedroom or visiting area (however all PPE procedures must be adhered to during access into building).
		5. Consult clinical guide for supporting compassionate visiting arrangements for those receiving care at end of life document[[10]](#footnote-10)
	3. All special considerations must be individually risk assessed and impact risk assessments to the wider home, and team should be undertaken.
	4. **EFCs (Essential Family/Friend Carers) Special considerations to provide enhanced care**
	5. Enhanced care could include but is not limited to, personal care and mealtime support.
	6. Considerations for providers if EFCs wish to be able to provide enhanced care:
		1. Training (including IPC, PPE, Safeguarding, Moving and Handling etc)
		2. Weekly COVID testing
16. **Environment**
	1. It is recognised that whilst risk assessments and visiting arrangements for residents need to be person centred, risk assessments of environments will also need to be specific to each individual setting. The following recommendations are made to hopefully encompass all settings but not necessarily apply to all settings.
	2. COVID status: If a home is classified under the current outbreak status then visiting will be discussed with local IPC team, PHE and a risk assessment undertaken.
	3. **Outdoor Visiting**
		1. Outdoor visits should remain preference **only** when the weather allows, and **only** when suitable for the resident’s needs.
		2. How to facilitate outdoor visits
			1. Outdoor visits should take place in a space large enough to adhere to 2m social distancing with access to easy clean furniture.
			2. Enclosed Outdoor visits. Outdoor buildings should be considered with the sole purpose of facilitating visits and should be furnished with easy clean furniture.
	4. **Indoor Visiting**
		1. Indoor visiting areas are essential where outdoor visiting may not be practicable due to weather, lack of outdoor visiting space, or where outdoor visiting may not be beneficial or suited to the resident’s needs. Where outdoor visiting is not possible, indoor visiting must be facilitated.
		2. How indoor facilitating can be facilitated:
			1. In the resident’s bedroom. For residents who are coming to the end of their life or may be bed bound, efforts should be made to facilitate visiting in their bedrooms. Visitors should be guided to the resident’s bedroom with all doors opened for them to reduce touch contact. Visitors must remain in the resident’s bedroom throughout the visits and should use the nurse call button for emergencies or if the visit needs to be cut short. Social distancing must be adhered to and furniture available to the visitor must be easy to disinfect post visit. After a visit in a resident's bedroom the visitor must be guided out the home with doors being opened to reduce touch contact of surfaces.
			2. Designated visiting room. Where there is the ability to repurpose a room within the care home for visiting, this should be considered. Designated visiting rooms need to be clearly identified to prevent misuse. Designated visiting rooms should be as close to the access to the care home (this may not necessarily be the main entrance and could include side doors or fire escapes) as possible to reduce footfall throughout the home and to reduce risk to other residents. Where possible, access should not be through communal areas and designated visiting rooms should ideally have direct access from the outside. Designated visiting rooms must be included in all risk assessments and in the visiting policy. It may be preferable to erect plastic screens where social distancing may be difficult due to space restraints. Designated visiting rooms must be large enough for visits to adhere to the 2m social distancing and should be furnished with easy clean furniture. Decontamination must be recorded in the room and should occur after each visit has taken place.
			3. Changing areas. Changing areas could be considered to provide visitors with a space to change into fresh clothes to further mitigate the risk of bringing COVID in from the community. It should also be considered that if visitors opt to change their clothes when they visit, that their “visiting clothes” are stored at the care home to maintain quarantine from outside COVID risk.
	5. **Drive-Thru:** Drive-Thru visiting is something relatively new and a great innovative idea born out of the pandemic. Drive-thru visiting entails EFCs parking up in their car whilst the resident sits outside of the car. This type of visiting is weather dependant and will also be determined by the safety needs of the resident. With drive-thru visiting, the EFCs wouldn’t be able to get out of the car and would need to keep 2m distance.
	6. **Window Visiting:** There would need to be a distance of 2m between the EFCs and the resident as, although not in direct company, the window may need to be open to help with conversation. For those who may be shielding or at higher risk, other ways of supporting communication such as portable phone handsets can be used so the window can stay closed. The handset would need to be wiped clean each time.
	7. **Decontamination**
		1. Visiting areas must be effectively decontaminated before and after each visit. Consider:
			1. Fogging equipment as additional decontamination measures
			2. Wipe clean furniture
			3. Displayed cleaning schedule detailing when a visiting area was clean and by who
				1. Cleaning schedule should also include touch point cleaning and furniture that has been cleaned
			4. Where an EFC has visited a resident in a bedroom then the route taken should be decontaminated and clean after the visitor has commuted to the bedroom and after the EFC has left the bedroom and commuted out the building.
			5. In bedroom visits will also require cleaning of surfaces in the bedroom that the visitor may have touched as well as the nurse call system should that have been used.
		2. All decontamination after a visit (including any changing areas) should be recorded by the employee facilitating visits and audited along with all other IPC records.
	8. **Access to visiting areas**
		1. Access to visiting areas must be dynamically risk assessed. Consider:
			1. Distance from outside to visiting area
			2. Reducing footfall through the home
			3. Avoiding communal areas
			4. Avoiding high traffic areas
			5. Completing an impact risk assessment on the rest of the home.
17. **Visiting Procedures**
	1. It is essential to set out clear and easy to follow visiting procedures. Consider the following when developing visiting procedures:
		1. Facilitating weekend visits
		2. Appointment system. Consider:
			1. Visiting appointments diary
			2. Communicating to staff when visits are booked
			3. Designating only a select number of staff to arrange visiting appointments
			4. Arranging for staff on rotas specifically to facilitate visits (consider using winter control fund and ICF money)
			5. Utilising the Lancashire Auxiliary Workforce (LTSA) as visit facilitators
			6. Reasonable adjustments for those people who have protected characteristics under the equality act by reason of disability.
		3. Maximum of two EFCs at one time from one household or support bubble. Where a visitor may require a personal carer then an individual risk assessment will need to be undertaken.
		4. Visits to be no less than 30 minutes however visits should be accommodated for longer durations based on home size, capacity, staffing capacity to facilitate, and dynamic risk assessments
		5. Decontamination time between visits
		6. On arrival visitors must be accompanied to the hand washing facilities.
			1. During visit any required use of facilities (e.g. toilet) would also require visitors to be accompanied
	2. Gifts:
		1. Recommend that they are wipe cleanable, or
		2. Non-perishable and able to be quarantined for 72 hours if not wipe clean
	3. How EFCs or residents can request a visit appointment
	4. Supervised visits: Visits should only be supervised based on outcomes of dynamic risk assessments.
18. **Communication**
	1. All efforts must be made to include residents and their EFCs in planning face to face visits. This could be done through:
		1. Resident meetings
		2. Phone calls
		3. Emails
		4. EFC meetings which should be virtual
		5. EFC working groups
		6. Written letter
		7. Other communication methods
	2. Once a visiting policy and procedures have been agreed, these should be communicated with all residents and EFCs. Reasons for the decisions made on creating the visiting procedures should also be communicated. Consider the following
		1. Resident meetings
		2. Visiting Guidance Brochures/packs (these should be available in easy read, large print, or on other formats to suit the needs of those receiving them)
		3. Posters
		4. Social Media
		5. Website
		6. EFC working groups
		7. Phone calls
		8. Emails
		9. EFC meetings which should be virtual
		10. Written letter
19. **Best Practice examples and resources created by providers**
	1. There has been a tremendous amount of work already been done by providers in Lancashire. They have created excellent visiting procedures, risk assessments, care plans, policies, and more. There is now a dedicated “Lancashire Adult Social Care Providers Network” on Facebook where providers can share and upload their examples of their aforementioned best practice to support other providers in creating or adapting their own. The link for the group is:
	2. [**https://www.facebook.com/groups/806547913503568**](https://www.facebook.com/groups/806547913503568)
	3. The Facebook group is solely for managers and deputy managers in adult social care in Lancashire, Blackburn with Darwen, and Blackpool.
	4. This group will also aim to sign post providers to available resources and documents.
20. **Support for residents and EFCs**
	* 1. If a home fails to provide adequate support to facilitate visits or adhere to IPC and PPE guidance then residents and EFCs must be aware of the routes they can take to challenge this. These should include:
			1. The Care Homes Complaints Procedure
			2. Contact to Lancashire Adult Safeguarding Team[[11]](#footnote-11)
			3. Contact to Blackburn with Darwen Adult Safeguarding Team[[12]](#footnote-12)
			4. Contact to Blackpool Adult Safeguarding Team[[13]](#footnote-13)
			5. CQC tell us about your care link <https://www.cqc.org.uk/give-feedback-on-care>
21. **Appendices**
	1. MCA Guidance on contact in the context of COVID-19. *This will be added once approved*
1. https://www.mha.org.uk/files/2615/9707/4083/MHA\_More\_than\_just\_a\_visitor.\_A\_guide\_for\_Essential\_Family\_Carers.pdf [↑](#footnote-ref-1)
2. https://www.gov.uk/guidance/making-a-support-bubble-with-another-household [↑](#footnote-ref-2)
3. (Brooks SK, Webster RK, Smith LE et al. (2020) the psychological impact of quarantine and how to reduce it: rapid review of evidence *The Lancet* **395 (10227)**: 912-20.) [↑](#footnote-ref-3)
4. https://www.lancashire.gov.uk/media/919101/covid-19-resource-pack-v2-sep-2020.pdf [↑](#footnote-ref-4)
5. https://www.bailii.org/ew/cases/EWCOP/2020/17.html [↑](#footnote-ref-5)
6. This should be included in any visiting policy and guidance provided to relatives and residents [↑](#footnote-ref-6)
7. https://www.bma.org.uk/media/2768/bma-covid-19-risk-assessment-tool-july2020.pdf [↑](#footnote-ref-7)
8. https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-care-homes/covid-19-putting-on-and-removing-ppe-a-guide-for-care-homes-video [↑](#footnote-ref-8)
9. https://www.gov.uk/guidance/making-a-support-bubble-with-another-household [↑](#footnote-ref-9)
10. https://www.nhs.uk/conditions/end-of-life-care/

https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/ [↑](#footnote-ref-10)
11. http://www.lancashiresafeguarding.org.uk/lancashire-safeguarding-adults.aspx [↑](#footnote-ref-11)
12. https://www.blackburnwithdarwenccg.nhs.uk/about-us/safeguarding/safeguarding-vulnerable-adults/ [↑](#footnote-ref-12)
13. https://www.blackpoolsafeguarding.org.uk/ [↑](#footnote-ref-13)