COVID-19 Guidance on Access to Acute Hospitals for Nominated Support Partners, Accompanying Persons, Visitors and External Service Providers

03.09.2021

Version 1.0 (For Implementation on 13.09.21)

Version	Date	Key changes from previous version
1.0	03.09.2021	This document replaces "*COVID-19 Guidance on visitations to Acute Hospitals including Children's Hospitals, rehabilitation services and other healthcare settings providing a similar intensity of care*"

Note: If you have any queries on this guidance please contact the AMRIC team at hcai.amrteam@hse.ie

Contents

Scope

This document is applicable to acute hospital including children's hospitals, rehabilitation units, specialist palliative care inpatient units and maternity services. It should be considered in the context of the current overall guidance for control of spread of COVID-19 in acute and children's hospitals and the Interim Guidance on Infection Prevention and Control for the HSE (see www.hpsc.ie).

Introduction

Infection Prevention and Control (IPC) practice is critical to the safe operation of acute hospital services including the maternity and children's hospitals. The focus on the rigorous application of IPC measures is increased in the context of a public health emergency such as the current pandemic. Vaccination of the majority of the population has been associated with a striking reduction in the risk of severe COVID-19 in patients and staff resulting from exposure to the SARS-CoV-2 virus in the healthcare setting. There are however still significant risks in particular for many of those who use acute hospital services. The risks are greater for those who are not fully vaccinated and for those who have conditions associated with a high risk of severe disease or compromised immune function.

COVID-19 is spread primarily when susceptible people share an indoor space with an infectious person for a period of time. People with symptoms are generally more infectious but people can spread the virus to others before symptoms develop. In the context of an acute hospital setting any person, patients, staff or other people who enter the space may introduce infection. In the course of the COVID-19 pandemic there is persuasive experience of the introduction of COVID-19 and resulting outbreaks in acute hospitals and similar settings as a result of patients, staff and other people. Outbreaks of hospital acquired infection continue to occur in acute hospital settings even in the context of a very high proportion of fully vaccinated staff and patients. Although the overall impact of such outbreaks in terms of severe disease and death is much less for those who are fully vaccinated some patients, including some fully vaccinated patients, continue to experience very serious disease.

The risk of spread to a large number of people in the acute hospital setting is greater in settings where relatively greater numbers of people share a common space such as multi-

bed inpatient areas, multi-chair day care facilities and waiting areas in out-patients and similar settings. The risk is likely to be greater in settings where people are closer together and where ventilation is poor. There is therefore a continuing need for caution in relation to the risk of infectious people entering a hospital. The management of risks associated with infectious patients and staff are addressed elsewhere. This document relates to the management of risk associated with people other than patients and staff who enter the hospital.

While there is considerable scope to use technology to facilitate social contacts between patients and those who are important to them hospital policies on access have to recognise that these solutions cannot entirely replace face-to-face contact for everyone in every situation. Hospitals must therefore strike a balance between the need to manage the risk of introduction of COVID-19 by people accessing the hospital but doing all that is practical to support essential access. The hospital should have the capacity and relevant skill sets within its staffing complement to manage essential access appropriately. In some instances, suitably trained volunteers may be able to guide and support those who access hospitals to adhere to guidance.

Reducing the risk of introducing COVID-19 to an acute hospital or similar setting

Since any person who accesses an acute hospital or similar setting may unintentionally introduce the virus the number of people who access acute hospital should be limited as much as is reasonably practical but with regard for the needs of patients as outlined above.

Those patients who feel able to manage without being accompanied or visited during their time in hospital should be encouraged to do so, particularly if they are spending a short time in hospital. However, some patients may find it very difficult to manage without personal contact with others who are important to them even for a short period of time. Most people can reasonably expect to be accompanied when they are expecting to receive new information that has a major consequence for their life and health. Many people who are in hospital for extended periods or have specific needs may suffer greatly from a lack of contact with family and friends. It is not appropriate to impose such extended periods of lack of contact on patients.

As the risk of spread of infection is greater with closer and more prolonged contact people who access acute hospitals should limit their interaction with others within the building to the greatest degree practical. They should limit their interaction with others to least possible number of people (staff and patients) necessary to fulfil their role.

No one should access an acute hospital, other than as a patient in need of essential care, if they have symptoms of COVID-19, if they have been advised to self-isolate or restrict movements because of COVID-19 or if they are required to restrict movements in line with government guidance for travel outside of Ireland. Very rare exceptions to this may need to be considered on compassionate grounds. In that case very careful risk assessment and planning is required.

Vaccination is recommended for everyone aged 12 years and older who needs to access and acute hospital as this helps to reduce risk of introduction and spread of COVID-19. However, people should not be required to produce evidence of vaccination.

Testing of asymptomatic people for SARS-CoV-2 in advance of access to the hospital is not required as a routine. This guidance recommends that the risk of inadvertent introduction and spread of SARS-CoV-2 into the acute hospital setting is managed by assessing for symptoms, and checking that people accessing the hospital are adhering to public health guidance on restriction of movements and to good infection prevention and control practice. A practice of routine testing of asymptomatic people before accessing the hospital is likely to be a barrier for some people and to result in delays and practical challenges for implementation. There is no evidence that routine testing of asymptomatic people will add materially to the risk reduction measures recommended here. Hospitals may consider testing of asymptomatic people as an option for specific periods or in certain settings based on their hospital risk assessment. Where testing of asymptomatic people is implemented it should be carefully planned and there must be clear communication regarding the management of those who decline testing and those who have a positive test. Testing of symptomatic people and of contacts, where required should be through the usual processes for management of symptomatic people.

Hospitals should do everything practical to dissuade patients and relevant others from visits at the hospital door or gate that are not planned with the hospital staff. Such visits are

potentially high risk because there are no visitor health checks and IPC precautions are often neglected.

Everyone who accesses an acute hospital must adhere to directions on essential infection prevention and control practices including maintaining social distance (in so far as appropriate to their role), mask use, respiratory hygiene and cough etiquette and hand hygiene

All those who regularly access the acute hospital setting in the role as Essential Service Provider or Important Service Provider should have a basic training in and should consistently apply basic infection prevention and control measures necessary to protect themselves and others.

Restrictions on Access

Restrictions on access should be applied on the basis of HSE-AMRIC guidance, and a risk assessment that is reviewed regularly in view of the evolving public health situation. The risk associated with access is generally greatest when the incidence of infection in the population served by the hospital is higher. The risk may be greater also during periods of exceptionally high hospital occupancy, in wards providing care for patients at particularly high risk of severe disease and in wards where patients are accommodated in multi-bed areas. Providing access in busy general Emergency Departments is particularly challenging and often needs to be significantly restricted. In all circumstances however it is necessary to retain flexibility to take the needs of the person into account in application of restrictions on access.

Refusal of Access

Refusal of access should be very exceptional however hospitals will generally refuse access to those who show evidence of infection unless there are extraordinary circumstances such as expected imminent end of life or other compassionate circumstances and the risk can be managed with specific additional measures. Hospitals may be obliged to refuse access to a person who is unwilling or unable to comply with reasonable measures to protect all patients and staff or if the person has not complied with reasonable measures during a previous visit.

Communication

Restrictions on access are a cause of distress and disappointment to patients, their friends and families. Information that is clear and up to date and is consistent across website, leaflets and when talking to staff helps people to understand and accept and to cope with any restrictions that are necessary. This communication should make it clear how access is facilitated, any restrictions that apply, the reasons for the restrictions and the expected duration of restrictions. Patients and other should be provided with a clearly defined pathway to appeal against restrictions that they consider being unreasonable. This process should provide access to a person other than the staff providing direct care to the patient (such as a duty manager or ADON) and be capable of responding to appeals in a reasonable time frame. Patients and others should be clearly informed as to how to use the hospitals complaints process if they wish to complain about access at any time during or after their attendance at the hospital.

Equity of Access

Access of visitors and other people to patients who are accommodated in single patient rooms is associated with a lower risk of spread of infection. If the person accessing the patient lived with or had daily very close contact with the patient before admission to hospital it is likely that the patient will have already had intense exposure to the person prior to admission. Furthermore the nature of single room accommodation means that the visitor or other person is not sharing space with other people for an extended period as happens in a multi-bed area. Therefore from the perspective of infection prevention and control greater access can be supported with a low level of risk when patients are in single room accommodation. When single rooms are allocated on the basis of clinical need (for example severity of disease or need for privacy on compassionate grounds) this is likely to be accepted as reasonable and fair by most people. If access to single rooms is allocated on the basis of non-clinical considerations (for example health insurance) this may be seen by many people as unfair. Hospitals should ensure that equity of access is considered in developing their institutional policy on access.

General Guidance on Access

In acute hospitals or sections of an acute hospital where there is no ongoing COVID-19 outbreak reasonable access should be facilitated to the greatest degree practical for those patients who ask to receive people.

In general access should be arranged in advance with the ward.

If possible, access should be scheduled to avoid heavy footfall in the hospital and in the ward/unit/multi-bed room. It is expected that each hospital will consider the number of people who can have access at one time and discuss these plans with their infection prevention and control advisors. This is particularly challenging when multi-bed rooms represent the majority of the bed capacity and when rooms or waiting areas are small or poorly ventilated.

Each patient should have a number of nominated visitors or a nominated support partner or accompanying person.

Information for people who are accessing the facility should make it clear that they will be checked in advance of access for symptoms and determination if the person is required to quarantine, self-isolate or restrict their movements for any reason. Visitors and other people should declare that they have no symptoms and are not required to quarantine self-isolate or restrict their movements for any reason before entry.

If hospitals chose to use a temperature check prior to access people should be advised accordingly. A temperature check cannot substitute for checking for symptoms and advice on self-isolation/restricted movement.

People accessing the hospital are required to sign in on entry to the hospital. They should be guided in performing hand hygiene when they arrive. The sign in may be in the format of an acceptance of personal responsibility for their behaviour and for unavoidable risk.

People accessing the hospital are required to perform hand hygiene regularly and should wear a surgical mask during the visit. If wearing a mask is not practical, they should wear a visor that extends from above the eyes to below the chin and from ear to ear. However, if both the person accessing the hospital and the patient are fully vaccinated and are alone in a room

together there is no requirement for mask or other face covering if the patient has normal immune function

It is generally not appropriate to ask people accessing the hospital to wear gloves, apron, gown or eye-protection during access unless the patient they are seeing has a specific confirmed or suspected infectious disease that requires this.

The hospital should provide any necessary personal protective equipment to all those accessing the hospital. In most cases this will mean a surgical mask.

While physical contact (for example an embrace, hug or holding hands) between the patient and other people may increase the risk of transmission of infection it is not appropriate or practical for staff to intrusively monitor or police contact between patients and those who access the hospital to spend time with them.

Access should occur in the patient's room if the room is a single room. In the case of a multi-occupancy room, ideally access should be in a room away from other people where distance can be maintained. This will often not be possible because moving the patient to another room during access may not be practical. In that case, the person should stay in the bed space of the patient they have come to see, and should avoid interaction with anyone other than that person and the staff that they need to interact with.

The duration of the access should be appropriate to the needs of the patient but it may be necessary to limit the duration of the access to manage footfall and because of the needs of other patients.

Gifts of baked goods whether homemade or commercially produced are most unlikely to pose a significant risk and should not be restricted on infection prevention and control grounds.

There is no requirement to limit or restrict patients from receiving items such as books, magazines, confectionery, keepsakes or objects of religious or personal significance.

Some patients may express a preference not to receive people. The patient's right to decline or request to see people shall be respected.

Visits by children should be facilitated if the child is accompanied by an adult who takes responsibility for ensuring appropriate conduct and the child is able to comply with the general requirements for visiting.

Essential Service Providers (Defined in Appendix 2)

Controls on access for ESPs should be the minimum required manage infection prevention and control risks and should be limited to the most exceptional circumstances and for defined periods in the context of specific Infection Prevention and Control (IPC) or Public Health advice.

Important Service Providers (Defined in Appendix 2)

Important Service Providers (for example hair dressing) should be facilitated in providing services in the hospital to the greatest extent practical at times when those services are open to the general public.

Nominated Support Partner Access in Maternity Services (Defined in Appendix 2)

A nominated support partner plays a central part in supporting a person using maternity services. The support person also has a right to be present and to participate in the care process to the greatest practical degree. Controls on access for nominated support partners should be the minimum required to manage infection prevention and control risks, must be clearly explained and should be applied with consideration for individual circumstances and needs.

Testing of asymptomatic nominated support partners in advance of access is not generally required as outlined above.

Proof of vaccination of nominated support partners in advance of access is not required.

Labour and delivery; On arrival in labour or for induction of labour a nominated support partner should be facilitated in accompanying the woman through the admission and initial assessment process and on the pathway until settled in her assigned bed space.

If the woman goes directly to a single patient occupancy room there is no infection prevention and control requirement for the nominated support partner to leave during the process of childbirth and labour. Every practical effort should be made to ensure that a single patient room is provided throughout where there is a clinical reason to anticipate a particularly long, complex or high risk induction or labour so that access for a nominated support partner can be maximised. Likewise women who are having a miscarriage, stillbirth or other adverse pregnancy outcome should be prioritised for a single patient room to facilitate unrestricted access for a nominated support partner and even if a single room is not immediately available it is essential to facilitate access for the nominated support partner to the greatest possible extent while waiting for a single room to become available.

At present it remains necessary to limit access for nominated support partners to periodic visits when the woman is accommodated in multi-bed areas. This is because of the need to minimise the risk of exposure of other women and infants to COVID-19. At a minimum, hospitals should facilitate access for a nominated support partner for two hours per day either as a block or as two shorter periods as appropriate to the needs of the person. Access should be scheduled as flexibly as possible between 8 am and 8 pm and with a view to avoiding having a large number of people present in a multi-bed room at any at one time. As with all aspects of this guidance it is important to apply this with consideration for the needs of the patient and their nominated support partner. When the woman is preparing to transfer to a single-patient occupancy area (for example in the labour ward) the nominated support partner should be facilitated in joining her and accompanying her through the transfer process subject to the clinical time constraints that may apply in the situation. Once the woman is in a single-patient room there is no requirement to limit access for a nominated support partner.

The COVID-19 related risks do not differ materially between vaginal delivery and delivery by Caesarean Section and therefore COVID-19 related concerns do not require that a partner be excluded from attending a delivery by Caesarean Section if attendance would otherwise be appropriate.

Post-natal care; There is no IPC requirement to limit access of the nominated support partner if the woman is in a single patient room. At present it remains necessary to limit access for nominated support partners to periodic visits when the woman is accommodated in multi-

bed areas. This is because of the need to minimise the risk of exposure of other women and infants to COVID-19. At a minimum, hospitals should facilitate access for a nominated support partner for two hours per day either as a block or as two shorter periods as appropriate to the needs of the person. Access should be scheduled as flexibly as possible between 8 am and 8 pm and with a view to avoiding having a large number of people present in a multi-bed room at any at one time. As with all aspects of this guidance it is important to apply this with consideration for the needs of the patient and their nominated support partner.

Parents should generally be facilitated in visiting an infant who is in the neonatal intensive care unit (NICU)/neonatal care unit with due regard for the need to manage the risk to all infants in the NICU. Control of access and scheduling of visits is particularly important in a NICU setting where there are many infants in an open area and space is very limited.

Ante-Natal Care; A nominated support partners should be welcome to attend at the 12-week and 20-week scans, early pregnancy assessment unit attendances, unscheduled attendance including attendance at emergency services and other antenatal appointments or attendances if there is reason to anticipate that the attendance is likely to be associated with particular stress or to involve communication of particular emotional significance. It is important to take a person centred approach to recognising contexts in which the presence of a nominated support person is required.

Limitations on space in many maternity services mean that restrictions on access for nominated support partners are necessary at this time for most routine antenatal visits in many maternity services. The support of those who feel able to attend unaccompanied is greatly appreciated.

If restrictions on nominated support partners in excess of those outlined above are considered essential this should be based on a documented risk assessment, that is reviewed regularly and that is readily available to women and their support partners (for example on the hospital website). Such risk assessments may consider if there is an ongoing outbreak of COVID-19 in the facility, the infrastructure, staffing levels, the current level of cases in the

community and the potential adverse impact of restrictions on patients, infants and their families.

Accompanying Person (Parent/Guardian/Carer) in Children's Services

Hospital services for children and adolescents (up to 16 years old) encompass services for many children with special and complex care needs. Although most children's inpatient stays are short, a child-centred approach to care requires that parents/guardians have access and can stay with the child throughout this period. This is to provide a sense of security and comfort to their child through their presence during their hospital stay. Therefore, the management of access in this context requires a different approach factoring these considerations into the risk assessment. Similar issues may arise for adults notably for some adults with special needs:

1. One **accompanying person** should be supported to be with a child during their hospital admission or other hospital attendance. Parents/Guardians/Carers may rotate the role of accompanying person.
2. Testing of an asymptomatic accompanying person in advance of visiting/accompanying the patient is not required for reasons outlined above. Hospitals may consider testing of asymptomatic people as an option for specific periods or in certain settings based on their hospital risk assessment. Where this is implemented it should be carefully planned and there must be clear communication regarding the management of those who decline testing and those who have a positive test.
3. Proof of vaccination for accompanying persons in advance of access is not required but it is appropriate to inform people that being fully vaccinated reduces the risk of COVID-19 for everyone in the hospital.

Frequency of Visitors and Number of Visitors

Routine visiting when there is no Outbreak

Hospitals should aim to facilitate at least **four routine visits per week** in the absence of any critical or compassionate circumstances that require increased frequency of visiting.

The number of people participating in each visit should normally be 1 person unless there are specific circumstances that require that the visitor is supported by an additional person.

Visiting on Compassionate Grounds (Definition in Appendix 1)

There is no upper limit on the frequency or duration of visiting that is acceptable where critical and compassionate grounds (as set out in Appendix 1) apply, subject to the ability of the hospital to manage the visiting safely.

Visiting in the context of an outbreak of COVID-19

Visiting and access within the ward/unit/hospital will generally be suspended in the first instance **with the exception of critical and compassionate circumstances**. Access for important service providers will generally be suspended during the early phase of an outbreak. When the situation has been evaluated and control measures are in place the extent to which visiting can be managed should be reviewed regularly.

Significant considerations in the risk assessment include the outbreak related care workload for staff and the number of staff available, which may limit capacity to manage visiting. If the outbreak is confined to one wing or one ward or unit in a hospital there may be fewer requirements for visiting restrictions in other wards or units.

All visits during an outbreak are subject to the visitor accepting that all visiting during an outbreak is associated with a risk of infection for the visitor and that they choose to accept that risk. The hospital should request visitors to confirm that they have been advised of the risk to them, that they accept that risk and will comply fully with any measures they are asked to follow for their own protection or the protection of staff or patients. All visitors should be provided with any necessary personal protective equipment.

Arrangements for virtual visiting (telephone or video-link) and window or out-door visiting should be reviewed to ensure that they are as supportive as possible.

The messages around visiting during an outbreak should be communicated clearly to patients and the public and reinforced by placing signage at all entry points to the hospital and by any other practical means of communication with families and friends.

Patients' requests to visit home while inpatient in an acute hospital

In some circumstances, visits home may be an essential part of the therapeutic or discharge process. If the patient is fully vaccinated the risks associated with this are low. Even for non-vaccinated patients, where this is essential for clinical care the risk must be accepted and managed.

It is also important to acknowledge that patients who are able to do so have the right to leave hospital at any time if they choose to do so.

In some cases, patients may seek to plan a social visit to their home or another house while an inpatient. Visiting to a residence outside of the hospital should comply with public health restrictions that apply to visiting private houses by the general public at the time. The risk associated with such planned visiting should be assessed and discussed with the patient. The risk can generally be managed with appropriate, planning and precautions particularly if the patient if fully vaccinated and is not immune compromised. An approach to risk assessment is presented as appendix 2 to this document.

If a patient is absent from the hospital for less than 12 hours and in the absence of any reported unintended exposure there is generally no requirement for the patient to be subject to any additional testing or IPC measures other than those that apply to all patients on their ward on their return.

If the patient in question is fully vaccinated and most patients and staff on the ward are fully vaccinated there is generally no requirement for the patient to be subject to any additional testing or IPC measures other than those that apply to all patients on their ward on their return even if they are away overnight.

In the context of a patient who is not fully vaccinated and who has been away for more than 12 hours (typically an overnight stay), the IPC precautions applied to the patient should be those that apply to a new admission on their return.

Appendix 1 Definition of Terms

Visitors

For the purpose of this guidance, visitors may be taken to include people, typically family members or friends, who come to the hospital for a social visit. The term visitor is not intended to include the following categories of people who require access to the acute hospital setting.

Nominated Support Partner

For the purpose of this guidance, a nominated support partner is the person nominated by women accessing maternity services to accompany her to provide support and to act as an advocate as appropriate.

Hospitals should consider applying a similar model of nominated support partner with similar levels of access for other groups of patients who are likely to experience frequent and prolonged hospitalisation for life threatening illness.

Accompanying Person (Parent/Guardian/Carer)

For the purpose of this guidance, an accompanying person is a parent or guardian accompanying a child or a carer accompanying a person with special needs in the acute hospital setting

Essential Service Providers (ESPs)

For the purpose of this guidance Essential Service Providers are people who provide professional services including healthcare, legal, financial and regulatory services. Key examples include those who attend the hospital to provide healthcare services such as medical, nursing, social work, safeguarding, dental, physiotherapy, occupational therapy or podiatry services and those who provide legal services, chaplaincy services, advocacy services, or inspection of the hospital for monitoring or regulatory purposes.

Important Service Providers (ISPs)

For the purpose of this guidance Important Service Providers are people who provide services that are important to a patient's sense of self and wellbeing but that are not strictly necessary. Examples of ISPs include those who provide personal care (for example hairdressers). A

hospital should consider if it is possible to have a list of important service providers with whom there is an established relationship and clarity around infection prevention and control requirements.

Fully vaccinated

A person is considered fully vaccinated as follows.

1. 15 days after the second dose of AstraZeneca (Vaxzevria);
2. 7 days after the second Pfizer-BioNTech dose (Comirnaty);
3. 14 days after the second Moderna dose (Spikevax);
4. 14 days after Janssen (one dose vaccination course).

If other vaccines become available the requirement for vaccination will be as advised by HSE.ie.

Critical and compassionate circumstances are difficult to define and of necessity require judgement. The term should not be interpreted as limited to circumstances when the death of a patient is imminent. Where critical and compassionate grounds (see examples set out below) apply the duration and frequency of visiting should be as flexible as possible subject to the ability of the hospital to manage the visiting safely.

The following are examples of critical and compassionate circumstances:

1. Circumstances in which end of life is imminent;
2. Miscarriage, stillbirth or other adverse pregnancy outcome;
3. Circumstances in which a patient is significantly distressed or disturbed and although unable to express the desire for a visit there is reason to believe that a visit from a significant person may relieve distress;
4. When there is an exceptionally important life event for the patient (for example death of a spouse or birthday);
5. When the visitor may not have another opportunity to visit for many months or years or never (for example because they are leaving the country or are themselves approaching end of life);

6. Increased visiting is recommended by their doctor as a non-pharmacological therapeutic alternative to an increased dose of an existing agent or introduction of a new anxiolytic or sedative agent;
7. A patient expresses a strong sense of need to see someone whether for personal reasons, to make financial or other arrangements or to advocate on their behalf;
8. A person nominated by the patient expresses concern that a prolonged absence is causing upset or harm to a patient;
9. Other circumstances in which the judgement of the medical or nursing staff, registered health or social care professional, spiritual advisor or advocate acting for that the patient is that a visit is important for the person's health or sense of well-being.

Appendix 2

Assessing Risks Associated With a Visit to a Residence or Similar Setting Outside of the Hospital

It is appropriate to have an approach to assessing and managing the risk associated with visits outside of the hospital. This is important to ensure that the patient and relevant other people are fully informed of the risk to them and to others associated with the proposed visit and to support the ward manager in managing the risk to all patients and staff associated with the proposed visit. This document is intended to support the patient, relevant other people and the ward manager in dealing with these issues arising from proposed visits outside the hospital when such visits are consistent with general public health guidance in force at the time.

Patients who are able to do so may choose to leave the hospital in the absence of an agreed plan with the ward manager or clinical team. If that patient subsequently requests to return to the hospital, this poses a significant challenge for the ward manager and clinical team. However, it is expected that a patient who wishes to return in such circumstances would normally be accommodated as appropriate to their clinical condition and in a manner that manages that risk to other patients and staff.

Strong and supportive communications between patients, family and staff should be in place. For all circumstances, the patient and/or family member should be advised of any requirements in advance of leaving the hospital in order that they can make an informed decision regarding any external visits. Communication plans and risk assessments should be documented.

Risk Assessment

Assessing Risk Associated with a Patient Visit outside of a Hospital
It is not possible for the clinical team/ward manager to seek verification or documentation regarding the information provided by the patient or the person hosting the visit. The risk assessment and advice provided to the patient is based on accepting the good faith of the person providing the information

Characteristic	Comment
Vaccination status of the patient intending to visit	The risk is much lower if the person is fully vaccinated
Vaccination status of the person(s) the patient intends to visit	The risk is much lower if the person is fully vaccinated
Vaccination status of other patients who share space with the patient	The risk is much lower if most other patients in a multi-bed area/ward are fully vaccinated
Level of independent function of the patient	Risk generally lower for patients who are very functionally independent
Medical condition of the patient with respect to risk of severe COVID-19	Risk is generally lower with younger patients and those with underlying illness that does not represent a high risk for severe COVID-19
Accommodation of the patient in the hospital	Risk is generally lower if the patient has their own room in the hospital
Behaviour of the patient in the hospital	Risk is generally lower if the patient copes well with staying in their own room most of the time if this is necessary for any reason after their return
Travel to and from the hospital	Risk is generally lower if transport is to and from the hospital in a vehicle driven by one of the people from the house they will be visiting and particularly if that person is fully vaccinated
The number of people they will be in contact with	Risk is generally lower, the lower the number of people the person will be in contact with during the visit. For example visit to a spouse or other individual is low risk whereas a visit to an extended family is much higher risk Consider if the host can give an undertaking regarding the number of people who will enter the house while the patient is there
The people they will be in contact with	Risk is generally lower if the people they intend to be in contact with can give an undertaking that they are fully vaccinated and exercising a high level of precaution in relation to their own possible exposure in the two weeks before the visit Risk is generally lower if the host is able to give an undertaking regarding minimising the risk that any person who is currently infectious for COVID-19 or is a COVID-19 contact will not be in the household
The host's assessment of the ability of others present to accept measures to reduce risk of infection (staying away if symptomatic, hand hygiene, distancing and mask use when appropriate)	Risk is generally lower if the host can give an undertaking that the people present are able to accept and follow measures to protect the patient during the visit
The duration of visit	Risk is generally lower if the visit is shorter (1-2 hours is much safer that 8-10 hours). See guidance in text related to duration of visit.

Managing the assessed risk

If the risk is assessed as low, it is appropriate to advise the patient and relevant others accordingly.

The following are characteristics of a low risk visit.

1. The patient if fully vaccinated, is relatively independent in activities of daily living and does not have medical conditions that place them at high risk of severe COVID-19;
2. The patient has their own room and copes well with staying in their own room much of the time if this is necessary for any reason after their return;
3. The patient will travel in a car driven by one of the people they intend to visit;
4. The patient is going to visit one or two people who are fully vaccinated, have no symptoms and can undertake to adhere to measures to reduce risk of infection;
5. The duration of the visit is short (less than 12 hours).

If it is confirmed on return that the visit went as planned, then no additional IPC precautions are required with that patient on return. However, they should be monitored carefully for symptoms suggestive of COVID-19 for 14 days after their return, particularly if they are not fully vaccinated.

If the risk is assessed as medium to high, the patient and relevant person as appropriate should be advised that the visit poses such a risk to them and to other patients that the clinical team/ward manager advises against the visit. The risk should generally be assessed as medium to high if the characteristics of a low risk visit as outlined above are not met.

If the visit is assessed as medium to high risk but is essential, the patient should generally be managed as for a new admission on their return to the hospital. It may arise that a patient leaves the hospital in the absence of an agreed plan to minimise risk to exposure to COVID-19. In most circumstances the patient should be managed as for a new admission on their return (see text of guidance).

ENDS