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Visiting Guidance for Hospitals in Scotland

Safely supporting visiting across Scotland's hospitals

2 November 2020

Introduction

The importance of visiting within hospitals cannot be overstated, bringing comfort to both those receiving visitors and to those visiting. 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 modified by the presence of familiar faces of family and friends who visit. We also know that visits can have a positive effect on nutrition, healing and recovery. As such, visiting should be seen as a fundamental part of the care of a person in hospital.

In the initial stages of the COVID-19 pandemic, visiting was suspended to essential visits only where not seeing a family member would cause particular distress or suffering. At the time this was necessary to minimise the spread of COVID-19 and to keep patients, visitors and staff safe. However, the absence of visitors increases social isolation, causing its own problems and associated harm. Therefore, we need to balance the risks appropriately and ensure a more person-centred approach to visiting where possible.

Key principles

This guidance has been designed with the following principles in mind:

- COVID-19 areas (also known as red pathways) will remain as essential visiting only.
- Patients on the Low Risk pathway who have gone into hospital following a period of isolation and testing to reduce any COVID-19 risk can be visited only by a person who has come from the same household where the patient has been isolating (this would include someone who has formed an extended household)
- Visiting should adopt a person-centred approach. 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. 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.
- Patient, staff and visitor safety is crucial.
- “Blanket” policies for all hospitals, or all patients with particular characteristics, should be avoided.
- An evidence-based approach is required for both national and local implementation of visiting practice.
- A staged approach to the reintroduction of visiting 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 community hotspots or outbreaks, hospitals may have to impose visiting restrictions to protect patients, staff and visitors. It is important to note that the presence

of a local outbreak may *not* automatically require hospitals to revert to "essential visits" – this will depend on local circumstances.

- Visitors should wear face coverings.
- The 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).

It is intended to align each stage of visiting with the Tiers in Scotland's Strategic Framework, to encourage person-centred visiting, provide clear information and most importantly promote safety for patients, staff, visitors and communities.

The impacts of isolation

The pandemic has created an unprecedented situation which at times necessitates close control of hospital visiting and this has had a significant impact on patients, families and staff. 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 or life-changing illness, has been significant. This situation makes hospital visiting, and indeed other person-centred improvement work, an important element of the NHS Scotland recovery plan.

Staged approach to the reintroduction of visiting

COVID-19 is still with us and can be transmitted easily.

To reduce the risks the careful attention to infection and prevention control measures around visiting must be maintained. Key among these will continue to be regular handwashing, the use of alcohol-based hand rub, wearing face coverings, and adherence to physical distancing.

If there are risks identified, restrictions may be resumed. As is the current position, visiting to any area where there is an outbreak of COVID-19 will have to be reviewed in accordance with public health guidance, and visits should be restricted to all but essential visits.

At the beginning of July a system of "designated visiting" was introduced for **all** in-patients. Patients in non-COVID areas have been able to have visits from a designated visitor. Visitors have been required to arrange a visit in advance, observe physical distancing wherever possible, wear face coverings and limit movement in other areas of the hospital. Visits have not been permitted where a potential visitor – or someone they live with – has shown symptoms of COVID-19, nor where there has been COVID-19 present in the hospital area where the patient is.NHS clinical staff

reported that overall this system is working well. The ability to change who the designated visitor is also remains in place.

In recent months, some health boards have had to revert to essential visitors due to an increase in cases of COVID-19.

From November 2, Scotland is moving to a new system of local restriction levels based on the prevalence of COVID-19 in the local authority area.

This visiting guidance, which updates our earlier guidance of June 30 2020, is linked to these Strategic Framework tiers. It is intended to help hospitals and health boards balance the risks of infection with the need to provide an environment that supports healing, well-being and the right to family life, and minimises the harm caused by separating people from their loved ones. It considers how visiting may take place in a safe way that balances the risk between spread of infection and family separation, safely and proportionately – recognising that the presence and involvement of family is of vital importance to recovery and well-being.

The visiting stages set out in our earlier guidance are now aligned with a corresponding tier in the strategic framework:

- For hospitals in Tier Zero local authority areas, essential visits and two designated visitors observing physical distancing will apply
- For hospitals in Tier One local authority areas, essential visits and two designated visitors observing physical distancing will apply
- For hospitals in Tier Two local authority areas, essential visits and one designated visitor observing physical distancing will apply
- For hospitals in Tier Three local authority areas, essential visits only will apply. However, in Tier Three there clinicians at hospital level will be empowered to move to one designated visitor if they judge that this is safe and appropriate
- For hospitals in Tier Four local authority areas, essential visits only will apply.

This guidance makes clear that for areas in tier three essential visits will apply, with the ability for clinicians at hospital level to decide to progress into one designated visitor if they judge that this is clinically safe. This allows local decision makers to exercise judgement about what is appropriate in response to local needs.

Decisions to move to a higher or lower level will be made at national level. Notice to staff, patients and visitors would typically be 3-4 days when decisions are made at national level. Where hospitals within tier three areas in the strategic framework judge it safe and appropriate to move between essential visiting and one designated visitor, staff, patients and visitors should have as much notice as is reasonably possible.

Strategic Framework Tier	Tier Zero	Tier One	Tier Two	Tier Three	Tier Four
Visiting	Essential Visits And Two designated visitors at the same time observing physical distancing *Or, if it is not possible to maintain physical distancing for two visitors at the same time:* Two designated visitors each day, each one visiting separately	Essential Visits And Two designated visitors at the same time observing physical distancing *Or, if it is not possible to maintain physical distancing for two visitors at the same time:* Two designated visitors each day, each one visiting separately	Essential Visits And One designated visitor observing physical distancing	Essential Visits only (End of Life, birth partners, children, patients with mental health issues including dementia, learning disabilities, autism) *And, if clinicians at hospital level judge it to be safe and appropriate:* One designated visitor observing physical distancing	Essential Visits only (End of Life, birth partners, children, patients with mental health issues including dementia, learning disabilities, autism)
Required	Visitors must maintain physical distancing wherever possible Visitors must wear face coverings; Visitors must have access to hand hygiene facilities Restricted movement to other areas of hospital unless of part of care for patient – i.e. birth partner attending scan, parent accompanying child or other similar situation				
Settings	Hospitals/ wards with no COVID-19 outbreak. Essential visits can still take place to COVID-19 areas (now known as red pathways). COVID-19 areas should remain at essential visitors only.				

In Tiers Three and Four

Essential visitors only:

An essential visit is one where it is imperative that a relative or friend is allowed to see their loved one in a number of exceptional circumstances.

Examples of essential visits include but are not limited to:

- A birth partner supporting a woman during hospital visits
- For 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 and weeks
- to support someone with a mental health issue such as dementia, a learning disability or autism where not being present would cause the patient to be distressed
- to accompany a child in hospital.

These include any other situation where clinical staff assess that it is essential to involve family or carers for ethical or patient safety reasons.

It is important to note that these examples of essential visiting are intended to be illustrative and not exhaustive. A carer or interpreter – or someone else fulfilling a similar necessary function – should not be considered as a visitor.

In Tier Two (and Tier Three, if clinicians judge it to be safe and appropriate):

One designated visitor:

A relaxation of visiting restrictions will commence with one designated visitor. This does not mean that there are no risks, therefore this will be limited to one designated visitor only (see definition below), at 2m safe distancing, wearing a face covering, as well as any further PPE that the area being visited considers necessary. Hand hygiene will remain crucial to protect visitors and patients alike.

Patients should be asked to identify a designated visitor who will be able to visit them while in hospital.

Visitors must not attend 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 visitors of the importance of this. Any visitors who arrive at the ward/department with symptoms should be asked politely to leave and return home directly to follow advice on NHS Inform.

Visitors must arrange with staff a time to visit in advance in order to manage numbers of people present at any one time so physical distancing can be maintained.

NHS Boards should not impose set time restrictions on visiting as this would make physical distancing harder to maintain 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.

The number of people able to be accommodated for visits to 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 visitors at any one time than multiple occupancy areas. Individual settings should consider how many visitors it is possible to accommodate at any one time. This should however be done against the context of overall footfall throughout the hospital.

Visitors should wear face coverings or any other PPE as indicated by the clinical team and must adhere to strict hand and respiratory hygiene by using alcohol based hand rub on entering and leaving the ward/department or following any contact with their loved one, 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 visiting a patient with suspected or confirmed COVID-19, visitors should be provided with the appropriate PPE.

Physical distancing must be maintained where possible during visits.

Visitors should not visit other patients or clinical areas during their visits.

We expect these principles to be applied flexibly and compassionately, taking account of the local context, recognising the need to be person-centred at all times and especially in areas such as ICU, learning disabilities, autism, mental health, frail elderly, dementia and maternity. In general situations when someone is receiving information about life-changing illness or treatments, or other similar situations where support from another is essential for support and well-being.

Specific examples of application include: In maternity settings, partners or birth partners being able to attend ante-natal, clinic or scan appointments with their partner. A parent or guardian can accompany a child to hospital. Frail elderly people who don't have dementia can now be visited by a loved one by arrangement. Discussions about cancer treatment can be attended by a loved one or carer.

In the case of someone with learning disabilities or mental health, visits 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 paid carer or family member to participate in care, reducing the stress and distress experienced by the individual.

This list is not intended to be exhaustive and we expect this guidance to be applied consistently and compassionately.

Other people who are in attendance to support the needs of the person in hospital, such as a carer/supporter/personal assistant, should not be counted as an additional visitor. Where possible, when this extra support is needed, advance contact with

staff will be helpful in enabling them to discuss local considerations and make appropriate arrangements.

In-person visits 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 virtual visiting will not work for a significant group of people and it should not be used as the default option or to replace in-person visiting. Virtual visiting is available for extreme and rare circumstances where an in-person visit 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 visiting.

Anyone with symptoms of coronavirus should not visit, even if these symptoms are mild or intermittent, due to the risk they pose to others.

In Tiers Zero and One

Introduction of two designated visitors

When local authority areas are in either Tier Zero or Tier One we expect hospitals to begin the phased introduction of two designated visitors per patient. This is in addition to essential visiting and, as with the initial reintroduction of visiting, it must be done in a careful way that takes all necessary precautions to help prevent the spread of COVID-19.

Patients will be asked to name two visitors who can see them in hospital during their stay. The designated visitors are not fixed and can be changed if a patient needs to see another person other than those originally identified. Given the need to maintain physical distancing and to help staff manage the safe operation of clinical treatment, there will be some requirements around how this is organised:

- As with the introduction of one designated visitor, visitors will arrange visits in advance with staff if necessary
- Pre-arrangement of visits is to support the ability to physically distance in clinical areas, but this may not be necessary on sites with single room accommodation as long as the visitor is named and lets staff know when they are arriving and leaving. Visitors will be expected to leave contact details for Test and Protect purposes.
- Two visitors from the same household may visit at the same time.
- If it is possible for two visitors who do *not* live in the same household to be present at the same time and maintain a physical distance, it may be possible to visit together and every effort should be made by staff to accommodate this if it is safe to do so and requested by the patient or their visitors.
- In some circumstances, the layout or physical space available may mean only one visitor can be present at a time. In these circumstances visitors must undertake visits separately. If it is possible for staff to accommodate two visitors in one day this is encouraged in the interests of supporting patients to be supported by loved ones as much as possible, if requested by the patient. Each local care area should have local visiting plans and risk assessments.

- Current requirements around wearing face coverings, provision of contact details and rigorous hand hygiene including handwashing or the use of alcohol-based hand rub and adherence to physical distancing will remain in place.
- 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 two visitors 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 designated visitors at the same time – may be possible, whereas a high frequency of visits or visits by two designated visitors at the same time may not be possible in smaller or older areas.

The maximum possible interaction with loved ones should be accommodated and patients and visitors should have any limitations and the specific reasons for them clearly explained.

Two designated visitors

Two designated visitors routinely allowed, by prior arrangement with the clinical area (this is two visitors in total, not two visitors in addition to the one named visitor allowed in other tiers). The two visitors should not visit the patient at the same time, unless they belong to the same household and/or can be safely accommodated in the space available while maintaining physical distancing between themselves, staff and other patients and visitors.

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 visitors' 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. In maternity settings, where possible, a child or parent could attend ante-natal, clinic or scan appointments with the pregnant woman and her partner. Frail elderly people who don't have dementia can now be visited by a loved one by arrangement, allowing for example adult children and spouses to visit. As is currently the case, visits for someone with learning disabilities or mental health 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 paid carer or family member to participate in care, reducing the stress and distress experienced by the individual.

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 the number of people who can visit loved ones at the end of life**. The flexibility and compassion of clinical staff in supporting this 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. This guidance is intended to ensure that patients nearing the end of life can spend meaningful time with their loved ones in their final days and weeks.

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.

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 a designated visitor. Further principles about managing visits by faith representatives are included at Appendix Three.

Definitions - essential visit and designated visitor

An **essential visit** is one where it is imperative that a relative or friend is allowed to see their loved one in a number of exceptional circumstances. These include at end-of-life, for patients with a mental health issue such as dementia, autism or learning disabilities where the absence of a visitor would cause distress, to accompany a child in hospital, or any other situation where clinical staff assess that it is essential to involve family or carers for ethical or patient safety reasons.

A **Designated Visitor** is someone chosen by the patient who they would like to be their named visitor. This might be a spouse or next of kin or a friend. That person will be the first to visit in the early stages of allowing visiting and we recommend this person should also be the main link for communication. The designated visitor is in addition to any essential carer/personal assistant/support required for care. The designated visitor can be changed if required. This stage of visiting will mean each patient being able to have two **Designated Visitors**.

Planning for changes to visiting guidance

We suggest approaching any change in visiting guidance from three perspectives – that of the individual patient and their characteristics; the individual visitor and their characteristics; and the specific environment of the hospital in question.

Where changes in visiting guidance are expected – whether because of a national decision to move between tiers or a decision by clinicians at hospital level in Tier Three areas to move to one designated visitor – it is expected that patients, staff and visitors 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. Where visiting moves to allow Designated Visitor/s, patients should be asked who they want their Designated Visitor/s to be.

Care should be taken first of all to determine whether the individual patient wishes to receive visitors and who they want to see as their second Designated Visitor/s.

Where guidance allows for two Designated Visitors, both Designated Visitors must arrange with staff a visiting time in advance if necessary, to manage numbers of people present at any one time and physical distancing..

Designated Visitors are likely to have specific concerns and expectations about their relative and the conditions of visiting, which could be discussed in advance. Some patients may find the conditions associated with recommencement of visits difficult and emotional. Staff should be supported to prepare visitors as well as possible and be familiar with approaches which may help. Designated visitors can be changed if required. We have prepared a sample information leaflet that you might find helpful to support visitors.

Staff may be fearful about the risks of harm associated with expanded numbers of visitors 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 visitors and how they can best support emotionally challenging situations.

Both staff and designated visitors would benefit from being supported to anticipate different responses and prepared with some potential coping strategies. In the context of visiting restrictions continuing for some time, there is much to be learned from care teams who have been especially successful in adopting a range of methods to maintain connections between relatives, residents and themselves. Continuing to develop augmented channels of communication such as virtual visiting will be important.

It will be particularly important when guidance allows two Designated Visitor/s, with the extra demands placed on areas to accommodate physical distancing with more visitors, that there is an appropriate assessment of the individual, the visitor and the hospital or environment. This will enable documented local risk assessments to be undertaken.

The patient

The needs of 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 visiting is to support emotional well-being for the patient and promote good recovery. The patient needs to be at the centre of all the 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. Communication may 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 visit happen?

Consideration needs to be given to how frequently a patient may wish to see their visitor/s. It may be necessary to stagger visits and to limit the length of time of visits in order to ensure not too many people are present at the same time. It will also be important to think of practical issues such as where the visit might take place (see below).

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

Visitors

As with identifying of one Designated Visitor, the family of a patient may require to be supported in making the decision as to who is to be the second Designated Visitor. If a patient has been in hospital for a long period of time, the health and wellbeing of their family member may have changed and this may cause distress to visitors. Staff should be prepared to support both anxiety and upset should it occur. The following should be considered before visitors are permitted to visit:

- Visitors must not have symptoms of COVID-19.
- Visitors must not attend if they are self-isolating for suspected or confirmed COVID-19
- Visitors must not attend if they have recently returned from a country requiring quarantine
- Visitors must not attend if they are a household contact or have been otherwise informed that they are a close contact of a confirmed case of COVID-19 and have been advised to self-isolate or have to self-isolate for another reason (e.g. travel from a country requiring quarantine).
- The overall health of each visitor needs to be taken into account especially should they be an individual who may be in a particular at-risk group. They should be advised of the risks which may result from any visit to the hospital.
- Designated Visitor/s can be changed by arrangement if required.
- Visitors will need to consider how they will travel to the hospital and in particular whether their journey necessitates the use of public transport. Guidance on how to travel safely is available from Transport Scotland.
- Visitors will be required to wear face coverings at all times.

- They will be required to restrict themselves to the locations where the visit will be taking place as directed by hospital staff.
- Visitors must move directly to the clinical area where a visit is to take place. They must not gather or linger in communal areas of the hospital. At all times they must follow the instructions of hospital staff. This is particularly important in areas where tighter restrictions are in place.

The hospital

Every hospital should be encouraged to risk assess and where required develop a Visiting Protocol. When patients with COVID-19 are present in an area we suggest that there should be essential visits only. If patients are isolated in a single room this will provide more flexibility in how the situation is managed locally. Local protocols should describe in plain and accessible terms the process of visiting 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

Regardless of the location of the visit there are some practical steps that need to be considered. These will include:

- Could a one-way system be introduced to minimise the risk of contact with others?
- What needs to be in place to minimise/avoid contact with other patients and staff?
- How will the hospital ensure visitors follow good practice such as hand hygiene, respiratory hygiene, physical distancing etc?
- Is there sufficient space to allow two visitors from the same household to visit at the same time while being physically distant from others?
- Is there sufficient space to allow two visitors from different households to visit at the same time while physically distant from each other and other people?

Toilet facilities:

- Visitors must 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 visiting.

Feedback on the guidance

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

ID:	

Appendix One: 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.			
Additional Local Units Description of Risk			

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 Two: Sample Visiting Guidance for Families and Carers

Two Designated Visitors

We are expanding controlled visiting. Your continued support in protecting not only our patients and staff, but also you as visitors and the wider community, is equally important.

It is critical that visits only take place at pre-arranged times. These will be jointly agreed between you, the person you are visiting and staff. This arrangement is in place to ensure we control the number of people in one area of the hospital at any one time. If you and another designated visitor are members of the same household, you should be able to visit together if there is sufficient space to allow you both to physically distance from other people. If you and another designated visitor do not live together, you may be able to visit together if there is sufficient space to allow you both to be physically distant from each other and from other people.

You may be asked to limit your visit to a set amount of time, to allow other visitors to visit other patients, and to allow staff to manage numbers of people in any one area at a time.

Action to be taken

1) You will be asked before entering the clinical area to perform hand hygiene using alcohol based hand rub or by washing your hands with soap and water. Hand-washing should take a minimum of 20 seconds, following the hand-washing/hand rubbing guide which will be visible in the area you are visiting.

2) You will again be asked to clean/rub your hands with the alcohol-based gel when you leave.

3) You will be asked to wear a face covering. You should bring one with you and put it on before entering the hospital. You may be asked to wear additional protective garments by staff where needed.

4) You are asked to maintain a two-metre distance between you and your loved one, even if you were part of the same household or social bubble prior to admission to hospital. This is because the risks of infection change and become much higher once someone comes into hospital. We fully understand this is difficult for both you and your loved one, however it is a critical protective factor for you both, our staff and the wider community.

5) In addition, you may be asked a series of questions by the staff – this is normal in the current times and is intended to try and make sure that everyone stays safe.

6) Part of the process of being a Designated Visitor for someone in hospital includes being asked to provide your contact details; this is normal in the

current circumstances and is to assist Public Health, Trace and Protect colleagues should there be a need to contact you.

7) Please do not bring in food parcels, flowers, helium balloons or similar items.

1) Have you felt unwell recently – especially with a cough, breathlessness, tiredness, a temperature or vomiting or diarrhoea?	
2) Have you been in contact with someone, in the past 14 days, who is suspected of having or is confirmed as having COVID-19?	
3) Have you been told by your GP or other NHS professional that you should not be visiting a hospital?	
4) Please supply your contact details: these may be used by Public Health as part of the 'Test and Protect' strategy, should there be a necessity following your visit to the hospital.	

Appendix Three: Spiritual Care guidelines

Spiritual Care

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.