Guidelines for Visitation during COVID-19 to Support Compassionate and End of Life Visitation.

The COVID-19 pandemic presents a number of challenges, including the ability for a family/support person to be able to visit a patient or resident. There is a public health order to limit visitors to essential visits only.

The definition of an essential visit can be difficult to determine and would benefit from a guideline to support decision making. The interests of the patient/resident and consideration of the safety of others who may be impacted by the visit must be considered. A risk assessment is required to ensure risks are identified and analyzed, and appropriate mitigation strategies are put in place to support visits where possible during COVID-19, or provide alternative means for a visit such as virtual visit or provide a rationale for when a visit request cannot be accommodated.

Essential visits are granted because of unusually distressing circumstances affecting a patient or resident. There may be a variety of reasons for a family member/or support person to want to visit an individual in hospital or Long Term Care during the COVID-19 outbreak, and a risk assessment should be completed prior to any compassionate visits being considered. **Essential visits** may be broadly defined as:

- Visits for **compassionate care** (end of life and critical illness, with anticipated death within 48hrs)
- Sites may in rare situations make an exception and allow one **essential visitor** where the patient's/resident's care needs cannot be met without the visitor's assistance. Such visits are considered **paramount to patient care and well-being**, e.g. assistance with feeding or mobility that cannot be supported by healthcare staff. Such visits may also include pediatric patients, maternity patients or patients with specific behavioral, mental health or spiritual needs that cannot be supported by onsite health care staff.

LONG TERM CARE FACILITIES:

Long Term Care facilities (LTCF) are currently advised to restrict visitors to essential visits only, as advised by a directive from the Public Health Officer (Letter from Dr. Bonnie Henry, PHO)

Guidelines for visitation should follow the BCCDC clinical decision pathway for residents in COVID-19 LTCF with outbreaks. If a resident at a COVID-19 LTCF is at end of life and the resident or family/support person would benefit from a compassionate visit, a discussion with the director about visitation should occur (with consideration as to whether PPE is available).

1. **Recommendation for LTC Facilities:** Continue to follow the PHO/MHO Exemption form for visitation process, and any further PHO/MHO orders related to visitation restrictions at LTC facilities.

ACUTE CARE FACILITIES

Guiding questions to consider in making a decision should include but not be limited to the following:

1. Is there an alternative means of visitation that is achievable and acceptable by those requesting the visit? Virtual (e.g. Zoom, Facetime, Amazon Echo etc.), telephone, or letter writing or email, gift drop offs, or other options that enable connection but do not require an in person visit?
2. Is the person at end of life (prognosis to be determined by MRP)? Is this likely the last time someone will be able to see this person prior to passing?
3. Is the visit necessary in order to allow the least harm/least restrictive measures to the patient and to support the staff to safely provide care? (e.g.: to manage responsive behaviors during care provision that might be injurious to health care staff)
4. What would be the risk of not allowing visitation at this time? Can the patient's needs be met in any other way (e.g.: health care staff taking over feeding duties)?
5. Is PPE available for visitors to protect the visitor and/or vulnerable residents and patients in the vicinity of the visitor, and does this availability accord with Provincial PPE orders e.g. level 4-6. (especially if visiting a COVID-19 positive patient)?
    a. If no shortage, allow the essential visit to proceed and limit one visitor at a time, recognizing some discretionary circumstances. (e.g. if end of life is anticipated but does not occur, visitor may return for a second visit)
6. Is there a PPE shortage such that visitors are not allowed PPE (level 4-6 on PPE Allocation Framework)?
    a. If in level 4-6 shortage, contact Infection Control to determine if other measures can be used to reduce risks (e.g.: 14 day quarantine following visitation)

Who should be involved in the decision making?

Patient/Resident: must provide their perspective as to why they believe they should be granted a compassionate/end of life visit and from whom they would like this visit to be from. If unable to provide this rationale, due to cognitive or physical impairment, then family/support person's perspective should be sought by the healthcare team.

a. Does the patient consent to have the visitor attend the facility? Consent must be obtained by a capable patient for the visit to occur (some families want to visit despite the risk, and some patients don't support the visit). If the patient/resident is not capable then an SDM should consent or refuse on behalf of the patient/resident.

Healthcare Team: should review rationale for visitation on a case by case basis. This should be done by team consensus, with stakeholders including the MRP and Operational lead, with consideration of involving other stakeholders who can provide input into the decision. These individuals are not limited to Social Workers, Clinical Nurse Leaders, Physicians/Nurse Practitioners/MRP, Client Relations, Risk Management, Spiritual Care, Infection Control, Public Health, Aboriginal Health and Ethics Services:

a. Does the healthcare team believe that an in-person visit is for **compassionate end of life** reasons (i.e.: within an end of life 48hr window)? If yes, try to support where possible.

b. Does the healthcare team believe that an in-person visit is **paramount to patient care and well being** (i.e.: high risk of behavioral or mental health deterioration or physical needs such as feeding, that cannot otherwise be supported by onsite staff)? If yes, try to support where possible.

c. Is the patient an active or suspected COVID-19 positive patient? (if yes, is PPE available?)

d. Is PPE necessary for the visit, and is it available for visitors? If yes, try to support where possible.

e. Is PPE necessary for the visit, but not available due to shortages? If yes, contact Infection Control to see if any other measures can be put in place to reduce risks.

f. Limit number of visitors to 1-2, once per day for 2 hours, with some exceptions permitted. (e.g.: pediatric and maternity patients, patients with complex care needs including behavioral or mental health needs) Contact manager of care in the area to determine if specific population visitation restrictions are in place. (e.g. contact maternity patient care manager regarding visitation restrictions)

g. Length of time for visit should be determined in advance, 2 hours, or an approved timeframe determined by the healthcare team.

h. All restrictions/guidelines for visitors need to be communicated and documented including plan if guidelines/restrictions are not followed. A guide to difficult conversations when declining visitation can be utilized.

i. If team consensus cannot be achieved, then visitation will not be allowed.

Visitors: must be informed of the risks of visitation, both to themselves, as well as to other patients and residents within the facility. The visitor must be aware of and agree to the terms of visitation, as set out by the health care team.

a. Ensure all proposed visitors are aware of the risks of COVID-19 exposure, including health risks to the visitor (particularly if they are frail and have medical conditions themselves, or have frail family members who they are returning to at home).

b. Ensure visitors are provided with information about mechanisms to mitigate these risks, including excellent hand washing techniques, possible need for self-isolation for 14 days post visitation, PPE donning and doffing (if required/appropriate).

c. The visitor must agree to restrict the visit to 2 hours per visit for the timeframe approved by the healthcare team. (One time visit, daily visit, etc…)

d. Has the patient/resident (or if unable to consent has family/support person) determined who they would like to be the designated visitor(s)? The designated visitor must agree with restrictions placed on the visitation.

e. Limit visitors to 1 or 2 maximum per day, with an age restriction that minors can only visit if it is considered end of life for the parent or primary care person, otherwise visitation should not be supported.

f. Per recommendations from Infection Control, Visitors will NOT be allowed to visit if they meet any of the following criteria:
    i. They have an illness that can be transmitted (symptoms including fever, cough, or feeling unwell)
    ii. They are on self-isolation for COVID-19
    iii. They are being tested for COVID-19
    iv. They have tested positive for COVID-19: they will not be allowed to visit until they are deemed recovered by Public Health. In end of life situations when there may be a critical need to visit a loved one, visitors with symptoms may be provided with Personal Protective Equipment (PPE) and escorted to and from the room. Staff should contact Infection Control for further guidance.

2. **Recommendation for Acute Care Visit:** Allow patient/resident and their support person to provide rational for the need for the visit. Follow the decision algorithm and utilize the above questions/considerations to make an informed, thoughtful decision and communicate same with patient and support person.

Final Decision and Appeal Process:

If a decision is made to restrict a requested visit, then a discussion with the requestor/patient/resident needs to occur and rationale provided for decision. If there is a disagreement with the decision, then an appeal process can occur, which would be adjudicated by a minimum of 3 individuals to make the decision based on the information available. The decision makers for the appeal process would be a combination of 3 of the following individuals: a Physician or Nurse Practitioner not the patient/resident's MRP, Client Relations & Risk Management, Ethics Services, Infection Control, Public Health, and an Operational Director or Leader from the facility where the patient/resident is admitted. The individuals involved in the appeal will not be the same persons involved in the original decision, although the appeal committee may consult with the original group to understand the rationale for their decision.

3. **Recommendation for Decision Making:** Ensure decision is communicated to patient and their family/support person and documented, including rationale and who was involved in making the decision. Considering utilizing the following guide to the difficult conversation.