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An Roinn Sláinte
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Dear Colleagues,

RE: Update to visitor guidance to in-patient health settings in times of Coronavirus (COVID-19)

On 9th April 2020 I issued advice on restricting visitors to in-patient healthcare settings during the Coronavirus (COVID-19) pandemic. At this time the approach taken in Northern Ireland was to prohibit visiting in Intensive Care Units. I appreciate that staff found this a consistent message and to date in the majority of cases this has been adhered to. As we emerge from the peak of the COVID-19 surge I have received many requests to relax this approach and to facilitate where possible the opportunity for family members/loved ones to have the opportunity to spend some precious time with their dying relative.

I have therefore consulted with a wide group of staff and I have sought advice from CCaNNI on this issue specifically relating to ICU. As a result I would draw your attention to the Principles attached at **Annex A**. This updated guidance, to be used alongside the previous published guidance, outlines the principles for facilitating visiting for patients who are approaching the end of their life particularly but not limited to those patients in Intensive Care Units. The guidance applies equally to care home settings and other community settings as well as hospitals.

Whilst virtual visiting is to be promoted and used it is important that, wherever possible and safe to do so, you support families and loved ones to say goodbye to COVID-19 positive patients receiving end of life care; such visits are important both for the patient and their loved ones.

Advice to patients and their families should indicate that permission to visit end of life COVID-19 positive patients should be sought in advance from the nurse in charge. If

agreed, only one visitor at a time for a specified amount of time should be permitted to visit. PPE where deemed necessary should be provided in order to protect the visitor as well as guidance by staff about behaviour while visiting a COVID-19 positive patient.

Please ensure pandemic guidance is followed and advice sought from the Infection Prevention & Control team. Visitors with underlying conditions should be advised of the risks to themselves. All permitted visitors should adhere to strict hand hygiene and infection control precautions on arriving and leaving the area.

Finally, I would ask that you revise your public facing information to take account of the above updates.

This guidance comes in to force with immediate effect.

Yours sincerely,

Professor Charlotte McArdle
Chief Nursing Officer

CC: DoH Policy Cell

Annex A

Principles for End of Life Care:
Facilitating Patient Visiting at end of Life during COVID 19 Pandemic

Introduction

1.1 The COVID-19 pandemic and the ensuing government policy on social distancing and isolation has created concerns relating to visiting people either in hospitals, care homes, hospices or their own homes. While this can be accepted and adhered to by the majority of the population it becomes difficult, and one could argue inhumane, at the time of or the period leading to the death of family, friends and loved ones.

1.2 Deaths from COVID-19 and other diseases and illness occur across the entire range of care facilities. Patients die at home, in nursing and residential homes, in hospices, community hospitals, general wards of acute hospitals, emergency departments, and high dependency and intensive care units.

1.3 There is no argument with the logic of introducing processes for reducing the footfall through any of the above areas to reduce the risk of infection for staff, other patients and the general population.

1.4 People generally understand that they could contract infection from a patient dying of COVID-19 and thus come to physical harm themselves. They also understand that they could spread the infection to others outwith the care setting where the patient is dying. However when facing the prospect of losing a loved one it is conceivable that this logic could become immaterial and meaningless.

1.5 Current UK Government/NI Executive guidance on travel from home during COVID-19 does not explicitly specify that visits to a dying family member is allowed.

As a consequence, inconsistent interpretations of the guidance mean that variable policies are in place. Some are more stringent, and limit or may entirely exclude access of family to a patient dying of COVID-19. Other approaches are more lenient and permit exceptions sometimes without explicit consideration of the wider implications of population harm or Personal Protective Equipment (PPE) limitations.

1.6 Limiting travel in the wider community is an important aspect of Northern Ireland's effort to reduce both reduce the spread of COVID-19 and to limit the deaths resulting from COVID-19 and so enabling visiting, even when limited to the end of life, could be seen to be at odds with that risk reduction measure.

1.7 Although the UK Government's updated principles on visiting notes end of life visiting as essential, current NI executive guidance for the public on travel from home does not explicitly specify visits to a dying family member as permissible. Indeed there have been approaches from MLAs to the Minister of Health to be explicit about this issue.

1.8 The principles outlined below set out a path to allowing family, friends or loved ones to safely visit dying patients using the correct PPE, treating all dying patients equally with dignity and compassion, while protecting other patients, visitors and healthcare workers.

1.9 Where at all possible hospital and care home staff are advised to facilitate a final viewing of deceased patients and clients prior to the body being sealed in a body bag as advised in the updated guidelines for funeral directors - https://www.health-ni.gov.uk/publications/covid-19-guidance-surrounding-death

However the final decision on whether or not this can be safely facilitated lies with the Nurse in charge/ care home manager at the time and will be dependent on the environment and the availability of staff to both assist and support family members/loved ones particularly if PPE is required.

1.10 The Scottish Academy of Medical Royal Colleges (the 'Scottish Academy'), the Royal College of Physicians of Edinburgh (the 'College'), Marie Curie and Scottish Care state that:

1.10.1 When patients are judged to be dying within hours or days, the presence of family at their side for short visits, or longer stays, is vital to palliative and end of life care and a timeless part of the human experience of life and death. It provides comfort not only to the dying patient, but also to those present, and the inability to be present is a source of anxiety, distress and moral injury that may be long-lasting.

They go on to state that:

1.10.2 As a principle decisions regarding the presence of family at the bedside of their dying relative should not simply be considered as matters of infection control.
1.10.3 We can and should as far as is humanly and practically possible find ways to allow families and loved ones to be together at this time.
1.10.4 With personal protective equipment, social distancing, and isolation, family members can balance risk to themselves and others just as the caring professions do.
1.10.5 All patients and their family, carers, loved ones, wherever they are dying and whatever they are dying from, should be offered good quality and compassionate care.

1.11 The Scottish Academy of Medical Royal Colleges (the 'Scottish Academy'), the Royal College of Physicians of Edinburgh (the 'College'), Marie Curie and Scottish Care have devised an ethical framework to guide the decisions being made by clinicians and care givers when determining the appropriateness for face to face visiting. This framework, based on a number of broad principles has been adapted to fit the Northern Ireland context and is outlined below:

2.0 Ethical Framework to determine the Appropriateness of Face to Face Visiting during the COVID-19 Major Incident Period

2.1 Respect

A patient's current or previously known wishes about their own end of life care should be taken into account. Clinicians should act with honesty and integrity in their communication with patients and should communicate and document decisions regarding visiting and the reasons behind them transparently. Organisations have a responsibility to ensure that staff are aware of and engaged with the rationale for the local guidance. There must be transparency in how the competing factors of social responsibility, PPE resource, and direct and indirect risk of infection and of psychological harm are being balanced.

2.2 Family/Loved One presence

The presence of family, loved ones. Carers should be considered and where practically and humanly possible be accommodated across all care settings.

2.3 Minimising Harm

Harm from visiting can occur to the visitor, to those they subsequently come in contact with, or to others in the care facility. The patient themselves may experience harm if they feel guilt about exposing family visitors to the infection. That harm must however be balanced against harm to the dying person occasioned by absence of family, harm to family who are unable to be present (both immediate and longer term in bereavement), and harm caused to care staff who substitute themselves for absent family and undertake difficult telephone communication.

2.4 Reciprocity

Where there are resource constraints, particularly during high surge periods, patients should receive the best care possible when nearing the end of life, while recognising that there may be a competing obligation to the wider population. In this situation visiting, even at time of death, may be refused on the basis of the need to protect others and share scarce resources.

2.5 Capacity and Consent

The capacity of family to provide informed consent relating to the risks associated with visiting should be taken into account as should the capacity of the patient to receive visitors.

2.6 Flexibility

As the clinical situation evolves both at the individual and population level, decisions will need to be kept under review with clear guidance at national level.

3.0 Practical Principles for facilitating Visits for Family Members/Loved Ones at end of Life.

3.1 End of Life care constitutes a special circumstance and where feasible patients approaching the end of life should be afforded the opportunity to spend time with family members and/or loved ones. This is applicable to all areas of care including intensive care units.

3.2 In the case of death the opportunity for family members/loved ones to view the body of the deceased should, where possible and feasible, be facilitated in accordance with the

guidance outlined in Guidance for Funeral Directors paragraphs 21 and 22 - https://www.health-ni.gov.uk/publications/covid-19-guidance-surrounding-death.

However the final decision on whether or not this can be safely facilitated lies with the Nurse in charge/ Care home manager at the time and will be dependent on the environment and the availability of staff to both assist and support family members/loved ones particularly if PPE is required.

3.3 The following practical principles adapted from the Scottish approach and outline the main considerations when determining the appropriateness or practicalities for accommodating face to face visits with dying patients.

3.3.1 People have the right to be with a loved one/family member/next of kin at the time of death and this should be respected and accommodated where possible. This is the expectation of the CMO/CNO and the health Minister for NI.

3.3.2 Family members and/or the loves ones of a patient dying from COVID-19 must be able to make an informed decision about whether visiting is the right thing for them or the patient in their particular circumstances.

3.3.3 Where possible, and as early as possible, staff caring for patients with COVID-19 should record the patient's wishes about their end of life care and should identify the person they wish to have with them during their dying moments.

3.3.4 Staff should, with the patient's permission, share this information with family members as early as possible in the patient's COVID-19 care journey.

3.3.5 Only in extreme cases should family members/ loved ones next of kin be denied the possibility to be with a patient at the time leading to or of death. Where this is the case the reasons should be clearly outlined to the patient and his/her family members and/or loved ones.

3.3.6 Care facilities are entitled to limit the frequency of visits, duration of visits, or numbers of visitors in accordance with the risk to other patients, other care staff, or other practical considerations in the care setting. However, the reasons for this must be documented and be in accordance with the framework outlined above.

3.3.7 Organisations especially those with limited space may limit the number of visitors to one at a time - when this is the case the situation should be explained clearly to those wishing to visit. In any case there should be no more than 2 people visiting at any one time.

3.3.8 Infection prevention and control requirements should not be so rigid as to prevent family members/loved ones from saying goodbye in as humanely a way as possible- this includes the ability for them to hold hands and touch the dying person.

3.3.9 When face to face visits are being accommodated visitors should be made aware of the PPE requirements and should be supported to adhere to these. Only where visitors are able and willing to comply with PPE requirements should the visit be facilitated/permitted.

3.3.10 In all cases, visitors must agree to undertake the subsequent isolation and quarantine restrictions appropriate to the contact that has occurred in association with their visits.

3.3.11 Where face to face visiting cannot be accommodated the reasons should be explained to the family and the patient and all efforts to accommodate virtual visiting should be made.

3.3.12 Each organisation should have a policy and guidelines for accommodating virtual visiting - these should be known by all staff and should be shared with family members and used as and when required.

3.3.13 In any case where there is increased risk to visitors due to the possibility or proximity of aerosol generating procedures then full PPE should be offered to the visitor and the visitor should provide confirmation that he/she understands the risk posed to him/herself and others.

3.3.14 Where AGPs are being conducted during the time leading to death then visiting should as far as possible be limited to periods outside of these procedures (If possible there should be no visit until at least 1 hour after an AGP procedure).

3.3.15 Anyone who is unwell and/or exhibiting symptoms of COVID-19 - a new, persistent cough and fever or high temperature - should NOT visit any patients in a hospital or other care facility.

3.3.16 Clinical teams in more acute settings, particularly ICU and HDU, should receive support in family liaison from other staff members, including chaplaincy, bereavement and counselling services, thus enabling them to focus on direct patient care.