**COVID-19: REGIONAL PRINCIPLES FOR VISITING:**

**NURSING & RESIDENTIAL CARE HOMES IN NORTHERN IRELAND**

# Visiting with Care - A Pathway

Pathway applicable to all Care Homes in Northern Ireland.

This document replaces, in its entirety, the Care Homes elements of the Department of Heath's visiting guidance **COVID-19: Regional Principles for Visiting in Care Settings in Northern Ireland,** which was originally published in June 2020.

**Publication date: 30 April 2021**

**Implementation Date: 7 May 2021**

**This Version effective: 20 October 2021**

**VERSION CONTROL**

| Version | Effective Date | Summary of Changes |
|---|---|---|
| 1.01 | 07 May 2021 | None - Original Document |
| 1.02 | 26 May 2021 | **Para 4.6**<br>• Update to detail around Care Partner scheme continuance<br><br>**Appendix 1:**<br>• Confirmation of review decision to expand maximum number of visits per week to 3, from originally notified maximum of 2.<br>• Update to detail around Care Partner scheme continuance |
| 1.03 | 20 October 2021 | **Para 1.7**<br>• Minor amendments to reflect events as they transpired<br><br>**Para 3**<br>• General updating of pagination / numbering<br><br>**Para 3.3**<br>• Addition of clarification over visiting arrangements for Ministers of Faith/Religion<br><br>**Para 4**<br>• Overall update to reflect the passage of a number of reviews and the progress to date.<br><br>**Pathway Summary**<br>• the wording around children quoted in "*General Easing*" amended to revert to that used in "*Cautious First Steps*"<br>• removal of need for use of Aprons while visiting, and reinforcement of need for good hand hygiene practice<br>• Appendix 1b – revised to take account of easing of restrictions in the wider population, and drawing a distinction between organized trips and residents simply leaving the home for their own reasons |
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## 1.0 INTRODUCTION & BACKGROUND

1.1 COVID-19 has presented one of the greatest public health challenges faced by the world in many decades, impacting unimaginably on all our lives, but particularly on those living in care homes and their families. The approach to managing the pandemic has meant that many difficult requests have been made of the public around health service access and care provision, especially visitor access tonursing and residential care homes during these unprecedented times. There are particular challenges which care homes have faced in trying to protect residents from outbreaks of infection in individual care homes, while trying to ensure they can maintain contact with loved ones. Protecting residents was a priority as we knew how devastating coronavirus outbreaks in care homes could be.

1.2 During this COVID-19 pandemic, it was necessary to introduce significant restrictions to normal care home visiting arrangements in order to reduce the risk of residents contracting coronavirus. The Regional Principles for Visiting Guidance, which applied to all health care settings in Northern Ireland, were produced, introducing restrictions broadly aligned to the UK-wide Alert levels, based on the best scientific advice available at any given time.

1.3 That guidance recognised the rights of residents to receive visitors, and the rights of next of kin, partners, children, parents and carers to visit their loved ones while in health and social care facilities and independent care sector facilities in Northern Ireland. However, the exceptional circumstances around the pandemic and the vulnerability of care homes residents meant that normal levels of visiting and contact simply were not feasible.

1.4 As the pandemic has progressed, guidance around visiting in all care settings, including in care homes, has been kept under constant review, with amendments made as experience and the science allows. The most recent version took effect on 1 March 2021 in line with the national decision to revert to Alert Level 4.

1.5 Following the publication of the NI Executive's plan to manage a return to a more normal life as the pandemic eases, the Department of Health (DOH) commissioned

the Public Health Agency (PHA) to develop guidance to support a safe approach to increased visiting in care homes. The resulting Pathway includes arrangements for residents to receive visitors, as well as permitting them to leave the home to visit other households, community facilities and excursions.

1.6 PHA assembled a working group including representatives from:

- Health & Social Care Board (HSCB);
- PHA;
- Regulation & Quality Improvement Authority (RQIA);
- NI Health & Social Care Trusts (HSCTs);
- Commissioner for Older People NI (COPNI);
- Patient & Client Council (PCC);
- Departmental Policy Directorates;
- Relatives groupings; and
- Independent Healthcare Providers

A survey was issued to Residents, Families and Care Providers seeking their views on relaxing visiting restrictions. 1,345 surveys were returned including 939 from families, 77 from residents and 329 from the care home sector. A number of "ECHO" online video-conferencing training sessions were also facilitated with care home providers. This scoping indicated wide support across all three parties for relaxation but with a phased, cautious approach.

In addition, a review of the available evidence and intelligence from other countries was undertaken. This evidence alongside feedback from the survey and expert public health advice informed the development of a Risk-Benefit Matrix which was used to inform decisions in terms of the steps within the pathway.

1.7 This document was produced to reflect the group's recommendations. The Minister of Health accepted the recommendations, and authorised that the new arrangements should come into effect from **Friday 7 May 2021.**

## 2.0 LOOKING FORWARD: MOVING TOWARDS NORMAL VISITING

2.1 The first priority continues to be to limit the instances of COVID-19 acquisition in care home settings, by preventing transmission of the SARS-CoV-2 virus as much as possible, thereby ensuring the health and safety of residents, visitors and staff. Visiting was only restricted because it was absolutely necessary to do so to protect against the risk of transmission of SARS-CoV-2 virus and the subsequent development of COVID-19 infection. Given progress that has been made, the time is now right to take steps to carefully re-introduce visiting.

2.2 We welcome the good news that, thanks in no small part to the efforts of our health and social care workforce and the wider public, we are now seeing infection numbers consistently declining, and the resulting threat of health services being overwhelmed has receded. While transmission rates, hospital pressures and deaths remain higher than we would wish to see, we recognise that significant steps have been taken to protect care home residents in particular prioritisation in terms of vaccination and enhanced testing. These programmes sit alongside multiple other protections including infection prevention and control measures, and close monitoring of all those entering a care home.

2.3 Care Home residents who receive both doses of the vaccine should have a high level of personal protection from COVID-19. However, to date the full impact of the vaccine for individual resident protection or transmission of COVID-19 to others remains unknown until a full analysis of the available data has been completed; given this position it is important that we take the time to evaluate the impact of the vaccination programme rather than expose anyone to additional risks at this stage.

2.4 Evidence has become available outlining the detrimental impact of restricted visiting on the health and well-being of both residents and their families and loved ones. It is intended that this Pathway will enable contact through visiting which approximates more usual circumstances or as close to usual circumstances as possible, given the current context and supported by appropriate mitigations.

2.5 The Pathway at ***Appendix 1*** sets out the graduated approach to easing the restrictions in all care homes in Northern Ireland, depending on:

- The home **NOT** being in an outbreak situation; and

- The care home manager's dynamic risk assessment which may have different outcomes in each individual care home. The Care Home Manager remains responsible for making decisions regarding permitting visitors into any home on a day to day basis. However, such decisions must be based on a risk assessment, to which families and residents should be given the opportunity to contribute.

- The expectation is that care homes should continue to work to facilitate a range of visiting options in line with the roadmap below.

2.6 These remaining restrictions, although significantly relaxed, remain in place necessarily to protect residents and their visitors, and also to maintain safety for all others, including other families, all Health and Social Care staff and therefore the wider population.

2.7 It remains crucially important that everyone involved plays their part in ensuring that the Pathway can be safely implemented. This requires that everyone (residents, families, care homes and statutory bodies) is aware of their responsibility to ensure that safe visiting can proceed, and work together to ensure that meaningful visiting can proceed while ensuring that the risk to residents and others in the care home is minimised as far as possible.

2.8 Details of the specific roles of residents, families, care homes and statutory bodies are provided in ***Appendix 2***.

## 3.0 PRINCIPLES FOR RETURNING TOWARDS MORE NORMALISED VISITING

3.1 The following principles should be followed by everyone when considering their approaches to visiting. This includes residents, relatives, care home managers, staff, visiting staff and those with responsibility for local oversight arrangements:

- **Responsibility** – everyone, including family members, has a responsibility to follow any advice and guidance, and to take action to help our care homes stay safe homes.
- **Maintaining well-being** – decisions should focus on supporting meaningful contact to happen safely wherever possible, to protect and restore well-being of residents and their loved ones, and in line with residents' care needs.
- **Safely balancing risks of harm** – visiting (or not visiting) carries risks of harm and everyone should work together to consider and minimise these.
- **Equitable access for all residents** – fairness (or equity) means recognising that some residents will have different needs or preferences for visiting and supporting these where at all possible, within wider safety considerations for the home as a whole. Equity means giving residents the sufficient contact they need to maintain their health and well-being wherever possible.
- **Individualised approach** – every resident should have an individualised visiting plan (within their care plan) which is person-centred and takes account of individual preferences and needs, and balanced against the needs of everyone in the care home, so that any restrictions to meaningful contact are proportionate.
- **Equality/choice** – residents (and/or their representative decision-makers) have the right to choose their designated visitors.
- **Flexibility** – local flexibility and professional judgment remain key to decision making in complex circumstances. Factors such as the characteristics of the home, its staffing availability, COVID-19 outbreak status and use of IPC measures including personal protective equipment (PPE) are all variables to take into account when setting home-specific policies.
- **Respect for human rights** – local visiting policies should take account of the European Convention on Human Rights (ECHR), and in particular Article 8, which provides a right to respect for private and family life. Whilst it is important that any visiting policies take account of the evolving evidence about the harm posed from the virus, these need to be carefully balanced with the evidence about the positive

impact on health and wellbeing from seeing family and loved ones has on residents in considering what is necessary, justified and proportionate.

**Exceptional Circumstances: End-of-Life**

3.2 When a resident is receiving palliative care, or approaching end-of-life, an individualised risk assessment should be undertaken with regards to accommodating visiting, as follows :

- A resident may have indicated who they would like to have visit them as they approach end of life. If this has not been recorded, residents thought to be approaching end of life should be asked who they would like to visit them where possible. Family, next of kin and/or appropriate others may be able to advise wheresomeone is unable to provide this information himself or herself.

- Only in extreme cases should family members/ loved ones next of kin be denied thepossibility to be with a resident as they approach the end of their life. Where this isthe case the reasons should be clearly outlined to all concerned.

- All requirements in terms of the care home's visiting policy, which includes applicable Infection Prevention and Control (IPC) measures, use of PPE etc. must be adhered to. IPC requirements in these circumstances should not be so rigid as to prevent family members/loved ones from saying goodbye in as humanely a wayas possible - this includes the ability for them to hold hands and touch the dying person.

- Every effort should be made to support people important to the resident in visiting them, with due regard to risks and responsibilities regarding COVID-19. However, some restrictions to prevent the transmission of COVID-19 will still need to be applied. A palliative care approach involves caring for the resident and those closeto them to ensure that there is relief from distress, support and dignity at end of life. Maintaining contact between a resident and those close to them can alleviate anxiety and emotional distress for both parties. An individualised approach to visiting is necessary to balance the public health and infection control guidance with the need for compassionate care at end of life.

- Staff caring for those where end of life is anticipated in the coming days should record the resident's wishes, identifying the person(s) they wish to have with them during their final days of life. Advance care plans should be considered as early aspossible and should involve family members who can then help the person "decide"without angst or guilt who they wish to be present.

- Where a resident has been clinically assessed as actively dying, (considered to be the last 72 hours of life) visits should be facilitated over the full 24 hour period wherever possible. Local risk assessments should be undertaken to determine the number of visitors permitted to be present at any one time and the total number of visitors within any 24 hour period.

- Where young children need to visit the resident (e.g. their parent or grandparent), this will be agreed locally with the person in charge and consideration given to anyadditional protective measures that may be required.

**Other factors to consider:**

**Pastoral Care - Ministers of Faith/Religion**

3.3 We recognise that Ministers of Faith/Religion can perform a valuable role in providing pastoral support to some residents. Such visits should not be counted in the allowed number of visits as set out in in the Pathway schedule. However, Ministers of Faith/ Religion should normally only visit one resident during any one visit, as visiting across a number of residents could significantly increase the risk of transmission of the virus to vulnerable people. Ministers are encouraged to undertake lateral flow tests prior to their visits, to give greater confidence in our ability to keep people safe.

**Residents Leaving the Care Home – Trips Out**

3.4 In light of the easing of restrictions for the general public to meet up socially outside, and other easements, it is now appropriate that care home residents may also resume trips out of their care home where they have the physical capacity to do so.

- In the first instance it is recommended that each resident with capacity to safely leave the care home should be facilitated, and this will reviewed as the pathway progresses.
- Arrangements for such trips out must be agreed in advance with the care home, particularly the proposed duration of the trip and thus the anticipated time of return

to ensure that this can be safely facilitated.

- A reasonable approach to the timing of such trips, and the agreed time of return should be agreed with the care home manager.
- Such trips out will require the resident and anyone accompanying them to follow the restrictions applicable to the general public, and will be subject to a risk assessment.
- Where the resident complies with IPC advice and with the restrictions applicable to general public there will be no requirement to isolate on return to the home.

**NB: Fuller detail of these arrangements are at Appendix 1b of the Pathway (below)**

## 4.0 IMPLEMENTATION PROCESS

This updated guidance document originally took effect from 7 May 2021, with visiting facilitated in line with the approach outlined under"**Cautious First Steps**" in the Grid at ***Appendix 1***. Every four weeks thereafter, a panel of Public Health Officials review the relevant data and based on that make a recommendation to Minister as to whether we should move further along the roadmap.Their recommendation is submitted to the Department of Health for review and approval by the Minister and this decision is shared with the sector as soon as possible thereafter.

4.2 This process repeats for each stage as we commence the progress back towards more normalised visiting arrangements for care home residents. There will be three weeksof data collection at the end of each review period, and then a one week consideration period to allow Public Health Officials to consider whether it is appropriate to recommend progression to the next stage, with the decision made public thereafter. In addition, there may be circumstances where public health advice may recommend a change before the 3 week period pending the available evidence.

4.3 **PLEASE NOTE:** while it is everyone's hope and intention that the progress along the roadmap continues to be a linear journey back towards normal, there remains the possibility that at any stage such progress may have to be stalled or even reversed should the science and the transmission rates in the care home sector and/or the wider population merit it.

4.4 Throughout the process, and specifically at each review point, Public Health advisors from the PHA will consider the available evidence on transmission, outbreaks, mortality, vaccination and other relevant information to inform the recommendation on progress. A more detailed list of data and the sources from which it will be sourced are included at ***Appendix 3***.

4.5 Care Homes will continue to report implementation of visiting guidance as per the RQIA Data Warehouse.

### The Care Partner Scheme

4.6 The Care Partner Scheme stands outside the scope of this Roadmap and remains additional to visiting; it will continue to be available for the duration of the Covid-19 pandemic period. However, as progress is made along the Pathway, it may be found that the need for formal Care Partnering arrangements will recede, so a gradual

scaling back of such arrangements would be expected.

4.7 Full details of the scheme are available online, at https://www.health-ni.gov.uk/Covid-19-visiting-guidance.

## 5.0 COMMUNICATION AND ENGAGEMENT WITH RESIDENTS, FAMILIES AND OTHERS, INCLUDING A MEDIATION FUNCTION TO ADDRESS DISPUTES

5.1 All stakeholders should recognise that residents and/or their representatives must be involved in the individual discussions and decision-making about their own situations. A record should be kept of the assessment of risks, and agreements reached regarding an individualised visiting plan for each resident.

5.2 Clear and regular communication with residents and families will be key in the successful implementation of this pathway. Care home providers should work in collaboration with residents and relatives to ensure that all official information and guidance is cascaded directly to those affected by it.

5.3 Residents and relatives should be involved in the development of care home policy, and in the decision making regarding the risks and benefits in facilitating visiting as well as the development of individual visiting care plans. This will facilitate an understanding that the arrangements required to safely manage visits to care homes must be aligned with the specifics of each individual's needs, and reflect the guidelines contained in each stage of the "**Pathway**" process.

5.4 HSC Trusts and their Care managers should work alongside care homes and residents/families throughout this process, working together to agree individual arrangements for each resident. There is an expectation that any local issues relating to individual residents and/or care homes should be resolved at this local level. Where unresolved challenges remain in respect of the implementation of this guidance, the Department or other appropriate statutory agency will consider the issues and provide direction. This may include drawing on professional advice as appropriate, for example around Public Health issues and Infection Prevention and Control matters.

5.5 Details of the specific roles of residents, families, care homes and statutory bodies are provided in ***Appendix 2***.

**Appendix 1**

***This Grid outlines the arrangements which will apply in line with the roadmap back to normalised visiting - this is subject to change and will be reviewed frequently (see Appendix 1a).***
***Local outbreaks in specific HSC Trust areas and Care Homes may require an additional specific local response.***

## Pathway Moving towards Normalised Visiting in Care Homes NI

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|---|---|---|---|---|---|---|---|---|
| | | Progression is dependent on the outcome of review and is not guaranteed. To note there is the potential to accelerate the easing of restrictions, but also to apply a 'brake' or to regress to a previous step if required and dependent on monitoring. Likewise the potential to accelerate the easing of restrictions will also be kept under review. Public messaging will be critically important and needs to be consistent, clear, accessible and repeated | | | | | | |
| | | 4 week block | | 4 week block | | 4 week block | | 4 week block |
| | Revie | **Cautious first steps** | Revie | **Gradual Easing** | Revie | **Further easing** | Revie | **Preparing for the future** |
| | | | | | | | | |
| **Visiting in the home** | | Following completion of a scheduled review on 24 May 2021, the number of visits per week has been increased to 3, with visits limited to two people at one time and lasting up to 1 hour. Visits to be accessible over a 7 day period as well as after 5pm. | | Increased number of people able to visit at one time to maximum of 4 from no more than 2 households at any one visit and a maximum of 4 visits per week. | | No restriction on number of people who may visit but visits limited to visitors from two household per day. | | No restrictions on the number of visits or visitors. |
| | | Children can visit and the responsibility will rest with the adult for | | Children can visit and the responsibility will rest with the adult for supervision to | | Children will be encouraged to visit and the responsibility will rest with the adult for | | No restrictions on the number of visits or visitors. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | supervision to ensure they adhere to all IPC measures. Any child visiting will be included in total number of visitors for the arranged visit. | | ensure they adhere to all IPC measures asappropriate. Any child visiting will be included in total number of visitors for the arranged visit. | | supervision to ensure they adhere to all IPC measures. Restriction on numbers lifted. | | |
| | | Handwashing to replace use of gloves to enable handholding. Aprons and masks to remain. | | Close physical contact extended to include 'brief' hugging. Effective hand hygiene practices and masks to remain | | Close physical contact enabled to include 'brief' hugging. Effective hand hygiene practices and masks to remain. | | Standard IPC measure including hand washing. |
| | | Booking system for all visitors including evenings and weekends | | Booking system for all visitors including evenings and weekends. | | Booking system for all visitors including evenings and weekends. | | No booking system required. |
| | | Visiting in residents own room with window open | | Visiting in residents own room with window open. | | Visiting in residents own room with window open. | | Visitors able to move around home. |
| | | Visitors and residents may meet within the grounds of the home with access to gardens. | | | | | | |
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|---|---|---|---|---|---|---|---|---|
| **Trips out of the home** | | Residents may resume trips out of the home following the restrictions applicable to the general public – see **Appendix 1b.**<br><br>Where the resident complies with IPC advice and with the restrictions applicable to general public there will be no requirement to isolate onreturn to the home. | | Residents may resume trips out of the home following the restrictions applicable to the general public – see **Appendix 1b.**<br><br>Where the resident complies with IPC advice and with restrictions applicable to general public there will be no requirement to isolate on return to the home. | | Overnight stays may be facilitated in accordance with appropriate risk assessments following the restrictions applicable to the general public – see **Appendix 1b.**<br><br>Where the resident complies with IPC advice and with restrictions applicable to general public there will be no requirement to isolate on return to the home. | | |

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|---|---|---|---|---|---|---|---|---|
| | | Shared Care[1]arrangements to resume as previously defined following risk assessment. | | Shared Care arrangements to resume as previously defined following risk assessment. | | Shared Care arrangements to resume as previously defined following risk assessment. | | Shared care arrangements established to meet individual need. |
| | | | | | | | | |
| **Services into the home** | | Church Ministers and Faith Groups may book a visit (see para 3.4 above); this in addition to the 2 visits noted above. | | Church Ministers and Faith Groups may book a visit (see para 3.4 above); this is in addition to the visits noted above. | | Individuals from community & voluntary sector groups | | Linking Generations work with schools etc. may commence |
| | | Hairdressers may attend as per Executive easing. | | Healthcare Students from FE colleges may resume placement. | | | | |
| | | Visiting professionals to resume if not already. | | | | | | |
| | | Care partner arrangements to continue. | | Care partner arrangements to continue. | | Care partner arrangements to continue, but by agreement these may be scaled back to reflect easing of access restrictions | | Formal Care Partner arrangements to be stood down. Normal access conditions to apply. |

1 Shared Care is a specific arrangement in place for people with learning disability.

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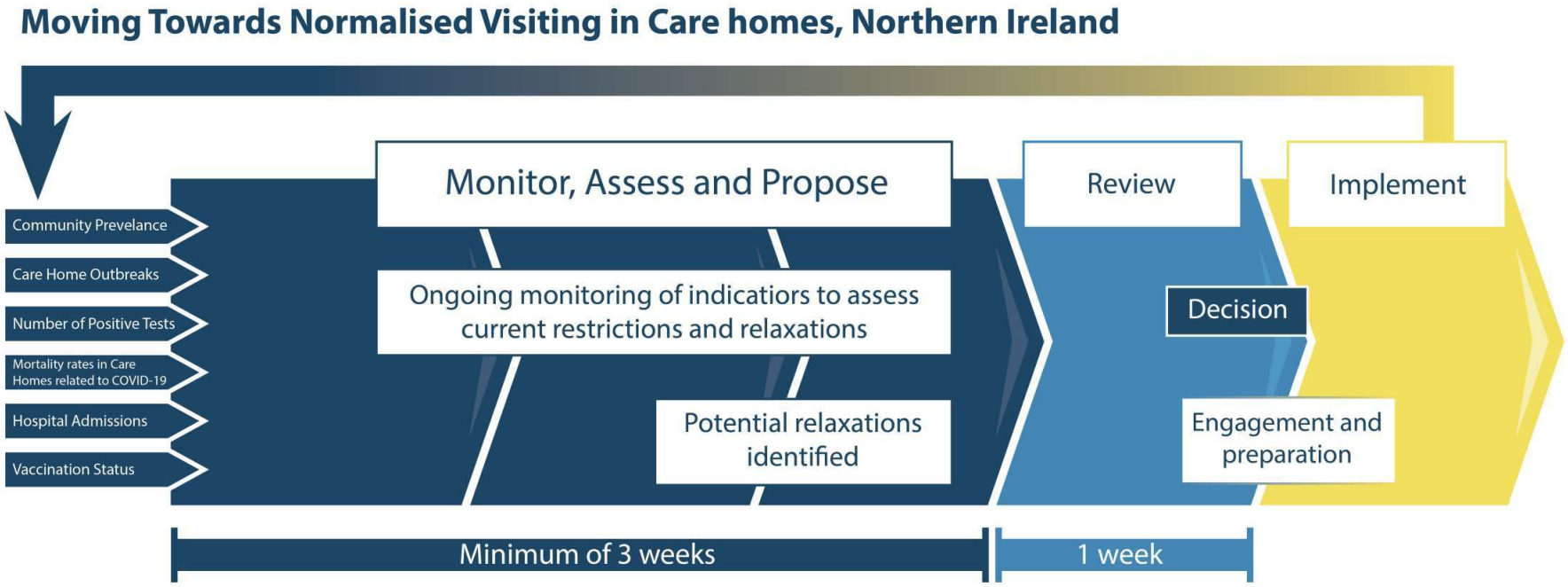
|---|---|---|---|---|---|---|---|---|
| **Enabling factors** | | Enhanced cleaning of individual and communal spaces. | | Enhanced cleaning of individual and communal spaces. | | Enhanced cleaning of individual and communal spaces. | | Enhanced cleaning of individual and communal spaces. |
| | | Maintain adherence to current IPC measures[2]. | | Maintain adherence to current IPC measures. | | Maintain adherence to current IPC measures. | | Maintain adherence to current IPC measures. |
| | | Appropriate mechanisms available to manage easing of visiting restrictions[3]. | | Appropriate mechanisms available to manage easing of visiting restrictions. | | Appropriate mechanisms available to manage easing of visiting restrictions. | | |
| | | Screening of all visitors for signs and symptoms of COVID-19. | | Screening of all visitors for signs and symptoms of COVID-19. | | Screening of all visitors for signs and symptoms of COVID-19. | | Screening of all visitors for signs and symptoms of COVID-19. |
| | | Isolation arrangements to respond to individual circumstances and as per policy. | | Isolation arrangements to respond to individual circumstances and as per policy. | | Isolation arrangements to respond to individual circumstances and as per policy. | | Isolation arrangements to respond to individual circumstances and as per policy. |

2 IPC measures include: hand hygiene, wearing PPE, respiratory hygiene, cleaning of the environment

3 Additional funding has been made available to support homes to put in place measures to facilitate visiting during the pandemic

**Review Cycle for Moving towards Normalised Visiting in Care Homes in NI Pathway**



In line with the Executive Roadmap, progress through the phases will be based on a 4 weekly cycle of review of evidence and will seek to balance the benefits with the potential impact on the transmission of the virus.

| Key Factors to monitor and inform the 4 weekly review | |
|---|---|
| Public Health Expert Reference Group will review and analyse surveillance data | |
| 1. | Community prevalence |
| 2. | Care Home Outbreak status |
| 3. | Care Home COVID-19 Testing results [4] |
| 4. | Mortality associated with COVID in Care Homes |
| 5. | Hospital admissions |
| 6. | Vaccination status of staff and residents in care homes |

4 All staff and Care partners in care homes undertake a PCR weekly test for COVID with residents being tested monthly.

**Appendix 1b**

## SUPPORTING RISK ASSESSMENT & RISK MITIGATION FOR TRIPS OUT OF THE CARE HOME

**Where the home is not in Outbreak:**

### 1. Care Home Organised Trips Out

Organised trips out may be facilitated subject to risk assessment (see suggested factors for consideration at para 3 below).

The care home manager should balance the benefits of such trips against a consideration of the risks to others in the home, in the event that the residents taking part become infected during their trip, and the ability of the home to isolate the residents on their return should they subsequently test positive.

### 2. Individual Residents' Visits Outside the Care Home

Decisions about facilitating individual resident's visits outside of a care home should be taken in partnership on an individual-by-individual basis with the residents' personal needs and care home circumstances considered.

If a resident with capacity wishes to leave the home then members of staff at the home cannot prevent them from doing so. People who are able to do so will naturally wish to leave the care home, i.e. for a short walk or, where the Executive's restrictions permit, to visit family and friends, as well as attend places of worship etc.

Should a resident choose to do so, they must do so in line with NI government COVID-19 restrictions in place at the time (see https://www.nidirect.gov.uk/articles/coronavirus-covid-19-regulations-guidance-what-restrictions-mean-you) .

**Mitigating factors to reduce risk of COVID-19 transmission during residents' visits out of the home**:

(i) Advice on safe car sharing should be provided: https://www.publichealth.hscni.net/publications/advice-car-sharing-english-and-translations

- Wash hands or use hand sanitiser before and after the journey
- Wear face coverings whilst in the car
- Minimise the number of people in the car (ideally resident and 1 designated facilitator only)
- Keep the car well ventilated with frequent fresh air changes
- Sit as far away as possible (ideally the visitor should be in the back seat where possible)
- Clean car surfaces after every journey (including seatbelts and internal/external handles)

(ii) The nature and number of trips each resident undertakes per week should be taken into account as part of the individual risk assessment.

(iii) Any person supporting the resident's trip should follow appropriate IPC measures.

(iv) Advice should be provided to the resident and visitor on the importance of social distancing, respiratory and hand hygiene and use of face coverings.

## 3. Factors informing the risk assessment

The risk assessment may include but is not limited to:

(i) Confirming that the resident and the person(s) accompanying them (if appropriate) is aware of the requirements around avoiding close contact with any person known or suspected to be suffering from COVID-19.

(ii) The clinical vulnerability of the resident - including general health, comorbidities and vaccine status

(iii) The risk to others in the care setting if the resident(s) develop(s) COVID-19 – including level of mixing with other residents and clinical vulnerability of the residents, vaccine uptake in the home and risk posed to other individuals

(iv) Levels of community transmission of COVID-19, both locally and regionally

If undertaking a visit out is not advised because of the risk to the individual and/or other residents and staff, care providers should record the outcome of the risk assessment clearly and communicate this to the resident and others as appropriate.

**Where the home is in Outbreak:**

**Context:**

An outbreak in a care home will normally lead to the home closing to admissions and discharges to and from other vulnerable, usually healthcare, establishments. However, there are circumstances where an individual would be able to return to their usual living arrangements outside the care home, even during an outbreak, such as when a period of respite is completed. There are also circumstances where a resident may return to their care home on discharge from hospital and this will be arranged between the Hospital and care home. Should any issues require clarification during an outbreak this should be sought from the PHA Duty Room.

**Care partner arrangements can continue in outbreak conditions**

Remaining residents should maintain some degree of flexibility of access out of the care home, as detailed below.

**1. Care Home Organised Trips Out**

In the event of an outbreak in a care home, the home should normally discontinue organised Trips. Local policy and outbreak management arrangements should be followed.

**2. Individual Residents' Visits Outside the Care Home**

If a resident with capacity wishes to leave the home then members of staff at the home cannot prevent them from doing so. People who are able to do so will naturally wish to leave the care home, i.e. for a short walk or, where the Executive's restrictions permit, to visit family and friends, as well as attend places of worship etc.

Should a resident choose to leave the home in such circumstances, they must still do so in line with NI government COVID-19 restrictions in place at the time. (https://www.nidirect.gov.uk/articles/coronavirus-covid-19-regulations-guidance-what-restrictions-mean-you). The same mitigating factors apply as noted (at page 21) above.

Decisions on facilitating an individual resident's visits outside of a care home should be taken in partnership on an individual basis with the resident's personal needs and care home circumstances considered. Such decisions will be supported by dynamic individualised risk assessments.

**Appendix 2**

## ROLES AND RESPONSIBILITIES

There are key roles for all in facilitating the return to normalised safe visiting and the role of each stakeholder is outlined below:

### THE ROLE OF RESIDENTS' RELATIVES/VISITORS

Family and friends of residents should be aware of the benefits of visiting their loved ones, but also be aware of the challenges which care homes, as distinct from other health and care settings, face in safeguarding all residents from infection. The restriction of visitors to care homes has been a key strategic component of managing the pandemic and it was introduced to protect residents, their families and staff by reducing the risk of infection.

Families/friends intending to visit must help ensure their loved ones remain safe, by:

- **S**taying at Home, if symptomatic
- **A**rranging visits in advance, and notifying the care home of any changes
- **F**ace coverings – and any other necessary PPE, should be worn as appropriate
- **E**ngaging with the care home – you are partners in care and should work together for the goodof your loved one.

It is crucially important, therefore, that visitors make themselves aware of the restrictions which apply to the visiting of their loved one, and work together with the care home and the statutory agencies to ensure that they can safely engage in meaningful visiting while ensuring that the risk to their loved one and others in the care home is minimised as far as possible.

### THE ROLE OF CARE HOMES

Care homes have worked together with families and statutory agencies to make care homes and visiting as safe as possible, and to support continued contact between residents and their loved ones.

Care home staff have worked tirelessly throughout the pandemic to support continued contact between residents and their loved ones within the limits of the applicable guidelines, but these restrictions have been hugely challenging for residents and their loved ones, as well as for care home staff and colleagues.

As we begin to ease along the pathway to increased visiting, care homes and their staff should ensure that they facilitate the increasing recommended levels of visiting, putting in place management measures to ensure that this is done as safely as possible.

## THE ROLE OF PHA

The PHA will continue to provide infection and prevention control (IPC) advice, support care homes through the PHA Health Protection Duty room with regard to public health advice on enquiries and managing outbreaks, and also carries out surveillance including outbreaks of COVID-19 in care homes. They will also work to gather the voice and experience of those living in care homes in orderto inform improvements in the quality and delivery of services.

## THE ROLE OF THE HSCB

Regionally, the Health and Social Care Board is responsible for the overall process of planning and arranging services for the people of Northern Ireland based on an assessment of local/ regional needs, policy direction, trends and available funding.

It will engage with and work in partnership with care home sector providers, residents and families, Trusts, PHA, RQIA, DOH and other statutory stakeholders to ensure that the guidance and care pathway is supported, implemented and will contribute to solution finding where any difficulties arise.It will provide specific advice, support and relevant data from a commissioner and funding perspectivewhere this is required.

## THE ROLE OF HEALTH AND SOCIAL CARE TRUSTS

HSCTs should work with care homes to support them with implementation of the guidance. In addition,they must assure themselves that care homes that accommodate their clients are operating in accordance with the most up to date guidance for visiting care homes, and that they are implementinga dynamic risk assessed approach to visiting at their premises. This may include:

- providing support and advice to care home providers in the implementation of the guidance
- providing support and advice where there are difficult to navigate situations relevant toparticular HSCT clients;

- considering if the arrangements in place for individual clients recognises the balance in managing infection transmission with protecting the mental health and emotional well-beingof residents and family relationships;
- considering if the arrangements in place for individual clients take account of each client's personal health and care needs (e.g. those who may be hearing impaired, visually impaired,cognitively impaired etc.);
- considering if the arrangements in place recognise and facilitate the role of care partners, support may be required in identifying the care partner or managing the process;
- ensuring that individual clients and their relatives have been involved in agreeing visiting arrangements, recognising that residents and/or their representatives should be involved in the individual discussions and decision-making about their own tolerance of risk and theirown judgements about the balance of risks; and,
- ensuring that there are mechanisms for ongoing review of clients' individual visiting arrangements.

## ROLE OF COPNI

The Commissioner for Older People in Northern Ireland can assist by putting older people and familiesin touch with organisations best placed to resolve their concerns. The Commissioner can also provideassistance to any older person or their representatives in making a complaint where the older person'sinterests have been adversely affected by any actions.

## ROLE OF THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

In respect of "Visiting with Care", the role of RQIA is to ensure that the guidance is being implementedin a meaningful way across all registered care homes. RQIA will ensure the guidance is shared withthe care homes and continue to offer off support and advice so visiting can resume safely taking intoaccount the individual needs of the residents.

RQIA will liaise with the local Health and Social Care Trusts where homes are challenged in respectof individuals or lack confidence in respect of implementation of the guidance.

During inspections RQIA will review visiting arrangements in the care home to ensure they are in linewith the guidance that is current, at the time, and meet the relevant regulations and care standards for homes.

Inspectors will ensure the home has an up to date visiting policy and that residents care plans areupdated to reflect this and individual visiting arrangements in place.

RQIA will continue to gather information from homes and report on this through inspection reports

## ROLE OF THE DEPARTMENT OF HEALTH (DOH)

The Department (DoH) has overarching responsibility for developing the policy around visiting arrangements in care homes as well as other health care settings in Northern Ireland.

**Appendix 3**

**Review of routine data sources to inform care home visitor policy**
Collation and analysis of information from routine data sources is a crucial element of monitoring the impact of COVID-19 in care homes.

The table below outlines key data variables that may provide important early indicators of rising COVID-19 infection in care homes. Regular review of patterns and trends will be used to support decision making related to visiting policy in care homes.

PHA will continue to review data sources weekly through the care home cell and will provide regular updates to the DoH to inform care home visiting policy.

| Information | Data source |
|---|---|
| Community prevalence at regional and local council government level | • Contact tracing cell (CTC)<br>• DoH dashboard |
| COVID admissions to hospital | • PAS data<br>• DoH dashboard |
| Care Home Outbreaks<br>• Number of outbreaks<br>• Asymptomatic / symptomatic status of outbreaks<br>• Size or outbreak - attack rates (indicating spread) | • PHA Health Protection duty room (HPDR)<br>• PHA surveillance team weekly care home outbreak report<br>• Care Home Daily returns on COVID status<br>• DoH dashboard |
| Mortality associated with care homes | • NISRA<br>• DoH dashboard |
| Care home testing results<br>• Number of positive tests per month in care homes in staff and residents<br>• Positivity rates<br>• Asymptomatic testing coverage for staff and residents (pillar 2) | • BSO Data Warehouse<br>• PHA Monthly Care Home testing report |
| Vaccination status in care homes | • Care Home Daily returns on COVID vaccination status |
| Scientific evidence supporting the Government's response | • Evidence considered by the Scientific Advisory Group for Emergencies (SAGE) |

- All relevant data sources will be closely monitored on an ongoing basis to ensure appropriate interpretation is applied to emerging patterns and trends.

- Any data limitations will be highlighted to minimise the risk of misinterpretation including where analysis may be limited by small numbers, incomplete data or other caveats which may reduce the accuracy of reporting.

- Please note that whilst testing and vaccination are both encouraged across the care home sector, neither are a requirement to facilitate a visit to a care home.