Policy:

NP 018 Visitors policy

Executive Director Lead	Executive Director of Nursing and Professions
Policy Owner	Julie Smalley DHON nursing homes
Policy Author	Julie Smalley DHON nursing homes

Document Type	Policy
Document Version Number	V3
Date of Approval By PGG	29/08/23
Date of Ratification	September 2023
Ratified By	QAC
Date of Issue	29/8/2023
Date for Review	31/08/2024

Summary of policy

This policy relates to visitors to our in-patient, stepdown and nursing home services. It promotes a flexible and person-centred framework which supports staff and visitors to always feel confident and safe. It makes clear reference to best practice, Risk safeguarding and Zero tolerance. It is unambiguous and accessible.

Target audience	All SHSCFT staff including staff seconded into or working in SHSCFT services, volunteers, Governors, and the Board of Directors

Keywords	Person-centred -Inclusive- Human Rights- individualised

Storage & Version Control
Policy version and advice on availability and storage

Version 1.1 To include the Standard Operating Procedure for VIP/Celebrity Visits to the Appendices and to change the Author/Lead New policy commissioned by EDG on approval of a Case for Need. 2018

Version 2.0 – Amended June 2022 to include information relating to the Human Rights Act, Mental Health Act Code of Practice, Safeguarding amendments, reference to the Smoke Free Policy and a review of all local Standard Operating Procedures within the appendices. The appendix now includes a Standard Operating Procedure for visits to PICU – Endcliffe Ward.

Version 3.0 – Amended June 2023 to include name changes for acute wards, closure of Buckwood View and the closure of the Assessment and treatment unit learning disabilities. The policy is now also inclusive of Beech Cottage Stepdown unit. A template letter to use when visitors' behaviour is unacceptable has been added at appendix C. All SOPS are now on new trust template. Now included is reference to person centred visiting which includes guidance for assistance dogs visiting premises. It also includes the addition of

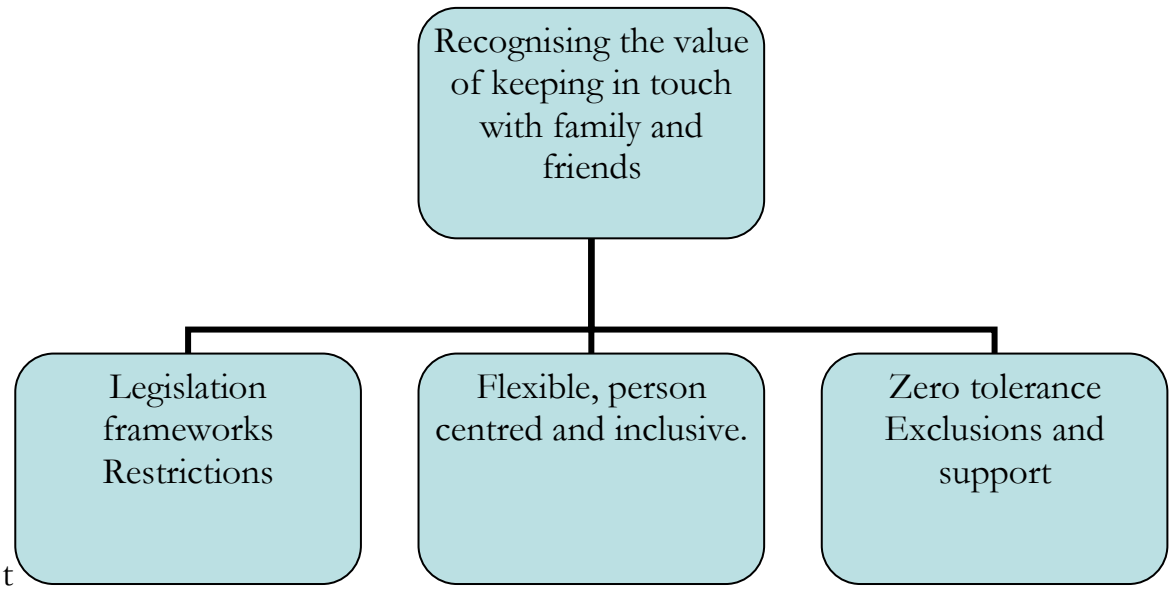
Version 3.0 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version 1.1 amended June 2022 Any copies of the previous policy held separately should be destroyed and replaced with this version.

This policy is available on the Trusts intranet and website.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
1.1	To include the Standard Operating Procedure for VIP/Celebrity Visits to the Appendices and to change the Author/Lead	October 2018	New policy commissioned by EDG on approval of a Case for Need.
2.0	To include information relating to the Human Rights Act, Mental Health Act Code of Practice, Safeguarding amendments, reference to the Smoke Free Policy and a review of all local Standard Operating Procedures within the appendices. The appendix now includes a Standard Operating Procedure for visits to PICU – Endcliffe Ward	June 2022	Amendments made during consultation, prior to ratification.
3.0	Review on expiry of policy	June 2023	Review undertaken to update the policy using the new SHSC template, relevant updates for in-patient wards to include new names ward closures, Beech Cottage was not previously referenced in the policy, so this has now been added. There is also a visitor's SOP. All other SOPs updated on the new trust template. This policy places more emphasis on a Person-centred approach to visitors which includes guidance for assistance dogs. It also includes the addition of the Fire and Safety Officers contact details as he was previously referenced in the policy.

Contents



t

1.0 Introduction

1.1 Version 1.1 was updated following the recommendations from the Metropolitan Police Service investigation" Operation Yew Tree" (October 2012) and the subsequent Independent Oversight of NHS and Department of Health Investigations into matters related to Jimmy Savile (Kate Lampard June 2014 updated February 2015).

1.2 It is recognised that admission to hospital or nursing home can be very stressful, and people can quickly feel isolated from their family and friends. Visiting people in hospital/residential care is an integral part of health and social care and can promote the service users' well-being. It is important that service users can maintain contact with family, friends, or anyone else they wish to see for the duration of their stay in hospital.

1.3 This policy places a focus on visitors to the five specialist in-patient areas, acute, dementia, forensic and intensive rehabilitation services. It is also inclusive of the two nursing homes and Beech Cottage step down unit. The policy also applies wherever there are service users present e.g., Community Team bases, Trust headquarters, day services. Please note this list is not exhaustive.

1.4 Due to the complexity of services within inpatient areas of the Trust, visiting procedures may differ, an example of this would be restricted items in Forensic services.

1.5 We will ensure that a current Standard Operating Procedure (SOP) is in place which has a consistent approach across all areas. The SOP will meet the needs of the specific areas that reflect best practice, to promote the concept of patient and family-centred care and incorporate all relevant Infection Prevention and Control and Safeguarding principles to maintain the safety of service users.

1.6 It is not practical to have open access to inpatient areas as this could pose a security problem and be disruptive to other service users; however, visiting will be accommodated wherever possible in the most person-centred way the policy allows in line with the service users wishes or best interests.

1.7 Within Mental Health (MH) and Learning Disability (LD) services, legal requirements must be met regarding service users, both informal and detained, being visited by children. This policy does not cover these requirements. Refer to the Trust's Visits by Children to Inpatient or Residential Care Settings Policy for further guidance.

1.8 The most relevant part of the Human Rights Act 1998 to the visiting policy is Article 8, which is the right to respect for private and family life, home, and correspondence. This right protects a person's right to autonomy, their right to make decisions and choices for them self's, the right to maintain relationships with others (friends, partners) and their ability to participate in their community as they define it. A person's right to family life encompasses not only to blood relatives and partners but also to chosen families.

In conducting their relationships, a person has the right to do so without these interactions being interfered with or observed by staff.

This right to conduct personal relationships is especially important in their home. A person's 'home' is defined as their current home - which can include nursing homes and wards.

The right to privacy in correspondence means that people have a right to have privacy in terms of how they communicate with their networks via letter, phone, social media etc, without staff observation or interference.

Article 8 is a qualified right. This means that in some circumstances interferences and limitations to this right can be applied - so long as those limits are:

- Lawful: This means that there is a legal basis that enables the Trust to impose a limit or restriction on a person's Article 8 rights. For example, via the Mental Health Act or Mental Capacity Act.
- Justified: This means that there is a reason that justifies a restriction being imposed, such as security, public safety, to protect health or morals, to prevent disorder or crime, and /or to protect the rights and freedoms of other people. For example, to protect from the risk of infectious disease, or to protect against a risk to harm or exploitation from another.
- Proportionate: This means that there needs to be a reasonable link between the restriction applied and the justification for its imposition.
- Least restrictive. This means that any restriction imposed must be the absolute minimum possible, applied for the shortest duration possible.
- Where human rights issues are engaged and restrictions imposed, the above should be considered in clinical documentation and /or care plans. Where restrictions are imposed, patients and their networks should be consulted as much as possible about the restriction and the decision to impose restrictions discussed and explained to them by staff.

2.0 Scope

This policy is applicable in all inpatient Nursing homes and non-inpatient areas across Sheffield Health & Social Care Foundation Trust.
It is NOT applicable for children visiting Mental Health inpatient/nursing homes (refer to 1.7).

3.0 Purpose

3.1 Facilitate appropriate visiting arrangements for people being cared for on in-patient wards enabling them to keep in contact with family and friends.

3.2 Enable staff to manage the ward or care environment and care safely and efficiently whilst balancing the therapeutic and social needs of service users and maintaining privacy and dignity.

3.3 Promote good Infection Prevention and Control practices.

3.4 Promote the 6 principles of Adult Safeguarding and ensure any visits by children and young people are in their best interests.

- Empowerment – Personalisation and the presumption of person-led decisions and informed consent. "I am asked what I want as the outcomes from the safeguarding process, and these directly inform what happens."

- Prevention – It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognize the signs and what I can do to seek help.”

- Proportionality – Proportionate and least intrusive response appropriate to the risk presented. “I am sure that the professionals will work for my best interests, as I see them, and they will only get involved as much as needed.”

- Protection – Support and representation for those in greatest need. “I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able.”

- Partnership – Providing local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse. “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me.”

- Accountability – Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life.”

4.0 Definitions

4.1 Within this document “the Trust” is SHSC.

4.2 Within this document staff should be understood to be any person working for SHSC and includes permanent, temporary, Bank and agency staff and volunteers and students/trainees.

5.0 Details of the policy

This policy has been reviewed and updated in line with changes to services. SHSC recently undertook a consultation with service users and staff to choose new names for the acute wards, the Assessment and Treatment unit and Buckwood View nursing home are no longer operational. The standard operational policies (SOPs) for the in-patient wards and enhanced care nursing homes have also been updated in line with the Trusts new template and processes for monitoring. The policy has been strengthened to emphasise the importance of visiting and keeping in contact with our service users and with a greater focus on being person-centred.

6.0 Duties

6.1 It is the responsibility of the Board of Directors to ensure policies and procedures are in place which meet local and national legislation and support best practice. The Executive Director with Lead responsibility for this policy is the Director of operations and transformation.

6.2 It is the responsibility of General Managers and those in equivalent roles to:

- Disseminate this policy to Ward Managers/Clinical Managers/Service Managers.

- Oversee the implementation of the policy.

- Monitor compliance with the content of the policy.

- Ensure that all areas have a mechanism for logging entry and egress from services for all visitors.

6.3 Ward managers/clinical managers/nurse/person in charge is responsible for:

- Staff in their areas being aware of the content of the policy.
- Using their discretion, in the best interests of the service user for whom they are caring, in relation to visiting.
- Having information on times to avoid visiting such as protected mealtimes, whilst being as flexible and inclusive as the environment allows, for example supporting relatives to visit at mealtimes in the nursing homes if requested.
- Maintaining a safe environment
- Reporting any accident/incidents involving visitors
- Completing any Incident Reporting Forms
- Notifying the area's Senior Nurse in the specific area, at the earliest opportunity of any concerns relating to visiting or visitors
- The implementation of this policy and its content.
- Maintaining the privacy and dignity of service users
- The health and safety of any visitors to the area
- Reporting any incidents involving visitors to the ward manager/nurse (person) in charge
- Ensuring that all visitors are informed of the need to log their own entry and egress to the service.

6.4 All Staff

- Must ensure that compliance with the Visitors' Policy and any associated local procedures.
- All incidents involving or observed by staff must be reported in accordance with the Incident Reporting Policy.
- Heads of Service (and equivalent) are responsible for ensuring that the necessary health and safety requirements are incorporated within the local visitors' guidelines and procedures. In addition, they are also responsible for monitoring of visitors in line with the Trust's policies and procedures.
- All staff have a duty to protect, respect and fulfil the human rights of service users according to the Human Rights Act 1998 (HRA). Furthermore, all policy and practice must be compatible with the HRA.

7.0 Procedure

7.1 All health and social care professionals will always treat visitors with courtesy and respect. In return it is expected that staff and service users are treated with the same respect and courtesy by visitors.

7.2 Visiting arrangement information must be provided either on admission or as soon as is practical to the service user and any visitors. This information can be provided verbally and supported by signs and information leaflets/booklets.

7.3 If a visitor is presenting anti-social behaviour, creating a nuisance, or is verbally aggressive, the staff must consider asking them to leave to maintain the safety of the therapeutic environment of the unit.

7.4 Staff should consider at times of stress and concern; people exhibit frustrations in different ways which may include agitation or a raised voice. It may be beneficial to explore these concerns by talking privately, showing empathy, and considering allowing the visitor to remain if the service user would also benefit from a longer stay. Consider action to move the service user and visitors to another location where the behaviour can be managed and de-escalated.

7.5 However, if there are no clear reasons for the anti-social, nuisance or aggressive behaviour then the visitor must be asked to leave.

7.6 Refusal of access, and/or asking visitors to leave can occur in the following situations:

- There are two principal grounds which could justify the restriction or exclusion of a visitor: clinical and/or security grounds.

- The decision to prohibit a visit by any person whom the patient has requested to visit or has agreed to see should be regarded as a serious interference with the rights of the patient and a blanket restriction may be considered a breach of their article 8 rights. There may be circumstances when a visitor must be excluded, but these instances should be exceptional, and any decision should be taken only after other means to deal with the problem have been considered and (where appropriate) tried.

- Any such decision should be fully documented and include the reasons for the exclusion, and it should be made available for independent scrutiny by the CQC or service commissioner and explained to the patient.

- Hospital managers should review the effect on the patient of any decision to restrict visits. These policies should be risk-based and not impose blanket restrictions, e.g., no visitors for the first four weeks after admission.

- Restriction or exclusion on clinical grounds. From time to time, the patient's responsible clinician may decide, after assessment and discussion with the multi-disciplinary team, that some visits could be detrimental to the safety or wellbeing of the patient, the visitor, other patients, or staff on the ward. In these circumstances, the responsible clinician may make special arrangements for the visit, impose reasonable conditions or if necessary, exclude the visitor. In any of these cases, the reasons for the restriction should be recorded and explained to the patient and the visitor, both orally and in writing (subject to the normal considerations of patient confidentiality). Wherever possible, 24-hour notice should be given of this decision.

- Restriction or exclusion on security grounds. The behaviour of a particular visitor may be disruptive, or may have been disruptive in the past, to the degree that exclusion from the hospital is necessary as a last resort. Examples of such behaviour include:

    - incitement to abscond.

- smuggling of illicit drugs or alcohol into the hospital or unit
- transfer of potential weapons
- unacceptable aggression, and
- attempts by members of the media to gain unauthorised access.

- A decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate, the reason for the decision should be communicated to the person being excluded (subject to the normal considerations of patient confidentiality and any overriding security concerns).

- Hospital managers should regularly monitor the exclusion from the hospital of visitors to detained patients.

- Restricting visitors to informal patients who lack capacity to decide whether to remain in hospital could amount to or contribute to an unlawful deprivation of liberty or a breach of the individual's human rights. It may indicate that a deprivation of liberty (DoL) authorisation or Court of Protection order under the deprivation of liberty safeguards of the Mental Capacity Act (MCA) may need to be sought, or formal admission under the act.

- All incidents of verbal abuse or physical violence directed towards staff by visitors is unacceptable and must be reported to the Police. Where it is considered that the physical security measures of the premises or procedural arrangements to address or mitigate the identified risks require review, staff should liaise with the Trust Security Officer for advice and support.

- When asking someone to leave the Trust site, staff must not place themselves at risk. Ensure that you take a colleague with you for support and politely outline the behave that is not acceptable and ask them to leave. If the visitor's behaviour becomes aggressive and hostile contact the police but do not attempt to eject the visitor once they have refused to leave.

- Once the visitor has left provide an explanation and support to the SU as to why the actions were necessary. Complete an incident form (including an incident form under the Incident type: Mental Health Legislation, Cause group: Other – MH Legislation, and Cause 1 – Visiting Refused/Restricted). Inform line manager or on-call if out of hours and document in SU clinical records. Ensure that the incident is thoroughly discussed at the next MDT, sooner if required and make a clear plan for the management of this visitor moving forward. This may include a formal letter for which a template is provided at appendix C

7.7 Where an authorised visitor to the work area engages in unacceptable behaviour which likely to give staff, service users or other persons for which a duty of care fear for their safety, the manager is authorised to restrict further access to the workplace to the person or persons causing the fear until such time as determined the threat of fear has been mitigated. All such incidents are to be reported to the Trust via the Incident Reporting System and, if considered appropriate due to the nature of the fear caused the Police and the Trust Security Officer to assist in seeking legal redress where considered appropriate.

7.8 All incidents involving physical assault by a visitor upon a member of staff, service user or persons for which a duty of care is held are to be reported to the Police and the Trusts Security Officer informed to assist in pursuing redress where considered appropriate.

7.9 In cases where visitors may have trouble visiting within agreed visiting times, perhaps due to distance to travel to the unit, their individual requirements should be accommodated, where it is reasonably possible.

7.10 When a service user's condition or terminal illness gives rise for concern staff will use their discretion and be flexible about visiting arrangements.

7.11 In some service areas e.g., inpatient units for people with dementia, it is recognised that family members and close friends are often closely and directly involved in the planning and delivery of care. When appropriate, flexible visiting arrangements will be agreed locally to support and encourage this involvement. SHSC staff strive to be inclusive and aim to work with the principles of https://johnscampaign.org.uk/ within our nursing homes and G1.

7.12 Areas to which visitors have access should be clearly sign posted, and access is at the discretion of the multi-disciplinary team. To allow for the privacy of other service users it is not desirable that visitors are given free access to any communal sleeping/bedroom areas.

7.13 Where the service user is in a single bedroom access to visitors will be at the discretion of the Multi-Disciplinary Team.

7.14 Under no circumstances is a visitor to have access to the area's clinical room.

7.15 It must be explained to visitors that the service user they are visiting must not be taken off the area/ward without discussion and agreement of staff.

7.16 Visiting celebrity/high profile person/fundraiser/member of parliament (MP) or local elected members.

- Any celebrity/high profile person/fundraiser/MP or elected Member who requests to visit inpatient/residential areas will be directed by Trust staff to the Trusts Communications Department.

- The Communication Department will organise and facilitate any appropriate visits in collaboration with the directorate concerned, having considered issues, regarding, respect, dignity and service user consent and the structure of the visit and any publicity arising out of the visit.

- Celebrity/high profile/fundraising/MP or elected members and similar visitors will always be accompanied and should not have access to treatment/bathroom/bedroom areas or observe any intimate care.

- Unexpected celebrity high profile/fundraising/MP or elected members and similar visitors who attend an area without prior arrangement and not in the capacity of visiting a specific service user as a friend or relative will not be granted access to any of the service user areas and will be advised that a visit must be officially organised via the Trust's Communications Department.

- Visits should be arranged in line with 'purdah' Guidance (guidance on the conduct of civil servants in the pre-elections period).

7.17 Children Visiting (Please see the Trust's Visits by Children to Inpatient or Residential Care Settings Policy)

- In areas where the visiting of children is supported:
    - Children must always be supervised by the adult who accompanies them.
    - Children will not be permitted into the patient's bedroom and designated child visiting locations, which are available on each service area, should be utilised.
    - Staff reserve the right to ask that children be removed if they are found in bedroom spaces or clinical areas.
    - Trust staff will not supervise children on behalf of the adults attending any Trust areas.

7.18 Volunteers. Please see the Trust's Volunteer Policy for further guidance.

7.19 Domestic Pet Animals

- Domestic pet animals can enhance the quality of life for many people. However, animals can carry infections such as MRSA, psittacosis and Salmonella which can occasionally be transmitted to humans, particularly people who are immune-suppressed or who have other health problems. Some animals may also be difficult to control and may pose risks to patients due to their behaviour.

- To minimise the risk to service users who are receiving care, domestic pets are not allowed on Trust premises. The definition of pets includes all warm- and cold-blooded species including dogs, cats, lizards, snakes, fish, birds and insects.

- The only exceptions to this rule are guide dogs for the blind, hearing dogs for the deaf, dogs trained to help people with conditions such as epilepsy and autism, and dogs/cats which belong to the Pets as Therapy (PAT) scheme. These animals are not excluded from the Trust premises because they are recognised as providing substantial benefits to service users. https://www.equalityhumanrights.com/sites/default/files/assistance-dogs-a-guide-for-all-businesses.pdf

- This guidance describes the infection control advice governing the visiting of guide dogs for the blind, hearing dogs, dogs trained to help people with conditions such as epilepsy and autism and PAT animals.

- Pets as Therapy (PAT) animals and Guide Dogs

- All cats and dogs used by the PAT organisation will have a record detailing their vaccinations, visits to the vet and state of health. This helps to minimise the risk of the animal harbouring an infection which could be transmitted to service users. A copy of the animal's health record should be available on request. PAT animals are also temperament assessed, fully wormed, and covered by the PAT insurance scheme.

- All visits must be pre-arranged with the area/unit/ward and any PAT animal visiting a clinical area should always be accompanied, by its registered owner. However, if the circumstances on the ward/unit/area have changed since the visit was arranged, the person in charge of the area will determine whether the PAT animal will be allowed into the area and whether any conditions or restrictions are necessary.

- When a PAT animal, guide dog or assistance dog visits the Trust premises, the following procedures must be adhered to:

    - The staff member arranging the visit must ensure that consideration is given to how the pet/assistance dog will access the ward/unit/area to ensure service user and public safety in general areas.

    - Staff and service users must wash their hands before and after handling the animal.

    - The animal must be properly trained and always supervised by its owner.

    - Staff must identify whether there are immuno-suppressed or otherwise vulnerable service users who may be put at risk from contact with the animal. If such a risk is identified the animal must be kept away from the service users at risk or even excluded from the area.

    - The animal must be kept on a lead or otherwise suitably restrained and must not be allowed to wander freely around clinical areas or elsewhere on Trust premises.

    - Animals must not be present whilst food is being served or eaten by service users.

    - The staff member arranging the visit must always ensure the hygiene of the area.

    - A suitable area must be identified for the animal's toileting needs.

    - Water should be provided for the animal's consumption.

7.21 Palliative Care

- When service users are receiving palliative or end of life care, clinical staff may feel that it would be beneficial to a service user's psychological wellbeing if they were allowed access to their pet dog or cat. In these circumstances the area should contact the infection control team to agree the visit and any measures which may be required to ensure the safety of other service users.

- Under no circumstances should any animal not exempt above be allowed access to any clinical or non-clinical areas managed by Sheffield Health & Social Care NHS Foundation Trust without prior consultation with the Director of Infection Prevention and Control or Deputy Chief Nurse.

7.22 Refreshments for Visitors

- Ward areas do not routinely provide refreshments for visitors. However, if a visitor has travelled a long distance, has become upset during a visit or is visiting the ward due to more direct involvement in the care planning and delivery process, then it may be appropriate to provide the visitor with a drink on the ward (this is at the discretion of the staff on duty/ nurse-in-charge).

- In accordance with Health and Safety guidance, visitors are not allowed access to the kitchen areas. Staff should inform visitors of the location of any cold or hot drinks machines and the location of any other facilities from where drinks can be purchased.

7.23 Visitors and smoking

- SHSC is a smoke free site both within premises and within our external grounds. For the health and safety of our service users, visitors (including staff members) are not permitted to smoke in any of our buildings, ward garden areas, car parks or grounds. There are no areas where vaping (including e-cigarettes) by visitors is allowed.

- We do not allow tobacco products or matches/lighters onto wards and ask that visitors do not bring these onto premises for people that they may be visiting. In the interest of safety staff may need to check items brought onto the ward before they are given to the person they are visiting.

- We understand that smoking is an addiction, so we offer effective alternatives for patients to support and manage their cravings. This includes Nicotine Replacement Therapy, vaping products, and specialist support from our QUIT team.

- Visitors must be informed that smoking is always prohibited whilst on Trust grounds / property. Visitors who do not comply with the smoke free restrictions should be kindly asked to leave the site.

7.24 Use of photographic equipment by visitors

- Visitors must be aware that cameras, including mobile phone cameras and camcorders must not be used by visitors on Trust premises. Please contact the corporate affairs team for further guidance on obtaining consent to take photos and or film.

7.25 Raising concerns/whistleblowing policy

- Further information and resources available to assist in any internal/external communications can be found in the Trust's Whistleblowing and Allegations Against Staff Policy available on the Trust Website. This policy reinforces the Trust's stance regarding dealing with, and acting on concerns raised by staff which will be key to instilling confidence in staff, service users and the public that the Trust takes its responsibilities seriously. Information about this policy is displayed in all areas.

7.26 Infection Prevention and Control Issues

- It is important to minimise the risk of introducing infection into the ward areas as well as reducing the risks of visitors acquiring an infection.

- The following guidance should be followed:

    - If areas have alcohol hand gel dispensers at ward entrances, posters should be in place asking visitors to use them on entering and leaving the area and demonstrating the technique to be used.

    - In the event of an outbreak of diarrhoea and or vomiting on the area staff must advise visitors to clean their hands using soap and water instead of alcohol hand gel and consideration must be given to closing the area to visitors. The Infection Prevention and Control Team should be contacted for further advice and guidance.

    - Visitors are requested not to sit on the beds, but use chairs provided.

    - Visitors must not use service user's toilets on the ward.

- Visitors feeling unwell, or who have a cold or have had any diarrhoea and/or vomiting within the previous 48 hours must refrain from visiting.

- Visitors are not required to wear personal protective equipment (PPE) unless visitors are providing direct clinical care for relatives. For routine social contact PPE is not required.

- Visiting restrictions may be put in place for infection prevention and control purposes on the recommendation of the clinical team and/or the Infection Prevention and Control Team (IPCT).

- If an outbreak of infection occurs, staff should refer to the Trust's Infection Control Policy.

- In relation to Covid, national advice is that visiting in all inpatient areas should return to pre-pandemic levels.

7.27 Inpatient Wards and nursing homes Visitor Restrictions During an Infection Outbreak

- It is essential that prompt and effective infection prevention and control (IPC) measures are implemented in preventing/controlling the spread of infection between service users, visitors, and staff.

- There are times when it is necessary for the ward management, in conjunction with other teams e.g., IPC team, to carry out a risk assessment on visiting a ward. For example, during an infection outbreak on a ward, steps may need to be taken which affect all visitors, including restricted access and ward closure, to manage and control the outbreak effectively.

- Throughout the outbreak, advise can be sought from the IPC team on individual circumstances regarding any visitors to a ward, this includes planned maintenance, healthcare professionals, and requests to visit service users e.g. for the service user's mental health and wellbeing, end of life care, if the service user has special needs.

7.28 Protected Mealtimes

- Mealtimes should be a relaxed and enjoyable occasion in an environment that encourages service users to eat an adequate diet to meet their needs. Protected mealtimes are promoted by the National Patient Safety Agency (NPSA 2007) and are assessed through Patient-Led Assessments of the Care Environment (PLACE). However, we encourage visitors to our nursing homes and G1 to support at mealtimes if this is part of person-centred care planning.

- All health inpatient and nursing homes settings operate protected mealtimes. This involves restricting visitors during mealtimes unless visitors are present to assist with mealtimes. The focus is on providing uninterrupted time for service users to enjoy their meals. Signs will be displayed to indicate mealtimes and inform visitors of the policy.

8.0 Development, Consultation and Approval

- This policy was developed in conjunction with Lead infection Control nurse, Head of Mental Health Legislation Human Rights Lead, Matrons ward Managers and Safeguarding lead. Guidance followed from relevant sources, and all involved in developing the policy.

- All Matrons Ward Managers Estates Security Groups and individuals consulted (including staff side groups and service user / carer involvement including link back to the Equality Impact Assessment).

- Any changes made because of the consultation including key changes e.g. legislative changes

- Clinical Quality and safety group July 2023

- Safeguarding Assurance Committee August 2023

- Policy Governance Group (PGG) August 20223

9.0 Audit, Monitoring and Review

This section should describe how the implementation and impact of the policy will be monitored and audited. It should include timescales and frequency of audits.

If the policy is required to meet a particular standard, it must say how and when compliance with the standard will be audited.

a. The policy will be audited one year after implementation by the Senior Matron

b. Care Networks will monitor the implementation of the policy via their Senior Management Teams.

c. The policy will be reviewed in June 2026

Monitoring Compliance Template

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Every three years	Review and consultation	(Matrons)	Every three years	Quality Assurance Committee	Julie Smalley Matrons and HON	Quality Assurance Committee

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. Reviewed June 2023

10.0 Implementation Plan

a. This policy will be available on the Trust intranet website in the policies section. An 'All SHSC' email alert will be sent to all staff to inform them that the policy is available on the Trust intranet. Clinical and Service Directors are responsible for ensuring that all their staff are aware of and know how to access all policies.

b. The Integrated Governance team will maintain an archive of previous versions of this policy, and make sure that the latest version is the one that is posted on the Trust intranet.

c. Where paper policy files or archives are maintained within teams or services, it is the responsibility of the Team Manager to ensure that paper policy files are kept up to date and comprehensive, and that staff are made aware of new or revised policies. Older versions should be destroyed to avoid confusion. It is the responsibility of the team manager to make sure the latest version of a policy is available to all staff in the team.

d. Service Directors will lead the implementation and ongoing use of this policy, on behalf of the Executive Director of Nursing and Professions. The Safeguarding Assurance Committee will review implementation one year after implementation. The policy needs to be reviewed quarterly at local service governance meetings.

e. The policy will be issued via an all-staff email which will explain the key principles within the policy.

f. The Safeguarding Assurance Committee will review the implementation of the policy with an audit one year after its initial implementation.

The implementation plan should be presented as an action plan and include clear actions, lead roles, resources needed and timescales. The Director of Corporate Governance team can provide advice on formats for action plans; however, an example layout for the plan is shown below:

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
e.g. Upload new policy onto intranet and remove old version		September 2023	TBC
Ensure all staff are aware of the updated policy.	General Managers service managers Matrons	September 2023	TBC

11.0 Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0	2016	2016	N/A	N/A
1.1	2018 amended October 2018 to include SOP for VIP/celebrity visits and change of author	2018	N/A	
2.0	Amended June 2022 to include Human Rights Act, Mental Health Act Code of Practice, Safeguarding amendments, reference to the Smoke Free Policy and a review of all local Standard Operating Procedures within the appendices.	2022	June 2022	N/A
3.0	Amended August 2023 New Sheffield Health and Social Care Templates New ward names Closure of Firshill Rise and Buckwood view Strengthen links with Whistleblowing policy, Zero Tolerance policy. Included Guidance for assistance dogs Emphasis on person centred care and support for older adults.			

12.0 Training and Other Resource Implications

None identified during policy review.

13.0 Links to Other Policies, Standards, References, Legislation and National Guidance

- South Yorkshire Safeguarding Adult Procedures available via the Trust intranet
- SHSCFT Safeguarding Children Policy
- SHSCFT Visits by Children to Inpatient wards Policy.
- SHSCFT Incident Reporting and Investigation Policy SHSCFT Nutritional Strategy
- SHSCFT Infection Prevention and Control Policy
- SHSC Whistleblowing Policy
- SHSCFT Security Policy
- SHSCFT MCA Policy
- SHSCFT MHA Policy
- SHSCFT Allegations against Staff policy
- Jimmy Savile Investigation: Broadmoor Hospital (Department of Health and West London Mental Health Service 2014 updated 2015)
- The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust (2014)
- Department of Health Investigations into matters relating to Jimmy Savile - Kate Lampard 2014
- Department of Health Investigations into matters relating to Jimmy Savile Lessons learnt – Kate Lampard 2015
- Rotherham, Doncaster and South Humber NHS Foundations Trust – Visiting of service users on the in-patient areas policy 2015
- Patient Led Assessment of Care Environment (PLACE); Health and Social Care Information Centre NHS England (2013)
- National Patient Safety Agency (NPSA 2007)
- Health and Safety at Work Act 1974
- Health and Social Care Act (2008)
- Mental Health Act Code of Practice (2015)
- Guidance on the Conduct of Civil Servants in the Pre-Elections Period, Cabinet Office General Election Guidance 2015
- https://www.equalityhumanrights.com/sites/default/files/assistance-dogs-a-guide-for-all-businesses.pdf
- https://johnscampaign.org.uk/

14.0 Contact Details

Title	Name	Phone	E mail
Matron (author)	Julie Smalley	0114 2264816	Julie.smalley@shsc.nhs.uk
Matrons	Naomi Hebblewhite Kim Parker Grace Kinsey-Oxspring Shirley Lawson	0114 2718046 0114 2263306 0114 2262204 0114 2718173	Naomi.hebblewhite@shsc.nhs.uk Kim.parker@shsc.nhs.uk Grace.kindsey-oxspring@shsc.nhs.uk Shirley.lawson@shsc.nhs.uk
Human Rights Officer	Tallyn Gray	0114 2263666	Tallyn.gray@shsc.nhs.uk
Head of Infection Prevention Control	Angela Hendzell	0114 3050707	Angela.hendzell@shsc.nhs.uk
Head of Safeguarding	Hester Litten	0114 2718418	Hester.litten@shsc.nhs.uk
Head of Mental Health Legislation	Jamie Middleton	0114 2718110	Jamie.middleton@shsc.nhs.uk
Fire and Safety Officer	Stephen Price	0114 2711819	Stephen.price@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

	I confirm that this policy does not impact on staff, patients or the public. Julie Smalley 30/06/2023	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**Potentially children are discriminated within the policy as they are not afforded the same visiting rights as adults**		**A stand-alone policy for children visiting our inpatient areas is signposted and noted within this policy**
Disability	**No**		
Gender Reassignment	**No**		
Pregnancy and Maternity	**No**		

Race	**No**		
Religion or Belief	**No**		
Sex	**No**		
Sexual Orientation	**No**		
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - Policy Amended

Impact Assessment Completed by:
Julie Smalley – 30/06/2023

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	√
2.	Is the local Policy Champion member sighted on the development/review of the policy?	
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	√
5.	Has the policy been discussed and agreed by the local governance groups?	√
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	√
	Template Compliance	
7.	Has the version control/storage section been updated?	√
8.	Is the policy title clear and unambiguous?	√
9.	Is the policy in Arial font 12?	√
10.	Have page numbers been inserted?	√
11.	Has the policy been quality checked for spelling errors, links, accuracy?	√
	Policy Content	
12.	Is the purpose of the policy clear?	√
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	√
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	N/A
15.	Where appropriate, does the policy contain a list of definitions of terms used?	√
16.	Does the policy include any references to other associated policies and key documents?	√
17.	Has the EIA Form been completed (Appendix 1)?	√
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	√
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	√
20.	Is there a plan to i. review ii. audit compliance with the document?	√
21.	Is the review date identified, and is it appropriate and justifiable?	√

Appendix C

Sheffield Health and Social Care NHS Foundation Trust

Dear XXX

I am writing to you in my capacity as XXX following a number of concerns /a concern that have been brought to my attention regarding your recent visits to XXX.

Our staff, volunteers and anyone visiting Sheffield Health and Social Care NHS Foundation Trust (SHSC) premises have the right to feel safe and respected and to go about their duties without experiencing harassment. I have been made aware that during visits to XXX you behaved in a manner that was not in keeping with either our Zero Tolerance of Harassment (Third Party) Policy, nor our Visitors Policy.

SHSC takes the safety of our staff and visitors extremely seriously and we recognise that harassment of staff and our service users, by others, has an impact on staff and other service users/residents. When this occurs, we will do all we can to take account of this impact and take appropriate action, where this is possible.

If any behaviour occurs that is deemed to be anti-social, creating a nuisance, or verbally aggressive, staff will consider asking you to leave to maintain the safety of the therapeutic environment of the ward/nursing home/stepdown unit Should these behaviours continue, we may place a restriction on your visiting or may exclude you from visiting the premises. Following exclusion from the premises, we would seek an Acceptable Behaviour Agreement between you and the management team at XXX

Where any occurrence of your behaviour constitutes a criminal offence, we will report this to the police and support any prosecution they may pursue. Whilst we do not take such actions lightly, we have a duty to ensure the safety of our staff and our service users at all times.

I have enclosed a copy of our Zero Tolerance of Harassment (Third Party) Policy, our Visitors Policy and the standing operational procedure for visitors for your information.

A copy of this letter has been sent to our Complaints Department for information. If you would like to discuss this letter with me, or wish to raise any concerns, please contact me on XXX

Yours sincerely

XXX

Encs: Zero Tolerance Policy
Visitors Policy
Visitors Procedure for Site