CLINICAL GUIDELINE

Visiting guideline and decision making aid

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	1
Does this version include changes to clinical advice:	N/A
Date Approved:	3rd November 2022
Date of Next Review:	30th September 2025
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Approval Group:	Clyde Sector Clinical Governance Forum

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Royal Alexandra Hospital, Intensive Care Unit (ICU)

Visiting guideline and decision making aid

Content	
Title	**Visiting guideline and decision making aid**
Authors	Philip Henderson, John Hunter
Date published	September 2022
Review date	September 2025 or earlier in response to updated public health or NHSGGC guidance
Objectives	To facilitate patient visiting in the Intensive Care unit (ICU) at the Royal Alexandra Hospital (RAH) in a transparent, fair, and consistent manner. The tiered risk assessment has been developed in accordance with the NHSGGC guideline: Staff Visiting Guidance - NHSGGC The primary purpose of this guideline is the local implementation of the broader GG&C policy (link above), making this specific to the RAH ICU. The key benefits will be to facilitate patient and family wellbeing while acknowledging the European Convention on Human Rights, in particular Article 8, which provides a right to respect for private and family life.
Scope	To give explicit guidance on when and how visiting can be facilitated in the ICU.
Audience	All ICU staff.
Guideline Body	The baseline position is that all patients should be permitted a visitor in ICU. When visiting is not permitted this needs to be recorded in the patient's notes, and a discussion with the family member should be undertaken by a senior clinician and ICU nurse. The term "family member" should be interpreted in the broadest sense. Whoever the patient considers a close or important person should be considered a family member. All patients within ICU qualify for essential visiting. The basis for this is that the patients in ICU are all receiving important information about a life changing illness or treatments, and support from another person is essential for advocacy and wellbeing. Visiting review teams (VRT) recommend a range of options for visiting a hospital or area within a hospital. These options are described as options 1 to 5. Of note, in all options, essential visiting is permitted. Therefore, visiting to the ICU should always be permitted and there should only be a blanket ban on visiting in very exceptional circumstances usually dictated from an executive level, board level, or national (public health level). The key difference the options for visiting will determine is the number of visitors rather than whether visiting is allowed or not. The number of permitted visitors in not covered here but is available through the broader GG&C policy. There are two situations within ICU where visiting needs to be considered carefully and discussed with the patient, the visitor, the nurse in charge, and the consultant in charge. These are when the visitor has symptoms of a communicable disease; or where there is a continuous aerosol generating procedure (AGP) in a respiratory ("red") pathway patient. In the former situation (a visitor with a potential communicable disease) visiting should generally not be permitted except in exceptional circumstances (e.g. end of life care), after discussion with the consultant in charge and nurse in charge. Visiting with an ongoing AGP in a respiratory ("red") pathway patient may be possible and should be discussed with the consultant and nurse in charge. The visitor would need to be aware of the risks and a personal risk assessment undertaken. The guideline explicitly states that visiting is possible with a continuous AGP the details are as follows:

	"Visitors entering an AGP area in which airborne precautions are being applied, should do so after the fallow time has elapsed. Where this is not possible (continual [continuous] AGP zone), visitors should be advised that there may be a risk of exposure to respiratory viruses. Visitors should be asked to wear an FRSM where respirator fit testing is not possible [note fit testing almost certainly not possible unless the visitor is already fit tested e.g. works in a clinical area within GG&C]. Where a COVID-19 positive patient is receiving care that results in the creation of aerosols in the clinical environment (such as non-invasive ventilatory support or invasive mechanical ventilation) local risk assessments should be carried out to facilitate family support where possible and as safely as possible. This includes a careful consideration of the clinical condition of the patient and good communication with family members involving discussion of risk and benefit. Other factors that should be considered include, the health status of the visitor, including their general health and immune status with regard to COVID-19, along with any other relevant details." The decision making tool further outlines how this guideline will be implemented. This guideline does not apply to end of life care when visiting should be unrestricted. Specific guidance is outlined in: **Visiting decision making aid (at the end)**
References / Evidence	
References	Staff Visiting Guidance - NHSGGC https://www.nipcm.hps.scot.nhs.uk/media/2008/2022-10-06-appendix-21-v17.pdf
Evidence Method	Consultation with local and national guidance. An evaluation was undertaken considering how this could be implemented within the RAH ICU. Qualitative assessment of local practice alongside a response to recent events highlighting inconsistency in current approach. Flowchart has been reviewed by nursing staff on duty and feedback about the usability has been sought with ongoing revisions.
Related Resources	As above, under references
Related Guidelines	As above, primary resource is: Staff Visiting Guidance - NHSGGC
Table key	RAH: Royal Alexandra Hospital; ICU: intensive care unit; GI: gastrointestinal; PPE: personal protective equipment; AGP: aerosol generating procedure; FRSM: fluid resistant surgical facemask; FFP3: filtering facepiece 3 [mask]; COVID-19: Coronavirus disease-2019; CPAP: continuous positive airway pressure; NIV: non-invasive ventilation; ETT: endo-tracheal tube.

RAH ICU visiting decision making aid

Does the visitor have symptoms of a communicable disease? e.g. respiratory symptoms; GI symptoms; fever.

Yes → **Visiting not advised**. This should be reviewed with the nurse in charge and ICU consultant. Visiting may be allowed in certain circumstances decided on a case by case basis

No

Is the patient on the non-respiratory ("Green") pathway?

Yes → Visitor can enter the patient's room. Encourage use of the same PPE as staff.

No

Is the patient undergoing an AGP?

No → **Example situations:** Staff are wearing droplet precautions (e.g. using FRSM rather than an FFP3 facemask). The patients are normally those on conventional oxygen (face mask / nasal cannula) or breathing room air with no supplementary oxygen. The patients will generally be on the red pathway and / or COVID-19 positive and still in an isolation period.

Visiting guidance: Visitor can enter the patient's room. Visitors should wear a FRSM. Once the patient is outwith their isolation period visiting can follow as per the non-respiratory pathway.

Yes

<u>Is the AGP process continuous or intermittent?</u>

Continuous AGP: Nasal high flow, CPAP, or NIV, and the patient is having minimal breaks due to disease severity; an invasively ventilated patient (tracheostomy or ETT) who is having frequent disconnections, some examples of this may be: because of agitation or by the clinical team due to severe bronchospasm.

Intermittent AGP: An intubated and ventilated patient where there are prolonged periods (e.g. ≥ 60 minutes) without circuit disconnections; or Nasal high flow, CPAP, or NIV where the patient is able to have prolonged breaks (≥ 60 minutes) onto conventional oxygen (e.g. trauma or non-rebreather face mask).

Intermittent AGP

Best practice: allow the fallow time for the room to pass after the AGP is stopped or paused (e.g. after an ETT disconnection or stopping NIV / nasal high flow) and then allow the visitors into the room.

Visitors: should wear available PPE; this will normally involve routine droplet precautions particularly a FRSM. Note staff will usually be wearing different PPE from visitors in this situation (e.g. AGP precautions involving an FFP3 mask).

Risks: Visitors should be aware of the potential risk of exposure to the respiratory virus e.g. if there was an unexpected disconnection from the ventilator. It is advisable to help the visitor to make their own risk assessment of their potential risk in this situation, taking into account their co-morbidities, vaccine status, and recent illness or exposure to the respiratory virus. Although not compulsory the visitor can be encouraged to carry out lateral flow tests which can be supplied from the unit.

Continuous AGP

There is provision within the GG&C guideline (here) to facilitate visitors for these patients.

This situation needs discussed with the nurse in charge and the ICU consultant. Visiting is permitted but needs careful thought. The GG&C guideline states: "visitors should be advised that there may be a risk of exposure to respiratory viruses. Visitors should be asked to wear an FRSM where respirator fit testing is not possible [the usual situation]"

Record the decisions relating to visiting and the reasons behind this in the patient's notes (ICCA / carevue or paper notes).

Proceeding with in-person visiting should be carefully risk assessed, which primarily means assessing the risk to the visitor. The senior clinician (registrar or consultant) should talk the visitor through risk assessment with particular focus on the visitor's vaccine status, their comorbidities, recent respiratory virus / COVID exposure, or recent illness.

If the decision for the visitor, patient, and clinical teams is not to proceed with in-person visiting, virtual visiting, or the family looking through the room windows remains an option.