ANZSPM

# Visitor Limitations to hospitals and palliative care units in the COVID-19 Context

## INTRODUCTION

To our knowledge, there is no clear evidence base that specifically relates to visitation restrictions for the inpatient palliative care population during the COVID-19 pandemic. However, consensus guidelines have been informed by emerging evidence relating to viral transmission and infection control measures generally. We specifically reference those of the Association for Palliative Medicine of Great Britain and Ireland. Additionally, use of public health terms and definitions in this document have been based on those utilised in the Communicable Disease Network of Australia COVID-19 Series of National Guidelines (CAND SONG). We note that jurisdictional as well as institutional advice and requirements are under constant development and may be at odds with the guidance below. We recommend that the following guidelines are used to aid dialogue, appropriately exploring the values and priorities being considered locally.

It is also important to consider the expectations of the public during the pandemic, and how this may change over time. The messaging to society from governments, experts, healthcare providers, and the media can considerably influence these expectations and hence the acceptability of visiting limitations. Guidelines should therefore be transparent and based upon logical arguments from current evidence, with a consistent communications strategy from leaders across all sectors of the community. From a clinical perspective, acknowledging the potential for reversibility of disease and the uncertainty of prognostication, it may be useful to set a timeframe for treatment and visiting restrictions. At the end of the agreed timeframe, care can be reviewed via a formal family meeting where changes to visiting hours can be discussed. The process of dividing an unknown timeframe into shorter periods, bounded by explicit expectations and a definite follow-up, can make uncertainty more manageable for patients and their families.

The cultural aspects of end of life care should always be respected. This obligation does not change within a pandemic. The relevance of a person's cultural connection to their health beliefs and how they make decisions should be explored as early as possible during healthcare provision. Healthcare providers should be curious and seek to learn about the cultural values of their patients. Aboriginal health professionals should be utilised to facilitate and better understand the needs of the indigenous peoples of Australia. Interpreters should be used whenever helpful and possible. It is possible that that reconciling some cultural values and public health expectations during the COVID-19 pandemic will be challenging. Regarding visitation for instance, in many cultures there may be larger families and groups of visitors than usually expected. It may be that a key spokesperson (who may or may not be a relative of the patient) can support the discussion of needs with healthcare providers. Such challenges need to be explored with sensitivity. Explanations of the visiting policy should be clear and accompanied by the reasoning according to the knowledge about the SARS-CoV-2 virus. This approach is applicable to all cultures and initiates a discussion with no agenda about visiting, but rather respects and seeks a solution in partnership.

We recognise that achieving the right balance between compassionate care and public health imperatives will require expert communication, flexibility, creativity and genuine understanding of what is important to our community. This will best be achieved through consciously balancing these

objectives with careful use of compromise informed by ongoing assessments of the risks and benefits of acting otherwise.

This document intends to guide visiting restrictions during the COIVD-19 pandemic, noting the necessity to balance many complex factors affecting the needs of palliative care patients and their caregivers. While there has been a significant focus on visitor restrictions to limit viral transmission and to protect vulnerable populations, there remains limited clarity on how this should be managed for palliative care patients. This document should be considered an attempt to describe the **minimum access to visitors for palliative patients that would be appropriate**. Local contexts and the changing responses to the COVID-19 pandemic may affect how this advice can be interpreted.

## ETHICAL FACTORS TO CONSIDER

Decisions to limit visitation to people receiving care in hospital settings during the COVID-19 pandemic, are informed by numerous ethical concerns. We recommend that these concerns are acknowledged within the process of determining visiting restrictions during the pandemic. This list is not exhaustive, and there may be additional considerations relevant to the context of decision-making locally. The following headings provide a suggested ethical framework:

- **Equity, respect and fairness**
  - Prioritising the needs of people who are close to dying, their families, and their close communities through additional support for visitation prioritises equity over equality. This may create concerns of disadvantage and risk among others which will need to be responded to with clarity, sensitivity and compassion.
  - As a person approaches the dying phase of their illness, their physical, psychological, social and spiritual needs will be affected by access to their family and social network.
  - While the clinician's primary responsibility is to the care of their patient, holistic care also encompasses a social component. Hence, allowing family and friends to visit a dying person provides an opportunity for continuing care from these individuals. It also influences bereavement, in part related to facilitating significant conversations, additional support and the need to be present until the death occurs.
  - Providing additional access to visitors for people who are dying supports an equitable approach to care, recognising heightened needs and a limited timeframe for meaningful connection.
  - Compassionate, patient-centred care should be offered to all patients, with or without COVID-19, in all settings as they approach death.
  - It is critical that the visitation restrictions should be based upon a logical and consistent public health message. Where possible, consistent procedures should be utilised within and between healthcare services.

- **Harm minimisation**
  - It is important to limit predictable harms within the COVID-19 context which relate to visitation including:
    - Limiting transmission between healthcare workers, families and patients.
    - Patient outcomes with regards to psychosocial and spiritual distress or those impacted by unmet physical needs.

        - Family caregiver outcomes with regards to psychosocial and spiritual distress, and the risk of prolonged grief disorder. A pandemic raises anxiety and disrupts the lives of many in society, especially those who are also grieving for a dying relative.
        - Healthcare worker outcomes with regards to psychosocial and spiritual distress, including moral injury.
    - Every effort should be made to facilitate digital communication wherever possible. This should be particularly prioritised in deteriorating and terminal phases of care.

- **Honesty and transparency**
    - There should be transparency regarding the potential for public health needs to be prioritised over the personal autonomy of patients and their caregivers, and this should be communicated clearly a compassionately.
    - Visiting restrictions and their rationale should be clearly documented and communicated to patients and families, e.g. when being transferred from one care setting to another, including how restrictions may change if the patient deteriorates, enters the terminal phase, or their COVID-19 status changes.
    - Visiting restrictions should be included in advance care planning discussions to enable patients and families to make informed decisions regarding ongoing care and preferred place of care or death.
    - Advance care directives made before the COVID-19 pandemic should be reviewed according to the current context. COVID-19 may not have been considered in past advance care planning processes and therefore these may need to be reviewed to ensure informed decision-making.
    - The usual practice of notification when a patient rapidly deteriorates, to allow family to be present, should continue.

- **Flexibility and proportionate responses**
    - As the situation evolves, where risk and surge levels fluctuate, policies will need to be reviewed in conjunction with clear guidance at a state and national level. For example, in the context of low infection rates, adequate staffing and sufficient personal protective equipment (PPE), it may be feasible to safely facilitate and supervise visitation for the few COVID-positive patients. However, a decision would need to be made, based on the ability of visitors to safely use PPE, whether visitation should be permitted or not. Whereas, during times of high infection rates and high demand on healthcare services it may be necessary to forfeit visitations for all patients.
    - The potential risks associated with a suspected or confirmed COVID-positive patient also requires proportionate steps to mitigate these risks, relative to patients who are COVID-negative.
    - The expectation that exceptions to communicated rules should be granted by clinical teams is discouraged as it places unreasonable decision-making burden on individual staff members. Furthermore, the ensuing negotiations may damage therapeutic relationships and disrupt health professional teamwork in the delivery of care.
    - It may be that individual cases do warrant exceptions based on specific circumstances. Here, the decisions should be discussed, weighing up the risks, and focus on the benefits to the patient as the primary focus of care. Ideally, planning should be undertaken in anticipation of needs rather than in a reactive manner. Support to

families, alongside the maintenance of therapeutic relationships and health professional teamwork should be high priorities and underpinned by expert communication skills.

- **Capacity and consent**
  - Patients with capacity should provide consent to receive each visitor, and where this is not possible, their previously known wishes or the view of a proxy decision maker should be respected.
  - Efforts should be made to establish that each visitor understands the risk of exposure to the virus for themselves and their household contacts.

- **Justice and autonomy**
  - A balance of the best interests of the community versus the consent of individuals to accept personal risk must be struck. We suggest that the need for enforcement of mitigation strategies such as quarantine should be given due importance when weighed against the potential risks for the broader community.

## SUGGESTED FRAMEWORK FOR VISITATION OF INPATIENTS RECIEVING PALLIATIVE CARE

We propose graded levels of visitor restriction to people receiving palliative care in inpatient settings. This includes patients admitted to dedicated inpatient palliative care units and those admitted to hospital wards who are receiving palliative care from their treating team or a specialist palliative care consultation team. It is recommended that the local specialist palliative care service is involved with the determination of visiting restrictions for palliative care patients, e.g. in acute hospital wards where no consultation liaison team exists, we would recommend that a senior representative from the local palliative care unit is contacted. These levels represent a proportionate and equitable response, attempting to consider the following:

- level of surge (and therefore supply of PPE and staff capacity to supervise visitors)
- potential COVID-19 status of the visitors permitted
- potential COVID-19 status of the staff
- COVID-19 status of the patient
- phase of care of the patient.

We acknowledge that certain resources, such as the structural design of units or institutions to provide single rooms and private bathrooms; the availability of PPE; the bed capacity of the unit or ward and therefore total potential volume of visitor traffic; and the staff available to support patient care may impact how this advice can be interpreted locally.

This advice also assumes several responsibilities of visitors to health facilities for their presence to be safe and sustainable:

- All visitors must agree and be able to comply with hand hygiene requirements, wear any required PPE and undertake the subsequent isolation requirements relevant to their contact. The PPE available to be used must also be of the appropriate size for that visitor.
- Visitors must comply with additional advice relating to diminishing transmission risk within the hospital. Depending on the degree of community transmission this may include advice to stay in the patient's room only (including using the patient's bathroom rather than any communal or public facilities), and either supply food and drink for themselves or have

catering provided by the health care facility to avoid use of the ward kitchen and/or nearby food outlets. It may also include advice that they must leave the hospital or facility immediately after the visit (i.e. not spend time in public areas, lobbies, cafes etc.).

- Visitors should follow general public health directions for community members which may pertain to issues such as choice of travel and use of surgical masks. There are no specific implications for travel or use of a surgical mask for a visitor to a person with proven or suspected COVID-19 if appropriate use of PPE has been complied with at all times during the visit.
- A log should be kept of all visitation dates and times, with contact information to facilitate contact tracing if required subsequently.
- Screening should occur to prevent the visitation for visitors who are symptomatic with features consistent with COVID-19, or who fulfil criteria for self-isolation (e.g. close contact of a confirmed case) based on up to date advice from the CAND SONG and/or local state or territory public health advice.
- All visitors must comply with any public health directives applied to them as either close contacts, suspected or confirmed cases.
- It may be necessary to prevent admission to visitors who refuse to comply with restrictions. This will be challenging for staff and visitors alike, but despite best efforts miscommunication may occur. It is therefore important to plan how these encounters will be dealt with. Staff who are screening at entry points will need to be able to deal with the emotions of visitors and have communication skills to diffuse situations. Although we hope the involvement of security personnel is not needed, planning for their availability is important to protect healthcare workers.

We recognise that the implementation of visitor restrictions places an additional burden on the interdisciplinary team, in particular nursing staff, allied health clinicians and ward clerks. Restrictions will therefore need to be practical for staff to implement in their local setting. The tracking of visitors and any exemptions permitted for each patient can interfere with clinical care and should be carefully organised to minimise disruption to workloads. We endorse the practical guidance given in the Australasian College for Infection Prevention and Control and the Australian College of Critical Care Nurses position statement on facilitating next-of-kin presence for patients dying from COVID-19 in the ICU. The instruction, supervision and monitoring of PPE use and physical distancing as described will involve dedicated nursing time to implement safely.

The following table describes a staged response to the impact of COVID-19 in the community and on health services which forms the basis of the visitation framework which is to follow. Note that triggers for different response stages can occur from the community or from health services.

| Response Stage | Purpose of response | Stage trigger points | |
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| | | Community | Local Health Service |
| **1** | To ensure baseline COVID-19 risks to patients are limited whilst optimising end of life care. | Minimal to no active COVID-19 cases.<br>Asymptomatic community cases expected to be negligible. | Low demand: Minimal to no patient care with confirmed COVID-19 cases. |
| **2** | As per stage 1 PLUS ensure moderate COVID-19 community | Multiple community confirmed COVID-19 cases due to locally | Regular care of COVID-19 confirmed cases in high risk wards. |

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| | risks are limited to patients, visitors and staff. | acquired – contact of confirmed cases.<br>Minimal to no locally acquired – contact not identified COVID-19 cases.<br>Asymptomatic community cases expected to be negligible. | |
| **3** | Ensure all potential risk can be mitigated to all patients, visitors and staff. | Multiple confirmed COVID-19 cases due to locally acquired – contact not identified cases.<br>Unidentified asymptomatic cases unable to be quantified. | High volumes of COVID-19 cases. |

The following framework suggests a strategy for an **appropriate minimum** access to visitation for the inpatient palliative care population in each response stage that balances the factors and concerns described above.

| **Stage 1** | |
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| **Patients with no suspected COVID-19**<br>Physical distancing must be maintained | **Patients with suspected/confirmed COVID-19**<br>Physical distancing must be maintained<br>PPE and masks must be worn |
| **For patients NOT in deteriorating or terminal phase**<br>• Limit of 2 visitors at any one time from a list of 4 nominated visitors drawn up on admission, in discussion with the patient and/or caregiver<br>• Any changes to the nominated visitors should be made on a case by case basis<br>• Maintain usual visiting hours as much as possible<br>• Visits should permit a minimum of 2 hours per day<br>• No visitors under the age of 16<br>• Religious, spiritual or community leaders who are not employed by the health service are permitted to visit but must be included in the maximum of 2 visitors at any one time, although not the list of 4 nominated visitors<br>• 'Essential caregivers' (see below) may visit in addition to the above, including overnight, by negotiation as required and according to the patient's care plan, but must be included in the maximum of 2 visitors at any one time, although not the list of 4 nominated visitors | **For patients NOT in deteriorating or terminal phase**<br>• One visitor per day from a list of 4 nominated visitors drawn up on admission, in discussion with the patient and/or caregiver<br>• Any changes to the nominated visitors should be made on a case by case basis<br>• Visits are for a maximum of 2 hours<br>• Visitation once per day<br>• No visitors under the age of 16<br>• Every effort should be made to facilitate digital communication wherever possible |
| **For patients in deteriorating or terminal phase**<br><br>**As above, and additionally**:<br>• The limit of 2 visitors at any one time will be maintained during terminal and bereavement phase due to room size and physical distancing requirements | **For patients in deteriorating or terminal phase**<br><br>**As above, and additionally:**<br>• Family members who are under the age of 16 may visit (see below) and at these times two visitors are permitted together (the child and an adult) to allow for supervision and support |

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| • One adult visitor is permitted to sleepover, subject to local protocol but must be included in the maximum of 2 visitors at any one time<br>• Family members who are under the age of 16 may visit (see below) | |
| **Stage 2** | |
| **Patients with no suspected COVID-19**<br>Physical distancing must be maintained | **Patients with suspected/confirmed COVID-19**<br>Physical distancing must be maintained<br>PPE and masks must be worn |
| **<u>For patients NOT in deteriorating or terminal phase</u>**<br>• Limit of 2 visitors at any one time, the same two people throughout the admission<br>• Visits are for a maximum 2 hours<br>• No visitors under the age of 16<br>• Religious spiritual or community leaders who are not employed by the health service may not be permitted to visit, and so additional planning to meet spiritual needs may be required<br>• 'Essential caregivers' (see below) may visit in addition to the above, including overnight, by negotiation as required and according to the patient's care plan, but must be included in the maximum of 2 visitors at any one time | **<u>For patients NOT in deteriorating or terminal phase</u>**<br>• No visitors allowed<br>• Every effort should be made to facilitate digital communication wherever possible |
| **<u>For patients in deteriorating or terminal phase</u>**<br><br>**As above, and additionally**:<br>• The limit of 2 visitors at any one time will be maintained during terminal and bereavement phase due to room size and physical distancing requirements<br>• One adult visitor is permitted to sleepover, subject to local protocol, but must be included in the maximum of 2 visitors at any one time<br>• Family members who are under the age of 16 may visit (see below) | **<u>For patients in deteriorating or terminal phase</u>**<br>• One adult visitor, the same person throughout the admission<br>• Visits are for a maximum of 2 hours<br>• Visitation once per day<br>• Family members who are under the age of 16 may visit (see below) and at these times two visitors are permitted together (the child and the designated adult visitor) to allow for supervision and support<br>• Every effort should be made to facilitate digital communication wherever possible |

| **Stage 3** | |
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| **Patients with no suspected COVID-19**<br>Physical distancing must be maintained<br>Masks must be worn | **Patients with suspected/confirmed COVID-19**<br>Physical distancing must be maintained<br>PPE and masks must be worn |
| **<u>For patients NOT in deteriorating or terminal phase</u>**<br>• No visitors allowed<br>• Every effort should be made to facilitate digital communication wherever possible<br>• 'Essential caregivers' (see below) may visit in addition to the above, including overnight, by negotiation as required and according to the patient's care plan | **<u>For patients NOT in deteriorating or terminal phase</u>**<br>• No visitors allowed<br>• Every effort should be made to facilitate digital communication wherever possible |

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| **For patients in deteriorating or terminal phase**<br>• One adult visitor, the same person throughout the admission<br>• Visits are for a maximum of 2 hours<br>• Visitation once per day<br>• Every effort should be made to facilitate digital communication wherever possible | **For patients in deteriorating or terminal phase**<br>• One adult visitor, the same person throughout the admission<br>• Visits are for a maximum of 2 hours<br>• Visitation once per day<br>• Every effort should be made to facilitate digital communication wherever possible |

### Definitions and notes:

'Suspected' COVID-19 cases are consistent with the CDNA National Guidelines for Public Health Units. Currently as at 31 July 2020, this indicates an individual has met both clinical and epidemiological criteria for COVID-19.

Visitors may include partner, parents, children, siblings and/or identified next-of-kin. Adult is defined as over the age of 16.

Where visitors under the age of 16 are permitted to visit, they must:

- Be able to comply with handwashing, not touching the environment and wearing any required PPE, or are babies that can be carried throughout the visit
- Be accompanied by an adult at all times who is responsible to supervise them and ensure compliance with infection control measures
- Limit visits to a maximum of 2 hours, although shorter times may be appropriate depending on their ability to maintain compliance with infection control measures
- Be counted as one of the list of nominated visitors

'Essential caregivers' are adult visitors who assist in the management of the patient. Their role is defined by the Victorian Department of Health and Human Services as "providing essential care and support necessary for the patient's physical, emotional or social wellbeing that cannot be delivered by the health service care team or via electronic means". The number and duration of visits should not exceed the time required to provide essential supports only. For example, a familiar caregiver may visit to reassure a patient with cognitive impairment or delirium if they are unsettled.

Deteriorating and terminal phase refer to the Palliative Care Outcomes Collaboration (PCOC) Phases (pcoc.org.au).

## VISITATION OF INTERSTATE OR OVERSEAS VISITORS

Where a visitor wishes to travel from interstate or overseas in order to visit a loved one in an inpatient palliative care setting, we broadly recommend that this should be facilitated wherever possible, depending on the level of surge and staff capacity to supervise visitors.

Direct contact with the governmental health department and the local health service should be made prior to commencing travel. Where a period of self-quarantine is usually required, written permission to break quarantine for the purpose of visiting the health service should be sought from the governmental health department. This information should be coordinated to also grant permission to visit the local health service, so that seeking allowance from the local health service is not problematic. If granted, the terms of the permission should stipulate that the visitor should wear a surgical mask at all times, including when travelling to and from the hospital or facility and observe strict hand hygiene throughout their visit. The visit must be cancelled if the visitor develops symptoms consistent with COVID-19 or tests positive on routine screening. Consideration should be

given to the visitor's needs during potential bereavement and they should be informed of the restrictions that will apply (for example, a requirement to complete the remaining quarantine period without physical contact with other mourners).

## ACKNOWLEDGEMENT

The ANZSPM COVID-19 Special Interest Group would like to thank Dr Kathryn Daveson, Infectious Diseases Specialist (Queensland Health and ACT Health) for her advice in the preparation of this document.