RESIST
Antimicrobial Resistance and Infection Control Team

Normalising Visiting to and from Long-Term Residential Care Facilities (LTRCFs) for people with disabilities

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Version	Date	Key Changes from previous version
1.0	14.07.2021	First version of the document.

Note: If you have any queries on this guidance, please contact the AMRIC team at hcai.amrteam@hse.ie

Table of Contents

Own door supported accommodation and small group homes. 3
Definitions 3
Introduction 4
The challenge for service providers 5
Communication 7
Categories of visiting 7
General Guidance Applicable to Indoor Visiting 7
Frequency of Visiting and Number of Visitors 9
Visiting on Compassionate Grounds 9
Routine visiting when there is no Outbreak 9
Visiting where there is not a high proportion of vaccine coverage amongst residents. 10
Resident Outings 10
Visiting in the context of an outbreak of COVID-19 11
Community Housing Units 12
Appendix 1 Definition of Terms 13

This document replaces "COVID-19 Guidance on visits to and from Long-Term Residential Care Facilities (LTRCFs) for people with disabilities" version 1.3 issued June 2nd 2021

Scope and Limitations

The term LTRCFs encompasses all congregated care settings where people live for extended periods including nursing homes, certain mental health facilities and community housing units for people with disabilities. All designated centres for older people and designated centres for children and adults with disabilities must be registered with the Office of the Chief Inspector of the Health Information and Quality Authority (HIQA). HIQA monitors and inspects designated centres regularly to ensure that they maintain a high level of care and support. This guidance is also applicable to comparable facilities that are not designated (for example some religious homes). This document is applicable to most such facilities.

Own door supported accommodation and small group homes.

Residential services for people with a disability are based largely in own door supported accommodation or small group homes (comprised of 6 individuals or less living in the house). Such facilities are fundamentally different from large, congregated LTRCF settings both in terms of risk and the needs of the individual and require a specific approach. This document outlines such an approach based on a risk assessment to address visiting individuals in such facilities and visits from individuals to their family homes (or corresponding setting).

Definitions

The terms visitor, essential service provider, important service provider, vaccine protection and compassionate circumstances are defined in Appendix 1.

Introduction

Residents in LTRCFs have the right to receive visitors to support meaningful contact with family members if they wish to do so and also to participate in the life of the wider community. This document aims to support providers in fulfilling their responsibility by giving guidance to management, staff, residents and relatives to ensure that any restriction on those rights in the context of COVID-19 are proportionate to the risk at that time. Timely communication in a manner appropriate to the individual resident will include an overview of the proposed visiting arrangements and any updates or changes that may occur in accordance with Government policy, public health/infection control advice.

Vaccination has now been offered to almost all residents and staff of LTRCFs and most residents in most LTRCFs are vaccinated. Vaccination does not provide protection against infection or disease until some-time after vaccination has elapsed as outlined in Appendix 1 (definition of vaccine protection). Completing the vaccination schedule is important to achieve the best and most sustained protection that the vaccine can provide. Most LTRCF residents completed vaccination some time ago and can now be considered protected. The vaccination programme has therefore changed the balance of risk between harm related to restriction of visiting and harm related to COVID-19. Furthermore, residents who have had COVID-19 in the previous 9 months are also considered to have protection.

Immune system protection either as a result of vaccination or recovery from COVID-19 in the previous 9 months is not absolute. Cases of infection have occurred in people following vaccination and in the months after recovery. Usually these infections are mild however, in some cases very serious infections have occurred. The risk of infection for people with immune system protection are likely to be greater with some variants of the virus. Therefore healthcare workers and others who have been vaccinated or have had COVID-19 in the previous 9 months continue to follow the public health and infection prevention and control measures recommended for them.

Antibody testing is not recommended for routine use to assess immunity to infection, as there is no consensus on how to interpret the results.

This guidance differentiates between LTRCFs that have a high proportion of residents with vaccine protection and those LTRCFs that do not have a high proportion of residents with vaccine protection. Individual residents who are not vaccinated should be advised that they are at greater risk and supported in taking additional precautions if they choose to do so but they should be included in social and recreational activities inside and outside of the LTRCF if that is their choice.

The vaccination status of prospective visitors is also relevant to assessing the risks associated with visiting. A visitor who has vaccine protection is far less likely to acquire severe COVID-19 disease as a result of exposure to COVID-19 in a LTRCF. There is growing evidence that people who have vaccine protection are also less likely to develop asymptomatic infection and that most people who are vaccinated shed less virus if they do become infected. It is reasonable, therefore to expect that people who have vaccine protection are less likely to be the source of introduction of virus into a setting such as a LTRCF. While a LTRCF cannot be responsible for ensuring that visitors have vaccine protection it is appropriate to inform prospective visitors of the benefits of vaccination. Note however that people with symptoms of COVID-19 or other viral respiratory tract infection should be asked not to visit regardless of their vaccination status or previous COVID-19 infection.

The challenge for service providers

Vaccination of residents and staff of LTRCFs has had a dramatic impact in reducing the occurrence of infection and severe disease in residents of LTRCFs. It is therefore appropriate to progress to develop visiting policies with minimum restrictions and reflecting the regulatory responsibility of the Registered Provider/Person in Charge to ensure that the autonomy of residents is respected.

Providers of residential care for people with disabilities have adapted to changing guidance over recent months thus facilitating greater visiting. There are exemplars of how the competing challenges of facilitating visiting and managing infection risk can be balanced to serve the needs of residents. Those facilities for people with disability that are exemplars will guide others on normalising visiting. The facility should ensure, in line with established legal obligations, that it has the capacity and relevant skill sets within its staffing complement to manage resident care, including safe visiting, appropriately.

Visiting policy should be based on a risk assessment. The risk assessment should take account of the overall care needs, rights and wishes of residents, the vulnerability of the residents, the level of vaccination of residents in the facility, the current incidence of COVID-19 in the surrounding community and the capacity of the facility in terms of buildings, grounds and human resources to manage risks associated with visiting. Consultation with local Public Health teams and IPC expertise will assist the Registered Provider/ Person in Charge with review of their plans and risk mitigation, in order to facilitate visiting.

Risk assessments that underpin decisions regarding restricted visiting should be documented, including their rationale, in line with the Health Act 2017 (Care and Welfare) Regulations 2013, noting that the primary legal position is that in so far as is reasonably practicable, visits should not be restricted unless there is an identified risk. Restrictions should comply with the spirit of the guidance set out below and take account of the Ethical Considerations Relating to Long-Term Residential Care Facilities available at:

https://www.gov.ie/en/publication/37ef1-ethical-considerations-relating-to-long-term-residential-care-facilities/

It may be necessary for facilities to adapt their visiting policy to changing circumstances and public health guidance for example if variants of the virus emerge that cause more serious disease in RCFs. As such, providers should ensure that they have robust contingency and preparedness plans in place and review them regularly.

Managing safe visiting requires that prospective visitors undertake to co-operate fully with measures required to ensure that visiting represents the lowest possible risk to all residents and staff. Testing of prospective visitors in advance of visiting is not required at present. A study of testing of visitors in the UK showed that it was challenging to implement and did not reduce the number or scale of outbreaks (Tulloch and other April 2021).

Service providers will generally refuse entry to prospective visitors who show evidence of infection unless there are extraordinary circumstances such as expected imminent end of life and the risk can be managed with specific additional measures. Service providers may be obliged to refuse entry to a prospective visitor if the person is unwilling or unable to comply with reasonable measures to protect all residents and staff or if the person has not complied with reasonable measures during a previous visit. The reasons for any refusal of entry of a visitor should be clearly explained.

Communication

Restrictions on visiting and the loss of "meaningful contact" are of themselves a cause of harm to residents, their friends and families. Any lack of clarity regarding visiting arrangements and the reasons why they are required can exacerbate this stress and is avoidable. It is essential that the service providers engage with residents, involve them in decision making and communicate clearly with each resident and relevant others regarding visiting policy, including any restrictions. This communication should make it clear how visiting is facilitated, any restrictions that apply, the reasons for the restrictions and the expected duration of restrictions.

In addition to communication with residents, families and friends, restrictions in facility should be communicated in engagements with HIQA (along with expected duration of same) and with relevant advocacy services.

Categories of visiting

In relation to infection prevention and control (IPC) risk with COVID-19 any restrictions on visiting that may be required apply primarily to **indoor visiting**.

There is no IPC requirement to restrict "**window visiting**" where a person stands outside and speaks to a person at safe distance through an open window.

There is rarely an IPC requirement to restrict **outdoor visiting** if safe distance can be maintained. Outdoor visits are likely to be very weather dependent and depend on the suitability of this type of visit for the residents and visitor.

General Guidance Applicable to Indoor Visiting

Visits need not be scheduled in advance with the facility.

Visiting should be managed to avoid visitors congregating and interacting with other visitors or with residents other than the person they have come to visit and entry and exit points, in hallways and in communal areas.

To achieve this scheduling of visits may be required at peak visiting times. However, visiting should be managed at the lowest possible level of controls to meet the objective of managing congregation and interaction.

Visitors should be discouraged from interacting socially with other visitors indoors in the LTRCF or with residents other than the person they have come to visit. If residents and visitors

are outdoors, either seated or walking, social interaction is very low risk provided contact is avoided and people keep some distance between each other. There is not a requirement to wear masks outdoors, but close congregation of large groups of visitors and residents should be avoided.

There is **no requirement** to limit the total number of different people who can visit a resident or to maintain lists of nominated visitors although there is a limit (see below) to the number of people who can visit at one time.

Visitors should be made aware that any visitors with fever or respiratory symptoms should stay away and if they come to visit they will not be admitted. They should be aware of the visiting processes that apply which include:

1. A check for symptoms of COVID-19,
2. A check if they have been diagnosed with COVID-19 in the past 10 days,
3. A check if they have been advised to self-isolate or restrict their movements for any reason.

Visitors are required to sign in on entry to the facility (regulatory requirement). Visitors should be guided in performing hand hygiene when they arrive and before signing in. The sign in may be in the format of an acceptance of personal responsibility for their behaviour and for unavoidable risk.

Visitors are required to wear a surgical mask when in communal indoor space during the visit. The facility should provide any necessary personal protective equipment. They should be asked to go directly to the room of the person they are visiting and not to stop to speak with or drop in to see any other resident.

They can be advised that if they have vaccine protection and the person they are visiting has vaccine protection they do not need to wear a mask or avoid contact when they are alone with the person they are visiting.

Even in the absence of vaccine protection it is not appropriate to seek to prevent contact in particular circumstances, for example towards end of life for residents who are distressed.

It is not appropriate to ask visitors to wear gloves, apron, gown or eye-protection during the visit.

If the resident is not vaccinated or if for any reason they prefer to wear a mask they should be provided with a surgical mask to wear during the visit.

Visits should occur either in the resident's room if the room is a single room, or in the case of a multi-occupancy facility, in a room away from other people. The room should be ventilated during the visit in so far as practical taking account of weather and comfort. The goal is gentle air circulation not a breeze or draught that causes discomfort.

Visitors must comply with the required IPC related precautions while visiting, however, the resident's rights, privacy and dignity must be respected and it is not appropriate to invasively monitor visits.

The duration of the visit should not be limited for IPC reasons.

There is not an IPC requirement for restriction on gifts of goods or other items for visitors. There is no requirement for a period of storage of the item before the resident receives it.

Visits by children should be facilitated if the child is accompanied by an adult who takes responsibility for ensuring appropriate conduct and the child is able to comply with the general requirements for visiting.

Frequency of Visiting and Number of Visitors

Visiting on Compassionate Grounds

Where critical and compassionate grounds (as set out in Appendix 1) apply, maximum flexibility of visiting is appropriate subject to the ability of the LTRCF to manage the visiting safely.

Routine visiting when there is no Outbreak

Visiting where there is a high proportion of vaccine coverage amongst residents

From two weeks after the date when a high proportion (see Note below) of all residents in the facility are vaccinated, the minimum level of visiting should be 4 visits per week by up to 2 people at one time. Providers should put in place the necessary measures to progress to more normalised visiting and visiting frequency as quickly as possible in line with the considerations above.

Visiting arrangements apply regardless of vaccination status of the individual resident, however residents who do not have vaccine protection should be informed of the specific risk to them of seeing additional people in the absence of vaccination. The risk to the resident is lower if their visitors have vaccine protection. The LTRCF cannot be responsible for verifying the vaccination status of the visitor.

Visiting where there is not a high proportion of vaccine coverage amongst residents.

In the absence of a high proportion of vaccine coverage of residents (see Note below) **no less than 2 visits per week** should be facilitated.

The number of people participating in each visit should normally be 1 person unless there are specific circumstances that require that the visitor is supported by an additional person.

In a facility where a high proportion of vaccine coverage has not been achieved, the risks are greater nevertheless providers should consider how to progress to more normalised visiting and visiting frequency noting in particular that the risk are less for those individual residents who have vaccine protection. In residential facilities for people with disability where there is not one aged 70 years or older and assessed at very high risk of severe COVID-19 progression towards more normal visiting can happen more quickly.

NOTE "A high proportion" should generally be considered to mean that about 8 out of every 10 residents in the facility have vaccine protection. For this purpose, those who have had COVID-19 in the previous nine months but are now outside the infectious period should be counted as equivalent to residents who have vaccine protection. LTRCF should make every effort to achieve the highest possible uptake of vaccination amongst staff, as this is critical to protection of residents. It is not possible to protect residents from the risk associated with low vaccine uptake by staff by excluding visitors.

Resident Outings

Resident outings and visits to homes of families and friends are important for resident overall welfare. Outings and activities should comply with the public health measures in effect at the time in relation to groups of people meeting.

In the context of a LTRCF with a high level of vaccine protection there is no requirement to limit the movement of a resident within the facility after return from an outing or hospital

attendance regardless of the duration of the absence unless some significant and unanticipated exposure risk occurred or there is a specific public health or IPC recommendation that requires limitation of movement.

In the absence of a high level of vaccination non-vaccinated residents absent from the facility for more than 12 hours should be advised to limit their contact with other residents. Such non-vaccinated residents should be offered testing between day 5 and day 7 after their return and if they test not-detected and are asymptomatic they may return to normal activities at that time. For those with vaccine protection in such a facility there is no requirement to limit the movement after return from an outing or hospital attendance regardless of the duration of the absence unless some significant and unanticipated exposure risk occurred or there is a specific public health or IPC recommendation that requires limitation of movement.

Visiting in the context of an outbreak of COVID-19

The following approach applies to facility during an ongoing outbreak of COVID-19.

Facilities may need to decline indoor visitors to the facility, other than on critical or compassionate grounds, during the early stage of an outbreak if specifically advised to do so by Public Health. Access for Important Service Providers will often be suspended during the early phase of an outbreak.

When the situation has been evaluated by the outbreak control team and measures to control spread of infection are in place, family and friends should be advised that, subject to the capacity of available staff to manage, visiting will be facilitated to the greatest extent practical. At this stage of the outbreak, to promote wellbeing a minimum of one visit by one person per week should be facilitated for those residents who wish to receive visitors unless Public Health or Infection Prevention and Control have documented advice against this. The risk of visiting during an outbreak is lower if a high proportion of residents in the LTRCF have vaccine protection and if visitors have vaccine protection. More visiting can generally be facilitated in that circumstance.

If indoor visiting restrictions are necessary in the early phase of an outbreak, alternative forms of communications and engagements with families and others should be facilitated proactively and to the greatest extent possible, including through window visits, outdoor visits, video calls etc. Restrictions on visiting should be reviewed at least every 2 weeks. Significant considerations in the risk assessment include the outbreak related care workload for staff and the number of staff

available, which may limit capacity to manage visiting. If the outbreak is confined to 1 wing or 1 building on a campus, there may be fewer requirements for visiting restrictions in other wings or buildings.

All visits during an outbreak are subject to the visitor accepting a risk of infection for the visitor. The LTRCF should request visitors to confirm that they have been advised of the risk to them, that they accept that risk and will comply fully with any measures they are asked to follow for their own protection or the protection of staff or residents. All visitors should be provided with any necessary personal protective equipment.

The messages around visiting during an outbreak should be communicated clearly to residents and reinforced by placing signage at all entry points to the facility and by any other practical means of communication with families and friends.

Own door supported accommodation for individual or couples

Own door supported accommodation for individuals, or couples, does not pose a specific risk to others that is different from any other private house. Own-door accommodation includes such housing in a campus setting where visitors can enter in a manner similar to entering any house or apartment in the general community.

Own-door housing should not be regarded as a congregated setting. Individuals should be supported in following public health guidance applicable to the general population including self-protection measures for those over 70 years old or with medical conditions that place them at high risk of severe COVID-19. Note that people aged 70 years and older or with medical conditions that place them at high risk of severe COVID-19 (other than conditions that compromise their immune system) and who have vaccine protection can generally follow public health guidance as it applies to the population in general.

Community Housing Units

Community housing units for small groups are generally a lower risk setting than large, congregated care settings. Risk is further reduced when most in the group have vaccine protection. Any definition of “small group” is arbitrary but for the purposes of this document it

is taken to mean 6 individuals or less.

Each community housing unit should be assessed to determine if there are one or more individuals aged 70 years or over or individuals who have medical conditions that place them at high risk of severe COVID-19. If there are no such individuals or if those individuals aged 70 years and older and those who have medical conditions that place them at high risk of severe COVID-19 disease have vaccine protection no specific additional measures compared to those that apply to everyone need be applied and the community housing unit may then follow the general public health guidance that applies to any family home.

Appendix 1 Definition of Terms

Visitors

For the purpose of this guidance, visitors may be taken to include people, typically family members or friends, who come to the LTRCF for a social visit. Prospective visitors who are eligible for vaccination can help protect the resident they visit, other residents and themselves by accepting vaccination when it is offered to them and all visitors should follow necessary infection prevention and control precautions.

The term visitor does not include **Essential Service Providers** (ESPs). Essential Service Providers are people who provide professional services including healthcare, legal, advocacy, financial and regulatory services. Access for ESPs cannot be denied and they should only be limited in the most exceptional circumstances and for defined periods in the context of specific public health advice. ESPs that are eligible for vaccination can help protect residents and themselves by accepting vaccination and all ESPs should have appropriate training and follow necessary infection prevention and control precautions. All services should comply with any legal or public health restrictions on the provision of services in effect at the time.

The term visitor does not encompass **Important Service Providers** (ISPs) who provide services that are important to resident's sense of self and wellbeing but that are not strictly necessary. Examples of ISPs include those who provide personal care (for example hairdressers) and entertainers. ISPs that are eligible for vaccination can help protect residents and themselves by accepting vaccination and all ESPs should have appropriate training and follow necessary

infection prevention and control precautions. All services should comply with any legal or public health restrictions on the provision of services in effect at the time.

Vaccine Protection

The following definition of vaccine protection has been used in this document.

Individuals are considered to have vaccine protection as set out here:

1. 28 days after the first AstraZeneca dose;
2. 7 days after the second Pfizer-BioNTech dose;
3. 14 days after the second Moderna dose;
4. 14 days after Janssen (one dose vaccination course).

If other vaccines become available, the requirement for vaccination will be as advised by HSE.ie.

This guidance differentiates between LTRCFs that have a high proportion of residents with vaccine protection and those LTRCFs that do not have a high proportion of residents with vaccine protection. Individual residents who are not vaccinated should be advised that they are at greater risk and supported in taking additional precautions if they chose to do so but they should be included in social and recreational activities inside and outside of the LTRCF is that is their choice.

Critical and compassionate circumstances are difficult to define and of necessity require judgement. The term should not be interpreted as limited to circumstances when the death of a resident is imminent. Where critical and compassionate grounds (see examples set out below) apply the duration and frequency of visiting should be as flexible as possible subject to the ability of the LTRCF to manage the visiting safely.

The following are examples of critical and compassionate circumstances.

1. Circumstances in which end of life is imminent.
2. Circumstances in which a resident is significantly distressed or disturbed and although unable to express the desire for a visit there is reason to believe that a visit from a significant person may relieve distress.
3. When there is an exceptionally important life event for the resident (for example death of a spouse or birthday).

4. When the visitor may not have another opportunity to visit for many months or years or never (for example because they are leaving the country or are themselves approaching end of life).
5. Increased visiting is recommended by their doctor as a non-pharmacological therapeutic alternative to an increased dose of an existing agent or introduction of a new anxiolytic or sedative agent.
6. A resident expresses a strong sense of need to see someone whether for personal reasons, to make financial or other arrangements or to advocate on their behalf.
7. A person nominated by the resident expresses concern that a prolonged absence is causing upset or harm to a resident.
8. Other circumstances in which the judgement of the medical or nursing staff, registered health or social care professional, spiritual advisor or advocate acting for that the resident is that a visit is important for the person's health or sense of well-being.

ENDS