Ontario Health
Toronto

PURPOSE

This document provides guidance for all Toronto Region hospitals for visitor access including updated recommendations to guide a graduated visitor re-integration approach and associated operational requirements. This guideline replaces *The Recommended Visitor Restrictions with Exceptions for Acute, Rehabilitation and Complex Continuing Care Hospitals*[1] released by the *Toronto Region COVID-19 Hospital Operations Table* on March 20, 2020. The document is intended to be iteratively responsive to changing contextual facets of the pandemic. It will provide guidance for when visitor allowances should be relaxed or more restricted depending on both the institutional considerations and the wider, regional and provincial COVID-19 situation. **Essential visitors are care partners** that are any support person defined by the patient or client as family, including friends, neighbors, substitute decision makers, privately paid worker and/or relatives that advocate for a loved one's needs and support them in managing their health, healthcare, long-term care and overall well-being.

BACKGROUND

On March 20, 2020 *The Toronto Region COVID-19 Hospital Operations Table Recommended Visitor Restrictions with Exceptions for Acute, Rehabilitation and Complex Continuing Care Hospitals*[1] was released. Underpinning this policy was the increasing risk of community spread and shortages of personal protective equipment (PPE). This required the need to limit and restrict the number of people (including visitors) who are in hospital buildings and implement physical distancing strategies to mitigate risk to vulnerable populations. In this context, the initial visitor access policy articulated the need to limit visitors to only those who are deemed essential in specific circumstances.

There was also a need to update the visitor access guidance based on the evolving organizational, regional, and provincial COVID-19 pandemic phase. The critical need to restrict visitors and preserve PPE in efforts to maximize safety for all was further elaborated **regionally** in the Toronto Region COVID-19 Hospital Operations Table for Masking in Hospital[2] and Recommended Guidelines for Personal Protective Equipment Conservation[3] and **provincially** in the Pandemic Recommendations on the use and conservation of PPE from Ontario Health.[4] Specific details around visitor allocation included:

- Visitor access controls should be in effect to reduce the need for PPE.
- Visitors that are permitted entry to an inpatient unit under an exception, after screening for symptoms of COVID-19 and ensuring there are none, may receive allocation of 1 procedure mask and only if the hospital's PPE supply allows.
- Hand hygiene must be performed prior to donning the procedure mask and the visitor instructed that it must remain fully in place for the duration of the visit.

On May 26, 2020, the Ministry of Health [MOH] released the *COVID-19 Operational Requirement: Health Sector Restart*[5] document that provides direction for hospitals in Ontario in their restart efforts.
The document includes updated direction around **essential visitors***. Key guiding posts to consider in modifying visitor policies are in accordance with local COVID-19 data and the following essentials visitors:

1. Those who are visiting/accompanying a patient who is dying or very ill.
2. A parent or guardian of a child or youth.
3. Visitors of patients who require physical assistance.
4. Individuals providing essential support to a patient.

> *Building on the definition of essential visitors articulated in the Ministry of Health COVID-19 Operational Requirement: Health Sector Restart[5] **essential visitors (care partners)** are those allowed access to the hospital in situations based on compassionate care; visits that are paramount to the patient's/client's fundamental care needs, mental health and emotional support; enable processes of care and patient flow; and discharge from the hospital. Essential visitors are care partners that are any support person defined by the patient or client as family, including friends, neighbors, substitute decision makers, privately paid worker and/or relatives that advocate for a loved one's needs and support them in managing their health, healthcare, long-term care and overall well-being. In the case the substitute decision maker or power of attorney for care will determine the designated and alternative care partner.

Current State

Hospitals are now updating and adapting their visitor policies according to the direction provided in the *MOH COVID-19 Operational Requirement: Health Sector Restart*.[5] In this context, the Toronto Region COVID-19 Hospital Operations Table re-convened a working group to revise their Visitor Access with Exceptions for Acute, Rehabilitation and Complex Continuing Care Hospitals guidance document that was informed by evidence and ethical principles for decision-making.

On June 15, 2020, Dr. David Williams Chief Medical Officer of Health released the Visitors to Acute Care Settings Memorandum;[6] the Ministry of Health released COVID-19 Guidance: Acute Care Version 6[7] and COVID-19 Operational Requirements: Health Version 2[8] and the Ontario Hospital Association [OHA] released Care Partner Presence Policies During COVID-19

Considerations for Hospitals in Anticipation of Changes to Temporary Restrictions for Care Partner Presence During COVID-19.[9] Collectively, these documents validated our definition of essential visitors (care partners) and provide further direction for acute care settings to begin the resumption of visitors and revise visitor policies regarding essential visitors.

Justification for Recommendations

The safety of patients, family caregivers, physicians and staff continues to be paramount.[7,8] The recent MOH direction for gradual restart of deferred services recommends to limit the number of in-person visits for the safety of health care providers, patients and family members.[5-8] Thus, critical steps are still required to reduce and minimize opportunities for transmission. Specifically, there is still a need to identify who is deemed an essential visitor and the frequency, duration and number of interactions visitors have coupled with the volume of people within the hospitals at any given time. As the COVID-19 virus and supply chain capacity (e.g. PPE, testing, hand sanitizer) changes, the visitor policy will need to evolve in a safe, compassionate and evidence informed manner.[5-13] Changing visiting policies is, as the Canadian Foundation of Healthcare Improvement described, "not as simple as flicking a switch"[13] rather it requires a thoughtful, gradual re-integration of visitors and family presence policies into our hospitals in partnership with patients and family members.[6-13]

Principles, Substantive Values and Planning Assumptions

The ethical framework including principles and substantive values outlined in the initial *The Toronto Region COVID-19 Hospital Operations Table Recommended Visitor Restrictions with Exceptions for Acute, Rehabilitation and Complex Continuing Care Hospitals* [1] guided the review of visitor access in alignment with the revised direction from MOH[5]. Further, this framework and other sources of evidence, in particular the *Guidelines for Preserving Family Presence in Challenging Times,*[12] and *OHA's Considerations for Hospitals in Anticipation of Changes to Temporary Restrictions for Care Partner Presence During COVID-19*[9] guided our direction and shaped our planning assumptions and recommendations to determine the most desirable course of action.

The following planning assumptions were developed to guide **the recommendations for an updated visitor policy that considers a graduated reintegration of visitors** and are relevant for both ramping up and ramping down visitors.

- **Understanding the vulnerability, fear, and anxiety patients in hospitals and their loved ones are experiencing is heightened during the COVID-19 pandemic due to the spread of the virus itself and limits on visitor access.** The initial *The Toronto Region COVID-19 Hospital Operations Table Recommended Visitor Restrictions with Exceptions for Acute, Rehabilitation and Complex Continuing Care Hospitals*[1] was required to minimize the spread and impact of COVID-19. These limits on access were and continue to be considerably difficult and challenging for patients and families as they are experiencing increased stress, fear and anxiety by not being able to be physically present to support patients who are ill and/or recovering in hospital.[9,11-13]

- **Acknowledging the integral role and impact that family members have in providing physical, social, emotional and navigation of care.**[7-13] The importance of family presence and participation has shown to improve satisfaction and outcomes without additional risk.[14-24] There is evidence to demonstrate that family presence improves the quality of life (e.g. decreased anxiety during procedures); better outcomes [e.g. lower readmission rates, improved medication adherence, maintained cognitive function in older adults and prevention of falls transitions and understanding of discharge instructions] and care experiences [e.g. satisfaction].[14-24]

- **Customizing the recommendations locally based on organizational risk assessment.** This includes conducting ongoing risk assessment on the degree of active transmission in the community and nosocomial spread in patients and healthcare providers;[4,7-12] volume, availability of PPE, critical supplies [e.g. hand sanitizer, testing]; and ability to physically distance in common spaces and designated spaces [e.g. sheltering in place – where a parent stays permanently at the patient's (child's) bedside and does not leave, outdoor]..

- **Ensuring the availability (adequate supply, security) of Personal Protective Equipment (PPE) and critical supplies.** This includes masks, gowns, gloves, eye protection/face shields and hand sanitizer, and point-of-care testing (if appropriate given cost and availability e.g. pre-operatively) for staff, patients, and family.
- **Reducing the strain on human resources and accommodating work schedules.** Implications on staff when visitor access limits are put in place must be considered in designing person-centered, compassionate family presence guidelines.[7-13] Further, having adequate staffing to responsibly support the family's presence is required. This includes providing education on PPE donning and doffing, maintaining physical distancing and other pandemic-specific hospital-based guidelines etc.
- **Accounting for the overall volume of physicians, staff, researchers, learners, occupancy levels that will occur as hospital re-start and expand clinical services.** The overall volume of people entering hospitals and physical layout (e.g. multi-bedded rooms versus private room) will have implications on PPE distribution, critical supplies, and ability to maintain physical distancing requirements.
- **Considering the risk that family presence may pose coupled with the risk that these family presence access limits may create in the short and long term.** This includes determining if limits to family presence and participation create a safety, clinical, or emotional risk to the patient or resident that outweighs the risks associated with COVID-19.[7-13]
- **Determining who is considered essential visitors.** This includes articulation of clear criteria of what is deemed an essential visitor that complies with how essential visitor is defined in the Ministry of Health released COVID-19 Operational Requirement: Health Sector Restart[5] and care partner in Planetree's Guidelines for Preserving Family Presence in Challenging Times[12] and OHA's Considerations for Hospitals in Anticipation of Changes to Temporary Restrictions for Care Partner Presence During COVID-19.[9]
- **Determining access for, and phasing in, essential visitors.** In addition to defining essential visitors there are other limits (e.g. visiting hours, number of visits, allowable movement – at or away from bedside) that need to be considered that will evolve over time. This also includes phasing in of essential visitors[6,-10,12] based on the interplay of compassion, proportionality, equity and minimization of harm.

RECOMMENDATIONS

1. **Planning for Essential Visitor access should commence immediately.** Organizations should work in step with one another to operationalize this policy with an aim to implement this next phase **by June 30, 2020**. Patient and family caregivers should be engaged in ongoing implementation strategies at each local organization.

2. **Assess the need for visitor access limits based on current factual evidence through a risk and benefit analysis. Continually reassess as conditions evolve.**

   A number of factors contribute to the transmission of COVID-19 within the hospital. This is modelled in simplistic terms for illustrative purposes in Appendix A. These factors include the burden of COVID-19 within the community and inside the hospital (number of patients who are COVID-19 positive, active COVID-19 outbreaks) compounded by the number of people allowed into the fixed/closed space of the hospital setting.

   Risk can be modified or mitigated through a number of ways. This includes controlling the volume of people allowed in to the hospital, ensuring those who enter are appropriately screened and/or tested to ensure they are not COVID-19 positive; further ensuring those who enter are provided with instructions on appropriate use of PPE based on evidence and finally supporting an environment that maximizes the ability to physically distance which is dependent on the total space available as visitors move through the hospital to the patient area (e.g. shared multi-patient room versus a private room, elevator size, waiting area size).

   Organizations should assess (Figure 1) these risk factors to best customize and determine locally which phase is currently most appropriate for their setting. As circumstances change, risks should be re-evaluated while always considering the benefits of family caregiver presence. An example of a commonly used risk matrix is provided in Figure 1 whereby the probability of a risk factor occurring is evaluated in addition to the impact of the risk occurrence. Combined these help organizations understand the overall risk level of the situation recognizing that differences in risk factor weights have not been integrated below e.g. widespread community burden of COVID may be of higher risk weighting than an inadequate screening process. Additionally, as the model does not offer a numeric total risk score and there will be

times risk levels for each area will be more disparate, each organization will need to consider the overall situation to make a determination.

Figure 1: Example Risk Completed Assessment

Hospital Name X Assessment: June 12, 2020 – Overall Risk Level Determined to be Moderate			
Risk Factor	Likelihood Rare, Unlikely, Possible, Likely, Almost Certain	Impact Insignificant, Minor, Moderate, Major, Catastrophic	Risk Level Low, Moderate, High, Critical
Community or In Hospital Burden of COVID-19			
Widespread, active community transmission	Possible	Major	High
Widespread, active in hospital transmission	Rare	Major	Low
Expected Changes in Hospital Total Volume of People Entering			
Increase by 20% expected in the next 2-4 weeks	Possible	Moderate	Moderate
Efficacy of Identification of COVID-19			
Inadequate local testing capabilities	Unlikely	Moderate	Moderate
Inadequate screening process	Unlikely	Moderate	Moderate
Ability to Appropriately Use PPE/ Critical Resources			
Unavailable PPE/Critical Resources for both staff and visitors	Possible	Major	High
Inadequate staffing to support visitor's presence (e.g. education, reinforce appropriate PPE use)	Possible	Moderate	Moderate
Ability to Physically Distance			
Does the physical layout of the space cause concern for appropriate physical distancing	Possible	Moderate	Moderate

3. **Identifying Patient Types Requiring Visitors**
   Visitor type does not distinguish between family caregivers, friends or privately paid supports (i.e. sitters, private healthcare aides). The acceptability of a visitor should be determined by the circumstances surrounding the individual patient and the contextual considerations of the hospital and the pandemic. Visitors can be defined within the distinct categories and sub-categories below (Table 1) which provides a priority categorization for use through the phases. Appendix B provides further context for the terms used.

Table 1: Patient Groupings and Associated Visitors

Category	Description	Patient Population
Category 1 (Essential Care Partner)		
a. Patient with **Life Altering Event**	Time limited, visitor absence may result in devastating long term emotional, psychological or other health effects	Patients at End of Life, during Child Birth, requiring Major Surgery, are Critically Ill, Expected to Receive a Life Altering Diagnosis or having a Mental Health Crisis
b. **Vulnerable Patients**	Family Caregiver is the primary advocate for patient	Patient is Under 18 years of age, has a Cognitive impairment (dementia, severe brain injury/stroke), significant Developmental and/or Intellectual disability or is Unable to Effectively Communicate (aphasia, significant limits in English proficiency); NB Emergency Department Patients have been captured under Table 2
c. Patient Requiring Visitor to **Support Hospital Workflow**	Unmet care need or absence of Visitor causes undue burden on healthcare team or significant risk to patient safety	Patients requiring Escorts to appointments (e.g. to porter) and Patients requiring a Family Caregiver needed to avoid significant physical or psychological harm; decrease heightened emotionality
Category 2 (Essential Care Partner)		
d. Family Caregiver for **Long Stay** Patients	> 30 days	Patients in hospital for long stay
e. Patients Requiring **Transition of Care Support**	Family Caregiver provides support for coordination of care at major transition times e.g. discharge care, follow up instructions, new unit (long stay) orientation	Patients requiring support during significant transitions e.g. complex discharge or admission
Category 3		
f. **Low Acuity, Short Stay** Patient	Family Caregiver or other family who provides emotional support, augments patient experience or other paid non-essential workers	Low Acuity or Short Stay patients

4. Phases of Essential Visitor Guidance for Hospitals

The Center for Disease Control and Prevention (CDC) has identified and defined a series of pandemic intervals (Figure 2[1]) and linked these to metrics and activities to ensure that the system is prepared to respond to the pandemic. This model was can be used to anchor (Figure 3) the recommendations in the *Essential Visitor Guidelines for Toronto Region Hospitals During the COVID-19 Pandemic (see Appendix B for description)*.

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[1] Source: Centers for Disease Control and Prevention

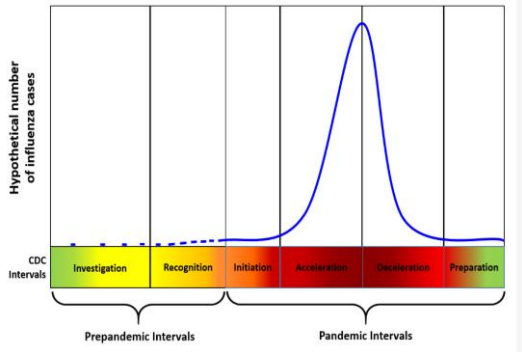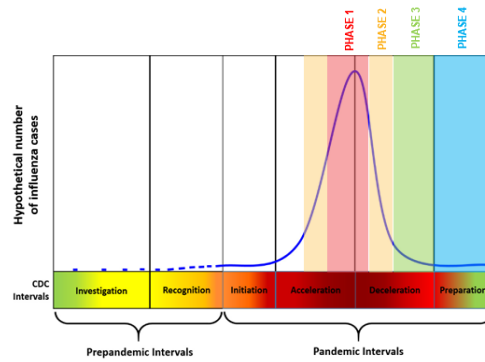**Figure 2: CDC Pandemic Interval Framework**

Figure 3: Phases of Essential Visitor Guidance Overlaid to CDC Pandemic Interval Framework

As the gradual restart of services occurs and in consideration of the recommended **risk assessment** conducted by each organization, specific guidance (Table 2) is provided across three phases, prior to the final phase four as the resumption of the hospital's visitor policies prior to COVID-19 e.g. 24hr Family Presence in some organizations (Phase 4 – open access). The first three phases include phase 1 where the greatest limits are in place on the categories of visitor exceptions allowed, the frequency & duration of visits and the total numbers of people entering into the hospital. These access limits are decreased through phase 2 and 3. Guidance is provided at the clinical team and institutional level and are meant to be a minimum starting place for hospitals while recognizing the intent to reduce variability across hospitals within the region. Variability can lead to confusion and distress for patients, family caregivers and healthcare providers who are receiving care across more than one hospital in the Toronto region. It is recognized that the phases are bi-directional. This document serves as a tool for ongoing alignment of visitor policies to respond to COVID-19. In the event of a second pandemic wave or internal outbreak, organizations may return to an earlier phase of this guidance document e.g. phase 3 to 2 or phase 2 to 1 (Figure 4).

In Table 2, situations are noted where the healthcare team is given local latitude to determine the most appropriate approach. In considering this approach, clinical teams should consider the visitor presence, or lack thereof from the perspective of patient, unit, or organizational impact in addition to any health equity considerations. Patient impact can include effects on their overall well-being or functional status. Unit considerations may include staffing to patient ratios, effects on other patients in the assignment while organization impacts include PPE consumption or physical distancing feasibility. Finally and importantly, health equity impacts must be considered and addressed (e.g. a single parent, without childcare support, needing to bring young children in at the same time to visit even when only one person is expected at the bedside).

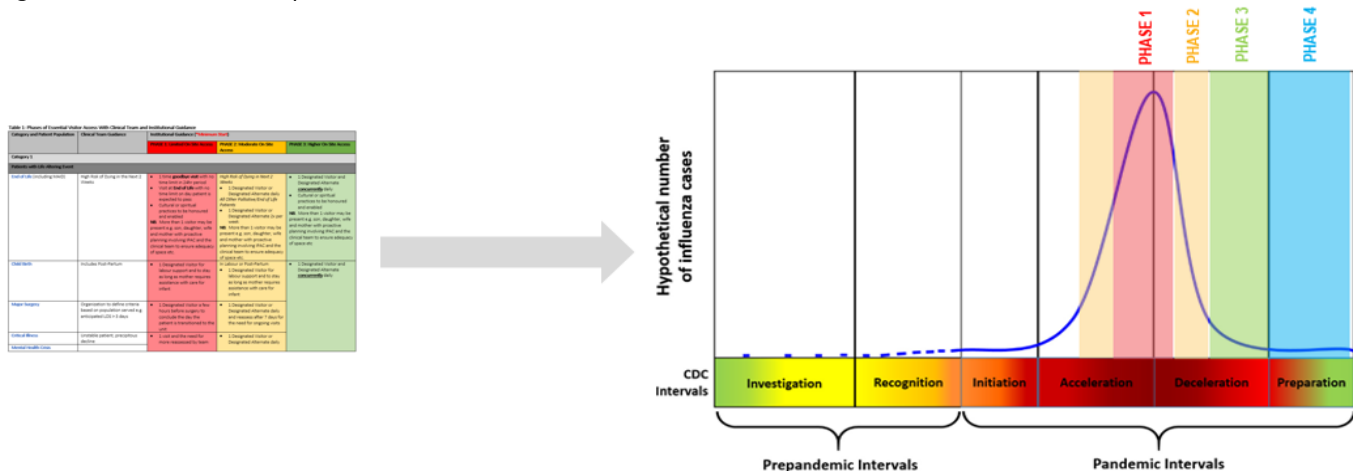Figure 4: How Table 2 Maps to the Pandemic Interval Phases

Table 2: Phases of Essential Visitor Access With Clinical Team and Institutional Guidance

Category and Patient Population	Clinical Team Guidance	Institutional Guidance (*Minimum Start)		
		PHASE 1: Limited On Site Access	PHASE 2: Moderate On Site Access	PHASE 3: Higher On Site Access
Category 1				
Patients with Life Altering Event				
End of Life (including MAID)	High Risk of Dying in the Next 2 Weeks	• 1 time **goodbye visit** with no time limit in 24hr period • Visit at **End of Life** with no time limit on day patient is expected to pass • Cultural or spiritual practices to be honoured and enabled **NB**. More than 1 visitor may be present e.g. son, daughter, wife and mother with proactive planning involving IPAC and the clinical team to ensure adequacy of space etc.	*High Risk of Dying in Next 2 Weeks* • 1 Designated Visitor or Designated Alternate daily *All Other Palliative/End of Life Patients* • 1 Designated Visitor or Designated Alternate 2x per week **NB**. More than 1 visitor may be present e.g. son, daughter, wife and mother with proactive planning involving IPAC and clinical team to ensure adequacy of space	• 1 Designated Visitor and Designated Alternate **concurrently** daily • Cultural or spiritual practices to be honoured and enabled **NB**. More than 1 visitor may be present e.g. son, daughter, wife and mother with proactive planning involving IPAC and the clinical team to ensure adequacy of space etc
Child Birth	Includes Post-Partum	• 1 Designated Visitor for labour support and to stay as long as mother requires assistance with care for infant	In Labour or Post-Partum • 1 Designated Visitor for labour support and to stay as long as mother requires assistance with care for infant	• 1 Designated Visitor and Designated Alternate **concurrently** daily
Major Surgery	Organization to define criteria based on population served e.g. anticipated LOS > 3 days	• 1 Designated Visitor a few hours before surgery to conclude the day the patient is transitioned to the unit	• 1 Designated Visitor or Designated Alternate daily and reassess after 7 days for the need for ongoing visits	
Critical Illness Mental Health Crisis	Unstable patient, precipitous decline	• 1 visit and the need for more reassessed by team after 24hrs based on severity of patient status	• 1 Designated Visitor or Designated Alternate daily	
Life Altering Diagnosis	Includes in and outpatient	• 1 visit or escort (outpatient) and team assessment for more visits after 24hrs	• 1 Designated Visitor or Designated Alternate daily • 1 escort (outpatient)	• 1 Designated Visitor or escort (outpatient) and Designated Alternate **concurrently** daily
Vulnerable Patients				
Emergency Department Patients	Time dependent need for essential care partners to support the clinical team with timely assessment (history, symptoms), obtaining consent to plans of care (diagnostics, treatment) and	• **All Category 1** Essential care partners e.g. Patients with Life Altering Events, Vulnerable Patients and those supporting Hospital Workflow will have 1 Designated Visitor available **on call in waiting space**	• **All Category 1** Essential care partners e.g. Patients with Life Altering Events, Vulnerable Patients and those supporting Hospital Workflow will have 1 Designated Visitor in Emergency	• 1 Designated Visitor present for all ED patients

Category and Patient Population	Clinical Team Guidance	Institutional Guidance (*Minimum Start)		
		PHASE 1: Limited On Site Access	PHASE 2: Moderate On Site Access	PHASE 3: Higher On Site Access
	discharge planning/follow-up	• Supports will be needed from organization for paging/telephone and/or holding space for these essential care partners	Department with patient	
Under 18 years Significant Developmental or Intellectual Disability	Includes care by parent; consider shelter in place	• 1 Designated Visitor or Designated Alternate daily	• 2 Designated Visitors (Care Partners) Daily • No in an out privileges	• 1 Designated Visitor and Designated Alternate **concurrently** daily • In and out privileges allowed
Cognitive Impairment	Examples: dementia, severe brain injury, severe stroke	• 1 Designated Visitor or Designated Alternate per week and increased by team as needed to more than 1x per week	• 1 Designated Visitor or Designated Alternate 3x per week and increased by team as needed	
Unable to Effectively Communicate	E.g. significant language barrier and all means of remote communication failed	• 1 Designated Visitor or Designated Alternate 2x per week	• 1 Designated Visitor or Designated Alternate 3x per week	
Patient Requiring Caregiver to Support Hospital Workflow Unmet Care Need or Absence of Caregiver Causes Undue Burden on Healthcare Team	Escort to essential appointment	• 1 visitor to accompany patient to outpatient appointment	• 1 visitor to accompany patient to outpatient appointment	• 1 visitor to accompany patient to outpatient appointment
	Visitor required to avoid significant physical, psychological harm, heightened emotionality (unable to calm without medication or restrain) by supporting fundamental care needs (e.g. feeding, bathing, emotional support)	• Frequency and time to be tailored to the specific needs of the patient and burden on the healthcare team	• Frequency and time to be tailored to the specific needs of the patient and burden on the healthcare team	• Frequency and time to be tailored to the specific needs of the patient and burden on the healthcare team
Category 2				
Long Stay Patients	>30 day stay	• No visitor	• 1 Designated Visitor or Designated Alternate 2x per week	• 1 Designated Visitor or Designated Alternate daily
Patients Requiring Transition Support	Coordination of care e.g. home care, follow up instructions	• No visitor	• 1 Designated Visitor daily through 3 days of transition (discharge or admission)	
Category 3				
Low Acuity, Short Stay Patient		• No visitor	• No visitor	• 1 Designated Visitor or Designated Alternate daily

5. Minimize the Risk

On completion of the **risk assessment**, organizations should consider the following recommendations to minimize the potential of transmission:

- Visitors are following regional screening recommendations on entry including prescreening. Information about visitors is logged and centralized to support tracking as needed.
- Care Partners are provided with an ID badge or sticker to support visual management and indication of passed screening
- Visitors are provided with appropriate PPE and trained on its use in addition to appropriate hand hygiene techniques
- Age is not a restriction for visiting, however organizations should assess the ability for the visitor to follow infection control practices and/or ensure appropriate supervision is available to adhere to any requirements
- Designated Paths: directly to and from treatment areas to support traffic flow
- Physical Distancing for all people across the hospital
- Visitors stay at the bedside or shelter in place (remain in hospital) as appropriate and for the Emergency Department a waiting space to support essential care partners to remain physically distanced and/or a method for 'on call' contact/paging for essential care partners without mobile phone access where hospitals are unable to accommodate an in-hospital waiting space
- Designate dedicated spaces for patients and Visitors if private rooms are not available; institute cleaning protocols; use outdoor space when available
- Identify designated caregivers and alternates to minimize the number of different people requiring training
- Decrease the volume of people within the hospital by scheduling visitors to support a distribution of people across various times and avoidance of the busiest timeframes

Guidance for COVID-19 Positive Patients and COVID-19 Positive Visitors

COVID-19 positive patients who meet the exceptions criteria in Table 2, should have access to essential visitors through proactive consultation of local Infection Prevention and Control (IPAC) specialists and clinical teams.

In general, COVID-19 positive visitors who are considered infectious or those who are considered exposed close contacts should not be visiting, as they should be self-isolating. In exceptional circumstances (e.g. End of Life), and on a case by case basis, this can be discussed in consultation with local Public Health, IPAC and the clinical team to ensure that a plan (e.g. visitor escorted with mask, hand-hygiene, stay at the bedside, brief visit duration, escorts wear PPE etc.) can be made safely in advance.

6. Support for Family Caregivers

- Communicate Proactively with Compassion
  - Use the hospital website, emails, letters, telephone and video calls
  - Include the why behind any changes in access by referring to resources like IPAC and unit leadership to support discussions
  - Emphasize what family caregivers can do rather than cannot do
  - Make communication available in culturally informed ways (common languages, short video for low literacy)
  - Ensure all staff understand the current standards – coaching and talking points
- Support Meaningful Connections to Minimize Feelings of Isolation
  - Redeploy staff in a new role as "connectors" to help with virtual technology
- Inform and Educate
  - Educate on steps needed to minimize risk: expectations for hand hygiene, use of PPE, guidelines for physical distancing, use teach back
  - Enhance discharge education and post-discharge follow-up (telehealth, enhanced social work support and home care to facilitate smooth transitions etc.)

7. **Appeals**

Hospitals should have a transparent appeals process for visitation. Information about the appeals process should be readily available for families and patients (i.e. signage, internet, etc.). Unit managers and program directors should be educated about the visitor policy and appeals process. They should educate their staff as appropriate.

With visitor access limits significantly affecting individual liberty, an appeals process is one way to maximize both individual autonomy and procedure fairness.

The following are the objectives of a standard appeals process to: 1) outline the process of resolution for disagreement with imposed visitation limitations; 2) ensure a fair (active equity lens for patients and visitors), accessible, efficient process; and 3) promote standardization within and between healthcare organizations. Organizations are encouraged work with their Patient and Family Advisory Committee (PFAC) to further improve the appeals process.

Appeals Process:
- Appeals should be managed by Patient Relations
- Appeals should align with existing both Patient Relations and Conflict Resolution policies and procedures
- Appeals information includes: name of patient, name of visitor and their contact information, patient location, patient reason for admission, details explaining the reason for the appeal, the request (i.e. frequency and duration), expected length of hospitalization, days admitted
- A minimum of three individuals should review all appeals (i.e. patient relations, bioethics, program manager, team members, quality)
- Consultation should occur with the healthcare team, unit manager and/or program director to better understand the patient and their context
- Appeal decision should aim for consensus; when consensus is not feasible majority opinion should override
- Appeals should proceed in a timely manner:
  a. Urgent Assessment: same day response, including weekends
     - Category 1 Patient with Life Altering Event
     - Involvement of manager on call
  b. Non-Urgent Assessment: within 48 hours
     - All patients, except those with Life Altering Events
     - Patient Relations to receive and coordinate all appeals
     - Consult appeals team and necessary stakeholders
  - The decision should be communicated to the requestor by Patient Relations and include: a) the recommendation(s) from appeal; b) the decision; c) the rationale for the decision; and d) any recommendation(s) or next steps, including timeframes.
  - Appeals metrics should be maintained for quality improvement

The following **criteria** should be used when evaluating requests/appeals for visitors:
- Safety, security and wellbeing of patients
  - Patients will be compromised significantly without a support person
  - Crisis, harm or dysfunction is foreseeable or occurring as a result of lack of access to visitors
  - Imminent risk to patient, staff or others (i.e. violent/dangerous behaviours, falls risk etc.), reasonably foreseeable or occurring as a result of lack of access to visitors
- Unreasonable burden on healthcare team
  - Care of the patient:
  - deters from the care of other patients
  - would otherwise require additional staffing and use of PPE
- Essential to the patient or visitor's wellbeing
  - Potential for long term harm, or severe short-term harm without visitation (i.e. dying patient with young children, existential crisis of a patient considering changes goals of care from curative to palliative)
  - Patient is declining overall without visitor or loosing functional ability

- Patient wishes
  - Has the patient articulated a strong wish for the specific visitor(s) requesting the appeal
- Health equity impact
  - Will granting appeal address health equity concerns (e.g. a single mother who needs to bring a child with her)
- Mission, vision and values of the organization

8. **Ongoing Monitoring and Triggers to Modify Responses**

   Based on iterative assessment of the situation, hospitals may be required to move between phases (Appendix C). As hospitals move between phases, visitor access will be more or less limited with varying requirements to modify mitigations. Hospital responses should be evaluated at a minimum on a weekly basis to determine the effectiveness of guidelines and requirements for further modification. The Toronto COVID-19 Essential Visitor Community of Practice will meet regularly to support monitoring of the effectiveness of this guidance document.

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N.B. Please note that this document is only providing guidance and/or recommendations to support individual planning for hospitals within the Toronto Region of Ontario Health. This document does not constitute provincial decisions, directions or guidance.

REFERENCES

1. Toronto Region COVID-19 Hospital Operations Table Recommended Visitor Restrictions with Exceptions for Acute, Rehabilitation And Complex Continuing Care Hospitals Version Date: March 20, 2020

2. Toronto Region COVID-19 Hospital Operations Table Recommended Guidelines –Masking in Hospitals Version Date: March 24, 2020

3. Toronto Region COVID-19 Hospital Operations Table Recommended Guidelines for Personal Protective Equipment Conservation Version Date: March 27, 2020

4. Ontario Health Personal Protective Equipment (PPE) use during the COVID-19 Pandemic Recommendations on the use and conservation of PPE from Ontario Health Release Date: March 25, 2020

5. Ministry of Health COVID-19 Operational Requirement: Health Sector Restart. Version 1.0 Release Date: May 26, 2020

6. Ministry of Health Chief Medical Officer of Health Public Health Visitors to Acute Care Settings Memorandum June 15, 2020

7. Ministry of Health COVID-19 Guidance: Acute Care Version 6 June 15, 2020

8. Ministry of Health COVID-19 Operational Requirements: Health Version 2 June 15, 2020

9. Ontario Hospital Association Care Partner Presence Policies During COVID-19
Considerations for Hospitals in Anticipation of Changes to Temporary Restrictions for Care Partner Presence During COVID-19 JUNE 2020

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Appendix A: Risk Factors and Mitigation Strategies Related to Visitors

Community and Internal Hospital Burden COVID-19 X **Number People In Closed Space e.g. Hospital** → **Uncontrolled Transmission of COVID-19 in Hospital**

Type of Person Entering Hospital
- Patients
- Staff and Physicians
- **Visitors**
- Learners
- Volunteers
- Contractors/Vendors
- General Public

Mitigation Strategies Related to Visitors

a. **Effective Identification of COVID-19 by:**
   - Screening
   - Testing

b. **Ability to Appropriately Use of PPE**
   - Effective PPE Made Available
   - Training/Education on Use
   - Supportive Reinforcement for Appropriate Use

c. **Ability to Physically Distance Dependent on:**
   - Space Available
   - Number of People in Space (Consider Scheduling to Level Volumes)

d. **Restricting Movement**
   - Stay at Bedside or Shelter in Place

Appendix B Visual Representation of Visitor Terms Used Within Guidance Document
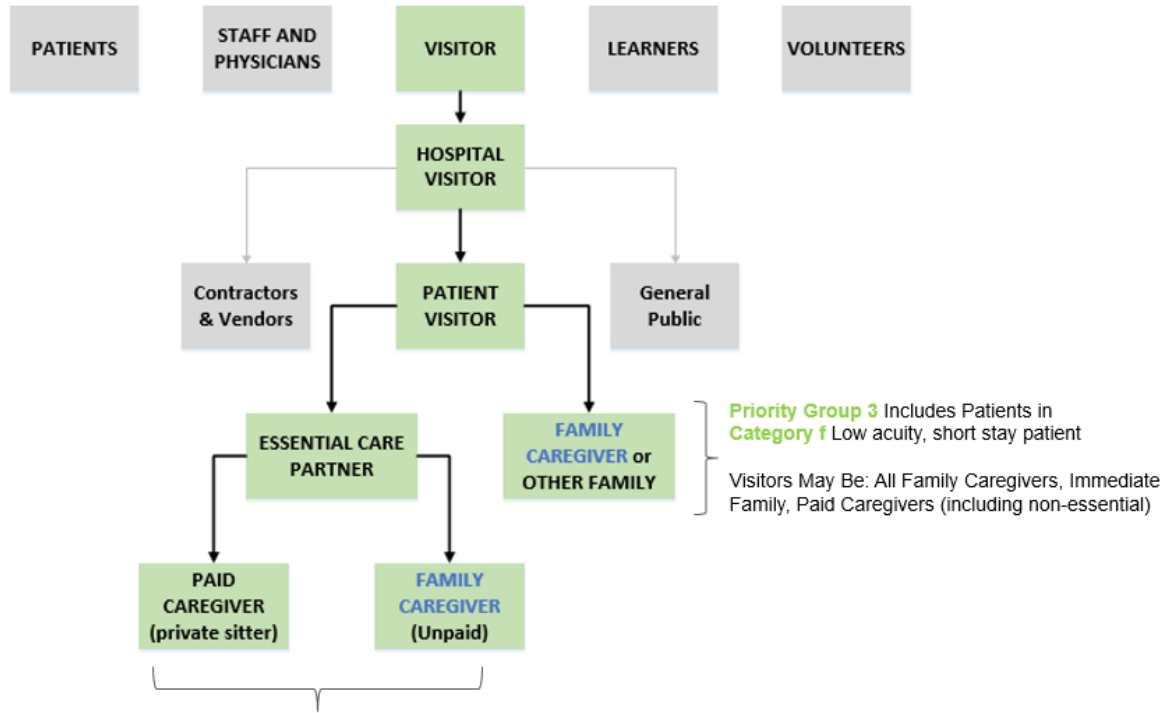
Document Guidance Considers This **Priority Categories 1 and 2** and Within Each Priority Category are Further Sub-Categories With Description
*While both Priority Category 1 and 2 visitors are considered Essential Care Partners, **Priority Category 1** has greater need for presence at the bedside in Phase 1
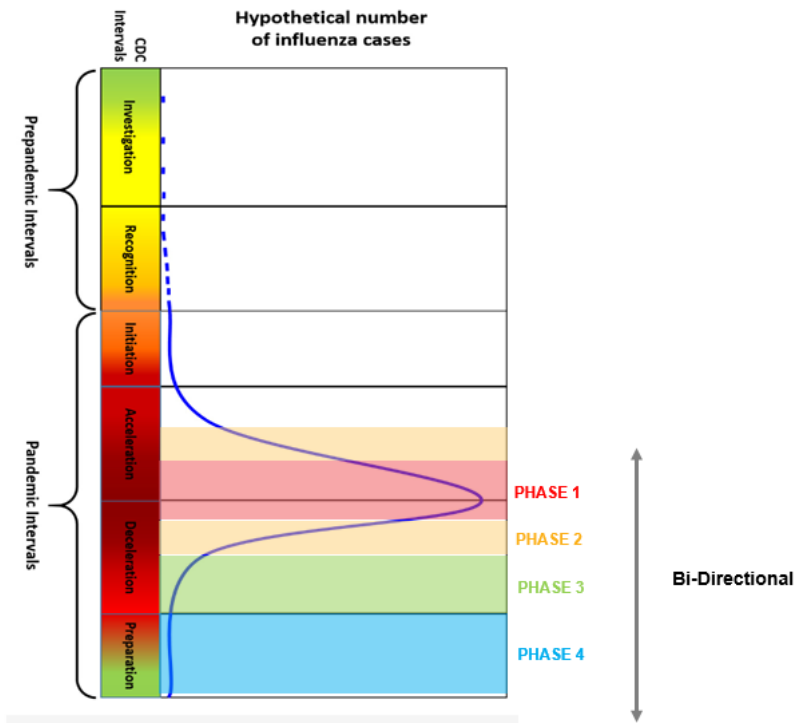
PHASE 1

Group 1 Visitors
a. Patients with Life Altering Event
b. Vulnerable Patients
c. Visitor Needed to Support Hospital Workflow
   • Low Frequency and Duration
   • Low Numbers

PHASE 2

Group 1 and 2 Visitors
a. Patients with Life Altering Event
b. Vulnerable Patients
c. Visitor Needed to Support Hospital Workflow
d. Long Stay
e. Transition Support
   • Increased Frequency and Duration
   • Increased Numbers

PHASE 3

Group 1 Visitors
All Visitor Types
   • Increased Frequency and Duration
   • Increased Numbers

PHASE 4

Return to Baseline Pre-COVID-19 Visitor Policies e.g. Family Presence in some organizations

Alternate Visitor: The alternate care partner is also familiar with the patient's diagnoses and health status and can perform health care, treatment and personal tasks for a patient with complex needs and attuned to subtle changes in their behavior or status.

Care Partners: are distinct from casual 'visitors' as they know their loved one best, they are uniquely attuned to subtle changes in their behavior or status (Planetree International)

Critical Illness: Critical illness refers to patients who are in grave physical and morbid conditions [e.g. cancer, heart attacks and strokes].

Designated Visitor: The designated care partner is the most familiar with the patient's diagnosis and health status and have been performing health care, treatment and personal tasks for a patient with complex needs and attuned to subtle changes in their behavior or status.

Developmental Disability: Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime.

Essential Visitors (Care Partner): Essential visitors (care partner) are those allowed access to the hospital in situations based on compassionate care; visits that are paramount to the patient's/client's fundamental care needs, mental health and emotional support; enable processes of care and patient flow; and discharge from the hospital. Essential visitors are designated and alternate care partners that are any support person defined by the patient or resident as family, including friends, neighbors, substitute decision makers, privately paid worker and/or relatives that advocate for a loved one's needs and support them in managing their health, healthcare, long-term care and overall well-being. In the case of those patients who are not able to participate in decision making the substitute decision maker and/or power of attorney will serve as the designated caregiver and/or determine who is the designated and alternative care partner. Examples include individuals who, for a variety of reasons, are unable to provide their own medical history and/or make decisions for themselves, those who react to a medical environment with heightened emotionality and are unable to be calmed without medication or restraint, and once-in-a-lifetime events like childbirth or end-of-life.

Family Caregiver: Family caregiver refers to any support person defined by the patient as family and is close with the patient and may be taking care of or providing emotional and social support to the patient when they are transitioned home. Family is defined in the broadest sense and refers to people, family, friends, neighbours, colleagues, community members who provide critical and often ongoing personal, social, psychological and physical support, assistance and care, without pay for people in need of support due to frailty, illness, degenerative disease, physical/cognitive/mental disability, or end of life circumstances (The Change Foundation)

Intellectual Disability: Intellectual disability involves problems with general mental abilities that affect functioning in two areas: intellectual functioning (such as learning, problem solving, and judgement) adaptive functioning (activities of daily life such as communication and independent living).

Life-altering Event: Life-altering events have an effect that is strong enough to change someone's life [e.g. end of life, child birth, major surgery, critical illness, mental health crisis].

Mental Health Crisis: A mental health crisis is any situation in which a person's actions, feelings, and behaviors can lead to them hurting themselves or others, and/or put them at risk of being unable to care for themselves or function effectively in the community.

No In and Out Privileges: No In and Out Privileges includes instruction that when the essential visitor leaves the hospital they cannot return to the hospital. This term can also apply to situations where visitors are only allowed to enter the patient room once per visit. Exceptions are on a case-by-case basis deemed by the clinical team and management review.

Screening: Screening refers to the process by which those entering the hospital are screened for symptoms of the virus; awaiting test results or a household member awaiting test results; and in recent contact with anyone diagnosed with COVID-19.

Sheltering in Place: Care Partners sheltering in place with a patient would remain in their loved one's room as much as possible and avoid other areas of the building for the duration of their visit [e.g. parent sheltering in place with a pediatric patient].

Visitors: Any person/people coming in to visit a patient or accompanying a patient to a scheduled appointment, surgery, procedure, emergency room visit, or being discharged home.

Vulnerable Patient: A vulnerable patients is someone who is or may be for any reason unable to protect and take care of themselves against significant harm or exploitation [e.g. patient is Under 18 years of age, has a cognitive impairment significant developmental and/or intellectual disability or is unable to effectively communicate.