Access to Hospitals for Visitors (Essential Care Partners): Guidance for Toronto Region Hospitals (Acute, Rehab, CCC) During the COVID-19 Pandemic September 28, 2021

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.

On November 17, 2020 the guidance was updated to reflect learnings since the release of *Access to Hospitals for Visitors (Essential Care Partners): Guidance for Toronto Region Hospitals During the COVID-19 Pandemic October 6, 2020.* Modifications were made to include an updated *risk assessment example, Table 2 – Phase 1 (Date to Return to Phase 1), recommendation 1, 5 (Minimize the Risk), 6 (Support for Essential Care Partners), and 8 (Ongoing Monitoring and Triggers to Modify Responses).*

On May 26, 2021, the guidance was updated to align with the provincial Roadmap to Re-open[1] with a 3 step plan. The 3 step plan allows the province to safely and gradually lift public health measures based on ongoing progress of province wide vaccination rates and improvements of key public health and health care indicators. Triggers for hospitals to move to the next phase of the ECP Access will be through provincial announcement of the next step of the plan.

On July 23, 2021, further guidance was provided to clarify requirements for phase 3. Essential Care Provider access to support patients is recognized as important and ideal. Nonetheless, differences may exist between organizations in how these recommendations can be operationalized, in particular due to physical space constraints and staff availability to support maximal visitation. Hospitals are required to follow provincial and municipal guidance including all infection and prevention control measures e.g. masking and physical distancing. Recognizing challenges that organizations may be experiencing, modified guidance is offered to provide additional recommendations.

[1] [1] Office of the Premier. Roadmap to Reopen. May 20, 2021. Accessed at https://news.ontario.ca/en/backgrounder/1000159/roadmap-to-reopen

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On September 24, 2021, recommendations were added involving:

- Considerations for **ECP vaccination** in light of Directive 6 for employees, contractors, volunteers and students
- **Continued alignment** of the ECP/Visitor phases **with the provincial Roadmap to Reopen** (no change from prior recommendations)
- **Active support to improve equitable access** for patients and families to the **appeals process** particularly in the Rehab/CCC long stay setting e.g. patients with limited English proficiency or cognitive impairment who may be unaware of an appeals process.

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 one 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 provided direction for hospitals in Ontario in their restart efforts. The document included 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.

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 provided further direction for acute care settings to begin the resumption of visitors and revise visitor policies regarding essential visitors.

On November 11th, the Toronto Region COVID-19 Hospital Operations Table re-convened the Visitor Community of Practice working group to review Phase 1 of Essential Visitor Access (limited on site access) in light of the worrisome trends in COVID Activity in Toronto/GTA Hospitals and associated Public Health unit regions moving under greater control. The group also discussed visitor food consumption in patient rooms since this has been identified as an important source of reported outbreaks in Toronto/GTA hospitals as well as escalation processes for visitor non-adherence to infection control practices.

On November 13th, 2020 in response to increasing COVID-19 community transmission, rising positivity rates, hospitalizations, outbreaks and modelling the Ontario government, released the Ontario COVID-19 Response Framework.[34,35] Recent modelling reveals if the new cases continue to grow at its current rate, the province could register up to 6500 new cases per day by mid-December.[35] In this context, the Ontario Government has lowered the thresholds for each of the five levels for weekly incident rates ($\underline{\geq}$ 40 per 100,000), positivity rates ($\underline{\geq}$2.5%), effective reproductive number ($\underline{\geq}$ 1.2), outbreak trends and the level of community transmission. Based on these new thresholds, the government announced moving Toronto, York and GTA public health units to move into red-control with stringent broader-scale measures and restrictions, across multiple sectors, to control transmission.[35] These changes came into effect on November 14th, 2020.

Given the longevity and fluctuating [e.g. potential for future waves] nature of COVID-19 and its' ongoing and prolonged impact, it is important to consider the psychological state of individuals

entering the healthcare system going forward, having endured significant stress simply from living through a pandemic. As such, a balanced, proportionate, equitable, flexible and compassionate approach to visitor policies is essential. This approach balances the need for visitor restrictions to be proportionate to the risks of acquiring COVID-19 but also to the harm of not having visitors enabling family caregivers to provide much needed contact, support and care to residents, to maintain their overall health and wellbeing.[10] This approach is equitable as it ensures giving patients the right amount of access they need to maintain their health and wellbeing.[10,14] This approach both flexible and compassionate and acknowledges that new conditions and procedures surrounding visiting may not work for all patients and essential care partners.[10,15-17] In this context, It is important to note that justification for reverting back to phase 1 visitation should not be taken lightly and requires an escalating risk environment that carries significant risks and harms for allowing visitors in Hospitals.

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.[9,18-21]
- **Acknowledging the integral role and impact that family members have in providing physical, social, emotional and navigation of care.**[7-13,18-21] The importance of family presence and participation has shown to improve satisfaction and outcomes without additional risk.[22-32] 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].[22-32]
- **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;[4,7-9,18,19] 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.[7-9,18,19] 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, and patient occupancy levels that will occur as hospitals 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.[7-13,18-21]

- **Determining who is considered essential visitors or care partners.** 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] care partner in Planetree's Guidelines for Preserving Family Presence in Challenging Times;[20] OHA's Considerations for Hospitals in Anticipation of Changes to Temporary Restrictions for Care Partner Presence During COVID-19;[9] and National Institute on Ageing. (2020). Finding the Right Balance: An Evidence-Informed Guidance Document to Support the Re-Opening of Canadian Long-Term Care Homes to Family Caregivers and Visitors during the COVID-19 Pandemic.[10]
- **Determining access for essential visitors.** When possible, being flexible with other limits is recommended (e.g. visiting hours, number of visits, allowable movement – at or away from bedside). However, flexibility of the limits needs to be considered based on the interplay of compassion, proportionality, equity and minimization of harm associated with exposure to COVID-19.

RECOMMENDATIONS

1. **Organizations should continue to remain aligned with the provincial Roadmap to Re-open, where operationally feasible. Discussion around changes in the ECP visiting phases will be triggered by provincial notification.**
2. **Hospitals considering mandatory COVID-19 vaccination requirements for ECP/visitors should refer to the recommended guidance in this document (see page 19). In keeping with these considerations, active support for appeals is strongly encouraged as soon as operationally feasible, particularly for the long stay Rehab/CCC patients to address equity issues.**
3. **Assess the need for care partner 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	Possible	Major	High
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/contact tracing in community	Possible	Moderate	Moderate
Ability to Appropriately Use PPE/ Critical Resources			
Unavailable PPE/Critical Resources for both staff and visitors	Possible	Major	Moderate
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	Likely	Moderate	High

Impact \ Likelihood	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Catastrophic (5)	Moderate Risk	Moderate Risk	High Risk	Critical Risk	Critical Risk
Major (4)	Low Risk	Moderate Risk	High Risk	High Risk	Critical Risk
Moderate (3)	Low Risk	Moderate Risk	Moderate Risk	High Risk	High Risk
Minor (2)	Low Risk	Low Risk	Moderate Risk	Moderate Risk	Moderate Risk
Insignificant (1)	Low Risk	Low Risk	Low Risk	Low Risk	Moderate Risk

4. Identifying Patient Types Requiring Care Partners

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. Care partners 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.

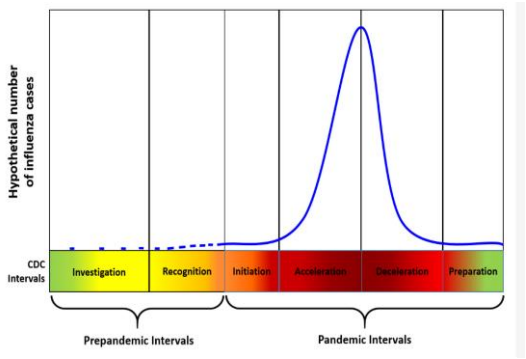
Table 1: Patient Groupings and Associated Care Partners

Category	Description	Patient Population
Category 1 (Essential Care Partner)		
a. Patient with **Life Altering Event**	Time limited, care partner absence may result in devastating long term emotional, psychological or other health effects	Patients at End of Life, during Child Birth, requiring Surgery, are Critically Ill, Expected to Receive a Life Altering Diagnosis or having a Mental Health Crisis
b. Vulnerable Patients	Care partner 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 here under Table 2
c. Patient Requiring Visitor to **Support Hospital Workflow**	Unmet care need or absence of care partner 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. Care Partner for **Long Stay** Patients	> 7 days	Patients in hospital for long stay
e. Patients Requiring **Transition of Care Support**	Care partner 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	Care partner or other person who provides emotional support, augments patient experience or other paid non-essential workers	Low Acuity or Short Stay patients

Phases of Essential Visitor Guidance for Hospitals

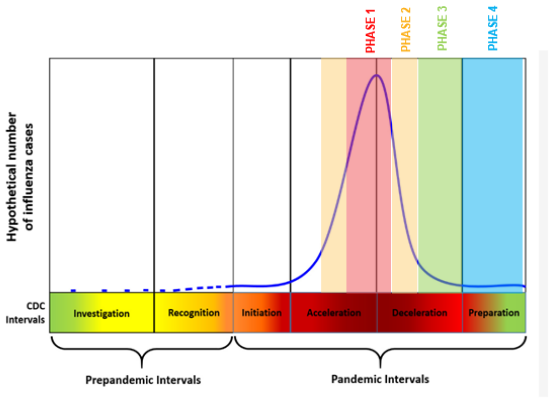
The Center for Disease Control and Prevention (CDC) has identified and defined a series of pandemic intervals (Figure 2) and linked these to metrics and activities to ensure that the system is prepared to respond to the pandemic. This model was can be used to anchor (Figure 3) the recommendations in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

Figure 2: CDC Pandemic Interval Framework



Source: Centers for Disease Control and Prevention

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 ECP 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, care partners 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 care partner 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

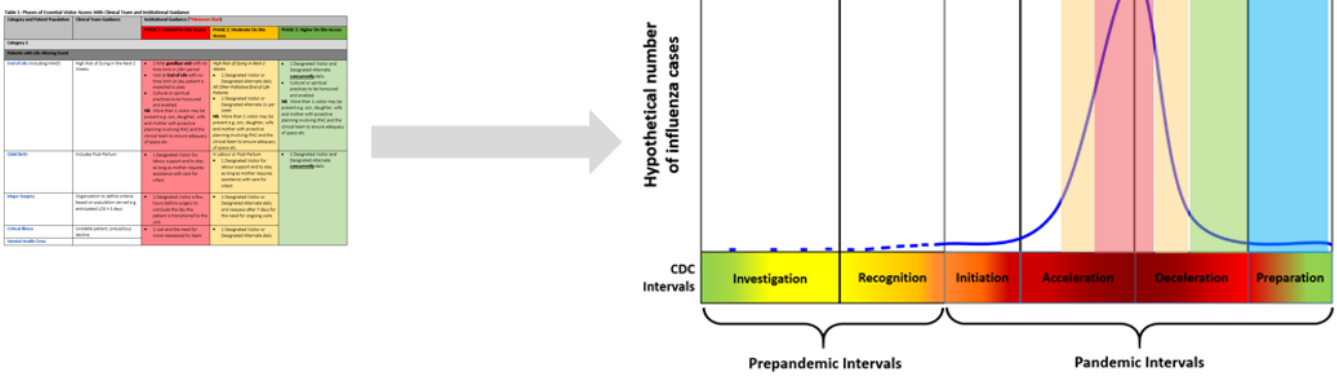


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Table 2: Phases of Essential Care Partner Access With Clinical Team and Institutional Guidance

Category and Patient Population	Clinical Team Guidance	Institutional Guidance (*Minimum Start)		
		PHASE 1 Modified: Limited On Site Access	PHASE 2a: Moderate On Site Access (Phase 2b in Table 3)	PHASE 3: Higher On Site Access
Category 1				
Patients with Life Altering Event				
End of Life (including MAID)	Patients at the end of life or palliative must be afforded liberal access to family members or people of great importance to them.	Patients with a **high risk of dying in the next 2 weeks** must have **24hr access to family/people of importance**. Patients with more than 2 ECP must be allowed access for other family members/people of importance including children. The clinical team must work with IPAC to enable access. Where space is limited, teams may offer scheduled access to accommodate different family members. **Patients who are otherwise palliative or have a significant life limiting course with greater than 2weeks expected must have daily access** to family/people of importance. Only 1 ECP per day at fixed times allowed. Accommodations must be made for those with young children to allow for additional access daily through proactive planning with IPAC.	Patients with a **high risk of dying in the next 2 weeks** must have **24hr access to family/people of importance**. Patients with more than 2 ECP must be allowed access for other family members/people of importance including children. The clinical team must work with IPAC to enable access. Where space is limited, teams may offer scheduled access to accommodate different family members. **Patients who are otherwise palliative or have a significant life limiting course with greater than 2weeks expected must have daily access** to family/people of importance. Two ECPs per day at fixed times but not concurrently. Accommodations must be made for those with young children to allow for additional access through proactive planning with IPAC.	Patients with a **high risk of dying in the next 2 weeks** must have **24hr access to family/people of importance**. Patients with more than 2 ECP must be allowed access for other family members/people of importance including children. The clinical team must work with IPAC to enable access. Where space is limited, teams may offer scheduled access to accommodate different family members. **Patients who are otherwise palliative or have a significant life limiting course with greater than 2weeks expected must have daily access** to family/people of importance. Two ECP per day at fixed times concurrently. Accommodations must be made for those with young children to allow for additional access through proactive planning with IPAC.
Child Birth	Includes Post-Partum	• 1 Designated ECP for labour support and to stay as long as mother requires	• 1 Designated ECP for labour support and to stay as long as mother requires	Child Birth:

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Category and Patient Population	Clinical Team Guidance	Institutional Guidance (*Minimum Start)		
		PHASE 1 Modified: Limited On Site Access	PHASE 2a: Moderate On Site Access (Phase 2b in Table 3)	PHASE 3: Higher On Site Access
		assistance with care for infant	assistance with care for infant	• 2 ECP at the bedside daily concurrent (e.g. Doula may be included as a 2nd visitor) • 24hr access <u>Major Surgery, Critical Illness, Mental Health Crisis</u> • Minimum: 2 ECP over the course of a day; 1 ECP at a time during fixed hours unless 2 ECP concurrently operationally feasible
Major Surgery	Organization to define criteria based on population served e.g. anticipated LOS > 3 days	• 1 Designated ECP a few hours before surgery to conclude the day the patient is transitioned to the unit **NB.** Additional access for a designated ECP or alternate within fixed visiting times should be available if the patient is unstable or if the outcome post-surgery warrants consideration	• 1 Designated ECP or Designated Alternate daily at fixed visiting times	
Critical Illness	Unstable patient, precipitous decline	• 1 visit and the need for more reassessed by team after 24hrs based on severity of patient status	• 1 Designated ECP or Designated Alternate daily	
Mental Health Crisis				
Category 1				
Patients with Life Altering Event				
Life Altering Diagnosis	Includes in and outpatient	• 1 visit or escort (outpatient) and team assessment for more visits after 24hrs	• 1 Designated ECP or Designated Alternate daily PRN • 1 escort (outpatient)	• 2 ECP over the course of a day; 1 ECP at a time during fixed hours unless 2 ECP concurrently operationally feasible
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,	• **All Category 1** Essential care partners e.g. Patients with Life Altering Events, Vulnerable Patients and those supporting Hospital Workflow will have 1	• **All Category 1** Essential care partners e.g. Patients with Life Altering Events, Vulnerable Patients and those supporting Hospital Workflow will have 1	• 1 Designated ECP present for all ED patients

Category and Patient Population	Clinical Team Guidance	Institutional Guidance (*Minimum Start)		
		PHASE 1 Modified: Limited On Site Access	PHASE 2a: Moderate On Site Access (Phase 2b in Table 3)	PHASE 3: Higher On Site Access
	treatment) and discharge planning/follow-up	Designated ECP available **on call in waiting space** • Supports will be needed from organization for paging/telephone and/or holding space for these essential care partners	Designated ECP in Emergency Department with patient	
Under 18 years & those <1yr transition pediatrics to adult[36]	Includes care by parent; consider shelter in place	• 1 Designated ECP or Designated Alternate daily	• 2 Designated ECPs Daily (not concurrent)	• 2 ECP over the course of a day; 1 ECP at a time during fixed hours unless 2 ECP concurrently operationally feasible
Significant Developmental or Intellectual Disability				
Cognitive Impairment	Examples: dementia, severe brain injury, severe stroke	• 1 Designated ECP or Designated Alternate 2x per week and increased by team as needed	• 1 Designated ECP or Designated Alternate daily at fixed visiting times	
Unable to Effectively Communicate	Example: significant language barrier, aphasia	• 1 Designated ECP or Designated Alternate 2x per week	• 1 Designated ECP or Designated Alternate daily at fixed visiting times	
Patient Requiring Caregiver to Support Hospital Workflow including Outpatients Unmet Care Need or Absence of Caregiver Causes Undue Burden on Healthcare Team	Outpatients	• 1 ECP to accompany patient to outpatient appointment if an escort is required for mobility support or patient has cognitive impairment, under 18years, significant developmental or intellectual disability, unable to effectively communicate	• 1 ECP to accompany patient to outpatient appointment if an escort is required for mobility support or patient has cognitive impairment, under 18years, significant developmental or intellectual disability, unable to effectively communicate	• 1 ECP to accompany patient to outpatient appointment if an escort is required for mobility support or patient has cognitive impairment, under 18years, significant developmental or intellectual disability, unable to effectively communicate • All outpatients can have 1 ECP for appointment where operationally feasible – hospitals are encouraged to find innovative methods to

Category and Patient Population	Clinical Team Guidance	Institutional Guidance (*Minimum Start)		
		PHASE 1 Modified: Limited On Site Access	PHASE 2a: Moderate On Site Access (Phase 2b in Table 3)	PHASE 3: Higher On Site Access
				accommodate this while managing space constraints
	ECP 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	>7 day stay	• 1 Designated ECP or Designated Alternate 2x per week As of June 2, 2021 For Rehab/CCC/RCC patients who are clinically appropriate outdoor access to allow 2 ECP plus 2 ECP allowed; children < 2yrs are not counted as a visitor and children <2yrs do not require a mask NB: All outdoor visitors should be actively screened; visitor and patients should be masked and remain physically distanced	• 1 Designated ECP or Designated Alternate daily at fixed visiting times For Rehab/CCC/RCC patients who are clinically appropriate outdoor access to allow 2 visitors plus 2 ECP allowed; children < 2yrs are not counted as a visitor and children <2yrs do not require a mask NB: All outdoor visitors should be actively screened; visitor and patients should be masked and remain physically distanced	• 2 ECP over the course of a day; 1 ECP at a time during fixed hours • 1 designate and 2-4 alternates at organizational discretion For Long Stay Rehab/CCC/RCC patients who are clinically appropriate, outdoor access to allow 5 visitors including ECP allowed; children < 2yrs are not counted as a visitor and children <2yrs do not require a mask NB: All outdoor visitors should be actively screened; visitor and patients should be masked and remain physically distanced; unmasking may be supported outside if physical distancing can be supported and monitored
Patients Requiring Transition Support	Coordination of care e.g. home care, follow up instructions	• No ECP	• 1 Designated ECP or Designated Alternate PRN	

Access to Hospitals for Visitors (Essential Care Partners): Guidance for Toronto Region Hospitals (Acute, Rehab, CCC) During the COVID-19 Pandemic September 28, 2021

Category and Patient Population	Clinical Team Guidance	Institutional Guidance (*Minimum Start)		
		PHASE 1 Modified: Limited On Site Access	PHASE 2a: Moderate On Site Access (Phase 2b in Table 3)	PHASE 3: Higher On Site Access
Category 3				
Low Acuity, Short Stay Patient		• No ECP	• No ECP	• 2 ECP over the course of a day; 1 ECP at a time during fixed hours unless 2 ECP concurrently operationally feasible

Access to Hospitals for Visitors (Essential Care Partners): Guidance for Toronto Region Hospitals (Acute, Rehab, CCC) During the COVID-19 Pandemic September 28, 2021

Table 3 Addendum: Phase 2b: All patients will be eligible for an ECP. Specifications set out below.

Category and Patient Population	Phase 2b
End of Life	Patients with a **high risk of dying in the next 2 weeks** must have **24hr access to family/people of importance**. Patients with more than 2 ECP must be allowed access for other family members/people of importance including children. The clinical team must work with IPAC to enable access. Where space is limited, teams may offer scheduled access for different family members. **Patients who are otherwise palliative or have a significant life limiting course with greater than 2weeks expected must have daily access** to family/people of importance. 2 ECPs per day at fixed times but not concurrently. Accommodations must be made for those with young children to allow for additional access through proactive planning with IPAC.
Child Birth	• 2 ECP at the bedside daily (e.g. Doula may be included as a 2nd visitor) • 24hr access
Under 18 years Significant Developmental or Intellectual Disability	• 2 designated ECPs at the bedside daily • 24hr access
Critical Illness Mental Health Crisis Life Altering Diagnosis Emergency Department Patients	• 1 ECP at the bedside daily • Times flexible throughout 24hrs to meet patient status/requirements
Major Surgery Cognitive Impairment Unable to Effectively Communicate Long Stay Patients Patients Requiring Transition Support Low Acuity, Short Stay Patients	• 1 ECP at the bedside daily • Guidance for ECPs to help stagger family presence across different time periods to support physical distancing e.g. morning versus afternoon/evening visits For Long Stay Rehab/CCC/RCC patients who are clinically appropriate outdoor access to allow 5 visitors including ECP allowed; children < 2yrs are not counted as a visitor and children <2yrs do not require a mask NB: All outdoor visitors should be actively screened; visitor and patients should be masked and remain physically distanced
Outpatients Patients Requiring Caregiver (Paid) to Support Hospital Workflow	• 1 ECP to accompany patient to outpatient appointment if essential e.g. mobility, cognitive, significant language barrier, <18yrs, intellectual/developmental disability • Paid Provider – frequency and time tailored to the specific needs of the patient and burden on the healthcare team NB. Guidance can be offered by institutions to support physical space restrictions especially waiting areas

5. Minimize the Risk

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

- Care partner are following regional screening recommendations on entry including prescreening. Information about ECPs is logged and centralized to support tracking as needed. Consider additional screening questions (MOH COVID-19 Screening Tool for LTC Homes and Retirement Homes July 14, 2021):
    1. Has a doctor, health care provider or public health unit indicated that you should currently be isolating (staying at home)?
    2. In the last 14 days, have you travelled outside of Canada AND been advised to quarantine per the federal quarantine requirement?
- Care Partners are provided with an ID badge or sticker to support visual management and indication of passed screening
- Care partner are provided with appropriate PPE and trained on its use in addition to appropriate hand hygiene techniques; masking requirements remain in compliance with provincial and municipal guidance
- Age is not a restriction for visiting, however organizations should assess the ability for the care partner 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
- Continue to prioritize the ability for organizations to support physical distancing for all people across the hospital in alignment with provincial and municipal guidance
- Care partners 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 ECPs 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 care partners to support a distribution of people across various times and avoidance of the busiest timeframes
- No eating or drinking at the bedside or in clinical areas without prior arrangement with infection prevention and control specialists - allowance for in and out privilege is preferred to support eating and drinking for care partners
- In situations where care partners are not adhering to infection control practices, hospitals should:

1. ensure understanding by the care partner of the requirement (e.g. address language, hearing or cognitive challenges) and consequence
2. support any accommodations required for care partners in order for them to meet the infection control requirement
3. assess impacts to the patient and document discussions with patient/SDM to seek alternatives e.g. alternate designate, virtual connections
4. recognize the requirement to protect the safety of other patients, care partners, learners, staff and physicians
5. define an internal escalation process

Guidance for COVID-19 Positive Patients and COVID-19 Positive Care Partners

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

In general, COVID-19 positive care partners 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. ECP escorted with mask, hand-hygiene, stay at the bedside, brief visit duration, escorts wear PPE etc.) can be made safely in advance.

Consideration for ECP COVID-19 Vaccination Requirements

Hospitals will need to independently determine if ECP COVID-19 vaccination requirements (proof of COVID-19 vaccination or COVID-19 testing results) will be warranted within their local context. The following are considerations that hospitals should be aware of in determining if vaccination requirements are appropriate.

- Relevant principles, substantive values and planning assumptions for this policy as it relates to ECP Vaccination include:
  - **Preventing undue strain** on health human resources
  - Understanding the **vulnerability, fear and anxiety of patients and essential care partners** may be heightened during COVID-19 pandemic
  - Considering the **risk family presence may pose** related to transmission of COVID-19 in relation to the short and long-term **risks of limiting family presence** on patient and essential care partner health and well-being.
  - **Customizing** the **recommendations** locally based on **organizational risk assessments**
  - Acknowledging the **integral role and impact that family members have** in providing physical, social, emotional and navigation of care support.

  - Ensuring the **appropriate use of healthcare resources** including maintaining system testing capacity and operationally efficient processes.
  - **Patients** or substitute decision makers have the right to choose or **designate their visitor/ECP** including whether they will agree to receiving a visit from an unvaccinated person.

- For external context, as of Sept. 24, 2021 there is **no mandatory requirement in Ontario for ECPs'/visitors to be COVID-19 vaccinated**. For long-term care, all homes are accepting visitors regardless of vaccination status in accordance with the Guidance for LTCH in Ontario and **Directive #3**[39]. Also, for Hospitals, the recent (August 17th, 2021) release of **Directive # 6**[39] does not require mandatory COVID-19 vaccination of employees, contractors, volunteers or students within public hospitals. In both situations, screen testing of asymptomatic persons using rapid antigen testing, is offered as a requirement for those who are not fully vaccinated. Accordingly, it may then be more difficult to justify that ECPs uphold a greater standard of mandatory COVID-19 vaccination as they do not have the same professional duties to patients as health care providers. It is important to note that this screen testing is different from COVID-19 diagnostic testing of individuals who are symptomatic, have had a high-risk exposure or in an outbreak setting as directed by the local public health unit. Also, effective September 22nd, 2021 in Ontario, **Proof of COVID-19 vaccination**[37] will be required **for** certain **non-essential businesses** and settings with the provision of enhanced vaccine certificate QR codes by Oct. 22, 2021. This requirement is specifically not applicable to outdoor settings, for children < 12yrs or in settings where people receive medical care, grocery stores or medical supplies as these are described as "essential" services.
- On September 22, 2021, the **Ontario Human Rights Commission**[40] provided a position on requiring proof of COVID-19 vaccination to protect people at work or when receiving services. The requirement of proof is generally permissible under the Human Rights Code as long as protections are put in place to make sure people who are unable to be vaccinated for Code-related reasons are reasonably accommodated. There is a duty to accommodate for medical or disability related reasons. People who are unable to receive the vaccine must provide a written document, supplied by a physician or registered nurse extended class or nurse practitioner stating they are exempt for medical reasons from being fully vaccinated and how long this would apply. Organizations with a proven need for COVID-19 related health and safety requirements might also put COVID-19 testing in place as an alternative to mandatory vaccinations or as an option for accommodating people who are unable to receive a vaccine for medical reasons. Organizations should cover the costs of COVID-19 testing as part of the duty to accommodate. Ensuring access to vaccines and testing for vulnerable Ontarians is a necessary element of any vaccine mandate or proof of vaccination regime.

Ethical considerations are offered below:

- There are clear disparities in COVID-19 vaccination rates across the Toronto Region, tied closely to communities with economic inequality and inadequate social protection. For these communities, in particular, the consequences of limiting ECP access, based on vaccination status, will lead to further disadvantage. This issue is highlighted in the Patient Ombudsman COVID-19 Special Report August 2021[38] especially with the most vulnerable patients e.g. frail, elderly, patients with diminished physical or cognitive capabilities, mental illness and those with limited English proficiency leading potentially to increased use of physical or chemical constraints or patients being discharged AMA.
- Organizations must avoid undue hardship for patients and ECPs as a result of requirements including actions that cause significant difficulty or expense e.g. COVID-19 testing costs incurred by ECPs
- When individual rights are limited by organizations, they have a greater obligation to minimize any harm resulting from the restrictions. If ECPs are limited in access based on vaccination status, organizations should dedicate efforts to maximize virtual access as well as provide regular updates to ECPs.

Ethical Considerations

	Mandatory Vaccination ECP	No Mandatory Vaccination ECP

Do No Harm	• Prevent harm to staff and patients
	  • How likely and significant is harm in context (Vaccination rates, PPE, Directive 6, ECP restrictions)
	  • Is there evidence non-vaccinated ECPs will lead to outbreaks and significant harm
	  • Are there less restrictive measures to achieve desired outcome
		• Harm to patients due to restricted access shown in previous waves
		• Harm due to restricted access is not comparable to harm from not participating in leisure/non-essential activities

Stewardship	• Responsible for vulnerable patients • Scarcity of HCPs currently • HR costs to requiring ECP vaccination– logistics 24hr testing for exceptions • Increase restrictions to ECP will require increased efforts to offset restrictions (i.e. more virtual access, more frequent updates)	• Uncertain if it is the role of healthcare organizations to move beyond education and advocacy for vaccination to a more extreme position
Solidarity	• Everyone should carry responsibility for public health measures	
Health Equity		• Exacerbates existing health equity issues - many unvaccinated are marginalized • Patients with SDH may be further disadvantaged
Proportionality	• Sectors with very vulnerable patients, or patient populations without high vaccine rates may warrant greater restrictions to prevent harm	• Difficult to prove mandatory vaccination is warranted given all other measures in place
Equity	• Vaccinate status may be seen as a morally relevant consideration in accessing health organizations who have vulnerable patients	• Inequitable – not all hospitals require staff to be vaccinated; staff have greater duty as professionals • HCPs responsibility to get vaccinated is not equal to that of a lay person (i.e. ECP)

*Possible human rights challenges

- Acceptable to violate right when it is absolutely necessary to protect others
- Obligation to accommodate rights up until “undue hardship”

Consideration for ECP COVID-19 Vaccination Requirements Cont'd

Recommended Guidance

i. Communication Plan

- Hospitals should have a **robust communication plan** that describes clear requirements for ECP/visitor COVID-19 vaccination and or screen testing in exceptional populations/circumstance to support hospital screening/clinical teams and manage expectations.
- Consider providing instructions on how ECPs/Visitors can obtain their COVID-19 vaccination receipts online at https://covid19.ontariohealth.ca and also how to arrange COVID-19 screen tests in the community or locally within the hospital.
- Outline expectations that visitors, regardless of COVID-19 vaccination status, are still required to wear appropriate PPE as directed by the hospital. At this time, this is a medical grade mask upon entrance to the hospital and additional PPE if visiting a patient on Additional Precautions.

ii. Operational Requirements

- Hospitals should provide **locally appropriate procedural guidance** for ECP/visitor COVID-19 vaccination requirements including:
    - Scope of Policy:
        - ✓ Determine if it is inclusive of both inpatient and outpatient visits.
        - ✓ Determine if there will be exceptional populations or patient circumstances that will permit visitors/ECPs (see below).
        - ✓ Determine if there are exceptional areas of the hospital (i.e., Emergency Department.
        - ✓ Determine if rapid antigen screen testing will be utilized for asymptomatic ECPs (in compliance with the Human Rights Commission). Rapid antigen screen testing is a point in time measure that may support screening. Symptomatic individuals and any ECP with a positive rapid antigen test should be directed for appropriate confirmatory PCR testing. Rapid antigen testing typically has lower sensitivity and specificity than PCR testing. Organizations will need to determine the value of adding rapid antigen testing in light of operational burden and screening value for unvaccinated ECPs.

    - Criteria:
        - ✓ Visitors will be required to provide documented proof of full COVID-19 vaccination (must be 14 days from the date of 2nd dose).

- ✓ If rapid antigen screen testing for unvaccinated visitors is utilized, the test will need to be taken within an appropriate time, in alignment with public health restrictions/community prevalence of COVID-19, before their visit where exceptions apply (see exceptions below). For those unable to access rapid antigen screen testing due to logistical (unplanned admissions) or equity reasons (financial barriers), a mechanism to test visitors/ECPs onsite will need to be supported as indicated in the Ontario Human Rights Commission.

- Process:
  - ✓ Determine location for symptom screening, screen testing and required proof of vaccination (i.e., receipt saved on phone, printed or QR code). Consider options to locally print receipts if required. Determine the process for validating visitors vaccinated out of Province or Country.
  - ✓ If appropriate, develop operationally feasible screen testing processes e.g. community rapid antigen screen testing or local rapid antigen screen testing within hospital. If hospitals are considering local rapid antigen screen testing they should refer to the Ministry COVID-19 Guidance considerations for Antigen Point-of-Care Testing (Version 7.0, August 25th, 2021) and requirements set out by the Ontario Human Rights Commission.
  - ✓ Consideration should be given to the burden of cost for ECP/visitor-funded with community rapid antigen/PCR testing as described by the Ontario Human Rights Commission. Note: Private PCR testing is costly and recent direction from the Ministry of Health indicated that Assessment Center or Hospital testing capacity through lab-based PCR testing should not be made available to hospital staff or other identified groups to meet asymptomatic testing requirements under directive # 6 (see September 7th, 2021 Ministry Memo from Director, Testing Strategy Coordination Branch).
  - ✓ If applicable, timely availability of rapid antigen screen testing should be offered including 24hr access for time sensitive populations and urgent/emergent patient situations (e.g. Labour and Delivery, Emergency Department, Urgent/Emergent Surgeries, End of Life)
  - ✓ Develop a documentation process for entering COVID-19 vaccination proof or negative COVID-19 test results, as appropriate,

within the timeframe required and in compliance with privacy requirements.

- ✓ Develop visual tools (i.e., visitor badge) for indicating that a visitor/ECP has passed required screening process.

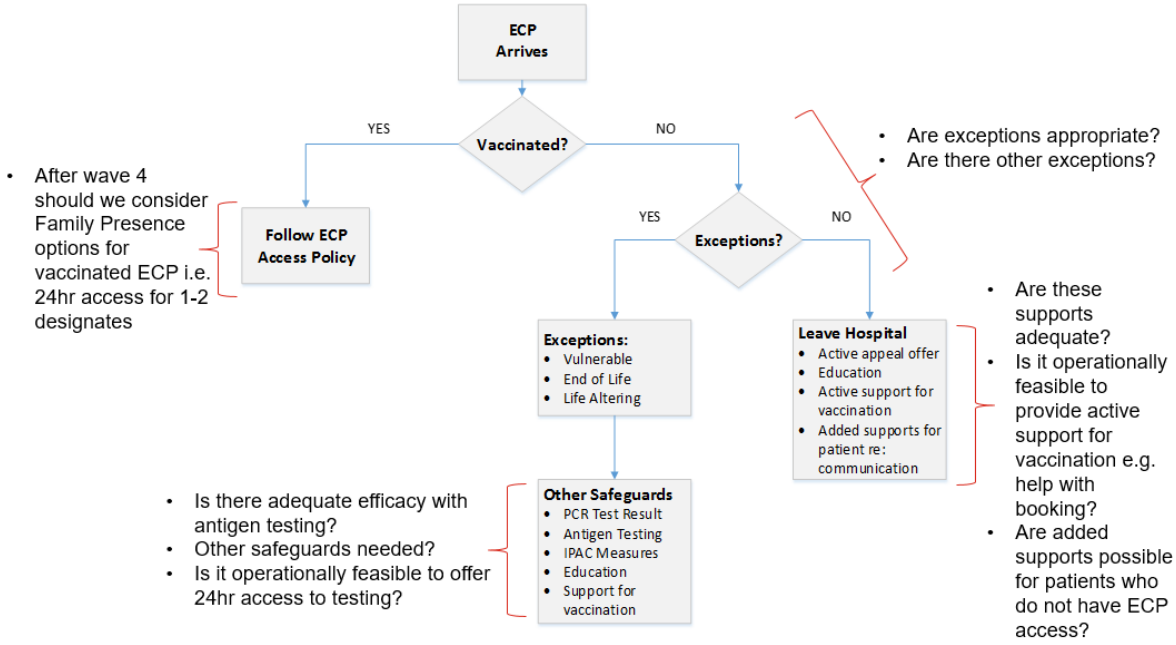
iii. Addressing Equity and Ethical Considerations

- **Unvaccinated ECPs/visitors** should be **offered public health education** to support targeted efforts at building vaccine confidence **and removing barriers** for vaccine access. Where possible, access to COVID-19 vaccination onsite is ideal e.g. onsite retail Pharmacy to offer added convenience. Where unvaccinated ECPs/visitors are denied access to the hospital, organizations have a greater obligation to actively support removing barriers and providing access for vaccination – this must be in compliance with the Ontario Human Rights Commission
- Hospitals should **weigh all ethical and equity considerations** outlined above in defining their own policy
- Organizations should recognize that COVID-19 **vaccination in combination with other IPAC measures** e.g. PPE, physical distancing, screening, restricting volume **is most effective in safeguarding staff and vulnerable patients**. However, **proportionality** recognizes the **consequence of inadequate ECP access** may also lead to significant short and long term issues

iv. Supporting Exceptions

- **Exceptions to allow ECP access** in certain patient populations (where the harm of not allowing access is significant to the patient) **regardless of COVID-19 vaccination** status should be offered. These populations may include:
  - Vulnerable patients e.g. <18yrs, cognitive impairment, significant developmental or intellectual disability, unable to communicate effectively (limited English proficiency, aphasia)
  - End of life patients < or > 2wks
  - Patients experiencing a life altering event e.g. child birth, critically ill, receiving a life altering diagnosis, serious surgery, mental health crisis
  - In outpatient areas all vulnerable patients and those with significant mobility limits requiring an escort
  - Consideration should be given as to whether vaccinated visitors of this population should be permitted to extend their visiting hours (i.e., 24X7 access)
  - Long stay patients

ECP/Visitor Vaccination Considerations - Operational Summary



6. Support for Essential Care Partners and Patients

a. 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

b. Support Meaningful Connections to Minimize Feelings of Isolation

- Redeploy staff in a new role as "connectors" to help with virtual technology
- Staff/remote volunteers may have an added role to support patients emotionally to ward off isolation
- Ensure a clear process for active participation for essential care partners who are offsite when the patient/SDM has determined this to be appropriate e.g. virtual bedside rounds, daily updates and contact with the patient[36]
- Support for drop off and delivery of items for patients from care partners within the hospital

c. Inform and Educate

i. Educate on steps needed to minimize risk: expectations for hand hygiene, use of PPE, guidelines for physical distancing, use teach back

ii. Enhance discharge education and post-discharge follow-up (telehealth, enhanced social work support and home care to facilitate smooth transitions etc.)

Addendum to Recommendation 6: Support for Essential Care Partners

- Clear and consistent communication for the public, particularly patients and ECPs, that differentiates between external factors common to all hospitals e.g. community burden of COVID-19, Ontario and Toronto COVID-19 Stages of reopening with internal factors that are institution specific e.g. staffing, patient populations and structural factors (space limitations).
- Readily available and easily understood education material for ECPs about infection prevention and control measures e.g. PPE education, physical distancing to avoid transmission of COVID-19 to support clinical staff and care partners to correctly use PPE and enact IPAC safety measures. Clear information for patients and care partners about what constitutes a social circle.
- Tracking of care partner names and contact information by institutions to support contact tracing if needed.

7. Appeals

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

With ECP 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 ECPs), 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.

Recognizing limits to equitable awareness of the appeals process, for long stay Rehab/CCC patients, more active support of appeals should be considered e.g. systematic identification of patients with limited English proficiency or cognitive impairment and proactively offering of appeals process where visitation limits exist

Appeals Process:

i. Appeals should be managed by Patient Relations
ii. Appeals should align with existing both Patient Relations and Conflict Resolution policies and procedures

iii. Appeals information includes: name of patient, name of ECP 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

iv. A minimum of three individuals should review all appeals (i.e. patient relations, bioethics, program manager, team members, quality)

v. Consultation should occur with the healthcare team, unit manager and/or program director to better understand the patient and their context

vi. Appeal decision should aim for consensus; when consensus is not feasible majority opinion should override

vii. Appeals should proceed in a timely manner[36]:

Urgent Assessment: same day response, including weekends

- Category 1 Patient with Life Altering Event
- Involvement of manager on call

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

viii. 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.

ix. Appeals metrics should be maintained for quality improvement

The following criteria should be used when evaluating requests/appeals for ECPs:

a) 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 ECPs
   - 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 ECPs

b) 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

c) Essential to the patient or care partner'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 ECP or loosing functional ability

d) Patient wishes
   - Has the patient articulated a strong wish for the specific ECP(s) requesting the appeal

e) Health equity impact[36]
   - Will granting appeal address health equity concerns (e.g. a single mother who needs to bring a child with her)
   - Incorporate the use of the health equity impact assessment tool (Appendix D)

f) 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, care partner 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.

Addendum to Recommendation 8: Ongoing Monitoring and Triggers to Modify Responses

As the Province and the City of Toronto continue with various stages of reopening, hospitals should take a cautious approach to assess the impact of reopening. With each stage of reopening for the City of Toronto and schools, a period of stabilization should be allowed prior to changes in hospital visiting phases. This will allow for sufficient ability to assess the impact of changing case counts or upticks as a result of major external developments. The timeframe for stability will be at minimum 21 days after each step change. The Toronto Region COVID-19 Essential Visitor Community of Practice will be convened regularly before any anticipated increase in community burden based on local or provincial pandemic modelling and after each major external change to advise the TR-Hospital Operations Table on the appropriateness to move to the next phase within the Visitor Access guidance document.

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Appendix A: Risk Factors and Mitigation Strategies Related to Visitors

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

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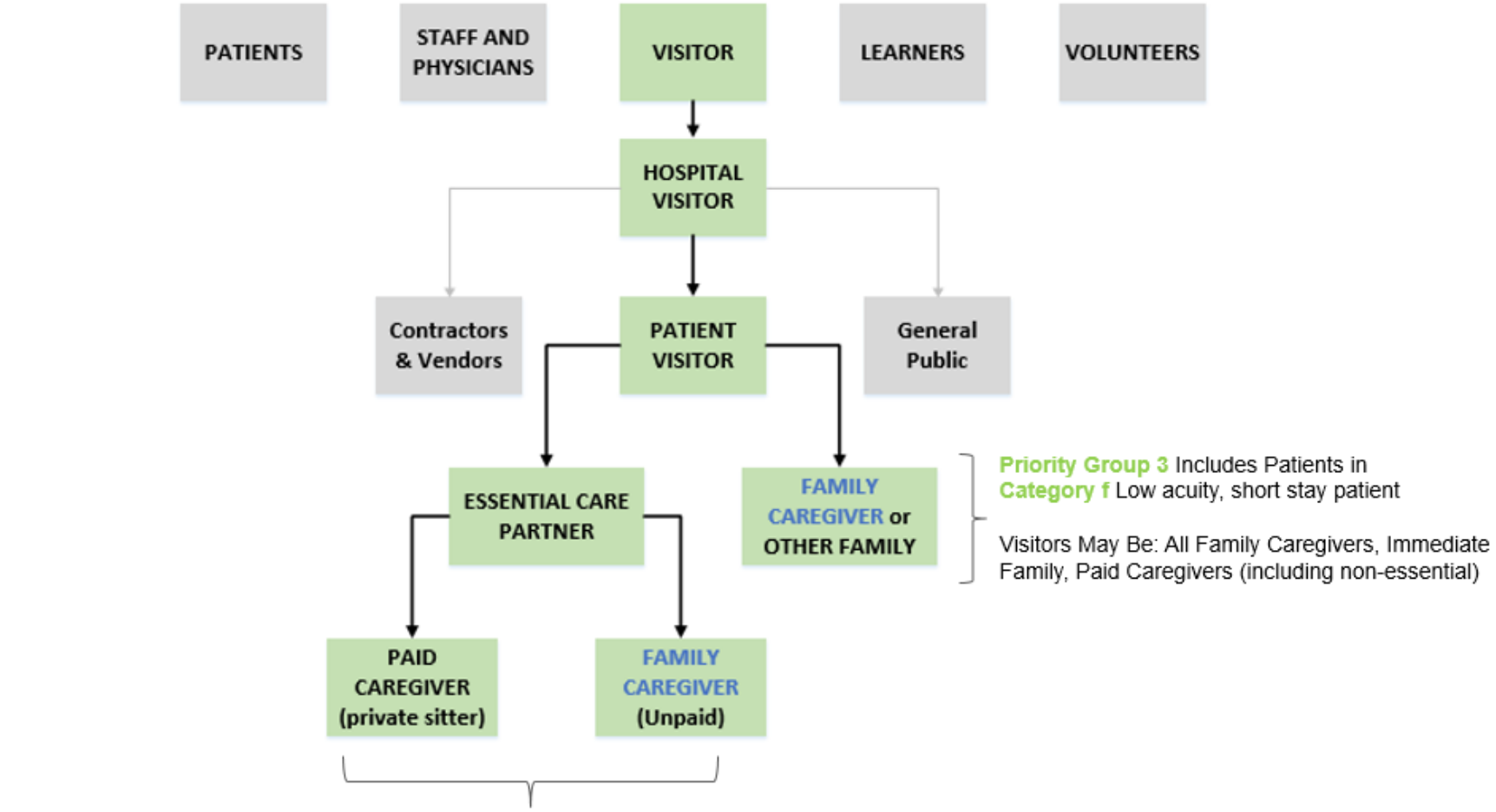
Appendix B Visual Representation of Visitor Terms Used Within Guidance Document



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

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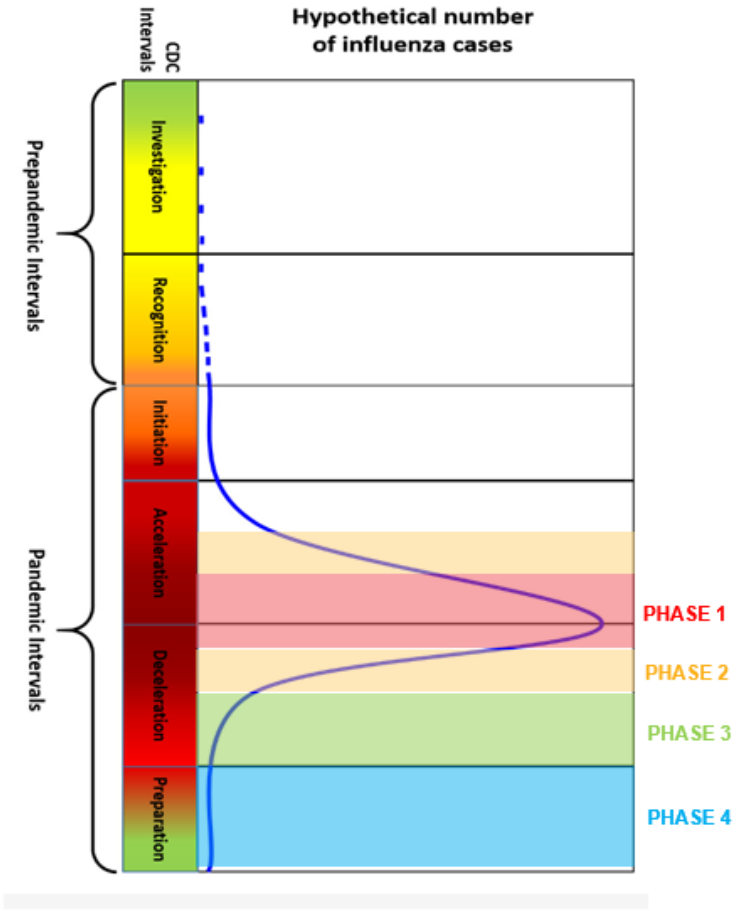
Appendix C Essential Visitor Phases Overlaid Against Pandemic Interval Framework



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

Appendix D Example of a Completed Health Equity Impact Assessment: http://www.health.gov.on.ca/en/pro/programs/heia/

Health Equity Impact Assessment: No eating or drinking policy

Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	Unintended Negative Impacts.	Identify ways to reduce potential negative impacts and amplify the positive impacts.
Age-related groups (e.g., children, youth, seniors, etc.) Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)	Elder senior visitors and visitors living with mobility disabilities who are given end-of-life 24-hour visiting privileges and are permitted to go in and out of the hospital to eat may experience functional challenges to go outside to eat, especially in cold conditions during the winter.	• The hospital may want to create a framework for determining exceptions to the 'no food or drink' policy that integrates considerations on the appellant's health context and relevant health equity considerations. • For visitors permitted in and out privileges to eat, the hospital may want to consider creating a designated area for visitors to eat. Establishing an indoor or outdoor space that is partitioned to promote physical distancing may allow visitors to eat safely. • For visitors with low incomes who are packing lunches, it may be helpful to provide clear direction on whether hospital fridges can be used to store food and that food must be consumed in designated visitor eating areas. • It may be helpful for the hospital to consider designating an eating space with specific times for visitors celebrating a religious event where food and drink consumption is culturally significant.
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.) Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)	The 'No Food or Drink' policy may negatively impact visitors living with chronic conditions like metabolic syndrome (i.e., diabetes). Aboriginal and certain ethno-racialized communities who experience higher levels of metabolic syndrome than the general public are also likely to be disproportionately negatively impacted by the 'No Food or Drink' policy.	
Religious/faith communities	Religious/faith communities may experience challenges with 'no food and drink policy,' especially on significant religious holidays where consumption of food is considered an important practice (i.e., Passover, Eid al, etc.)	
Low income (e.g., unemployed, underemployed, etc.)	Visitors with low-incomes who are given end-of-life 24-hour visiting privileges and are permitted to go in and out of the hospital to eat may not be able to purchase food in the surrounding area. Since allowing visitation after phase 1, some visitors use unit fridges to store packed lunches and are eating in patient rooms.	

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Essential Care Partner Policy Glossary

Alternate ECP: 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 ECP: 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 Care Partner: Essential 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 care partners 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.

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No In and Out Privileges: No In and Out Privileges includes instruction that when the ECP leaves the hospital they cannot return to the hospital. This term can also apply to situations where ECPs 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 who is not deemed an ECP

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.