Document name:	**Policy for Adult and Children visiting to inpatients in hospitals (including handling of non-patient visitors to the Trust).**
Document type:	Policy
What does this policy replace?	New Policy
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	January 2016 (V1)
Next review:	November 2017
Approved by:	Executive Management Team
Developed by:	Emma Cox, Named Nurse, Safeguarding Children
Director leads:	Tim Breedon, Director of Nursing, Clinical Governance & Safety.
Contact for advice:	Safeguarding Children and Adults Teams

Inpatient visiting Policy (including, adult child and handling of non-patient visitors to the Trust).

1. Introduction

Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the trust.

This policy aims to ensure that all visits are handled appropriately and patients are protected from any potential safeguarding issues relating to Trust visitors.

Adults and Children

This Policy will ensure the safety and welfare of adults and children are considered whilst enabling patients to maintain contact with their families and friends whilst on a hospital ward.

Visits from friends and family are central to the maintenance of normal, healthy relationships and these guidelines embrace this philosophy.

Non-patient visitors

The Policy will ensure that the handling of high profile and other visits to the Trust are managed and coordinated to maintain the safety and wellbeing of patients.

The policy covers visits to the Trust from people not connected to the organisation, which may include celebrities, ministers, royalty, and charities etc., which are organised by South West Yorkshire Partnership NHS Foundation Trust employees. It covers both requests to the Trust from individuals who want to pay a visit as well as requests from Trust staff for visits to be made.

During any year there will be a number of visitors to the Trust either through their own request, e.g. to make charitable donations, or through a request from a member or team of staff. Every such visit must follow the procedures within this policy to ensure that appropriate safeguarding arrangements are in place for patients.

2. Purpose

The purpose of this document is:

Adults and Children

To ensure the safety and welfare of adults and children whilst enabling patients to maintain contact with their families and friends whilst under the care of the Trust services.

For the purpose of this Policy an Adult is defined as anyone over the age of eighteen. Adult visiting is central to the maintenance of normal healthy relationships. In general the decision to allow such a visit will require a risk assessment.

Consideration must be given to risk associated with the bringing in of contraband items and when is an appropriate time to end the visit.

Restriction on visiting on security grounds

The behaviour or propensities of a particular visitor may be, or have been in the past disruptive or subversive to a degree that exclusion from the hospital is necessary as a last resort. Examples of such behaviour or propensities are: incitement to abscond, smuggling of illicit substances/ alcohol into the hospital, mental health, transfer of potential weapons, or unacceptable aggression or unauthorised media access. A decision to exclude visitors on the grounds of his or her behaviour or propensities should be fully documented and explained to the patient and, where possible, the appropriate, the person concerned.

Staff should be aware of Local safeguarding Adult Procedures.

For the purpose of this Policy a child is defined as an individual under the age of eighteen years. (There may be a situation where the next of kin/ carer are under the age of eighteen, this will require a discussion with the multi-disciplinary team).

Children's visits to their parents or other relatives in hospital are central to the maintenance of normal healthy relationships. In general, the decision whether to allow such a visit will require a risk assessment to be completed and consideration to whether the situation requires a discussion with the Safeguarding Children team.

On admission, staff will explain to the patient or/ and their carer that visiting by children and young people under the age of eighteen will only be allowed if closely supervised by a responsible adult (not the patient) who is preferably a family member or an adult with parental responsibility and that the accompany adult is responsible for the child's safety whilst visiting. All child visits must be supervised by a member of staff. Staff must receive training in this area in accordance with the Safeguarding Children training strategy.

Where staff has concerns regarding the safety or welfare of the child visiting ward, specialist advice from the Safeguarding Children Team should be sought and a request for service to Social Care may be forthcoming.

Circumstances where visiting by a child or young person may be restricted.

The decision to restrict the visits of children to any patient should be made the multi-disciplinary team where possible. In exceptional circumstances this decision may be made by the Nurse in Charge of the ward at that time.

Circumstances where the decisions to restrict a visit are as follows:

- Where there is a clearly identified risk to the child/ young person of distress or emotional harm due to the patient's illness.
- Risk of verbal or physical harm to the child/ young person.
- Consideration should be given to the potential risk of the hospital environment to the child/ young person itself and the possibility of cross infection.

- Actual or perceived risk of sexual harm/ exploitation from any patient on the ward.
- Risk of exploitation of the child/ young person by any patient e.g. where the action of the child puts the adult patient at risk, this could be the bringing in of contraband items.
- In the case where there is a failure in the agreement between the ward staff and the adult family member that they will supervise the child/ young person during visiting.

There may be an occasion when it is not safe for a child/ young person to visit and alternative arrangements cannot be made. In this instance alternative arrangements should be made at the earliest opportunity.

All visits must be demonstrably in the interests of the child/ young person.

Restriction on clinical grounds

It will sometimes be the case that a client's relationship with a relative, friend or supporter is anti-therapeutic (in the short or long term)to an extent that discernible arrest of progress or even deterioration in the client's mental state is evident and can reasonably be anticipated if contact were not to be restricted.

All visitors are not permitted within the dormitory/ bedroom areas, however, in certain circumstances this may be agreed at the discretion of the nurse in charge.

Non-patient visitors

This policy relates to the handling of high profile, anyone with a perceived authority and other visits to the Trust and has been developed following recent allegations of abuse by Jimmy Savile at other NHS facilities.

The policy covers any visitor to the Trust who may come into contact with patients or visit ward/clinic areas but are not families and friends of the patients or regulators/commissioners on Trust business. Examples include VIPs such as Ministers and Royalty, celebrities such as television/radio personalities, visits from Santa or local mascots, Mayors, sports personalities etc. The Trust's media management policy applies in respect of media contact with the Trust, including media attendance at Trust premises.

Duties (Roles and responsibilities)

Adult and Children

It is the duty of the Named/ Allocated nurse for the patient to organise adult and child visits. Consideration has to be given to risk, demonstrably in the interests of the child/ young person and planning.

All visits should occur during allocated visiting hours, avoiding protected mealtimes. In exceptional circumstances visits can be arranged via the Named/ Allocated nurse.

On General Inpatient areas children are welcome but remain the responsibility of the parents/carers at all times This is documented in the inpatient leaflet that is given to all patients on admission to our areas. They have access to the same areas as visitor's.

We do have private rooms for use if required and we would risk assess if necessary or have any concerns

Infection control precautions/ guidance should be considered at all times.

Non-patient visiting

It is the visit organiser's duty to ensure that this policy is followed for all visits including gaining the correct consents and ensuring that visitors are accompanied throughout their visit.

Further advice can be sought from the Communications Team, should any clarification be needed.

BDU directors / Quality Academy Directors will determine if visits are appropriate. The communications team should be notified of potential visits and ensure that any photographs/filming that takes place is properly managed and conducted with prior approval of service users / carers (in the case of a child / young person). The purpose of the visit and any request for consent should be explained by a staff member known to the service user.

3. Procedures

Adult and Child

All visits should be organised by the Named/ allocated nurse for the patient during the allocated visiting times. For child/ young people visiting the wards the visit should be supervised at all times by a member of staff in an appropriate visiting area, off the clinical ward area. Observations should be clearly documented in on-going care notes and staff members must have the appropriate skills to intervene and stop the visit if safeguarding concerns are raised.

Non-patient visiting

The following procedures must be followed by any member of staff organising a visit to the Trust.

a. Prior to the visit

All requests for visits or planned visits should be directed to the Communications Team, based in Fieldhead Hospital, at the earliest opportunity. If individuals are approached directly the visits must be approved by the relevant BDU / Quality Academy director (or someone with designated authority), and organised in conjunction with the Communications Team.

Any member of staff wishing to invite a visitor to their ward/work area should contact their manager before approaching the potential visitor.

If a visit is approved and arranged, the Communications Team will arrange for any internal or external publicity in respect of the visit, should it be appropriate.

b. On the day of the visit

All visitors should be met and escorted to the visit area by a named member of staff (chaperone) and that member of staff should stay with them throughout their visit. Visitors organised by the Trust should **at no time** be left unattended with patients and families. If appropriate, and if media representatives are present, a member of the communications team will also be in attendance throughout the visit.

If the visit is a group visit and the group is split to visit different areas then each group should be chaperoned throughout that part of the visit.

Any photograph taken of the visitor with a patient or their family should be done so with the express permission of the patient or family (and parent or guardian in the case of a minor). Any photograph taken by a member of the Trust or the communications team of a patient or their family will require the completion of a consent form. Consent forms can be obtained from the communications department.

The staff chaperone must ensure any ward protocols and infection, prevention and control protocols are observed by any Trust-organised visitor to their clinical area.

Should any concerns arise about safeguarding, advice should be sought from the Trust's safeguarding adult or safeguarding children team immediately.

c. Royal Visits

Any request for Royal Visits must be made to the Communications Team who will make a request on the Trust's behalf to the Lord Lieutenancy office. Should the request be successful the Communications Team will continue to liaise with the Lord Lieutenancy office and the Police to ensure the appropriate security arrangements are in place. Other staff will be involved as appropriate by the Communications Team.

The Royal visitor, and their accompanying party, will be accompanied by the Chair/Chief Executive of the Trust or another member of staff as appropriate throughout their visit.

The Communications Team will be the central liaison point throughout.

d. Ministerial Visits

Any request for a Ministerial Visit must be made to the Communications Team who will make a request on the Trust's behalf to the Minister's Private Office.

If the visit is agreed the Communications Team will liaise with the Private Office with regard to an itinerary and to ensure that security, if appropriate, is in place.

The Minister will be accompanied on their visit by the Chair/Chief Executive of the Trust or another member of staff as appropriate throughout their visit.

The Communications Team will be the central liaison point throughout.

e. Visits organised directly by patients and their families

The only time the procedures above may not be followed would be if the patient or patient's family has organised a visit themselves and not involved the Trust. These visitors would be treated the same as any other visitor to the patients on the ward. However, should the patient or their family organise for the media to visit them to take a photograph then the media management policy applies.

4. Training and Implementation

There is no training requirement for this policy. However, all staff members should be made aware of this policy and the procedures within it.

5. Trust Equalities Statement

South West Yorkshire Partnership NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.
The policy has been assessed against the protected characteristics and was found not have an impact against the same.

6. **Monitoring Compliance with this Procedural Document**

BDUs should alert the Communications Team to external visits and a central record will be held.

All visits should be arranged in accordance with this policy. If a visitor comes without following the process, the Nurse in Charge, must make the necessary arrangements before the visit can commence. If the visitor refuses to wait for the arrangements to be made, appropriate risk assessment to be completed and incident to be recorded, as deemed appropriate.

If there are any concerns that patients have been in a vulnerable position with regard to safeguarding then the Safeguarding adult or safeguarding children team and the Director of Nursing, or in their absence her designated deputy, must be informed immediately.

6.1 Stakeholder involvement

Consultation with relevant stakeholders secures 'buy in' and provides an opportunity to identify and eliminate potential barriers to implementation.

The lead director is responsible for ensuring relevant stakeholders have been consulted during the development of the policy. The following identifies some of the individuals or groups who might be consulted with. This is not an exhaustive list.

Stakeholder	**Level of involvement**
Executive Management Team	Approval – (may also be involved at the outset in confirming the requirement for a new policy or agreeing the development process)
Directors	Initiation, lead, development, receipt, circulation
Business Delivery Units (BDUs)	Development, consultation, dissemination, implementation, monitoring
Specialist advisors	Development, consultation, dissemination, implementation
Service user and carers	Development, consultation
Professional groups and leaders	Development, consultation, dissemination, implementation
Trust Action Groups	Development, consultation, dissemination, implementation
Staff side	Development, consultation, dissemination
Trust learning networks	Consultation
Local Authorities	Development, consultation
Police	Development, consultation
Other NHS Trusts	Development, consultation
University	Consultation

For this document, the Clinical Governance Support Team and the Executive Management Team were consulted. The Trust Board agreed when developing the Scheme of Delegation that responsibility for determining policy approval arrangements should be a decision reserved to the Board.

6.2 Equality Impact Assessment

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer. All new policies and procedures should be subject to an Equality Impact Assessment. A tool to support this process is included at appendix B to this document.

If any negative impact is identified, the policy should be amended or (if this is not possible) an action plan to mitigate the negative impact must be included.

7. Approval and ratification process

Procedures and guidance notes may be approved and issued by the lead director.

Policies for approval that have not been identified as requiring Trust Board approval should be submitted by the lead director to the Approvals EMT which meets monthly. The checklist at appendix C should be completed by the lead director.
Policies where authority to approve is reserved to the Board should be submitted to the Trust Board by the lead director after they have been discussed by the EMT.

8. Process for review

At the time of approval, all policies should have a clearly defined review date. This may be brought forward if earlier review is required, for example because of an identified risk or change in national policy.

The Integrated Governance Manager will notify the lead director two months before the policy is due for review.

The lead director will check the policy. If no amendment is required, this should be reported to the Executive Management Team or Trust Board for ratification by the review date and the policy will be reissued.
If the policy requires minor amendments, the revised policy should be presented to the EMT or Trust Board.

If significant amendment is required, the process described in section 5 should be followed.

An equality impact assessment (EIA) must be completed for all policies that have not previously been subject to EIA.

It should be noted that, for services that came to the Trust as part of the Transforming Community Services agenda, there will be a number of policies that, over time, will need to be aligned. Existing policies will continue to be followed until this work takes place. Each appointed Director lead for a policy will need to ensure that reviews include all existing policies that have been produced by previous organisations and that new/updated polices are clear which policies they replace.

9. References

Documents referred to in the development of the policy and documents that should be read in conjunction with the policy should be listed.

10. Version control

All policies and procedures must have the version number, date of issue and the review date clearly marked on the front cover and as a footnote.

Draft policies should be marked v1 draft, v2 draft etc during the consultation phase. Once approved the document becomes Version 1. Each time the policy or procedure is updated the version number must be changed.

The introduction to the Policy should make it clear whether a document replaces or supersedes a previous document, including the title(s) of any superseded or replaced documents.

11. Dissemination

Once approved, the integrated governance manager will be responsible for ensuring the updated version is added to the document store on the intranet and is included in the staff brief.

The integrated governance manager is responsible for ensuring the document being replaced is removed from the document store and that an electronic copy, clearly marked with version details, is retained as a corporate record.

If local teams down load and keep a paper version of procedural documents, the manager must identify someone within the team who is responsible for updating the paper version when a policy change is communicated via the staff brief.

12. Implementation

All policies and procedures must identify the arrangements for implementation, including:

- any resource requirements, including staff, and how these will be met;
- support available to assist implementation;
- arrangements for ensuring the policy or procedure is being followed;
- monitoring and audit arrangements.

13. Document control and archiving

13.1 Current policies and procedures

Current policies and procedures will be available on the intranet in read only format.

14. Monitoring compliance with the policy

All policies and procedure must identify the arrangements that are in place for ensuring and monitoring compliance. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission standards, NHSLA Risk Management Standards and Monitor Compliance.

Methods may include:

- monitoring and analysis of incidents, performance reports and training records;
- audit;
- checklists;
- monitoring of delivery of actions plans through TAGS or BDUs.

The document should identify the methods that will be used to ensure timely and efficient implementation.

For this policy implementation:

- is the responsibility of the Director lead for individual policies to ensure that this policy is followed in the development and presentation of individual policies;
- is monitored through presentation to EMT and Trust Board, evidenced by the minutes of meetings where policies are approved, or the appropriate ratifying body, again evidenced by the minutes of meetings where policies are approved;
- is monitored by the ratifying body through the policies checklist;
- is assured through occasional audit by the Trust's internal auditors.

15. Associated documents and supporting references

This document has been developed in line with guidance issued by the NHS Litigation Authority and with reference to model documents used in other trusts. It should be read in conjunction with

- the Trust Branding Policy;
- the Records Management Strategy, Non-Clinical Records management policy and non-clinical records retention and disposal schedule.

Appendix A - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment: January 2016

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Policy for the handling of non-patient visitors to the Trust
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		This policy aims to ensure that all visits are handled appropriately and patients are protected from any potential safeguarding issues relating to Trust visitors All staff
3	**Who is the overall lead for this assessment?**		Director of Nursing, Quality and Patient Safety
4	**Who else was involved in conducting this assessment?**		Safeguarding Team
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		Staff, I contacted ward managers, modern matrons, practice goverance coaches and consultation was sought through the polcies and procedures group. I was informed of protected mealtimes, medication times, ward times etc, accessibility on to the wards and appropriate visiting areas. Any comments were incorporated into the policy.
6	**What equality data have you used to inform this equality impact assessment?**		Elements of the policy were directed by the findings of the Lampard report (2015).
7	**What does this data say?**		For the Trust to have a policy, which includes VIP visiting.
8	**Taking into account the information gathered**	**No**	

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
	above, could this policy /procedure/strategy affect any of the following equality group unfavourably:		
8.1	**Race**	No	N/A
8.2	**Disability**	No	N/A
8.3	**Gender**	No	N/A
8.4	**Age**	No	N/A
8.5	**Sexual Orientation**	No	N/A
8.6	**Religion or Belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		This policy aims to standardise the approach to policy development, approval and dissemination and requires adoption of the Equality Impact Assessment throughout the organisation.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		N/A
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		N/A
9c	**Promotes good relations between different equality groups;**		N/A
9d	**Public Sector Equality Duty – "Due Regard"**		N/A
10	**Have you developed an Action Plan arising from this assessment?**		N/A

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
11	**Assessment/Action Plan approved by**	**Signed:** Emma Cox **Date:** 26th January 2016. **Title: Named Nurse Safeguarding Children**
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Inclusion Team:*** **inclusion@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on the web.** **Failing to complete an EIA could expose the Trust to future legal challenge.**	

If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Corporate Development or Head of Involvement and Inclusion together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Corporate Development or Head of Involvement and Inclusion.

Appendix B - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent)	N/A	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

Appendix C - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	Oct 2015	Emma Cox, Named Nurse Safeguarding Children	Draft	
2				
3				
4				
5				
6				
7				
8				