

Policy Title:	Arrangements for Visitors, including Visits by Children
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Policy Owner:	Colin Quick, Chief Quality Officer
Ratified by:	Kris Irons, Specialist Director
Responsible Signatory:	Colin Quick, Chief Quality Officer
Outcome:	<p>This policy:</p> <ul style="list-style-type: none"> • aims to ensure that appropriate visiting arrangements are in place. • visits by children are managed safely with appropriate regard to safeguarding.
Cross Reference:	OP05 Mental Capacity OP05.3 Adults with Incapacity (Scotland) OP06.1 Child Protection (Scotland) OP08.6 Safeguarding Children and Adults OP08.3 Adult Support and Protection (Scotland) H37.2 Banned and Restricted Items H97 Searching Patients and Visitors H35 Clinical Risk Assessment Priory Health & Safety Manual

EQUALITY AND DIVERSITY STATEMENT

Priory Group is committed to the fair treatment of all in line with the [Equality Act 2010](#). An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

ARRANGEMENTS FOR VISITORS, INCLUDING VISITS BY CHILDREN

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1 SCOPE

- 1.1 This policy applies to all Healthcare sites and services across England, Scotland, Northern Ireland and Wales. Where there are differences between nations, this will be clearly highlighted.

2 INTRODUCTION

- 2.1 Staff will recognise that maintaining contact with friends and relatives is an important element in a patient's treatment and rehabilitation. All patients have a right to maintain contact with family and friends and be visited, subject to carefully limited exceptions. Visitors are requested to notify the ward of their visit 24 hours in advance, if at all possible. This is important so that the team can let the visitor know if the patient is unavailable due to their participation in their treatment programme. It therefore may be better for the visit to take place at a different time. Even for those services where they operate a more open door policy on visiting it is helpful to ensure that the visit can take place at the most appropriate time and/or that the visitor is clear about any interventions that they can be involved in or not, such as in the instance of a patient being on an end of life care pathway.
- 2.2 Visits by children to patients, whether detained or not, are central to the maintenance of healthy relationships with parents or other relatives who are in hospital. Any visits by children should be considered in the context of the child's best interests and the nature of the relationship with the patient. A child who is presented as accompanying an adult visitor and has no legitimate relationship with the patient should not be permitted. (See section 6).
- 2.3 Visitors are welcome except in special circumstances which are deemed contrary to the health and well-being of the patient, these visitors are referred to as unauthorised visitors. Unauthorised visitors are not permitted.
- 2.4 Unauthorised means someone who is not authorised by the patient's Responsible Clinician, Responsible Medical Officer or Consultant to visit a patient or not authorised by the unit Hospital Director or Manager to be on the premises. This should be written clearly in staff communications and patient's clinical records. Preventing a visit by anyone the patient has asked to visit/and or agreed to see will always be regarded as an interference with the patients' rights. This means that any decision to refuse entry or ask someone to leave must be recorded clearly; reasons and evidence provided and explained to the patient and the person so they can raise concern or challenge the decision.
- 2.5 In the event of an infection control outbreak being declared, please ensure visits are reviewed and minimised/paused to essential only.

3 GUIDELINES

- 3.1 All visitors must sign the book that is held in reception and sign out when they leave. All visitors will be given an identification badge. Visitors include patient's visitors, professional visitors and contractors. Evidence of identity may be requested for professional visitors, a refusal to show

appropriate Identity Documents (for example a professional name badge) may result in refusal of the visit.

- 3.2 To ensure the safety of service users, visitors and colleagues, if there are any suspicions of visitors being under the influence of illicit substances or alcohol, visitors may be asked to leave or undertake a breathalyser test. A refusal to undertake the test may be considered as a positive result and the visitor will be asked to leave, where it is known that the individual has driven to the visit the Police will be notified of the suspicion of driving whilst under the influence.
- 3.3 Visitors will be advised about the items that are banned and restricted (this may be based on individual restrictions for the patient and/or blanket restrictions set in place by the ward/site) and asked to comply with the procedures in place to assist in ensuring that the service user does not have access to such items. An explanation of the risks for the individual patient should always be offered if requested and the visitor should be guided in how to challenge or request a review of restricted items.
- 3.4 Professional visitors are expected to make a prior arrangement or appointment. It is the responsibility of the staff arranging the visit to inform reception in advance. Staff should also ensure that they check if the professional visitor requires to meet with the patient in private and how this will be accommodated. For example, legal representatives, Independent Mental Health Advocates, independent doctors or approved clinicians may require sites to facilitate private meeting spaces and support them in understanding and agreeing any suitable security arrangements deemed necessary by the ward team.
- 3.5 It is the responsibility of the staff to record the forthcoming visit in the diary on the ward and to book rooms if required by following a locally agreed procedure.
- 3.6 There will be a local procedure in place for evening visitors to arrive and leave, when Reception is closed.
- 3.7 Visits should be encouraged and made as comfortable and easy as possible for the visitor and the patient in pleasant surroundings with access to drinks with a sense of respect of the patients' entitlement to the visit. Visiting times should be as flexible as possible. Unless there are safety risks, then visits should take place in private if that is the wish of the patient.
- 3.8 Written information for potential visitors should be provided outlining how to make arrangements for a visit, what visitors can or cannot bring with them and explaining that visits could be denied under certain circumstances. This could be in a welcome pack or a letter for relatives for those who live a longer distance away.
- 3.9 All patients must be supported and informed of how they can challenge or complain about any aspect of visiting and/or decisions made regarding visits and visitors. This should include offering support from advocacy including statutory advocacy where the patient is detained.
- 3.10 **Visits to Sites/ Services by VIPs or Celebrities** - There may be occasions when celebrities or VIPs visit sites or services for various reasons. The following safeguarding arrangements for sites with children must be in place in line with recommendations from the Lampard Report (2015)
 - a) Visits are to be agreed and arranged in advance, with the purpose for the visit clearly understood by all involved parties
 - b) Contact with service users will be agreed with the service users and their representatives in advance
 - c) The VIP or celebrity will be accompanied by a suitably senior colleague at all times during their visit
 - d) Confidential information will not be disclosed to the VIP or celebrity
 - e) Informal follow-up arrangements will not be made with the VIP or celebrity

4 UNAUTHORISED VISITORS

- 4.1 Patients have the right to accept or refuse visits from family, friends or carers. See more guidance in section 4.

- 4.2 Staff will provide assistance to patients who receive unwanted visitors, by mediating and facilitating the visitors to leave the premises.
- 4.3 A decision to permit or refuse access is at the discretion of the nurse in charge on the unit at the time, or other head of department. Granting or denying access should be a risk-based decision and include an account of on the factors and considerations. Patients must be supported in the situation whereby they have invited someone to visit that the nurse in charge believes will be a risk or contrary to the patient's recovery by talking through the issues with the patient. An initial conversation with the patient about why it might be in their best interests to invite a visitor previously refused is very important prior to making an agreement for a previously refused visitor to be able to visit.
- 4.4 A register of all visits refused by either the patient or staff must kept by the Hospital and recorded in the patient's electronic records. Any refusal of a visitor by a nurse in charge should be brought to the attention of the multi-disciplinary team and discussed at the earliest opportunity with a record made in the patient notes.
- 4.5 It may be necessary for access to be refused on the basis of risk to other patients, visitors or colleagues and not exclusively on the potential impact on the patient for whom the visit is intended.

5 RESTRICTION OR EXCLUSION OF VISITORS

- 5.1 The decision to restrict visits, impose special arrangements or reasonable conditions, or stop a visit by a person whom the patient has requested to visit or agreed to see is regarded as a serious interference with the rights of a patient. Any restriction or exclusion should only be used in exceptional circumstances and should be implemented only after other means of dealing with the situation have been exhausted. Any decision to restrict or exclude a visitor must be fully documented within the patient electronic records and made available for independent scrutiny by the regulatory body. All means should be taken to overcome the issues. Restrictions and exclusions should never be blanket rules and must be risk assessed individually for each person. Wherever possible, 24-hour notice should be given of the decision to the patient and the visitor.
- 5.2 There are two principle grounds that may justify the restriction or exclusion of a visitor:
 - 5.2.1 **Clinical Grounds** - It can sometimes be the case that the patient's relationship with a relative, friend or supporter is anti-therapeutic (in the short or long term) and that progress or even deterioration in the patient's mental state is evident and can be reasonably anticipated if contact were not restricted. Very occasionally concern may centre primarily on the potential safety of a patient's visitor. The reasons for any discussion taken by the RC after full discussion with the patient's multi-disciplinary team should be clearly documented and an explanation given to the patient and visitor concerned both orally and in writing.
 - 5.2.2 **NB:** If the MDT and/or the RC/RMO conclude that it is not in the best interests of a patient to receive some visitors on clinical grounds, which may be viewed as a restrictive practice, consideration should be given to documenting this decision either by following the 'Best Interests Decision' process or by obtaining the patient's consent.
 - 5.2.3 **Security Grounds** - The behaviour of a visitor may be, or has in the past been, disruptive to the extent where restrictions, conditions or exclusion from the Hospital is necessary. Examples of such behaviour include:
 - (a) Incitement to abscond.
 - (b) Bringing banned items.
 - (c) Bringing potentially dangerous weapons.
 - (d) Unacceptable aggression.
 - (e) Unauthorised media access.
- 5.3 There may also be situations that occur when visitors have been restricted or excluded from previous hospitals due to clinical or security grounds. If such information is available on admission, from previous health records, then a decision should be made by the multi

disciplinary team whether the restriction or exclusion should remain until the visitor has met with the team.

- 5.4 Any decision to restrict or exclude a visitor on the grounds of behaviour should be fully documented in the patient's clinical record and an explanation given both orally and in writing. Where possible and appropriate the reason should also be communicated to the visitor concerned. Staff should be aware that a visitor has the right, under the Data Protection Act 1998, to submit a subject access request for any or all information the organisation holds about them, including the reasons for any restriction or exclusion. Personal information covered by a valid subject access request can only be withheld under the exemptions set out in the Data Protection Act 1998
- 5.5 Any decision taken to exclude visitors must be reported to the Hospital Director in writing at the earliest opportunity by the RC, RMO or Consultant. Hospital Directors should regularly monitor the exclusion of any visitors and ensure the reasons for excluding visitors is fully documented and available for independent scrutiny if required e.g. by regulators or if the patient wishes to make a complaint about the decision.
- 5.6 Some treatment programmes, such as the Addiction Treatment Programme, do place restrictions on visitors. Those patients engaged in such treatment programmes will have signed a "treatment contract" consenting to such an approach and any restriction on visitors will be individually care planned.
- 5.7 Sometimes visitors are restricted by external agencies such as local authorities. If a patient has this circumstance in place then all visitors must provide photographic identification such as driver's license or passport to check that they are who they say they are. Occasionally a patient who may have been groomed will sometimes help a perpetrator by stating they are someone else
- 5.8 There may be legal considerations influencing visits such as Restraining Orders, Non-Molestation Orders, Domestic Violence Protection Notice/Orders, Female Genital Mutilation Protection Orders or court agreed contact arrangements for children. There is an expectation that colleagues should be made aware of these by the service user on admission, or by the relevant agencies.
- 5.9 The decision to restrict or exclude visitors to informal patient who lack capacity to decide whether to remain in hospital could amount to or contribute to an unlawful deprivation of liberty or a breach in the individual's human rights. It may indicate that authority is required for the continued admission and arrangements e.g. via a Deprivation of Liberty authorisation, Court of Protection order or a Mental Health Act assessment may need to be considered.

6 VISITS BY CHILDREN

- 6.1 Contact for children with relatives, friends and community networks should be promoted. Arrangements for visits by children to adults in our services or where the child is an inpatient themselves must be considered against the requirement to protect the child's rights to private and family life, taking their wishes into account in the decision-making process. However, the importance of safety, containment and conditional security cannot be understated. Staff must ensure that safeguarding and child protection measures are in place. (Refer to OP06 Safeguarding Children (Anyone under the age of 18) and OP06.1 Child Protection (Scotland).
- 6.2 Where it is proposed for a child to visit a Hospital, where some patients may be registered sex offenders, arrangements must be in place in accordance with section 10 of OP06 Safeguarding Children (Anyone under the age of 18) and OP06.1 v01 Child Protection (Scotland).
- 6.3 Arrangements for visits by children are to be determined by the multi-disciplinary team and be flexible enough to ensure that swift decisions are taken. The following points must be considered when making those decisions:
 - (a) Encourage and facilitate contacts between children and adults that must be considered in the child's best interests.

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- (b) Provide thorough assessments for the minority of situations where there may be some concern and discuss with the local authority safeguarding team and follow MAPPA processes where appropriate.
 - (c) Place issues of child welfare at the heart of professional practice for all staff involved in the assessment, treatment and care of patients.
 - (d) Consulting with the patient, the child (depending on age and understanding), those with parental responsibility and, if different, the person with day to day care for the child, advocates and where relevant, the local authority's child safeguarding team.
 - (e) Address the whole process including pre-admission assessment, admission, care planning, discharge and after-care.
 - (f) Within this process, swiftly ascertain the desirability of contact between children and patients, efficiently identify concerns and assess any risks of harm to the child.
 - (g) Establish an efficient procedure for dealing with requests for child visiting in those few cases where concerns exist.
 - (h) Establish a process for the facilitation of child visiting, in appropriate circumstances which is not bureaucratic and is supportive of children and adults. The process should not cause delay in arranging contact and should maximise the therapeutic value of such contacts for both children and adults whilst ensuring the child's welfare is safeguarded.
 - (i) Provide a separate children's visiting room to safeguard from potential harm where indicated and only exceptional circumstances, such as in the instance of an escorted visit to someone who is end of life, are they to be permitted in a patient's bedroom.
 - (j) The need for staff supervision of the visit where risks are identified, as agreed by the multi-disciplinary team and site's Safeguarding Lead where appropriate.
 - (k) Set standards for the training needs of all staff in relation to the consideration, facilitation and supervision of child visiting.
 - (l) Any visits by children should be considered in the context of the child's best interests and the nature of the relationship with the patient. A child who is presented as accompanying an adult visitor and has no legitimate relationship with the patient should not be permitted.
- 6.4 Where compulsory admission is being considered the needs and arrangements for children should be considered by the Approved Mental Health Professional (AMHP) or Mental Health Officer (MHO) in the local authority team and communicated to the hospital.
- 6.5 The AMHP/MHO should provide the hospital with information about the views of other person(s) with parental responsibility for the children of the patient where this is appropriate to do so and where these can be ascertained. The Hospital should ensure facilities for all patients to have contact with their children in a venue which is conducive to the child's safety and good quality contact for both child and patient.
- 6.6 The nurse in charge of the hospital is to consult with other members of the multi-disciplinary team, taking into account the initial assessment before taking a decision as whether a visit by a child is appropriate. Children should have appropriate supervision according to their age and need when they are visiting mental health patients. They should normally be accompanied by someone who has parental responsibility for their care and well being.
- 6.7 Children should remain supervised at all times whilst on site. Where a separate room is not provided for the visit, away from other service users and aside from communal areas, it is important for the risk assessment to consider how visits are facilitated, where communal areas may be accessed, such as grounds and communal spaces and where other service users and visitors may be present. Children should be always be supervised when accessing lavatories away from other service users
- 6.8 Visits from children often result in increasing risks for Service Users, therefore Service User risk assessments should be updated in advance of visits by children, as recognised in H35 Clinical Risk Assessment. Taking into account the potential impact of the visit on the service user's mental health.
- 6.9 There may be occasions where a visit from a child may need to be terminated which should be undertaken swiftly and safely in the best interests of the child or young person and an opportunity for that child or young person to be given age appropriate feedback and discussion, as well as the parent or carer, should an incident arise. Information about the reason for

terminating the visit should be explained to children and young person in a way that they are able to understand.

7 REFERENCES

7.1 Legislation

- Children Act 1989
- Children (Scotland) Act 1995
- Mental Capacity Act 2005
- Mental Health Act 1983
- Mental Health (Care and Treatment) (Scotland) Act 2003

7.2 Guidance

- CQC (2015) Specialist Mental Health Services: Provider handbook
- DH (2015) Mental Health Act 1983: Code of Practice
- Report of the Children and Young People's Health Outcomes Forum (2012) Children and Young People's Health Outcomes Strategy
- Scottish Government. Getting it Right for Every Child (GIRFEC)
- Scottish Government (2017) Getting it right for every child (GIRFEC): Update
- Welsh Assembly Government (2016) Mental Health Act 1983 Code of Practice for Wales

8 EQUALITY IMPACT ASSESSMENT

8.1 How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?

Protected Characteristic (Equality Act 2010)	Impact Positive/ Negative/ None	Reason/ Evidence of Impact	Actions Taken (if impact assessed as Negative)
Age	None		
Disability	None		
Gender identity and expression	None		
Marriage or civil partnership	None		
Pregnancy or maternity	None		
Race	None		
Religion or beliefs	None		
Sex	None		
Sexual orientation	None		
Other, please state:	None		
EIA completed by:			
Name:	Stefanie Johnston, Policy and Audit Facilitator		
Role/ Job Title:			
Date completed:	29/08/2023		