HÔTEL-DIEU GRACE HEALTHCARE

ESTD 1888

HDGH PATIENT VISITATION PLAN

Phased approach to reintroduction of visitation

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Contents

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Tiered Patient and Family Visitation Protocol: Hôtel-Dieu Grace Healthcare (HDGH)

Rationale

Impacts of the COVID-19 pandemic have been felt across Windsor-Essex County. Health systems are under extraordinary pressure where robust infection control practices and policies are imperative. Hospital and clinical leaders are changing policy and practice almost daily in order to stay ahead of the curve, doing their best to protect their patients, healthcare workers, community, and environments from being exposed to and contracting the virus. While such policies are understandable, they can be difficult for patients, families, and caregivers, causing emotional distress because of the lack of ability to receive and provide support to loved ones while in hospital. Families and caregivers are essential to the physical, emotional, social, and spiritual wellbeing of our patients at HDGH. During these unprecedented times, the goal is to determine how they may remain partners in the care of their loved ones, while maintaining health and safety of all of our patients and our staff.

Background

On Wednesday March 11, 2020 the World Health Organization declared the coronavirus, COVID-19, an outbreak pandemic. Subsequently, the province of Ontario declared a state of emergency. The safety and security of our Windsor-Essex community, our patients, staff, and physicians at HDGH was identified as our top priority with many of our "normal" policies, procedures, and practices modified and/or changed to meet the safety priority. HDGH services some of Windsor Essex community's most vulnerable individuals and we take our responsibility to them all very seriously. This prompted us to quickly examine our family presence policies for appropriateness during the pandemic.

As a result, effective March 21, 2020, visitors were restricted to only patients who require end-of-life care. No children or youth under the age of 18 were allowed to visit patients. Post-mortem visitation was not permitted as HDGH follows the guidelines set out by the Office of Chief Coroner of Ontario regarding Expedited Death Response.

Realizing the void created by such significant restrictions, a Family Support Team (FST) was established, comprised of redeployed staff from closed or scaled down outpatient programs. The purpose of this team was to provide emotional support and companionship for our patients. The team facilitated communication with families and offered a supportive role in other duties as required in patient care. A detailed chronology of how HDGH responded to the visitor restrictions can be found in **Appendix A.**

Aligning with the province of Ontario's "*Framework for Reopening our Province*", a phased approach for reopening family and caregiver visitation will be employed. Determining when to reopen visitation will depend upon:

- Virus spread and containment in Windsor-Essex County and at HDGH
- Health system capacity in acute care, Long- Term-Care (LTC) and at HDGH
- Personal Protective Equipment (PPE) supply
- Staffing and Resources

(See **Appendix B**).

Ethical Considerations

In an era where patient centered care is valued and collaboration with people with lived experience is expected, the COVID-19 crisis presents significant tensions between patient and family-centered care, patient safety, provider safety, PPE supplies and infection control. In an effort to minimize and control the risk of COVID-19 cases, many hospitals have made significant changes to their 'open family presence' and 'visitor policies,' and the vast majority of organizations have instituted very restrictive or 'zero visiting' policies. Exceptions exist in some organizations for patients who are near end of life and women giving birth – both of whom are permitted one visitor (see Appendix D).

The rapid shift to highly restrictive policies is understandable given the nature of the COVID-19 crisis. However, such policies are very difficult for patients, families and caregivers, causing significant emotional distress, concerns for patient safety and the lack of ability to support loved ones while in hospital. Families and caregivers must remain partners in care, but that partnership may look different during these challenging circumstances.[1]

The evidence is clear that the presence and engagement of patients in their care, and partnership with family members and caregivers ('family' as designated by patients) improves patient experience, safety and outcomes.[2]

HDGH will take a careful, phased approach to relaxing visitor/family presence restrictions. The health and safety of our patients, our staff, and our community will continue to be our priority. We will carefully monitor each stage for two-to-four weeks, and will assess the evolution of the COVID-19 outbreak to determine if it is necessary to change course to maintain the safety of our patients and staff.

A working group was established which included HDGH leadership, ethics, and Patient Family Advisory Council (PFAC) representation. Operations Managers, Charge Nurses, Unit Based Council Chairs were surveyed for input in the creation of the tiered visitation protocol (Appendix C). Further consultation with public health was attained to ensure HDGH plan aligns with safe practice.

PHASE 1: PROTECT AND SUPPORT

This Phase ensures that first and foremost the safety of our patients and staff is paramount. Restrictions are very strict and closures are put in place quickly coinciding with provincial guidelines and state of emergency directives.

PHASE 2: RESTART

This Phase will take a careful staged approach to relax the visitation restrictions while ensuring safety for patients and staff as the main priority. Phase 2 will consist of 3 Stages that will be monitored and reevaluated prior to progressing to the next stage.

PHASE 3: RECOVER

This Phase will focus on determining what the new Family Presence Policy will look like at HDGH going forward.

Phase 1 (Protect and Support)

In this phase, the goal is to protect and support the staff, patients and families as well as the organization. This necessitates the highest degree of restriction related to individuals entering the organization at any given time.

Criteria to consider for phase:

Refer to Appendix B criteria to consider for all details of consideration. In this phase, the majority of direction is taken from the Provincial and Federal levels of government as a result of emergency orders or directives. This phase is the most restrictive phase and is meant to control access to the organization for maximal safety.

Visitation is restricted as follows:

Complex Medical Care (CMC)

- No visitors unless patients are within last days of life and are considered palliative.

Rehabilitation

- No visitors unless patients are within last days of life and are considered palliative.

Toldo Neurobehavioural Institute (TNI)

- No visitors unless patients are within last days of life and are considered palliative.

Palliative

- Visitors are restricted to only those patients who require end-of-life care (note: there are no exemptions). These patients are limited to **one (1)** visitor in a twenty-four (24) hour period. That visitor must adhere to the visitor restrictions listed below:
    - Visitor will answer screening questions at the main entrance prior to entering the facility (if screening failed then entry is denied)
    - No children under the age of 18
    - All visitors must wear a surgical mask
    - All visitors will be restricted to visitation in the patients room with no access to any common area

In an effort to support patients and families connectedness virtual patient (Technology supported) and courtyard visitation set up when possible.

Outpatient and In Home Programs

These programs where possible are delivered by virtual means with the goal of limiting the amount of face to face contact. On site outpatient visits are limited to only those that cannot be done virtually. Any on site visit must be as a result of an absolute and critical patient care need meaning there is the potential for significant negative impact to patient if the visit is post-poned or cancelled.

Phase 2 – Stage 1 (Restart)

In this phase, the goal is slow re-introduction of support to patients at HDGH. At this phase there are some select outpatient programs opening in a slow and measured approach as well.

Criteria to consider for phase:

Refer to Appendix B criteria for all details of consideration. In this phase, it is important to reintroduce care partnership as an essential component of the care delivery model for patients at HDGH. Along with the introduction of Designated Care Partners (DCP) to the organization as part of a Coordinated Care Program, there is expanded visitation for patients at end of life and allowing for outpatient designated care partners. In this phase the disease burden, PPE supply, and staff burdens are considered, along with any Ministry of Health/OnHealth/Public Health orders or directives. Some of the limiting factors include the number of people in the buildings at given times, the amount of additional PPE that the organization will need to supply and the ability of any and all training to be completed in advance of any visiting.

Coordinated Care Program

Definition: The Coordinated Care Program (CCP) is a program that enables trained Designated Care Partners (DCP) to provide specific aspects of the care plan to a patient within a defined period of time. Care that is being provided will be

documented by staff as being carried out by the DCP in the clinical record. The DCP will be instructed to perform the care that is being documented and will be accountable to the DCP contract.

Designated Care Partner

Definition: A **DCP** is any person that the patient and/or substitute decision-maker (SDM) identifies. The patient and DCP works with the health care team to define how they will be involved in care, care planning, and decision-making. In the absence of the patient's ability to assign a DCP, reference will be made to the Hierarchy of SDMs in the *Health Care Consent Act, s.21*.[3] A **DCP** is not an alternative to or synonymous with a patient visitor. Therefor not intended or designed to be in lieu of patient visitor policy or processes.

Patients who require **DCP** at HDGH have been identified as:

a. Those who are planning for discharge whereby a **DCP** is required for health teaching,
b. Patients who have language barriers; patients who are non-verbal; patients with cognitive, emotional and/or physical disabilities as these patients may have the inability to understand the pandemic and the reason why visitation is limited.

Guidelines: *(Adapted from BC Ministry of Health, Infection Prevention and Control for Novel Coronavirus (COVID-19), May 19, 2020)*

- In accordance with public health guidelines for COVID-19, care partners will continue to be restricted to coordinated visits only.
- HDGH staff will determine if a coordinated visit is necessary in collaboration with patients, HDGH patient advocate and/or SDM
- Coordinated visits can include, but are not limited to:
    - Visits for compassionate care, including critical illness, palliative care, and end of life
    - Visits paramount to the patient's physical care and mental well-being, including:
        - Assistance with feeding;
        - Assistance with mobility;
        - Assistance with personal care;
        - Communication assistance for persons with hearing, visual, speech, cognitive, intellectual or memory impairments;
        - Assistance by designated representatives for persons with disabilities, including provision of emotional support; and
        - Visits for supported decision making.
- The **Coordinated Care** policy will be posted on the HDGH Website
- Orders from the Provincial Health Officer or a Medical Health Officer take precedent over this policy
- **DCP**s will be screened for signs and symptoms of illness, including COVID-19, prior to every entry into hospital
- **DCP** with signs or symptoms of illness, as well as those in self-isolation or quarantine, shall not be granted entry
- **DCP** must be physically, cognitively, emotionally able to provide the care elements identified.
- Prior to participation in coordinated patient care, it will be mandatory for all **DCP**s to attend training and orientation to include:
    - Explanation of coordinated care policy in plain language
    - Infection control practice such as hand hygiene, respiratory etiquette and safe physical distancing,
    - Reasoning for minimal community participation
    - **DCP**s will provide care to their loved one only and care shall be provided according to the care plan for the patient.
    - **DCP**s shall not be permitted movement throughout the hospital
    - A designated washroom will be identified for **DCP**s on each unit.

- Instruction on how to put on and remove (don and doff) required PPE when performing care for patients who are on Droplet and Contact precautions. If the **DCP** is unable to adhere to appropriate precautions, they shall be excluded from participation as a **DCP**. The DCP will be required to wear the appropriate PPE to provide the care being delivered and will be instructed by staff on what is required.
- **DCP** shall go directly to the patient room, remain there during the visit and exit the facility directly afterward

- All **DCP**s will be required to wear picture identification for the duration of their time in hospital – this ID is not transferrable to other family members.
- DCP will be required to sign a contract that identifies the training that has been provided, attestation that the DCP will adhere to all the standards outlined in the contract. Violations of the contract may result in cancellation of the Coordinated Care Program for this **DCP** and patient.

Determination of Required Designated Care Partners

- In collaboration with the Inter-Professional care team, the number of required **DCP** will be determined for each unit (note: only 1 **DCP** per patient can be approved)
- The team will determine the maximum number of **DCP**s that will be permitted on a unit at a time (may vary from unit to unit)
- **DCP**s will be providing care within a 2 hour coordinated visit,
- A schedule will be developed to ensure fairness and equity among patients. This will be pre-communicated to the care partners by the care team. (Patients in Odd number rooms visit on Odd number days and vice versa).
- The need may arise to increase or decrease the program hours based on the system and organizational pressures related the health crisis. This will be communicated to DCP and patient as soon as possible in the event that the hospital needs to adjust.

Palliative Visitation

Visitation will continue to be restricted to only those patients who require end-of-life (palliative) care. These patients who are actively dying as defined by the clinical team may have **two (2)** visitors present at any given time. Visitors must adhere to the visitor restrictions listed below:

- Visitors will answer screening questions at the main entrance prior to entering the facility (if screening failed then entry is denied)
- No Children under the age of 18 (unless accompanied by an adult)
- All visitors must wear a surgical mask
- All visitors will be restricted to visitation in the patients room with no access to any common area

All patient Care Units

In an effort to support all patients and families connectedness virtual patient (Technology supported) and courtyard visitation set up when possible. Ensuring appropriate social distancing for courtyard visits.

Protocol for visiting palliative patient in <u>ENHANCED PRECAUTIONS</u>:

- Restricted to **one (1)** person per 24 hour period.
- Visitor will be required to wear all appropriate PPE (Gloves, Gown, Face shield, and Surgical mask).
- Visitor will be instructed by staff about appropriate PPE and Infection Prevention and Control (IPAC) standards to be observed during visiting as well as donning and doffing procedures.
- Visitation is reserved for patients in their last days and does not extend beyond the single approved visitor for the day.

For patients who do not require coordinated care or palliative visitation, virtual visitation is strongly encouraged and will be supported.

Outpatient Care Visits
At this point some outpatient programs have begun operating with face to face visits on campus.
Patients who require family member present for their care needs to be met will be allowed **one (1)** designated care partner. Given the episodic nature of outpatient services the DCP in these instances may change from visit to visit. The expectation is that the DCP attending the visit will adhere to all IPAC standards and follow all instruction given by staff. It is expected that only a small number of patients (e.g. Very frail/elderly, patient with dementia, person who is non-verbal or severely disabled) require a family member to be present for HDGH staff to provide care in these circumstances.

Phase 2 – Stage 2 (Restart)

Criteria to consider for phase:

Refer to Appendix B criteria for all details of consideration. Prior to moving to this phase the IMRT will ensure that there remains an appropriate amount of PPE supply, disease burden continues to remain stable or reduced in the community and the impact on staffing remains manageable. The staffing impact will be determined by polling staff and operations managers.

Visitation is restricted as follows:

- CMC, Rehabilitation, TNI
    - The coordinated care program will increase in volumes of **DCP**s allowable on site as well as the available hours for coordinated visits.
- Palliative Visitation remains unchanged from Phase 2 Stage 1.
- Outpatient considerations remain unchanged from Phase 2 Stage 1.

Phase 2 – Stage 3 (Restart)

Criteria to consider for phase:

Refer to Appendix B criteria to consider for all details of consideration. In this phase the organization remains in a stable and sustainable position as it relates to PPE supply, disease burden and staffing impacts.

- Outpatient programs will operate same as Phase 2 Stage 2.
- Coordinated Care Program and Palliative Care visitation continues to operate at the same level as Phase 2 Stage 2. Additional visitation is supported as identified below.
- **CMC, Rehabilitation, TNI**
    - Patients may have **one (1)** family member or visitor identified as their designated visitor. The designated visitor must be registered by the patient's clinical unit and will be required to show personal identification to confirm their identity at the hospital entrance. The hospital screener will confirm that they are the registered visitor for the patient. Given the need to limit the overall amount of people within the building and to ensure fair and equitable visitation the following must be adhered to:
    - Visitors will be identified by the patient or SDM and pre-approved
    - Visitation Scheduled in 2 hour blocks of time
    - Patients in odd number rooms will be allotted visitors on odd number days and patients in even number rooms will be allotted visits on even number days.
    - Visitors must wear a mask at all times
    - Visitors are only permitted to visit with the intended patient

- No use of common areas is permitted
- Visitors must adhere to strict IPAC guidelines and will be instructed by staff if there are any unique circumstances.

In the event that the registered visitor for the patient is also the DCP for the patient the two roles will necessitate separation. That is to say that the visitation block of time is not the same time that the DCP visit occurs.

Phase 3 (Recovery)

This phase is characterized by the development of a "new normal". Outpatient programs are operating at or near pre-crisis levels.

Criteria to consider for phase:

Refer to Appendix B criteria for all details of consideration. In this phase community and the organization will have stabilized to the "new normal". This will include a secure PPE supply, disease burden remains manageable and staffing impacts have been fully mitigated.

Ensuring the health and safety of our patients, our staff and our community will continue to be our priority as we transition to a "new normal". The current "Family Presence Policy" will be used as a guide to develop the Family Presence Policy of the future that incorporates an enhanced response to pandemic crisis.

APPENDIX A – Timeline of Events

HDGH's Visitor Restriction Response to COVID-19

The impacts of the COVID-19 outbreak have been felt across Ontario, by families, workers, businesses and communities and most directly our Healthcare organizations.

On January 24th the Minister ordered that the novel coronavirus is a reportable disease

January 27th HDGH started posting facts with regards to the Coronavirus

February 20th – HDGH attended an information session with WRH and Public Health on COVID-19

March 3rd- HDGH attended a Table Top exercise re COVID-19 with WRH, Erie Shores, LTC, EMS and community partners

March 5th: COVID-19 Information Session with Dr. Wajid Ahmed; Medical Officer of Health and Internal Pandemic Planning Committee meeting

March 12th: Dedicated Pandemic Phone line set up for patients, clients and families questions related to COVID-19

March 13th: Entry points to main campus limited to Tayfour entrance and Emara Entrances only and signage put in place. Visitor restrictions implemented, limiting to the hours between 8:00 am and 8:00pm. No visitors allowed under the age of 18 and palliative care patients allowed to have 2 visitors. Visitor restrictions reviewed on an individual case for compassionate grounds.

March 16th: Pandemic Planning Committee transitioned into our "Incident Management Response Team (IMRT)"

March 20th: A letter and a FAQ document was issued and delivered to patients and families through our Patient advocate, Operations managers and clinical teams discussing the need to follow Ministry and Public Health Guidelines to further restrict visitation.

March 21st: Visitors further restricted to only patients who require end of life care. These patients limited to ONE visitor at a time. No children or youth under the age of 18 are allowed to visit patients. There will be no other exemptions.

March 27th: 24 redeployed Social Workers from programs that have been suspended due to COVID received education and training and became our Family Support Team

April 24th: Scheduled supervised Courtyard Visits with patients and families and coordinated supervised outdoor access for our patients supported by our Family Support Team commenced.

April 27th: Patient Giving Cart initiated which offers patients refreshments, snacks, puzzles, and books and also provides them with any essential toiletries. Our Family Support Team also assists patients in obtaining any essential items, including clothing

APPENDIX B – Criteria to Consider - Determining When to Ease Family Visitation Restrictions

HDGH will utilize the following 4 Criteria outlined in the Ministry document when considering moving to the next stage or Phase in our Protocol. These will be evaluated at the 2 to 4 week timeframe and will identify one of the following actions:

- **REVERT to the previous Phase or Stage**
- **REMAIN at the same Phase or Stage**
- **PROGRESS to the next Phase or Stage**

4 CRITERIA TO CONSIDER

1

2

3

4

VIRUS SPREAD AND CONTAINMENT in Windsor Essex AND at HDGH	**HEALTH SYSTEM CAPACITY in acute care, LTC and at HDGH**	**PERSONAL PROTECTIVE EQUIPMENT SUPPLY**	**STAFFING AND RESOURCES**
• A consistent two–to-four week decrease in the number of new daily COVID-19 cases. • A decrease in the rate of cases that cannot be traced to a source. • A decrease in the number of new COVID-19 cases in Windsor-Essex.	Occupancy rates at WRH Ouellette and Met Campus Occupancy rates at Erie Shores Occupancy at HDGH Long Term Care and Retirement Home burdens of disease and outbreak status.	• PPE usage and supply • N95 masks • Surgical masks • Level 3 Masks • 3D Face Shields • Gloves • Alcohol sanitizers	Staffing: • Clinical Staff • Non-Clinical • Students • Family Support Team • Patient Support Team Other Resources

Another major factor that will continue to influence and guide our work as well will be any Ministry or Public Health Guidelines or Mandates.

Appendix C – FEEDBACK ON VISITATION

Consultation with Operations Managers, Charge Nurses and Unit Based Council Members

QUESTION ASKED	FEEDBACK THEMES
1. What are some patient needs that would help us determine our first phase of visitors? (Who are the patients that would most benefit from visitation?)	• The patient should determine the visitor • Patients who are non-verbal, cognitive disabilities, language barriers • Need to have clothing, belongings like toiletries, shoes, phones, chargers • Patients who need assistance with meals • Family involved in discharge planning, health teaching for skills required to take care of patient at home post discharge
2. What are some risk factors to consider?	• Medically unstable patients, patients who are immunocompromised, vented and trached patients • Families not following guidelines • Infection control guidelines, bed bugs • Asymptomatic visitors • PPE Supply
3. What are safeguards that we need to put in place?	• PPE and IPAC guidelines and education/training FAQ sheet for families/visitors • Screening of visitors • Visitation rooms or space • Case by case basis • Consistent and fair
4. Should there be a limit on number of visitors on your unit at a time?	• YES • 1 Visitor at a time • Children? • Limit the number on one unit at a time
5. Should there be a time limit or a certain time of during the day for these visits?	• YES • Need to be scheduled visits • Start slow and grow • Certain times during the day
6. Should there be a schedule regarding certain units having visitation on certain days?	• Afternoons and evenings (decide on 2 hour times slots) • Pick times that won't interfere with Rehab • Time limited first then open more • Case by case

TIERED VISITATION PROTOCOL WORKING GROUP:

HDGH Staff: Marg Campigotto, Nicole Crozier, Eleanor Groh, Kathy Quinlan, Lisa Raffoul, Francine Stadler, Shannon Tompkins

HDGH PFAC: Barb Masotti, Karl Straky

Appendix D – Memo Chief Medical Officer of Ontario on Visitation

..\CMOH_Memo_Hospital_Visitors_Acute_Settings_COVID-19_March_19_2020.pdf

Resources

[1] Drury, J. (April 2020), Family Caregivers as Essential Partners in Care: More than Just a Visitor, Canadian Foundation for Health Care Improvement, Retrieved from: https://www.cfhi-fcass.ca/NewsAndEvents/blog/blog-post/cfhi-blog/2020/04/17/family-caregivers-as-essential-partners-in-care-more-than-just-a-visitor

[2] Institute for Patient- and Family-Centered Care. (2015). Canadian Foundation for Healthcare Improvement On Call Webinars: Better Together Campaign: Spreading Family Presence Policies to Accelerate Healthcare Improvement. Retrieved from: http://www.cfhi-fcass.ca/WhatWeDo/on-call/better-together-part1

[3] Hotel-Dieu Grace Healthcare (2019), Family Presence & Visiting Policy.

A Framework for Reopening our Province; Ministry Document

Visitor restrictions during a public health emergency; Markwell, Hazel; Godkin, Dianne

Public health services 2019 novel coronavirus infection guidance document; Public Health

COVID-19 Guidance: Hospice Care; Ministry of Health