COVID-19: REINTRODUCTION OF VISITORS GUIDANCE

Hospital visitors are an important part of the healing process and care transitions planning for patients. They can help educate the care team, provide consistent communication and be an advocate for the patient. Having a visitor at the bedside ultimately eases the anxiety and fear of the patient and family and leads to a better healing environment.

Infection prevention and control practices that protect the well-being of patients and staff, while rationing personal protective equipment, necessitate restricting visitors during the coronavirus pandemic. Policies may vary from hospital to hospital depending on the spread of the disease in the community, region and state; the type of care provided and the conditions for which the patient is being treated; the patient population and subsequent risk factors; and adequacy of space, supplies, staff and testing capability.

Using the references and resources below, the Missouri Hospital Association encourages hospitals to critically review their current and future visitor policies to determine which phase is most appropriate.

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HOSPITAL VISITOR POLICY EVALUATION RECOMMENDATIONS

Recommended guidance for visitation of a confirmed COVID-19 patient is as follows. ***These recommendations do not change, regardless of the phase of COVID-19 spread within a community.***

a. Visitation to confirmed COVID-19 patient
   i. Manage visitor access and movement within the facility per CDC guidance. This may include limiting access and entry points.
   ii. Restrict room access to known or suspected patients; consider alternative mechanisms of communication via personal devices.
   iii. Consider the following if the patient situation necessitates visitors (end-of-life, medical decisions, cognitive disorders, etc.).
      1. Screen visitors for signs of disease/illness upon entry to facility.
      2. Direct visitors to wear their own facemask. If they do not have one, the hospital may provide a cloth (preferred) or regular facemask if supply is adequate.
      3. Educate visitors about the risk of COVID-19.
      4. Provide instruction on hand hygiene, limiting surfaces touched, disease transmission and use of PPE.
      5. Maintain a record of anyone entering or leaving the patient room (visitors, staff, etc.).
      6. Prohibit visitors during aerosol-generating procedures.
      7. Provide guidance on where visitors can go while in the facility. Limit access as necessary.
      8. Advise exposed visitors (those in contact with a COVID-19 patient prior to admission) to report any signs and symptoms of acute illness to their health care provider for a period of at least 14 days after last known exposure to the sick patient.
   iv. Allow each patient under the age of 18 to have as many as two adult caregivers designated as permitted visitors for the duration of their hospital stay.
   v. Direct all visitors to follow respiratory hygiene and cough etiquette precautions while in the common areas of the facility.

Recommended guidance for visitation of all other hospitalized patients based on the phase of COVID-19 spread is as follows.

I. **PHASE 1: COVID-19-positive cases in some facilities in the state**
   a. Visitation to all other hospitalized patients
      i. Restrict visitors.
      ii. Post passive blockade-signage and general marketing regarding self-limiting visitation with signs/symptoms of respiratory illness.

II. **PHASE 2: COVID-19 community onset (COVID-19-positive inpatients and known COVID-19 positive individuals in the community)**
   a. Visitation to all other hospitalized patients
      i. Restrict visitors.
      ii. Post passive blockade-signage and general marketing regarding self-limiting visitation with signs/symptoms of respiratory illness.
      iii. Begin imposing limited entry points for visitors to the building.
         1. Partner with security and marketing/communication to identify and maintain access points.

III. **PHASE 3: Widespread community onset as determined by the local health department**
   a. Visitation to all other hospitalized patients
      i. Utilize an active blockade of entry with screening for signs and symptoms per CDC guidance.
      ii. Mandate that visitors must be 18 or older unless they are a parent/guardian of a patient.

This document is adapted from the Ohio Hospital Association.

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FREQUENTLY ASKED QUESTIONS

When should a hospital decrease the criteria for visitors during COVID-19?

Unfortunately, there is no single indicator of when a hospital should increase the numbers of visitors and reasons for visitation during COVID-19. The term "after COVID-19" cannot be defined when we lack treatment, containment and immunization. We are in a perpetual state of COVID-19 response in health care. Hospitals must decide which patients could have visitors depending on the patient and visitor condition (end-of-life, cognitive disorders, medical decisions/conditions, etc.); adequacy of supplies, staff and testing; level of infection in the facility, community, region and state; and regulatory guidance. Hospitals should use the guidance on page 2, based upon the phase of community spread, in addition to other factors described here to determine their visitation readiness.

What kinds of visitors should be reintroduced first?

Generally, hospitals have tried to make accommodations for visitors with special circumstances, when patients are at end-of-life or have a cognitive disorder, as well as for pediatric, maternal and newborn patients. Hospitals only should accommodate these unique circumstances when the risk to patients and staff are minimized or the value to care exceeds the perceived cost. As testing is more readily available and the time for testing results is reduced, hospitals may be able to bring limited numbers of visitors back into the hospital environment. However, the reason for visitors likely will be ethically driven to ensure patients do not die without a loved one present or in circumstances of extreme anxiety in patients who cannot understand why they are in a hospital. Other specialized circumstances likely exist, including patients whose outcome may be poor after discharge if the caregiver is not present for discharge planning. As staffing capabilities stabilize, hospitals may consider alternative visitation modalities, which require a lot of resources but do not require the family to be physically present. Hospitals may provide notices and set families up on routine scheduled televisits. This could allow for visitation to be more routine and enhance the patient experience.

How will we keep patients, staff and visitors safe?

Hospitals always are committed to keeping patients, visitors and staff safe. In addition to monitoring indicators such as supplies, staffing, testing and spread, hospitals should continue to screen all visitors and staff for signs of infection, and to communicate with patients, visitors and staff about current policies and procedures. Educating visitors on safe practices cannot be over emphasized.

What should we communicate to patients, visitors and staff?

Simply stated, everything. Communication should occur in a variety of ways (verbal, written, physical, etc.) and in a way that is easily understood (multiple languages, using visual cues, eliminating barriers, etc.). Hospitals will want to provide education in a way that communicates they have the time and interest to ensure visitors' safety. This helps convey a message to the family and caregiver that the hospital also is providing the resources needed to adequately address the needs of the patient during this time when families may not be at the bedside.

Hospitals will want to consider communicating several topics, including but not limited to the following.

- the current visitation policy and reason behind it
- information on patient safety and supporting their personal needs
- how to communicate with caregivers
- what to do if there is an emergency and they need to contact the patient
- proper handwashing techniques
- expectations while in the hospital
- how discharge planning will occur to prevent rehospitalization
- use of facemasks
- who to contact with questions regarding visitation practices
- how to access to the hospital/clinics

At minimum, what screening processes should be in place?

The CDC recommends screening for fever and COVID-19 symptoms upon entry to the facility. If fever or COVID-19 symptoms are present, the visitor should not be allowed entry into the facility.

Where are COVID-19 educational resources available?

The CDC offers education related to COVID-19. Additionally, MHA publishes information on a daily basis to its COVID-19 web page, including a visitor toolkit to aid hospitals.

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FREQUENTLY ASKED QUESTIONS — CONTINUED

Are visits to those with suspected or confirmed COVID-19 treated differently than visits to patients without suspected or confirmed COVID-19?

Not really. We cannot tell from symptoms alone if someone has the illness or not. All hospital visits should be in accordance with current hospital COVID-19-related safety practices which include the following.

- Screen all patients and visitors who enter the facility.
- Evaluate the risk to the visitor's health (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and the ability to comply with precautions. Ensure there is information readily available and provided on how the disease spreads and who may be most impacted by the illness.
- Evaluate the risk to the health of other patients. In facilities that are unable to adequately separate patients who have known or suspected COVID-19, visitation restrictions may not progress on the same timeline as a facility that is adequately able to separate by illness.
- Provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- Prohibit visitors during aerosol-generating procedures.
- Limit visitors to the patient room. Visitors should not go to other locations in the facility.

Where should visitor policies be posted?

Post visual alerts at the entrance of facilities and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide instructions (in appropriate languages) about hand and respiratory hygiene, and cough etiquette. Instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene.

Do patients and visitors need to wear masks?

Patients and visitors should, ideally, be wearing their own cloth face covering upon arrival to the facility. If not, they should be offered a facemask or cloth face covering as supplies allow, which should be worn while they are in the facility (if tolerated). They also should be instructed that if they must touch or adjust their cloth face covering, they should perform hand hygiene immediately before and after. Facemasks and cloth face coverings should not be placed on young children under age two; anyone who has trouble breathing; or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance. Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation and isolation of individuals who report symptoms still should occur.

What types of procedures are considered aerosol-generating procedures?

Some procedures performed on patients are more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking or breathing. These aerosol-generating procedures potentially put health care personnel and others at an increased risk for pathogen exposure and infection. Development of a comprehensive list of AGPs for health care settings has not been possible due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining if reported transmissions during AGPs are due to aerosols or other exposures. There is neither expert consensus nor sufficient supporting data to create a definitive and comprehensive list of AGPs for health care settings.

- Commonly performed medical procedures that often are considered AGPs, or that create uncontrolled respiratory secretions, include the following.
  - open suctioning of airways
  - sputum induction
  - cardiopulmonary resuscitation
  - endotracheal intubation and extubation
  - noninvasive ventilation (e.g., BiPAP, CPAP)
  - bronchoscopy
  - manual ventilation

Based on limited available data, it is uncertain whether aerosols generated from some procedures may be infectious, such as nebulizer administration* and high flow O2 delivery.

**Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected patients.*

Reference: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html

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SAMPLE HOSPITAL SCRIPTING

Scripting for screening visitors/patients at the door:

"Hi, I'm (name). Welcome to (hospital). To keep our patients, visitors and staff safe, we are screening all individuals to identify any respiratory illness. Before entering the building, I need to ask you some screening questions.

- Do you have a fever of 100.4 or greater?
- Have you been in contact with someone with known or suspected COVID-19?

Scripting for screener to defer visiting:

Our hospital continuously monitors our visitor policies to ensure that the well-being of our patients, visitors and staff is a priority. Because you have (a fever, a cough), OR Because widespread community COVID-19 onset has been identified, we ask that you not visit inside the hospital until you are feeling well OR until community onset has slowed. We appreciate your understanding while we make every effort to minimize the threat of any infectious diseases to our patients and staff.

Scripting for patients to wear a mask:

Because you have (a fever, a cough, traveled to a high-risk area), we want to keep you and others safe. Please wear a mask while inside the building, including in common areas and while around caregivers to prevent the spread of germs.

Placing patient into isolation and why we are wearing PPE:

Because you have (reason), we would like to do some additional screening. In the meantime, you will need to continue wearing this mask to help prevent the spread of germs. You may see staff wearing a gown and mask in addition to gloves. These additional steps are being taken to keep our patients safe, so please don't be alarmed.

Additional circumstances and talking points for problematic scenarios:

Yelling/demanding entrance/refusal to wear PPE – If patients and visitors become escalated due to wait times or are frustrated by the idea of wearing a mask, consider the HEAT approach.

- H – Hear them out. Allow them to share their concerns without interrupting.
- E – Empathize. Validate their emotions.
- A – Apologize. Apologize for the situation saying, "I'm sorry for these extra questions. Our goal is to keep everyone safe."
- T – Take action. If the patient should not enter the building, escalate accordingly to the house supervisor or senior leadership.

This document is adapted from the Tennessee Hospital Association.

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CMS RECOMMENDATIONS FOR HOSPITAL VISITOR RESTRICTIONS

Updated based on CDC guidance date 5/18/20

To mitigate the spread of COVID-19, the Centers for Medicare & Medicaid Services provided guidance to restrict visitation in health care facilities, including hospitals, critical access hospitals, psychiatric hospitals, inpatient hospice units and intermediate care facilities for individuals with developmental disabilities. For CMS restrictions on visitation in nursing homes, see QSO-20-14.

CMS provides the following expanded guidance to prevent the spread of COVID-19.

a) Visitors should receive the same screening as patients, including whether they have had the following.
- fever > 100.4
- contact with someone with known or suspected COVID-19.

*While CMS guidance for hospitals has not changed since the QSO-20-14 publication, the CDC recommends screening all patients about the presence of fever, symptoms of COVID-19 or contact with patients with possible COVID-19.

b) Health care facilities should set limitations on visitation, which may include restricting the number of visitors per patient, limiting visitors to only those that aid the patient or limiting visitors under a certain age.

c) Health care facilities should provide signage at entrances for screening individuals, provide temperature checks/ask about fever, and encourage frequent hand washing and use of hand sanitizer before entering the facility, and before and after entering patient rooms.

d) If visiting and not seeking medical treatment themselves, individuals with fevers, cough, sore throat, body aches or runny nose – or those not following infection control guidance – should be restricted from entry.

e) Facilities should screen and limit visitors for any recent trips (within the last 30 days) on cruise ships or overseas travel from certain countries.

f) Facilities should instruct visitors to limit their movement within the facility (e.g., reduce walking the halls, trips to cafeteria, etc.).

g) Facilities should establish limited entry points for all visitors and/or establish alternative sites for screening prior to entry.

h) Facilities can implement measures to:
- increase communication with families (phone, facetime, skype, etc.).
- offer a hotline with a recording that is updated at set times so families can get an update on the facility's general status.
- if appropriate, consider offering telephonic screening of recent travel and wellness prior to coming in for scheduled appointments, which may help limit the amount of visitor movement throughout the organization and congestion at entry points.

i) Consider closing common visiting areas and encouraging patients to visit with loved ones in their patient rooms.

Resources:
- CMS QSO 20-13-Hospitals Guidance for Infection Control and Prevention Concerning Coronavirus Disease
- CDC for Healthcare Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC for Monitoring Healthcare Personnel: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html
- Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
- https://www.vhca.org/ les/2020/03/Protocol-1_Active-Screening-Process-for-COVID%E2%80%9019-for-Visitors-and-Employees.pdf
- CMS QSO 20-20-ALL (March 20, 2020)

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COVID-19 STAFF AND VISITOR SCREENING GUIDELINES

Screening Hospital Staff

- Hospitals should have plans for monitoring health care personnel with exposure to patients with known or suspected COVID-19. The same screening performed for visitors and initial patient contact can be performed with hospital staff. Hospitals should consider screening staff at the beginning of every work shift for:
    - o Fever >100.0 HCP.
    - o Other symptoms such as cough, sore throat, muscle aches, shortness of breath, fatigue, nausea/vomiting, diarrhea, headache.
    - o Contact with someone with laboratory confirmed or suspected COVID-19.
- Implement a standard screening process and form to be used for all patients, visitors or staff presenting to the hospital to determine COVID-19 risk.
- Hospitals should follow CMS and CDC Interim Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19).
- Encourage sick employees to stay home. Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. Ensure that your sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Screening Hospital Visitors

- Hospitals should identify visitors and patients at risk for having COVID-19 infection before, or immediately upon, arrival to the facility. Patients and visitors should be screened for the following:
    - o Fever >100.4 visitor/patient.
    - o Other symptoms such as cough, sore throat, muscle aches, shortness of breath, fatigue, nausea/vomiting, diarrhea, headache.
    - o Contact with someone with laboratory confirmed or suspected COVID-19.
- Visitors should clean hands with sanitizer or soap and water upon entry/exit from hospital, patient care unit and patient room. Visitors may wear badge or label indicating that they have been approved for the visit or carry a completed screening tool with them.

Tips and Information

- Implement a standard screening process and form to be used for all patients, visitors or staff.
- Station hospital personnel at the entrances to the hospital to conduct an initial screen prior to facility entrance. The hospital can limit entrance options into the hospital.
- All screeners at entrances should wear level 1 masks.
- A cloth mask (preferred) or facemask should be provided to patients and visitors, according to CDC recommendations. Do not allow entry for a visitor that refuses to don a mask or follow hospital policies and procedures.
- Medicare regulations require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restrictions or limitations that the hospital may need to place on such rights and the reason for the clinical restriction or limitation. The hospital should consider making the policy a part of their emergency preparedness plan.
- Medicare has waived the requirement to have visitor policies and procedures related to COVID-19 during the emergency response. Hospitals will want a mechanism for communicating current hospital position on screening.

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