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**CHILD VISITING POLICY**

(Replaces Policy TP/CL/007 V.1)

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**Content**

|  |  |
| --- | --- |
|  | **Page** |
| **1.0 Purpose of policy** | **3** |
| **2.0 Definitions** | **3** |
| **3.0 Principles of good practice** | **4** |
| **4.0 Duties** | **4** |
| **5.0 Procedures on admission** | **5** |
| **6.0 Considering the best interest of the child** | **6** |
| **7.0 Parent consent/ Looked After Children** | **7** |
| **8.0 The visit** | **7** |
| **9.0 Terminating a visit** | **8** |
| **10.0 Leave from inpatient care including Section 17 MHA (1983) leave** | **8** |
| **11.0 Arrangements for discharge from inpatient care** | **9** |
| **12. Development, consultation and ratification** | **10** |
| **13.0 Equality and Human Rights Impact Assessment (EHRIA)** | **10** |
| **14.0 Compliancy Monitoring** | **10** |
| **15.0 Dissemination and Implementation of policy** | **10** |
| **16.0 Document Control including Archiving Arrangements** | **11** |
| **17.0 Cross-reference** | **11** |

1. **Purpose of policy**

Separating children from their parents during the course of a parent’s hospital admission can be a challenging experience for all involved. It is also important to consider parents / carer’s and siblings when children are admitted to our children and young people’s inpatient facility. Continuity of the child-parent relationship is important when a parent is admitted to hospital. Every effort to maintain contact should be made, provided this is in the young person’s best interests.

All hospitals are required to have written policies and procedures regarding the arrangements for children and young people who visit adults, or other children, in hospital. Policies should ensure that the best interest and safety of the children and young people are always considered, and detail how consideration is made of whether visits are in their best interests.

Environments that are friendly to children and young people should be provided. The Trust is committed to welcoming children and young people and to facilitating the visits of children to relatives who are inpatients.

This policy has been developed by Sussex Partnership NHS Foundation Trust (the Trust) and must be read in conjunction with the Trust and Safeguarding Children Partnership (formerly Local Safeguarding Children Boards) online Child Protection and Safeguarding Policies. Changes will be made to this guidance in accordance with national and local updates.

The 2015 revised Mental Health Act Code of Practice states “Article 8 of the

European Convention on Human Rights protects the right to a family life. In particular, every effort should be made to support parents to support their children.”

The scope of this policy applies to all inpatients of Sussex Partnership Foundation Trust.

Visits to the Trust’s forensic sites must use this policy in conjunction with local children’s visiting policy and arrangements.

1. **Definitions**

A child is defined as being under 18 years of age (The Children Act 1989/2004).

Where a child is ‘Looked After’ by the local authority children’s service, this

refers to children who are ‘accommodated’ or are subject to a care order arising

from family court proceeding. In the case of a care order, parental responsibility

is shared by the local authority and the parent with parental responsibility, while

If the child is ‘accommodated under Section 20’, parental responsibility remains

with the parents.

1. **Principles of good practice**

Safeguarding Children is Everyone’s business. The best interest of the child is at the heart of professional practice for all staff involved in the assessment, treatment and care of service users. It is also important to take account of the needs and wishes of children, as well as service users.

The Trust should establish a process for the facilitation of children visiting in appropriate circumstances, which is supportive of children and adults, which does not cause delay in arranging contact and which maximises the therapeutic value of such contacts for both children and adults whilst ensuring the child’s welfare is safeguarded.

Visits may be refused or terminated should the welfare or wellbeing of a child be at risk. The decision to initiate a child visit to hospital should be reviewed by the MDT or Nurse in Charge before each occasion.

* 1. **Duties**
* Policy Sponsorwill ensure an up to date, fit for purpose policy is in place
* Lead for Safeguarding children will oversee implementation and adherence to policy
* Safeguarding Children named and deputy named nurses will ensure Safeguarding training is in place and made available for all staff
* Matrons, lead nurses and ward managers, will ensure that provision for child-visiting is identified in each individual inpatient/residential facility. That the environment is warm, clean, well equipped, and allows sufficient privacy away from the main ward environment. This should include basic things such as somewhere comfortable to sit, a safe space to play on the floor, books, washable toys and drawing materials. The room should be free of hazards
* All Service leads will ensure that local information about child visiting arrangements for service users and their relatives is easily accessible for staff and patients, and is given to patients and carers at the earliest opportunity

**5.0 Procedures on admission**

In all cases, regardless of whether the service user is subject to the Mental Health Act, a decision needs to be reached as to whether it is the best interest of the child, for a visit to take place. Where possible this decision should be reached by the MDT. Where the child is the focus of the parent’s symptoms of mental illness, or the patient has expressed thoughts of harming the child, the decision regarding the any contact between the patient and children MUST be made by the Consultant Psychiatrist. The decision should be made in advance of a visit occurring, and recorded in the patients electronic notes.

Where there is already an allocated Social Worker, liaison should always take place in relation to child visits. Where possible parents and carers should be supported to give the child age appropriate information regarding whey their parent is in hospital or in the case of a sibling being admitted to Chalkhill.

When a service user is admitted, the admitting nurse and doctor must seek to obtain as much information as possible from the service user and/or significant others to establish if there are any children who may visit the service user. This information must form part of the initial care plan and must be recorded on carenotes at the first assessment.

A service user wishing to receive visits from a child will be asked to provide the following information:

* Full name of the child
* Date of birth of the child
* Gender of the child
* Address of the child
* Identity of those with parental responsibility
* Name, address and telephone number of the parent/guardian currently caring for the child
* Any additional needs of the child

**Any decision to agree a visit must be based on two considerations:**

* The welfare and best interest of the child
* The needs of the service user

**The welfare and needs of the child are paramount (Children Act 1989) and therefore will take precedence over those of the service user.** The decision to allow visits must be regularly reviewed by the multidisciplinary team.

**6.0 Considering the best interest of the child**

The decision not to facilitate a visit should be explained to the service user by a senior staff member with clear evidence of concerns, where possible with the support of those responsible for caring for the service users children.

When considering if a visit is in the best interest of the child, the team need to consider the wishes and needs of the child, remembering the following may override them:

* The age and overall emotional needs of the child
* The services users current mental state (which may differ from an assessment made immediately prior to or after admission)
* The service user’s ability to respond appropriately to the child for the duration of the visit (staff may be able to support this)
* The response by the child to the service user or his/her mental illness
* The views of those with parental responsibility

**NB For children aged 16 and over, it must be assumed they have capacity to make their own decisions and unless it is demonstrated that they lack capacity, their views on visiting must be given due weight.**

The service user must be informed when the decision to delay, postpone or refuse a visit will be reviewed. The service user, or another with parental responsibility, should be informed how to make representations to the MDT against any decision not to allow a visit and informed of the Trust PALS service and the Trust’s complaints processes.

Occasionally decisions need to change arrangements need be made in the absence of the wider MDT – typically out of standard working hours. On such occasions senior nurses and the RC will make the decision about visiting. This includes any decision to change the existing visiting arrangements e.g. refusing a visit when the MDT have already agreed to it.

This is most likely when a service user’s mental health has deteriorated, or the unpredictability of the clinical environment has changed, meaning there are insufficient resources available to accommodate the visit.

Those caring for the child should be kept fully informed of any decisions, and informed of the next possible opportunity to review when the visit can go ahead.

When making decisions, concerns may include the service user’s history (e.g. convictions/offences which identify the service user as presenting a risk, or potential risk, to children, or a history of current child abuse or neglect); the service user’s current mental state e.g., overtly hostile, delusions involving the child; the response by the child to the service user and the service user’s illness; the age, emotional needs, wishes and feelings of the child; the views of those with parental responsibility.

Reaching a conclusion about whether a visit is in the child’s best interest is a judgment arrived at by balancing the needs and emotional experience of the child with the needs and emotional experience of the service user, alongside any concerns or risk. Advice to help balance the complexities can be sought from the SPFT safeguarding team. On some occasions the MDT may decide it needs an additional specialist assessment of the child’s best interest to make the decision. In this situation a referral should be made to the relevant Children’s Services.

**7.0 Parental consent/Looked After Children**

In certain situations children’s social care services will need to be involved in the decision as to whether a visit is appropriate. This will arise where the child has an allocated social worker; is ‘Looked After’ by the local authority; is subject to a child protection plan; or, when the ward or unit staff have serious concerns for the welfare of the child. Discussion must take place with the social worker to agree the appropriateness of the visit and to identify the most appropriate adult to accompany the child.

Where a child is looked after by a local authority but is not subject to a care order, the person with parental responsibility is required to give their consent. In the case of a child who is subject to a care order (meaning parental responsibility is shared by the local authority and the parent(s) also holding parental responsibility), the consent of the responsible social services (children’s services) department must be obtained. They must however consult with any others who hold parental responsibility before making their decision.

In the case of a child living with someone who does not have parental responsibility (e.g. the child lives with a grandparent), contact should be made with the person with day-to-day care for the child explaining that a request for a visit has been made and the person with parental responsibility will be contacted.

If the person(s) with parental responsibility respond by stating that they do not agree to the child visiting the service user, the request for the visit must be declined if the child is under 16, but it should be regularly reviewed.

**8.0 The Visit**

* The visit must take place away from the main ward clinical environment, in a designated area. The child must be accompanied at all times by a responsible adult (18+) e.g. parent, grandparent, legal guardian, social worker or designated carer
* Ratio of staff to children must be considered, taking into account the children’s ages and potential needs, for example 1:2 staff child ratio.
* Visits must be pre-arranged to ensure the best interest assessment has been carried out and arrangements can be put in place to facilitate the visit
* A responsible adult must accompany the child throughout the visit. When the visit commences the identity of the responsible adult and their relationship to the child should be clarified and recorded in the health record on Carenotes
* Planned visits should be at times convenient for the child (e.g., after school) and when sufficient staff are available
* The child must not be allowed to wander around other areas or be left unsupervised. The responsible adult has responsibility for the child’s welfare and the child’s behaviour
* The multidisciplinary team will decide in advance the level of supervision required depending on the assessed level of need
* The room should be prepared in advance of the visit with age appropriate toys and equipment set out
* Prior to the visit taking place the facilitator should discuss the visit with the service user and prepare them for the visit.
* Reception staff and facilitators should be welcoming, introduce themselves to and talk to the child
* If a unit does not have a suitable child friendly environment then the visit will need to take place off site given all relevant considerations
* If a suitable child friendly environment cannot be found then the visit must be postponed
* Units may have specific care plans or guidelines related to the area of practice such as Forensic Healthcare which should always be considered for any visit
* **Chalkhill** our inpatient facility for children and young people, visits are welcomed from families and siblings. All visits are planned for on an individual basis, considering the needs of the young person, their siblings, and involving the parents and carers in this planning. There are a variety of areas that can be used within the unit and off site, and as a designated CYP unit, all areas are suitable for visits environmentally, and if this visit includes other children, a space away from the main ward area can be used in line with the needs of the unit at the time. Should the acuity of the ward be such that a visit could not occur safely, the needs of the siblings would be considered in this decision and alternative arrangements made. This may include an escorted or unescorted off-site visit, or the visit being postponed. This decision would be made on the advice of the nurse in charge in conjunction with the parents/carers. The nursing staff retain the responsibility for allowing, postponing or terminating a visit at any time in line with changing demands to maintain safety.

**9.0 Terminating a visit**

* Where a child is placed in immediate danger either from the service user or accompanying carer the police should be called and a referral to Children’s Social Care completed.
* The decision to terminate a visit may be taken as an immediate action to protect a child, from suffering harm or experiencing high levels of distress. The decision may also be taken where a child themselves expresses a wish to end the visit
* An explanation for the reasons behind the termination of any visit should be given to the service user, relatives and carers. If appropriate this decision will be reviewed and future visiting resumed if this is in the best interests of the child. The Consultant Psychiatrist responsible for the service user’s care will be informed of the decision and the subsequent review of future visits

**10.0 Leave from inpatient care -including Section 17 MHA (1983) leave**

Before making leave arrangements, the clinical team including RC must ensure:

* That any risks to the well-being of the child/children have been fully explored and documented and that suitable management arrangements will be put in place before the period of leave commences. This applies to leave for all patients who will have contact with children during their leave i.e. parents, other family members such as grandparents, and other adults
* Where risks to the child have been identified a referral to children’s social care services has been considered and documented
* That there has been a discussion with the child/children’s temporary carer to ensure that they understand: whether symptoms impact on parenting capacity, whether any potential risks are perceived if parental contact is unsupervised, that they understand the need for the safe storage of any medication that is being dispensed
* That liaison and co-ordination has occurred with all relevant agencies, for example, GP, Health Visitor, School Nurse, Social Worker If necessary a referral to Children’s Social Care should be made as soon as possible after admission
* That consideration has been given to the need for additional support or practical help for the family during the leave period from relatives or others
* That when children’s social care is involved with the family, they are aware of the leave, if there are any risks identified ~~and~~ any risk management or support plans
* The primary nurse or shift coordinator must ensure that any leave and aftercare arrangements are documented in the care plan and that both the service user and carer have copies of this
* The primary nurse should ensure that the child/children’s alternative/temporary carer provides feedback to the clinical team regarding the effect of the leave on the family, child or children

**11.0 Arrangements for discharge from inpatient care**

Prior to discharge, the RC, the primary nurse and care coordinator must ensure that the service user’s Care Programme Approach (CPA) care plan contains a plan to manage any risks or additional needs related to the welfare or care of the child/children resulting from the service user’s mental health problems, and that relevant information has been provided to the GP, Health Visitor, any Social Worker with responsibility for child/children’s welfare, or School Nurse, where appropriate.

Relevant carer(s) within the family system should be invited to discharge planning meetings and informed of their entitlement to have their own needs as carers assessed.

The patient’s CPA care plan and discharge summary must identify help that the service user may need at home in resuming parental responsibilities, such as ensuring that the child/children’s routine, for example attending a nursery or school, is maintained. Roles and responsibilities of all workers and agencies involved must be agreed and identified on the CPA care plan, addressing the needs of the child/children and the service user.

Where culture or faiths preclude visits to an inpatient unit, alternative arrangements which both give due consideration to risk and the welfare of the child, should be considered.

**12.0 Development, consultation and ratification**

All inpatient facilities were consulted with. Staff, service users, carers and partner agencies were consulted as appropriate. The reviewed document was circulated widely, including to the Safeguarding Named Nurses, Senior MHA team, Clinical Directors, Operational General Managers, Director Social Work and the Safeguarding Children Partnerships.

This document is ratified by the Professional Practice Forum.

**13.0 Equality and Human Rights Impact Assessment (EHRIA**)

An EHRIA has been completed and the policy amended accordingly.

**Cultural and equality considerations**

* The MHA should not adversely and disproportionately impact on different racial or ethnic groups, gender, gender identity, disability, sexual orientation, religion/belief or age
* Staff must be aware of their responsibilities and of the need to ensure that the provisions of the MHA are implemented fairly and equitably
* Interpreters must be made available where necessary and must be suitably qualified and experienced. Information should be made available in other languages and alternative formats for disabled people where relevant
* Decisions relating to the appointment of an Independent Mental Health Advocate (IMHA) or representative should take into account the cultural, national, racial or ethnic background of the relevant person
* An equality impact assessment is attached to this policy

**14.0 Compliancy Monitoring**

As part of the policy review the policy sponsor and author will ensure, through consultation, the correct roles and responsibilities for staff and forums / committees are identified within this document and associated procedures.

**15.0 Dissemination and Implementation of policy**

The policy will be posted on the Sussex Partnership NHS Foundation Trust intranet and staff notified through the weekly bulletins.

**16.0 Document Control including Archiving Arrangements**

This policy and protocol will be stored and archived in accordance with the Organisation wide policy for the development and management of procedural documents.

**17.0 Cross-reference**

SCP Sussex Child Protection and Safeguarding Procedures

Visitor’s policy

Compulsory Training Policy

Trust Induction Policy

CPA Policy

Toy policy