Appendix 5

ARRANGEMENTS FOR CHILD VISITS TO IN PATIENTS AND COMMUNITY SERVICES.

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Associated Documents

Trust Safeguarding Children Policy 2014

Introduction

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Purpose

2.1 This addendum concerns children and young people, up to 18 years, visiting any inpatient (adult or adolescent) setting or community service.

The Trust as a public service is fully supportive of the Think Family Ethos. As a system that aims to 'think family', the Trust endeavours to ensure that both adult and children's services join up around the needs of the family (HMSO publication 2008).

The Trust supports helpful and positive contact between children/young people and their parents/ carers who are Trust patients. However this must only occur if it is in the best interest of the child. The Trust will always aim to ensure that the needs of the child remain paramount.

2.2 In some cases there will be some concern about child visiting an in-patient service or attendance at a community service going ahead. Decision-making on these cases needs to be clear and consistent.

2.3 When a decision is made not to allow contact the reasons should be given. This should be clearly documented. If the parent/carer and other interested parties are unhappy with this decision, they can complain utilising the Trust Complaints procedure.

2.4 If there were concerns that the mental state and behaviour of the patient were likely to have a significant impact on the well-being of the child, then the visit would not be allowed. In these circumstances, other forms of contact such as telephone, letter or email, could be considered.

Section 3

Scope of this addendum

3.1 Targeted Audience

This addendum is directed at all Clinical staff.

3.2 Targeted Patient/Client/User Group

All service users using SLAM services.

This policy concerns children and young people visiting any inpatient (adult or adolescent) setting or attendance at any community setting. It can be used in conjunction with any local protocol that may be in existence in specific clinical academic groups.

Section 4

Background

4.1 This addendum is written within the guidance of the Revised Code of Practice on the Mental Health Act 1983, the Children Act 1989, Working Together to Safeguarding Children 2015 and also article 8 of the Human Rights Act 1998. New references

4.2 This policy should also be read in conjunction with the SLaM policy.

Section 5

Course of Action Required

5.1 General Protocol

5.2 The impact of mental health on parenting and on children should be assessed, both in the community and as part of the admission process and documented on the **Child Need and Risk Form** under the Patient Journey Risk tab.

Section 6

6.1 Inpatient Visiting

6.1.1 At the earliest opportunity, following admission, the multidisciplinary team should give consideration to the implications of child visiting, and a plan should be formulated and documented in the **Child Need and Risk Form** on ePJS by a member of the patient's care team. This plan should follow discussion with the person that has parental responsibility and/or anybody else who is currently facilitating the care of the child. Please note that this may be a range of different individuals, for example another parent, other carer or social worker . Children should be asked about their wishes and feelings, according to their age and understanding. Particular consideration should be given to the vulnerability of babies and non-verbal children who cannot express their wishes.

ALL child visits should be pre-arranged.

6.1.2 Considerations should include impact on the child, (e.g. adult aggressive, impulsive, frightening, causing distress to child, being withdrawn, over-intrusive), the views of the child, ward atmosphere, frequency and duration of the visit.

6.1.3 Normally a responsible adult will accompany children on these visits.

Young people below the age of 18 years in most cases should be accompanied by an adult.

6.1.4 Visits should be in an area which is child safe and not accessible to any other service users. Children should be accompanied at all times when on the unit, by a responsible adult.

6.1.5 A staff member should be allocated to facilitate the visit.

6.2 Decisions to deny Visits

6.2.1 Decisions to deny visiting will always be based on the child's best interest. It will depend on the adult's mental state, the child's wishes/needs and/or other factors on the ward including the general level of anxiety/disturbance that could compromise the safety or welfare of the child.

6.2.2 In certain circumstances, e.g. an acute change in the level of disturbance on the unit, the child visiting plan may need to be overruled. The decision will be the responsibility of the nurse-in–charge of the unit at that time.

When there is a decision to deny visits the reason for this should be documented.

Contact cannot ever be forced.

6.2.3 If a complaint is raised as a consequence of denial of a child visit, the Trust's existing complaints procedure could be used for this purpose. In the first instance local resolution should be aimed for.

6.2.4 Decisions not to allow visits need to be continually reassessed. A decision not to allow access at the point of admission may not be appropriate two or three weeks later when the patients' mental state has improved or other circumstances have changed.

6.3 Facilities

6.3.1 It is the responsibility of each clinical academic group to provide facilities to ensure visits by children and/or young people to their parent's areas are as comfortable and beneficial as possible. This should not be contained in the ward area. It should be a suitable room with appropriate toys and books which can be made available at the time of the visit, nappy–changing facilities. See standards *Appendix 2.*

6.3.2 Units may decide to share facilities, where an appropriate room is not available on the unit. In certain situations it may be appropriate to arrange visiting in a venue away from hospital. Local children's social care departments may be able to advise on suitable venues for such contact.

6.4 Recording

6.4.1 The decision of the team to agree or deny visiting by the child needs to be recorded clearly on the patient's multi-disciplinary record child need and risk screen comments box, together with the reasons for the decision made.

Section 7

Community Team Base Child Visiting Addendum

7.1 The Community Team should always assess; balancing the risks with the care and treatment of the service user when considering whether it is appropriate for a child to come to the team base. The potential impact on the child of being brought to the Community Mental Health Team should be considered and all efforts should be made to find an alternative venue. Always consider the advantages of visiting within the home environment.

7.2 If a parent chooses to attend the team base with a child or this is unavoidable, then the child should stay with the carer at all times and should under no circumstances be left alone.

7.3 The child remains the responsibility of their parent or carer at all times.

7.4 Workers should provide advice to the service user regarding coming into the team base with a child so that they might consider attending their appointment with another responsible adult who could look after the child during the appointment time.

7.5 The child need and risk screen should be completed and this should reflect where the service user should ideally be seen with the child.

7.6 Care Coordinators should always be mindful of school age children attending appointments at the team base or being present on home visits when one would usually expect them to be at school and should explore this further.

7.7 The Care coordinator also needs to consider the appropriateness of the child/ young adult being present when distressing or difficult issues are being disclosed by their parent. Clinician's may need to make a judgement regarding the involvement of the child/young persons, whilst being mindful of information the child/young person may have.

7.8 A selection of child appropriate toys/ activities should be kept in the waiting area or with the receptionist and should be checked regularly to ensure they are in a suitable condition.

8 Responsibility for the this Addendum

8.1 The clinical service lead is responsible for the overseeing this addendum, ensuring it operates smoothly, and ensuring that is reviewed at appropriate intervals.

8.2 Information about this addendum should be included in the Patient's Information Booklet. Localized leaflets should be made available. *Appendix 1*

9 References

1. DoH 1989 The Children Act, London, HMSO

2. DoH 1999 The Framework for the Assessment of Children In Need and their Families. London, HMSO

3. DoH 2015 Working Together to Safeguard Children. London, HMSO

4. DoH 2001 Reference Guide to Consent for Examination April 2001; www.doh.gov.uk

Appendix 1

Leaflets for Families and Clients

Visits by children and young people up to 18 years

We believe that helpful and positive contact between children and young people and their parents and carers who are in hospital can benefit both child and adult.

Occasionally the distress and behaviour of the person who is in hospital means that visiting would not be in the best interests of the child or young person and then other forms of contact such as phone, letter or email could be considered.

The care co-ordinator and the team will discuss this and draw up a child visiting plan. The visits will be pre-arranged and will take place in a safe and child friendly room, either on or near the ward.

When it is decided that visits would not be good for the child or young person, this decision will be continually re assessed, and when it is safe, visits will then go ahead.

If you disagree with these decisions, you would be able to talk with the senior nurse or responsible doctor.

PALS Patient Advice and Liaison Service can also be contacted by Freephone on 0800 731 2864 where there is a possibility of resolution through less formal action

www.pals.slam.nhs.uk
pals@slam.nhs.uk

If you are still not happy with the decision you could contact the Complaints office by phone on: 020 3228 2444/2499.

Appendix 2

Child Visiting Facilities Standards

Things to consider when setting up a child visiting facility:

Ideally the room should be away from the main clinical area so children and only used for child visiting and family visiting. It could be a room off the entrance lobby to several wards and shared between them.

Toilet and baby change facilities should be easily accessible.

There should be vision into the room and also facility for mothers to activate blinds for privacy when breastfeeding. Guidance on supervision and observation is contained in the body of the policy.

There should be a child and family friendly sign on the door and in the entrance area with details of how to book the room.

For new build and refurbishments advice should be sought from planning on site and equipping.

Health and Safety

Identify a responsible staff member from the team who will ensure:

1. The room is restocked with paper and drawing materials as necessary.
2. Toys are cleaned.
3. Any broken toys are removed and replaced.
4. Monitoring, cleaning and maintenance of room.

Infection Control

Toys and equipment are great fun for children. However, toys can become contaminated through handling or by children putting their mouths to them. Some germs can remain on toys for long periods of time.

Do:

- Store toys in a clean plastic washable toy box.
- Clean toys after each session with Sani cloths ordered from NHS Logistics [code VJT077] or hot water and detergent. Plastic toys can be washed in the dishwasher. Dry before re storage.
- Use clean, hard or plastic toys only.
- Do add toys and equipment to a regular cleaning rota and identify a staff member responsible for this.

Don't:

- Use any soft toys. They are an infection risks unless washed after each session in a washing machine.
- Do not provide play dough.

Room contents

- Furniture
- Comfortable chair for nursing mothers
- Small table and chairs for children.
- Other seating for other adults.