

Child Visiting Policy and Procedures

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Owner	Safety Management Group
Contact	Sarah Turner, Named Nurse for Safeguarding Children
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Search summary:

The importance of children and young people being able to visit their parents in hospital is self evident and may be beneficial to both child and parent. All child visits must be safe and in the best interests of the child.

This Policy should be read in conjunction with:
Oxleas Child Protection Policy and Procedures
Information Sharing Policy
Incident Reporting Policy
London Child Protection Procedures

VERSION CONTROL

Document Location

Oxleas NHS Trust Intranet	<i>See under Safe-guarding Children</i>
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Change History

Vrsn	Owner	Changed by	Change summary	Date
1.0	Safety Management	N/A	First issue of policy	May 2004
2.0	Safety management	Sarah Turner	Revised in line with updated London Child Protection Procedures	Feb 2008

Responsibility for distribution of this document

Sarah Turner, named Nurse for Safeguarding Children
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1. Policy Statement

1.1 The purpose of this document is to assist staff in ensuring that child visits to service users are safe and appropriate. The Children Act 1989 defines a child as being up to the age of 18 years. This guidance must be read in conjunction with; the relevant section(s) of **The London Safeguarding Children Procedures**, which is a multi-agency document setting out procedures to be followed in a wide range of situations; and Oxleas Child Protection Policy and Procedures.

1.2 Oxleas NHS Foundation Trust has a duty under s11 of the Children Act 2004 to ensure that its functions are discharged taking account of the need to safeguard and promote the welfare of children. This means:

- protecting children from maltreatment
- preventing impairment of children's health or development
- Ensuring children grow up in circumstances consistent with the provision of safe and effective care.

1.3 This policy and procedure document applies to all trust staff who facilitate or supervise child visits to service users in trust premises, or who manage others who do so. The document also applies to agency staff and other staff not employed directly by the Trust e.g. volunteers.

1.4 The Board of Oxleas NHS Foundation trust will ensure that the policy and procedures are implemented and that staff members are fully supported. This support will include supervision and safeguarding children training in line with the safeguarding children training strategy.

1.5 Visits by children to psychiatric wards, hospitals or units should be used to maintain a positive relationship for the child with the patient, who will usually be their parent or close family member such as sibling.

A visit by a child will only take place if it is in the best interests of the child.

2. Monitoring Statement

2.1 The trust will monitor compliance with this document via the Safeguarding Children Committee which reports to the Safety Management Group.

2.2 The Safeguarding Children Committee will receive information related to child visiting incidents and will consider implications from these with the child protection risk register. Where indicated emergent risks related to child visiting will be audited.

2.3 Individual wards/ units will monitor compliance with the policy and procedure, including:

- Availability of a suitable environment for visits to take place in.

- Information given to service users and carers about child visiting, included in unit info booklet/ on notices.
- Decisions about child visiting recorded in service user's notes.
- Details of child visits recorded in the service user's notes i.e. name of child visiting, relationship, interactions observed etc.

3. Introduction

3.1 The separation of children from their parents during the course of a parent's hospital admission can be a traumatic and distressing experience for all involved.

3.2 Many children will be very anxious at such an event, and even brief periods of hospitalisation can seem lengthy in a child's mind. The importance of children and young people being able to visit their parents in hospital is self-evident and is likely to be beneficial to both child and parent/carer, as well as a significant factor in the process of care and rehabilitation of the service user.

3.3 Mental illness in a parent/carer does not necessarily have an adverse impact on a child, but this must always be assessed.

3.4 Any considerations in relation to children visiting must take account of what is in the best interests of the child, ensuring that the welfare of the child is paramount, as defined within The Children Act 1989.

3.5 Wards and units should include information about their child visiting policies in information booklets given to service users and relatives on admission to the ward/unit.

4. Aims

4.1 To ensure that the child/young person's safety and wellbeing is placed at the heart of the professional practice of all staff.

4.2 To take account of the needs and wishes of children and service users.

4.3 To swiftly ascertain the desirability of contact between children and service users, identify concerns and assess any risk of harm to the child.

4.4 To ensure an efficient procedure for dealing with requests for child visiting.

4.5 To set standards for the provision of facilities for child visiting which will ensure the safety of all children visiting Trust premises.

5. Detention under the Mental Health Act

5.1 In those instances where a compulsory admission is being considered, the needs of and arrangements for children involved with the service user will be

considered by the Approved Social Worker (ASW), as an integral element within the assessment. This assessment should include checks with the appropriate Local Authority i.e. whether or not the child/family is known to local social care. This information will assist in determining whether the care arrangements for the child are satisfactory.

5.2 Where there are concerns about the safety or care arrangements of the child/ren the ASW must make a referral for assessment to the appropriate children's social care department. In these cases children's social care should be involved in decisions regarding suitability of the child visiting their parent.

5.3 Information regarding the child should be recorded by the ASW and communicated to the hospital on admission.

5.4 The ASW will provide the hospital/unit with information about the views of other person(s) with parental responsibility for the child/ren, (Appendix 1). Staff should be sensitive to situations where the relationship between parents has broken down so that any decision about child visiting is not used inappropriately in residence or contact disputes.

5.5 The professional carrying out the initial assessment will liaise with the ASW, Care Coordinator, GP etc to gather information about children, establishing who is caring for the child/ren during the period of hospitalisation.

6. Access to visiting

6.1 In all cases, whether the service user is admitted compulsorily or voluntarily, a decision in principle needs to be reached as to whether it is appropriate for a child visit to take place. This decision should be made with the multi disciplinary team taking into account any information provided by the ASW and/or the initial assessment of the service user's need for treatment as reflected in the care plan.

6.2 The ward/unit manager is responsible for the decision to allow/refuse a visit by a child. The decision must be based on the interest of the child being paramount, superceding those of the service user.

6.3 All decisions regarding a child visiting should be clearly recorded in the service user's notes.

6.4 The multi disciplinary team should swiftly and simply identify any concerns about child visiting which may be present in some cases. If there is not a scheduled meeting of the multi disciplinary team and a decision about a child visit needs to be made, this decision should be made at a ward round or a multi disciplinary discussion should take place.

6.5 In making the decision on whether to grant the request, the team will consider the current parental behaviours which may affect the child. Some of the considerations will include:

- The service users current mental state (which may differ from an assessment made immediately after admission)
- How the illness impacts on parental functioning
- The child's involvement in parental symptoms
- The impact of treatments on parenting capacity and behaviour
- The emotional impact on the child if there are changes in the parental response to them. This will include how the service user looks
- The nature of the unit/ward and the service user population as a whole.

6.6 It is essential that the wishes and feelings of the child are considered and continue to be reviewed. This will include:

- The child's wishes with regard to the visit
- The child's understanding of the parents illness/symptoms.
- Does the child have anyone to talk to about their parents illness/symptoms/ would they benefit from this.

6.7 The professional carrying out the initial assessment should establish at the earliest opportunity whether the child has an increased vulnerability, this will include:

- The age of the child, younger children/babies are more vulnerable
- Special needs (including not attending mainstream school)
- Known to CAMHS (Children and Adolescent Mental Health Services)
- Problematic living/care arrangements
- Child is a Child In Need or has a Child Protection Plan

6.8 Staff should refer to the London Safeguarding Children Procedures for more information on vulnerability. If any of these factors are present further information and advice should be obtained from CAMHS, GP, health visitor or children's social care etc as to whether the visit is in the best interests of the child.

6.9 It needs to be borne in mind that a range of options may present themselves when concerns are raised in any of these areas. This need not automatically result in the refusal of visiting or other sort of contact. If the concerns relate to the nature of the ward/unit or service user population at the time the visit is proposed, arrangements should be made for the visit to take place away from the ward or unit. The multi disciplinary team must aim to obtain a balance between the management of risk and the interests of service users and children.

6.10 In the vast majority of cases where no concerns are identified, arrangements should be made to support the patient and child to facilitate contact.

6.11 If the multi disciplinary team agrees to the request, then confirmation will be given to the service user. The decision should be documented in the service user's care plan and reviewed as necessary.

7. Decisions to refuse visits

7.1 The decision not to proceed with the visit should be communicated to the service user by a senior staff member/consultant both verbally and in writing, with clear evidence of concerns.

7.2 Reasons should be given about why it was felt that the provision of support and/or the supervision of visits were thought to be insufficient to alleviate these concerns. The decision should be documented in the service user's notes.

7.3 The service user, person with parental responsibility (Appendix 1), guardian, child (dependant on age and understanding) or where appropriate Local Authority should be made aware how the decision has been reached, and should be informed how to make representations to the multi disciplinary team against any decision not to allow a visit. This will include access to assistance and independent advocacy (PALS).

7.4 If the decision to refuse visiting is not based on clinical grounds, but due to the level of disturbance or type of service users on the ward/unit this should be reported to the unit manager, recorded in the service users records and reported as an incident for monitoring purposes.

7.5 Where the decision to refuse a visit has been made, consideration should be given to facilitating other forms of communication in the child's interest, including written communication or telephone contact with the child.

7.6 Unplanned and unexpected visits from children should be discouraged and this should be stated in service user/visitor information booklets and ward/unit notices. Where a child unexpectedly visits, the ward/unit manager (and multidisciplinary team members) will consider available information about the child, alongside the assessment of the service users needs and current mental state. Where a visit is not safe/appropriate it must be refused.

7.7 Carers with children should be informed that they should make alternative child care arrangements if they are planning to attend ward meetings/visit as it is inappropriate for babies/ children to be present. Ward staff should not be put in the position of looking after children.

8. Planning the visit

8.1 Service users and relatives should be informed that it is essential that prior to a visit the child's guardian telephones the ward/unit to seek advice as to whether it is appropriate for the child to visit that day. This should be made clear to service users and relatives on admission. **The final decision regarding the appropriateness of a visit on a particular day rests with the ward manager at the time of visiting.**

8.2 Directorates should ensure that the facilities available for service users to have contact with their children are private, safe and conducive to a positive

contact for the child and the service user. This should be a child friendly area which is safe, quiet, clean, warm and equipped with a selection safe, clean and appropriate toys and games to enhance the visit. The ward/unit will remain responsible for ensuring the toys are cleaned after use. There should also be facilities for refreshments as well as toilets that the child can use and nappy changing facilities where needed.

8.3 The location of the visit should be carefully considered. Where the ward environment or the care needs of service users would be likely to affect the visit, arrangements should be made for the visit to take place away from the main ward area. In some cases it may be better for arrangements to be made for visiting away from the hospital/residence. In the case of detained patients this will require due consideration of the need for leave, (see section 12).

8.4 In certain situations the local children's social care department will need to be involved in the decision as to whether a visit is appropriate. This will arise where the child has an allocated child care social worker, or staff have concerns for the welfare of a child. Discussion must take place with social care staff about appropriateness of the visit and to identify the most suitable adult to accompany the child.

9. The visit

9.1 Having a parent in hospital is likely to be an anxious time for a child and visiting hospital may be frightening. Staff should ensure that the environment for the visit is as relaxed and welcoming for the child as possible. When staff are supervising visits should ensure that they tell the child who they are and explain what their job is.

9.2 The child must be accompanied at all times by a responsible adult e.g. parent, grandparent, legal guardian, social worker. This person remains responsible for the child during the visit.

9.3 Children must not be allowed to wander around the ward/unit and should not come into contact with other service users. If a child comes into contact with an individual who presents a risk to children (previously known as a schedule 1 offender) the unit manager will be informed and an incident form will be completed. Consideration should also be given to the initiation of child protection procedures.

9.4 Names, dates of birth, address etc of service users children for whom they have care responsibilities should be routinely recorded in RIO. Where a child will be visiting this should also be recorded in RIO.

9.5 It **may be necessary** for a member of staff to be present throughout the entire visit, this will be at the discretion of the nurse in charge. If this is the case, the identified member of staff must have an understanding of the parent/child relationship and awareness of safeguarding children issues. Interaction observed during the visit must be documented in the patient's notes. If, due to staffing

constraints supervision of the visit is not possible, the visit should not take place. This should be reported as an incident for monitoring purposes.

9.6 If concerns arise about the safety or welfare of the child these must be discussed with senior staff including where appropriate the Trust's Named Professionals and consideration given to referral to children's social care for assessment.

10. Terminating a visit

10.1 The decision to terminate a visit should be taken as an immediate action to protect a child. The unit manager must be informed, details of the incident documented in the service users records and an incident form completed for monitoring purposes.

10.2 An explanation of the reasons behind the termination of the visit should be given, with the proviso that the decision will be reviewed and future visiting resumed if it is in the best interests of the child.

10.3 Either the senior nurse on duty, the senior Doctor on duty or Social worker for the clinical team must be informed immediately, relevant others must be contacted as soon as possible. Staff should consider the need to share information with social care. (See Oxleas Child Protection Policy and Procedures and the London Child Protection Procedures).

10.4 Where a child is in immediate danger the police should be called (999). Refer to child protection procedures.

10.5 If the child has a child care social worker, information about the circumstances resulting in the termination of the visit must be shared with the relevant children's social care department.

11. Service users leaving the Unit

11.1 Whenever consideration is being given to a service user, or groups of service users, leaving the unit, a risk assessment must be undertaken by the multi disciplinary team to consider any potential risk to children that the patient or service user(s) might present.

11.2 The risk assessment must take into account both the potential risk to specifically identified children who are related to, or otherwise known to the service user and the risk to children in general.

11.3 The conditions of any leave of absence and the levels of supervision during the leave must be in keeping with the risks identified in the assessment.

11.4 The multi disciplinary team should not only consider the immediate risks to the child but also:

- Whether it is in the child's best interest, both in the short and long term, for contact to take place.
- Whether the service user has any parental responsibility for child. This will be a key factor for consideration.

11.5 Where appropriate a referral to children's social care should be made in order that the child's need's can be assessed.

12. Issues specific to secure services

To be read in conjunction with preceding sections.

12.1 The aim of these guidelines is to ensure the safety and wellbeing of the child/young person visiting the Bracton Centre by ensuring the child visitor does not have contact with any service user other than the one they are visiting.

12.2 Service users within the Bracton Centre must submit a list of all visitors which will include the name, date of birth and relationship of the child. Only children who are closely related or have a significant ongoing relationship with the resident will be allowed to visit.

12.3 In all cases written permission of at least one person with parental responsibility for the child (Appendix 1) will be required before the multi disciplinary team approve a child visitor.

12.4 A member of the multi disciplinary team (usually the social worker) will contact the children's social care department covering the child's place of residence, to advise them of the request to visit and where necessary, request an assessment as to whether this would be in the best interests of the child.

12.5 A risk assessment will be carried out by the multi disciplinary team to determine whether it is in the child's best interests for the visit to take place. This discussion will normally take place in weekly ward rounds or at reviews.

12.6 Specific issues relating to the visit must be documented in the care plan. This information should also be recorded on the Register of Approved Child Visitor form. It should include

- The name of the child allowed to visit
- The name of the service user the child may visit
- The relationship between the child and service user
- Conditions of visiting i.e. length of visit, venue, level of supervision
- Name and written permission from person with parental responsibility
- Name of responsible adult accompanying child on visit

12.7 Each child authorised to visit will have a completed Registration form kept in the reception area. A separate Registration form must be completed on each child permitted to visit.

12.8 All child visits must be pre-booked.

12.9 Children's visits must be supervised, the level of which must be agreed by the multi disciplinary team.

12.10 A safe, child friendly area is identified within the main Bracton Secure area for approved child visits to take place. Units outside the main secure area have identified similar areas.

12.11 If agreed appropriate by the multi disciplinary team the use of the unit's grounds may be incorporated into the visiting arrangements, however this facility must always be prearranged and responsibility rests with the supervisor of the visit to ensure the child does not have contact with other service users.

12.12 Children visiting patients at the Farmhouse or Cottage must use the main Bracton Centre facilities.

12.13 If at anytime the member of staff believes a child to be at risk of significant harm child protection procedures should be followed. (See Oxleas Child Protection Policy and Procedures and/or London Child Protection Procedures)

Patients on leave from the unit

12.14 Whenever consideration is being given to a patient or group of patients, leaving the unit, a risk assessment must be undertaken by the multi disciplinary team to consider any potential risk to children that the patient might present.

12.15 The risk assessment must take account both the potential risk to identified children who are related to, or otherwise unknown to the service user and the risk to children in general.

12.16 The conditions of any leave of absence and the levels of supervision during the leave must be in keeping with the risks identified in the risk assessment.

12.17 If the service user is requesting leave to regularly visit a child, the multi disciplinary team should not only consider the immediate risks to the child but also whether it is in the child's best interest, both in the short and long term, for the contact to take place. Whether the service user has parental responsibility (Appendix 1) will be a key factor for consideration.

12.18 A specific practice protocol should be agreed between the Bracton Centre and the local children's social care and Families service in which the child is resident to clarify the expectations of each agency in relation to the risk assessment process.

12.19 If at anytime the member of staff believes a child to be at risk of significant harm child protection procedures should be followed.

13. Issues specific to complex needs/ residential / rehabilitation/ low secure units

To be read in conjunction with preceding sections

13.1 Whenever a request is made for a child to visit a service user, a risk assessment must be carried out by the Clinical Team to determine whether it is in the child's best interest for the visit to take place.

13.2 All visits by children must be agreed and planned in advance by the clinical team responsible for the care of the service user. This discussion will normally take place in weekly ward rounds or at reviews. The multi disciplinary team will determine the appropriateness of the visit for the service user and child, and where necessary will seek additional information before proceeding.

13.3 If there is any concern that the visit may not be in the best interest of the child approval to visit will not be given until the clinical team is satisfied that a visit would not be detrimental to the child.

13.4 It shall be considered good practice for a member of the clinical team to contact the child's local children's social care to advise them of the request to visit, and where necessary to ask them to undertake an independent assessment regarding the best interest of the child.

13.5 Using the information gathered in the assessment process, the clinical team should develop risk management measures including a risk assessment form for each child and a central register of children allowed to visit. These should clearly indicate:

- The name of the child allowed to visit
- The name of the service user the child may visit
- The relationship between the child and the service user
- Conditions of Visiting
- Name and written permission from person with parental responsibility (Appendix 1)

13.6 It is the responsibility of the service user and those adults wishing to bring children and young people to visit the unit to provide sufficient accurate information to allow child visitors to be registered. Provision of inaccurate or inadequate information may delay or prevent the registration of child visitors.

13.7 Children would normally only be allowed to visit residents who are close relatives or have a significant ongoing relationship with them.

13.8 Children's visits must be supervised at all times, the level of which must be agreed in advance.

13.9 All child visitors to the unit must be accompanied at all times by an identified responsible adult, who agrees to be responsible for them during the visit. The responsible adult must arrive and leave with the children. Responsible

adults will not be permitted to leave children unattended in the reception area or elsewhere in the building or grounds.

Service users leaving the Unit

13.10 Whenever consideration is being given to a service user, or groups of service users, leaving the unit, a risk assessment must be undertaken by the multi disciplinary team to consider any potential risk to children that the patient or service user(s) might present.

13.11 The risk assessment must take into account both the potential risk to specifically identified children who are related to, or otherwise known to the service user and the risk to children in general.

13.12 The conditions of any leave of absence and the levels of supervision during the leave must be in keeping with the risks identified in the assessment.

13.13 The multi disciplinary team should not only consider the immediate risks to the child but also:

- whether it is in the child's best interest, both in the short and long term, for contact to take place.
- whether the service user has any parental responsibility for child. This will be a key factor for consideration.

Parental Responsibility

The term parental responsibility is intended to reflect the everyday reality of being a parent and emphasise the responsibility of all those who are placed in that position. Aspects of parental responsibility can include the following:

- Consent to medical treatment
- Decisions regarding education
- Decisions as to the name of the child
- Appointment of a guardian for a child
- Consent or not to marriage (for a child between the ages of 16-18)
- Applying for passports
- Administering the child's property
- Allowing the child to be interviewed

The mother of a child automatically has parental responsibility. The father will have parental responsibility if:

- He was married to the mother at the time of the child's birth, or they marry subsequently, from the date of the marriage.
- His name is registered on the birth certificate and he was present at the time of registration (since 1st December 2003)
- He entered into a parental responsibility agreement with the mother
- He obtained a court order for parental responsibility
- He obtained a residence order for the child

Other persons can apply for parental responsibility by means of a residence order or parental responsibility agreement. The local authority can acquire parental responsibility if granted a care order, for the duration of the order.

The only means by which parental responsibility is distinguished are by: the child reaching the age of majority (18 years); the death of the child; or if a freeing or adoption order is made.