Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title: Child Visiting and Child Contact Policy

Version: 4

Reference Number: CO29

Supersedes
Supersedes: CO29 Child Visiting Policy

Description of Amendment(s):

- **Includes updated MH code of practice 2014**
- **Includes exceptional circumstance where contact on ward implicated**
- **Includes obtaining Voice of the Child feedback following contact**
- **Amended Child Visiting Record form CVR**
- **Changes to refusal of child visiting processes**
- **Removal of provision of toys due to infection control**
- **Addition of senior nurse to support management responsibilities**

Originator
Originated By: Amanda Smith

Designation: Named Nurse Safeguarding Mental Health Stockport and Tameside

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Amanda Smith

ERA undertaken on:

ERA approved by EIA Work group on:

Where policy deemed relevant to equality-

EIA undertaken by Amanda Smith

EIA undertaken on 10/03/16

EIA approved by EIA work group on

Approval and Ratification

Referred for approval by: Amanda Smith

Date of Referral: 03/11/2015

Approved by: Stan Boaler

Approval Date: 29/04/16

Date Ratified by Executive Directors: 6th June 2016

Executive Director Lead: Director of Nursing

Circulation

Issue Date: 6th June 2016

Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: 30/04/2017

Responsibility of: Amanda Smith

Designation: Named Nurse Safeguarding Mental Health Stockport and Tameside

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 6th June 2016

GUIDING PRINCIPLES

All Pennine Care NHS Foundation Trust Mental Health Act related policies are developed in accordance with the guiding principles as identified by Sections 118(2A), 118(2B) and 118(2C). These principles are as follows;

Purpose
Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm.

Least restriction
People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

Respect
People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

Participation
Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

Effectiveness, efficiency and equity
People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

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PENNINE CARE NHS FOUNDATION TRUST POLICY ON VISITS TO HOSPITAL IN-PATIENTS BY CHILDREN AND CHILD CONTACT AWAY FROM IN-PATIENT AREAS

1. Trust Statement

1.1 This policy covers hospital visits by children aged under 18 to all in-patients on wards managed by the Pennine Care Trust. In addition this policy covers child contact away from in-patient areas inclusive of home leave.

1.2 The Trust recognises that every member of staff has an individual responsibility for the protection and safeguarding of children. All staff should also be aware of the requirement to offer support for families affected by inpatient episodes whilst maintaining a safe and protective environment for children.

1.2 The Director of Nursing is responsible for overseeing the development of child visiting and the application of this policy across the Trust.

2. Purpose of Policy

2.1 The purpose of this guidance is to ensure the best interests and safety of the children and young people concerned are always considered and that visits by or to children and young people is not allowed if they are not in their best interests. However, within this framework, we will do all that we can to facilitate the maintenance of children's and young people's contact with friends and family and offer privacy within which that can happen.

3. National Guidance

3.1 National guidance on this issue is contained within paragraphs 11.11-11.16 and 27.10 of the Mental Health Act, Code of Practice (2008) and supplemented by the circular HSC 1999/222: LAC(99)32.

3.2 Other legislation that has been considered whilst developing the processes includes Childrens Act 1989 and 2004 and Human Rights Act 1998.

3.2 Other parts of the code of practice are relevant in terms of hospital visiting by children.

- *Chapter 1* – Statement of Guiding Principles, these must be applied to individual situations in so far as possible.

- *Paragraph 4.94* - The AMHP should provide an outline report for the hospital at the time the patient is first admitted or detained, giving reasons for the application and details of any practical matters about the patient's circumstances which the hospital should know.

3.3 The guidance emphasises that most visits by children to patients are central to the maintenance of normal, healthy relationships and that procedures should ensure that swift decisions can be taken in the vast majority of cases where the matter is straightforward.

3.4 The Paramountcy Principle contained within the Children's Act 1989 is important to the issue of children visiting service users 'When there is a conflict of interests between the needs of the adult and those of a child, the child's welfare is paramount'. This principle should be considered when making decisions on the processes set out by this policy.

4. Principles of Good Practice

4.1 It is important that policy and practice

- Focus on child welfare
- Take account of the needs and wishes of children as well as patients
- Address the whole process from pre admission to after-care
- Swiftly ascertain the desirability of contact and efficiently identify concern and assess any risk to the child
- Deal with those cases where concerns exist
- Maximise the benefits of contacts
- Set standards for facilities for visiting
- Set standards for training staff

4.2 This policy and the procedures within it are based upon a clear multi-disciplinary and where necessary, multi-agency approach to determining what should happen in any specific case

4.3 This policy is based upon the assumption that maintaining contact between patients and those close to them (including children) is positive and important and should be encouraged and supported wherever possible.

4.4 However, there may be occasions when it is not appropriate and this policy seeks to ensure that these situations are identified and dealt with in a fair and effective manner

4.5 Whilst the policy relates primarily to the circumstances of individual cases there is acknowledgement that there remains a need to manage the general circumstances on a ward and that this may, at times, impinge upon the arrangements for individual patients.

4.6 Also, this policy is about maintaining contact between patients and children with whom they have an important relationship. Other than for

the reason outlined above, and in accordance with this policy, child visitors are not at the outset permitted on in-patient wards.

In exceptional circumstances where a child is denied contact due to the level of the risk for in-patient (such as absconsion) has been identified by the multi-disciplinary team as too great to facilitate contact within the family room off a ward area, and there are no assessed risks to the child, and lack of contact is having a detrimental impact on that child, then there may be occasion to explore if contact can be facilitated safely on the ward. This decision must follow the principles of the child visiting policy and be fully documented within the clinical records and has consultant involvement. If a child visit is implicated on the ward this must take place in a private area (not bedroom) and a member of staff to be present at all times. This decision must be reviewed by the multi-disciplinary team, including the Consultant prior to any visit being undertaken. ***These circumstances must not be applied to wards within the Rehabilitation and High Support Division***.
There is no provision for managing visits by children other than this policy (e.g. those simply accompanying another adult who wishes to visit the patient).

4.7 The same principles apply with regard to young people who are in-patients whose friends may wish to visit them. Whilst such contact should be encouraged and supported it needs to be subject to this procedure and properly managed. Necessarily this must take into account the context of in-patients serves (e.g. it is unlikely that a large group of teenagers would be allowed to visit an in-patient at one time)

4.8 Overall, good practice requires that:

- Visits are encouraged and supported.
- The need for some flexibility is recognised.
- Child welfare issues are the primary focus.
- Decisions are made as quickly as possible and plans agreed, recorded and communicated.

4.9 Service managers must ensure information relating to this policy is provided to all inpatients at the point of admission and included within any local admission information leaflets.

5. Planning and decision making

5.1 Planning for visits by children needs to be done early and before admission wherever possible. Where compulsory admission is being considered the needs and arrangements for children involved with the patient should be considered by the Approved Mental Health Professional (AMHP) as an integral element of the assessment. Referral to Children's Services may be necessary but it is accepted that dependent upon the circumstances of the admission an AMHP would not have access to all information regarding the environmental safety and risks on

the admitting ward. This would require further planning by the inpatient team.

5.2 Where the admission is informal, the care co-ordinator (or practitioner making the referral for admission) has responsibility for considering the needs and arrangement of children involved with the patient. In both cases it may be necessary and appropriate to involve childcare colleagues from the local authority social services departments.

5.3 When considering child visits it will be necessary to plan and review this activity with the ward manager/ unit manager and consider within a clinical team meeting or ward round. When considering child visits when the patient is also a child or young person, it may be necessary to involve the patient's parents or carers in the decision making process about the appropriateness of any planned visit.

5.4 In any event, where there are children who may need to visit the ward manager or senior nurse in charge must complete a form CV1 (attached as an appendix to this policy) using the information provided at admission. This form identifies children who have an important relationship with the patient and may need to visit them. Where a patient is granted a period of leave and child contact is to occur (for example; their own child or another adult's child) then form CV3 should be completed.

Form CV1/CV3 may need to be up-dated by ward manager or senior nurse in charge as the in-patient stay proceeds and any further information comes to light.

5.5 Concerns about a child visit/contact may arise in a number of areas:

- the patient's history and family situation;
- the patient's current mental state (which may differ from an assessment made immediately prior to or after admission);
- the response by the child to the patient or his/her mental illness;
- the wishes and feelings of the child;
- the age and overall emotional needs of the child;
- the consideration of the child's best interests;
- the views of those with parental responsibility;
- the nature of the unit and the patient population as a whole e.g. PICU

These will need to be regularly reassessed before each visit to the ward by the child to reflect that the circumstance and health of both the child and patient may fluctuate following the admission.

5.7 The existence of any of these concerns does not necessarily mean that visiting should be refused but does mean that visiting has to be planned and carried out in a way that properly takes account of it.

5.8 A visiting/contact plan for each individual child (including those in sibling groups and grandchildren where applicable) must be completed on form CV1 and signed by the ward manager or senior nurse in charge or where appropriate, the AMHP or Care coordinator or Responsible Clinician (for detained patients). The visiting/contact plan (s) should be attached to the care plan, reviewed with it, and following any significant change in circumstances likely to impact upon child visiting arrangements.

5.9 Any significant changes in the child visiting/contact plan require a new form to be completed, otherwise a signed and dated entry on form CVR is adequate. Following the initial admission this would be the responsibility of the ward manager or senior nurse in charge and, where appropriate, the care coordinator.

5.10 The child visiting/contact plan may stipulate general arrangements with regard to child contact (e.g. time, frequency, duration, accompanying adult, supervision etc.,) but may also provide guidelines to inpatient staff about changeable circumstances that may affect individual contacts (patient's immediate mood or state of mind, child's emotional state etc.) or cause them to be cancelled or postponed. All these factors should be clearly documented using the forms provided within this policy.

5.11 Where there are concerns that relate to the risk to a child or their health and well being it may be necessary or appropriate to make a referral to children's service where they are not already involved or to consult them where they are already involved.

5.12 For children, consultation with those who hold parental responsibility will be important and they are likely to be involved practically in facilitating the contact. Where a child is looked after by the local authority their involvement also is essential, but does not preclude the involvement of others with parental responsibility. Where a child is Looked After but not subject to a Care Order, the person with Parental Responsibility is required to give their consent to the visit.

5.13 Where there are concerns over child visits/contacts or contentious issues it may also be necessary to convene a planning meeting to resolve the matter.

5.14 For young people aged 16 and over consultation with a person with parental responsibility is not always necessary unless there is evidence that the young person is particularly vulnerable to harm.

5.15 It will usually be appropriate for a person with parental responsibility to be consulted, but taking into account any concerns, the circumstances and the age and maturity of the young person that consultation may not take place. In such cases the reason for not consulting a person with parental responsibility need to be carefully agreed and recorded.

6. Review

6.1 All child visiting/contact decisions should be reviewed prior to each child visit and the form signed and dated to show this has occurred. If there are any changes then a new child visiting plan should be completed prior to any visit taking place.

7. Facilities

7.1 Any visit to hospital premises is a potentially distressing experience for a child and more so if it is to an in-patient mental health ward. Ideally, therefore, all wards should have child- friendly visiting facilities either on the premises or elsewhere that is suitable for the purpose.

7.2 Child visiting facilities should meet the following standards and be:

- Accessible without traversing wards or other in-patient areas.
- Well lit and decorated and comfortable furnished with domestic-style furniture
- Large enough to accommodate 4 or 5 adults and 3 or 4 children
- Safe (i.e., Anti barricade doors with viewing panel, wall mounted alarms etc)
- Close to non in-patient toilet facilities
- Accessible for disabled people.

7.3 Use of appropriate facilities away from the in-patients unit and even off the hospital site may be appropriate and negotiable with local child care services. However use of such facilities would be very much dependent upon the status and mental state of the patient.

7.4 Where a patient is considered to be at risk of absconsion that risk will be weighed against the benefits of the visit in making the decision to allow visits if the visiting area is away from the ward. This should be well documented within the patient's records and considered prior to each visit.

8. Managing Visits

8.1 Whilst occasionally flexibility might be possible the practicalities of child visiting are such that most visits will have to be carefully planned.

8.2 The visiting plan for each child (form CV1) will set out the general arrangements and parameters of visiting (locations, frequency, duration, requirements, limitations etc)

8.3 As indicated above visits made by children should take place in facilities arranged for that purpose. Where such facilities are not yet available, visits can still take place but consideration of the location and setting for the visit, and especially their impact upon the child will be a much

greater determinant of whether or not the visit can take place. Factors in this context will include:

- What facilities are available and their appropriateness to the age of the child
- The proximity and circumstances of other patients
- The likelihood of disturbance/disruption whilst the visit takes place
- Possible aggression or otherwise abusive behaviour directed towards the child

8.4 The visiting plan should indicate whether visits/contacts require supervision by staff. Within these parameters visits/contacts can be organised by ward managers who will need to ensure:

- The visit is timetabled, facilities booked and necessary staffing resources available
- The patient as far as possible understands the arrangements
- Any necessary contingencies are organised in the event of any need to cancel/postpone the meeting
- Other staff and agencies (as necessary) are informed

8.5 Levels of staffing to supervise visits must be specifically considered prior to the visit. If the required levels of staff are greater than anticipated and unavailable then the visit should be postponed or cancelled. Wherever possible this should be avoided. The prime consideration in determining whether or not to postpone or cancel a visit must be the likely impact of the visit upon the child, and not any potential subsequent difficulties on the ward, although these will have a bearing.

8.6 Prior to, and during the visit, it is important for the staff supervising to observe the child and to be aware of any signs of distress because of either the setting, the visit itself or the prospect of it. The child is likely to be subject to a range of emotions. Any observations should be recorded on the visiting plan and signed by the nurse responsible for the observations and these should be used to guide any future plans or actions to be taken.

8.7 In addition, there may be specific issues or circumstances that arise for a particular visit and may require some amendment to the agreed plan. These will include:

- Condition and wishes of the patient
- Condition and wishes of the child
- Circumstances on the ward (including unavoidable absence of necessary staff)
- Timekeeping

8.8 Ward managers/senior nurses need to consider in advance of the contact whether it should be expected to take place. In particular cases

this may need to be in time to advise the adult accompanying the child of possible cancellations and or delays before they set off from home.

8.9 Ward managers/senior nurses need to ensure the facilities have been checked and are in good order.

8.10 Once the child has arrived, and immediately prior to the visit ward staff should observe /converse with the patient to ascertain any likely potential threats to the welfare of the child. There should also be observation of / conversation with the child to ascertain their current state and likely response to the visit. Any changes to the plan need to be completed on the form CV1 prior to the visit occurring.

8.11 Once ward staff are satisfied that the visit can proceed as planned, the child (with accompanying adult if appropriate) and the patient should meet together in the agreed setting and ordinarily be encouraged to have maximum involvement with each other.

8.12 Good planning should ensure that any potential difficulties around the visit are anticipated. However, unforeseen circumstances may require additional precautions to be taken (e.g. by stronger staff presence during the visit) or even cancellation if this is unavoidable.

8.13 Ward staff should seek to be as unobtrusive as possible, intervening only if necessary. Potential difficulties occurring during a visit may have been identified, in which case staff should act in accordance with the visit plan. Where unanticipated problems occur staff should seek to act in the interest of the best welfare of the child, terminating the visit and removing the child if necessary.

8.13 When a visit is terminated early it will be important that:

- Reassurance is given to the child around where responsibilities lie (with adults);
- Any disturbance is dealt with according to normal ward procedures; and
- The visiting plan is reviewed prior to further meetings being arranged.

8.14 Whether the meeting runs it full course or is terminated, consideration needs to be given afterwards with regard to monitoring the condition and behaviour of the patient, given that such a visit (even a happy one) may carry a heavy emotional impact.

8.15 Wherever possible feedback should be obtained from the child on how they perceive the visit went and also be given the opportunity to raise any questions or concerns about the adult's mental health.

9. Recording and Review

9.1 After a child visit ward managers or the senior nurse in charge must ensure completion of the child visiting record, (attached to form CV1). This should note and comment upon:

- Deviations from the child visiting plan, for example, the length of the visit
- Identified issues arising from the visit, for example, and particular or specific needs of the child
- The condition and behaviour of the child in the visit and the patient in the visit and after it. Consider the mood / presentation of the child – are there any attachment issues?
- The need to liaise with other professionals pertinent to the child
- Wherever possible issues raised by the child during or after the visit i.e. 'capturing the voice of the child'

9.2 Child visiting arrangements for individual children should be considered before every visit. Special consideration should be taken into account if the following has arisen:

- A visit is terminated
- Visits are seen to have significant detrimental impact upon the child or patient.
- Other new information emerges about the child/patient/their relationship/other factors affecting the ward.

10. **Refusal of Child Visiting**

10.1 Whilst there is a presumption that visiting is positive there may be occasions when visits have to be refused, either generally or at a specific time. This might be because:

- Concerns exist that preclude a child visiting the patient (again visits by specific individual children need to be considered separately)
- Concerns exist that require further time for fuller assessment.
- Circumstances within the service or with regard to the patient preclude visiting at that time.

10.2 Where concerns exist that generally preclude a child visiting the reasons for this need to be carefully agreed and recorded. They also need to be discussed with the patient (within the limits of their current condition and understanding) and similarly conveyed to them in writing. Similar information should be given to:

- Any person with parental responsibility for a child or young person aged under 16 (subject to the provisions of paragraph 4.13, above
- Any young person aged over 16
- Any young person aged under 16 for whom a person with parental responsibility is not consulted
- Any known carer, advocate or legal representative of the patient.

10.4 Refusal of child visiting for purposes of making a further assessment should only take place at the onset of an in-patient stay or when new information or other significant change comes to light, including observation of previous contacts. In any event, the length of any delay before a decision should be kept to a minimum. Whilst this cannot be stipulated precisely, this should be reviewed on a weekly basis within ward round.

10.5 Where circumstances within the service preclude a visit taking place at a particular time arrangement should be made for a further visit as soon as reasonably possible.

11. Complaints and Appeals

11.1 A patient, recognised carer, advocate (including an Independent Mental Health Advocate), legal representative or young person may wish to complain about or appeal against a decision to refuse child visiting, and can use Form CV2 to support this.

11.2 In this context a complaint is an expression of dissatisfaction about an aspect of process or outcome which a person wishes to have investigated. As with other complaints those about child visiting can be dealt with through the Trust complaints procedure.

11.3 An appeal is a request that a decision made be reviewed because it was mistaken as to fact or reasoning. Any decision taken with regard to child visiting can be the subject of a complaint, an appeal or both.

11.4 Recognising the importance of timeliness an appeal against refusal of child visiting should take place within 10 days of it being lodged and the process is intended to be straightforward.

11.5 Appeals can be lodged verbally or in writing to the Trust, and will be considered by the Service line/Directorate Manager. In considering the appeal they will:

- Consider the reasons given for the appeal
- Review the form CV1 and any notes of meetings, assessments and accompanying information.
- Consult with the person who completed the CV1
- If necessary meet with the appellant
- Consider whether escalation to the Service Director is necessary

11.6 Having reviewed the evidence they will:

- Uphold the refusal either on the terms it was made or as amended by them, or
- Ask for the refusal to be re-considered in the light of new information provided or to be sought
- Overturn the refusal; identifying new terms upon which visits can be take place.

Given the timescales involved it is unlikely that the veracity of information leading to refusal would be challenged through an appeal.

11.7 Further consideration of decisions to refuse child visiting may arise from the complaints process which both investigate wider concerns than the appeal process and take longer to complete.

11.8 Any decision to refuse child visits following an appeal should be provided in writing to the appellant providing information on how to escalate this through the Trust complaints Process

12 Outpatients and Day Hospitals

12.1 Although this policy refers across inpatient services staff should apply the principles contained within the policy to outpatient and day hospital settings where possible.

12.2 Local variations may need to be made within those settings and where necessary a protocol should be developed and made available to staff.

13 Monitoring

13.1 The monitoring of the application of this policy will be the responsibility of the Services Manager within each area.

13.2 When incidents arise in relation to the operation of this policy they will be recorded in line with the Trusts Incident Reporting Policy but will also be reviewed by the Acute Care Forum on a regular basis.

13.3 Where investigations have taken place it is the responsibility of the Services Manager to communicate findings in line with governance procedures

13.4 Service managers will be responsible for ensuring training needs are addressed within the local areas and for communicating with the Child Safeguarding Lead and Learning and Development if a Trust wide training requirement is identified through the monitoring of this policy

13.5 It is the responsibility of the Services Manager to monitor the child visiting area on each unit. This includes the appropriateness of the area and the housekeeping arrangements.

14 Audit

14.1 The application will be monitored bi-annually and this will include a review of the child visiting facilities on each site.

14.2 It is the responsibility of the Governance Manager to ensure an audit is completed.

14.3 The results of the audit will be forwarded to the Child Safeguarding Forum.

15 References

- Mental Health Act 1983
- MHA Code of Practice 2008
- Guidance of the visiting of psychiatric patients by children Circular HSC 1999/222: LAC (99)32.
- Childrens Act 1989
- Childrens Act 2004
- Human Rights Act 1998
- Parents in Hospital Summary Report July 2007

PENNINE CARE NHS TRUST
Form CV 1

CHILD VISITING *(please complete one form for each child)*

1. Patient Details

Name …… RT …… Ward ……

2. Child Details

Name …… date of birth ……

Relationship to patient ……

3. Children's services involved with child? Yes ☐
No ☐

Children's Services contact Name …… Tel: ……

Referral needed to children's services? Yes ☐ No ☐

4. Details of Visiting

Name of adult accompanying the child ……

Relationship of accompanying adult to patient ……

Relationship of accompanying adult to child ……

Frequency of visits …… Length of visit ……

Location of visit ……

Degree of supervision required ……

5. What issues or concerns are raised if the child visits the patient?

6. What actions/arrangements will be needed to address these issues?

7. Approval of visiting in the light of the above

A Child visiting is approved in accordance with the arrangements shown on the next page

Signed

Ward Manager/Senior Nurse …… (dated)……..

Care Coordinator/AMHP/RC
(where appropriate) …… (dated) ……..

- -

B Child visiting is not approved

Signed

Ward Manager/Senior Nurse…… (dated)……..

Care Coordinator/AMHP/RC
(where appropriate) …… (dated) ……..

8. Has the decision not to allow visiting been explained to/discussed with the patient, and information given about the appeal process Yes ☐ No ☐

Signed …… Date ……..

FORM **CV2**

PENNINE CARE NHS TRUST
Form CV2

APPEAL AGAINST REFUSAL OF CHILD VISITING

This form should be completed by or on behalf of any patient who has been denied a child visit and wishes to appeal against that decision. The appeal will be considered by the Service line/Directorate Manager of the service.

The onus is upon the ward manager, care co-ordinator and Responsible Clinician (where appropriate) to justify not allowing visits. Consideration of the appeal will be based upon information contained within forms CV1 and CV2 that identify details of issues/concerns arising from visits, and any such enquiries as might be deemed necessary.

1. **Name of patient** ……

ward ……
RT number ……

2. **Name of child** ……

Date of birth ……

3. **I wish to appeal against the decision made not to permit visits from the above child**

Signed …… Date ……

Name in block capitals ……

or

Signed …… Date ……

Name in block capitals of a person appealing on behalf of the patient ……

FORM **CV3**

PENNINE CARE NHS TRUST
Form CV3

Child Contacts external to in-patient areas or Home Leave *(please complete one form for each child)*

1. Patient Details

Name …… RT …… Ward ……

2. Child Details

Name …… date of birth ……

Relationship to patient ……

3. Children's services involved with child? Yes ☐
No ☐

Children's Services contact Name …… Tel: ……

Liaison with children's services about contact needed Date:

4. Details of Child Contacts External to in-patient areas

Name of any other adult present at contact……...

Relationship of adult present to patient ……..

Relationship of adult present to child ……

Frequency of visits (if applicable)……Length of visit ……

Location of visit ……

Degree of supervision required ……

5. What are the issues or concerns for the child in relation to contact from the patient?

FORM **CV3**

6. What actions/arrangements will be needed to address these issues?

7. Approval of contact

A Child visiting is approved in accordance with the arrangements shown on the next page

Signed

Ward Manager/Senior Nurse ………………………………… (dated)……………………………….
or
Care Coordinator/AMHP/RC
(Where appropriate) ……………………………….   (dated) ………………………………………

- -

B Child visiting is not approved

Signed

Ward Manager/Senior Nurse ……………………………(dated)……………………………………
or
Care Coordinator/AMHP/RC
(Where appropriate) ……………………………….   (dated) ………………………………………

8. Has the decision not to allow visiting been explained to/discussed with the patient, and information given about the appeal process Yes ☐ No ☐

Signed ………………………………………   Date …………………………………………….

9. Has the decision not to allow a visit been discussed with the child and/or a person with parental responsibilities for them? Yes ☐ No ☐

Signed ………………………………………   Date …………………………………………..

10. Has the decision not to allow a visit been provided in writing to the patient, child and / or a person with parental responsibility for them? Yes ☐ No ☐

Signed ………………………………………   Date …………………………………………..

Form CVR

Form CVR

CHILD VISITING RECORD

Name of Patient …….

RT Number …….

Name of child ……..

Date of visit/ contact	Name and signature of staff to show if room checked/facilities in good order	Name and signature of nurse reviewing CV1 or CV3 & TARA prior to contact occurring If any changes then CV1 or CV3 needs completing again.	Issues arising/effect of visit on patient/child. Feedback from child obtained where possible	Name & signature of nurse making observations.

Messages From Children and Young People

Parents in Hospital Summary Report July 2007
Mental Health Act Commission, Care Services Improvement Partnership, Barnados

Children and Young People have told us what they would like from you when visiting their parents in hospital:

1. Introduce yourself. Tell us who you are. What your job is
2. Give us as much information as you can
3. Tell us what is wrong with our mum, dad, grandparent or guardian
4. Tell us what is going to happen next
5. Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens
6. Ask us what we know and what we think. We live with our mum or dad. We know how they have been behaving
7. Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
8. Please don't ignore us. Remember we are part of the family and we live there too!
9. Keep on talking to us and keeping us informed. We need to know what is happening.
10. Tell us if there is anyone we can talk to. MAYBE IT COULD BE YOU.

All staff should try to apply this ten point guide when interacting with child visitors to the unit

Flowchart for Child visiting / Child Contact