

ADASS ADVICE NOTE

Infection Control, Essential Visiting and Human Rights in Care Homes

02.11.20

Introduction

This guide has been developed by ADASS for DASSs in relation to thinking about care home visits from a Human Rights perspective, to support them in fulfilling their Public Sector Equalities Duty as well as requirements in the Care Act 2014 relating to personalised approaches and wellbeing. This of course sits alongside infection control arrangements that equally supports the right to life. This isn't about two opposing sides: public health versus resident rights; these are not mutually exclusive. What is paramount is understanding the risks, reducing them as far as possible, and taking decisions based on the potential impact on all aspects of health and well-being with individuals, the other care home residents, staff and their external contacts.

Concerns about infection control have meant that visits to care homes have been restricted as has the ability of care home residents to go out. When restrictions were first introduced at the beginning of the pandemic they were perceived as time-limited, and there seemed to be a general acceptance of policies excluding visitors from care homes. After all, there was a national lockdown. However, the impact of not seeing family and friends over a prolonged period (and with the prospect of this continuing for months to come) has seen that general acceptance break down. This in turn has highlighted the need to balance the safety afforded by controlling infection with the rights of the individual and the detrimental effect on people's emotional, mental and physical wellbeing of not having contact with people they need and the outside world.

Human rights are like an ethical yard stick and, by their very nature, complex. On the one hand, there are those who want, more than anything else, to be protected from a virus that is highly contagious and dangerous to people with underlying health conditions. On the other, there are many, particularly those who may be in the last years of their lives, who do not feel their lives are worth living without contact with the people they love. For most, there is probably a decision to be made about a balance of risks to themselves and to others. Those who are able to do so have a right to choose what risks they are willing to take for the benefit of seeing their family. Obviously, the accommodation of such choices has to have regard to the protection of others from harm. Those unable to make decisions for themselves are entitled to have choices made which are in their best interests in line with the principles of [Mental Capacity Act 2005](#), taking in to wishes and feeling reviewed holistically, not just with regard to protection from infection.

In Human Rights terms, there is a need to balance the continued management of COVID-19 risk, whilst affording people their rights, including the right to life, to a family life, to freedom from inhuman and degrading treatment, to autonomy, and to not be arbitrarily deprived of their liberty. There is also a need to take account of the common law principle of consent. It is a challenge for all as to how to support care homes to become both safe *and* open. This guidance note is for DASSs, working with their Directors of Public Health and their councils to support care homes in making these decisions.

Taking account of existing guidance and the legal framework

This Advice Note should be read alongside the latest guidance on visiting in care homes which, at the time this was written, was '[Update on policies for visiting arrangements in care homes: updated 15 October 2020](#)'.

It should also be read alongside the [Equality and Human Rights Commission's Parliamentary Briefing](#), which sets out the key provisions and requirements of those duties, and this letter from Justice Hayden which confirms the legality of visiting, even in areas of high and very high infection rates which can be found [here](#).

The legal context

The right to make decisions about how to live one's life is central to concepts of Human Rights. However, none of us are entitled to exercise those rights in a way known to endanger the lives of others.

Whilst it is important to remember that under the common law doctrine of necessity there is a general power to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm, such powers cannot be used indefinitely to restrict people's rights. In other words, such authority is intended to deal with an immediate crisis where intervention is urgently required to avert serious consequences e.g. serious assault on a third party, or self-harm. Whilst the initial use of restrictions to stop visits between care home residents, relatives and friends at the start of the pandemic in March, April & May 2020 can be justified; as time continues the need to develop more balanced and personalised approaches to visiting grow. To continue to use such powers without thought may lead organisations into difficult legal territory.

Visiting arrangements have implications for human rights ([Human Rights Act 1998](#)) including the right to life (Article 2 ECHR), the right to respect for private and family life (Article 8 ECHR) and the right to freedom from inhuman and degrading treatment (Article 3 ECHR). Under Section 6 of the Human Rights Act, public authorities have a legal duty to act compatibly with human rights in all they do. The duty also applies when a resident's care is being funded or arranged by the NHS or a local authority. [The British Institute of Human Rights \(BIHR\)](#), carried out research into the way that care homes had exercised their duties under the Human Rights Act. This suggested that social care professionals have not received legal training or information about upholding human rights or using emergency powers during the COVID-19 pandemic. This remains a concern given that the responsibility for decisions is left to the discretion of registered managers without sufficient understanding of balancing rights and risks.

The [Equality Act 2010](#) ('Equality Act') protects individuals from discrimination and promotes a fairer and more equal society. This Equality Act also imposes duties on bodies (such as councils) and therefore the care they commission through care providers to work in ways that promote people's rights. While COVID-19 poses unprecedented public health challenges, the Equality Act has not been amended or repealed. All duty-bearers with obligations under the Equality Act must therefore continue to act lawfully, taking necessary steps to prevent unlawful discrimination and deliver services with users' needs in mind.

The Care Act 2014 ('the Care Act') also sets out duties in relation to adult social care. It should be applied in accordance with the associated statutory guidance.¹ Under the Care Act, local authorities are required to assess the needs of people in their area who appear to require care and support, and the needs of their carers,² and meet those needs that are eligible. The Care Act is underpinned by a 'wellbeing principle', which requires local authorities to promote individuals' wellbeing when carrying out their care and support functions.³ How this is achieved will depend on the individual's needs, but should include a focus on preventing or delaying care needs arising, promoting independent living, and enabling individuals to participate as fully as possible in decisions - including by providing information and advocacy.⁴ Local authorities also have safeguarding duties under the Care Act.⁵ They are required to make or arrange enquiries if they believe an individual is

¹ Department of Health and Social Care (24 June 2020), '[Care and support statutory guidance](#)'.

² [Care Act 2014](#), ch.23, part 1.

³ Department of Health and Social Care (24 June 2020), '[Care and support statutory guidance](#)'.

⁴ Ibid.

⁵ [Care Act 2014](#), s.42-47.

experiencing or at risk of abuse or neglect, and if so to establish what action should be taken.⁶ The Care Act further provides a framework for commissioning services that comply with the Equality Act 2010.

Taken together, these duties mean local authority Directors must as far as possible:

- Work to support care providers ensure they not applying 'blanket bans' on visiting
- Support care providers to develop proportionate guidance that balances risks of infection, with rights to private and family life
- Be conscious of the unintended consequences that can arise as a result of restrictions being applied. (For example, families making decisions to take a loved one home at the end of life, is likely to result in a higher demand for community-based support.)
- Support providers to ensure that visiting policies use a dynamic risk assessment process, which take into account people's personal circumstances, as well as the vulnerability of residents in the care home and the home's actual environment
- Support providers to develop visiting policies that ensure people – residents and families – having full information about the risks and benefits of visiting verses not being visited and seek explicit consent to any restrictions.

As ADASS, we would very much welcome examples of how providers, with their Directors of Public Health, and DASSs, have created environments where homes can be both safe and open to visitors.

Are visits to residents of care homes legal, even in tier 3 areas?

As the letter published by Justice Hayden emphasised⁷, even in areas where there is the highest risk of infection, regulations provide for exceptions where indoor gatherings can take place, and this includes visits to care homes

Exceptions in relation to indoor gatherings

5.—(1) These are the exceptions relating only to indoor gatherings.

Exception 1: visiting a dying person

(2) Exception 1 is that the person concerned ("P") is visiting a person whom P reasonably believes is dying ("D"), and P is— (a) a member of D's household, (b) a close family member of D, (c) a friend of D.

Exception 2: visiting persons receiving treatment etc

(3) **Exception 2 is that the person concerned ("P") is visiting a person ("V")** receiving treatment in a hospital or **staying in a hospice or care home**, or is accompanying V to a medical appointment **and P is—**

- (a) a member of V's household,**
- (b) a close family member of V, or**
- (c) a friend of V.**

It is worth noting that the regulations talk about 'exceptions' to rules on indoor gatherings, as opposed to 'exceptional circumstances' where visiting is permitted. In other words, it is lawful for people to visit their relatives in care homes. Therefore, the challenge is how to make those visits as safe as

⁶ Ibid.

⁷ <https://www.judiciary.uk/wp-content/uploads/2020/10/Letter-from-Mr-Justice-Hayden-for-website-1.pdf>

possible and in ways which are least likely to risk harm to the person themselves, and others. Infection control is critical.

Are 'blanket' bans on visiting legal?

There is a duty to take reasonable, proportionate and practical steps to ensure people are included in decision making, and their rights protected. In some cases that could mean asking a resident to adapt the precise visiting arrangements they desire. Even where a resident with capacity does agree to restrictions requested by the care provider, that does not absolve the home of their duty to mitigate the effect of the restrictions by looking for alternative solutions or relieve the DASS of working with their DPH to find means of making visiting as safe as possible for those who have information about the risks, agree to protect others and give informed consent to enable visiting to happen.

Any changes to normal (pre-covid) visiting policies which restrict rights must:

- take into consideration the needs of the person and other people,
- be flexible, with review and end points, and
- remain open to challenge.

We consider, having sought advice, that blanket restrictions leave providers and councils open to legal challenge (whether local or through care home chains) and, even in situations where the local COVID restrictions are at the highest level, there must always be consideration for personal and exceptional circumstances so as to comply with PSED and Human Rights requirements. Thought must be given to balancing the risk of harm and distress to residents and their families due to not having visits, with the risk of harm to residents, staff and visitors through COVID-19 infection. The common law principle of consent should be applied, alongside emergency powers.

Risk assessments

DASSs will want to make sure that their public health colleagues and care providers ensure they take a person-centred approach to their visiting policy, taking account of individual needs and capabilities, the environment and a number of different circumstances.

For example consideration could be given to the level of risk presented by a visit to a relative by someone who rarely goes out, wears PPE and visits in an infection controlled room accessed by a separate entrance, compared to managing visits by someone who has limited understanding of how to use PPE and where the home's environment limits safe visiting space.

Providers should be supported to seek the views and wishes of each resident in relation to visiting, and be supported in attempts to provide safe, zoned visiting areas. Where this is not possible, expectations should be made clear that current and prospective residents (or their representatives or advocates if they lack capacity) will be clearly informed, so that they can weigh up the risks and consider these along with alternatives with the provider and with social workers.

Making information available to inform dynamic risk assessments

ADASS recommends that DASSs, with their DHP, triangulate information to support care homes in determining the safety and suitability of visiting. The Local Authority with responsibilities for Public Health should take into account infection rates and the wider risk environment.

The 'visiting care homes during coronavirus' guidance provides criteria for inclusion in determining the safety of visiting. At the very least the following information should be considered:

- local testing data, including test and trace data, to form a view on the accuracy of local outbreak information including data on uptake, results and frequency of testing in the local area, as well as to form a view of community prevalence
- any national oversight taking place in an area due to transmission risks.
- advice of the Director of Public Health (DPH) about how visiting is managed on the level of COVID-19 infection being experienced locally. This advice will be reviewed by the DPH and could change rapidly if an outbreak occurs. Any such advice should balance people's physical and mental health needs and take into account the views of the DASS, the care home's circumstances and an approach to personalising the risk.

Visiting in High level Covid-19 infection areas

In areas where highest levels of restrictions are in place, there should still be due consideration of the need to support visiting and the detrimental impact on the individual of not having a visit. Current guidance states in exceptional circumstances, for example at the end of life, visiting is to be supported. We believe that this requires greater latitude as some providers are interpreting this as allowing visits to people only in their very final hours, to great distress. There are many individuals who are greatly disturbed and distressed by a lack of visits, not just those in the last hours of life. The reality is the 'end of life' is a difficult to predict timeframe.

Providers should take into account factors including:

- The level of distress & harm experienced by residents as a result of not having contact with loved ones
- Situations which limit a person's ability to make use of alternative ways of maintaining contact (for example, challenges in using digital technology)
- The willingness of individual residents to make informed choices to maintain contact, where the risks to others can be managed.
- Where residents lack capacity to make such informed choices, practitioners need to use the framework of the Mental Capacity Act to determine what the person might have chosen to do, had they had the capacity to decide.
- The importance of allowing families to work together to plan and support a loved one through their final days and hours, in a safe enough manner.

Although the provider (as the registered manager) has the ultimate responsibility in terms of the safety of visits, and whether to suspend them, the local authorities themselves will be under their own obligations under the ECHR and Public Sector Equality Duty to ensure individuals who are affected are none the less supported to access their human rights - for example challenging 'blanket' bans on visiting, or considering when such bans, in the context of other concerns about a 'closed' culture developing need to be considered as a safeguarding issue. (See ADASS Tool: [Safeguarding people in 'closed' environments](#))

The Local Authority should seek to ensure that care providers are not being either unduly risk averse or risk tolerant and should assist them to resolve dilemmas. Risk assessments and visiting arrangements for residents need to be person-centred and risk assessments of environments will also need to be specific to each individual setting.

Summary

This guidance document encourages DASSs and their staff to work with care providers to develop balanced and dynamic visiting protocols. In the absence of national guidance that we believe fully incorporates rights and responsibilities, the following are some of the principles to consider:

- Local authorities and providers must not impose blanket policies in their settings and exceptions should not be overly limited. All risk assessments, care plans, and visiting arrangements, must be undertaken in a person-centred manner.
- Care providers should work to maintain contact between the individual and their key relatives and friends at all times. Where and when face-to-face visits are felt to be unsafe, in order to avoid fundamental breaches of Human Rights care providers should be supported to use alternative contact methods. This could be achieved, for example, by using digital technology to promote contact, or by considering whether the restrictions proposed are *proportionate* given the impact they may have on an individual, and the realistic level of risk a visit might pose to the resident and others.
- Work should be undertaken to ensure that residents are fully informed of the risks and benefits of visiting or not visiting and that they and their family give explicit consent in relation to risk, for example:
 - a) what risks they want to avoid at all costs and the restrictions that that will entail and that they consent to (which could be that they do not see family members for several months if the pandemic is prolonged)
 - b) the risks that they are willing to take (if managed as safely as possible and if the lives, safety and wishes of others can be managed)
- Directors and respective care providers they commission should comply with duties under the Equality Act and demonstrate how they have considered, on an ongoing basis, the impact of their decisions on care home residents with different protected characteristics.
- Further consideration must be given to [ethical framework for adult social care](#)

Ongoing discussions

ADASS is in ongoing dialogue with DHSC, care provider organisations (who provide support to wide range of needs including learning disabilities, autism, mental health, dementia and those with physical disabilities), ADPH and others in the sector. Modifications to the current Government guidance are being sought, particularly in the light of the current national lockdown and three-tiered system of local COVID Alert Levels in England. We are developing opportunities to share examples of visiting arrangements being made as safe as they possibly can be.

At the time of writing, the Care Minister had advised that there will be pilots to trial designated visitors with regular COVID-19 tests. This would enable selected relatives, friends, or informal carers of care home residents to be treated as key workers to allow more frequent visits under a pilot scheme in England. ADASS welcomes the pilots for keyworkers, however we are concerned that this is both too little and too late, and that people are in distress due to not seeing people who are critical in their lives.

Appendix

Additional information: keeping the person at the centre of the decision-making process including where they lack capacity to make decisions

- Local Authorities must promote the person's wellbeing as described under [section 1 of the Care Act 2014](#); in terms of visiting this is to maintain contact with their loved one and to meet the needs of carers
- Wishes and feelings of the individual must always be central to any decision-making process in line with the principles of the Mental Capacity Act 2005.
- Consent must be obtained from the person when consulting with others, if the individual is capacitous. Where individuals lack capacity, decisions must be made in line with Principle 4 of the Mental Capacity Act 2005.
- Where the individual lacks capacity, providers must consider historic visiting wishes and needs and consult with the person's LPA's, advocates, persons of importance to the individual, and any other professionals where necessary. Mental capacity assessments must be completed with best interest decisions clearly documented in these situations. The government has published advice [on caring for residents without relevant mental capacity](#) and [MCA and-DoLS during the coronavirus covid-19 pandemic](#)
- Where there is an existing authorised deprivation in place for an individual and a further restriction is imposed, the Managing Authority must inform the Supervisory Body and the appropriate steps must be undertaken as prescribed in the DoLS scheme.
- Face-to-face visits by practitioners are an important as part of the DoLS legal framework and for other aspects of life and wellbeing (for instance, from doctors, nurses or social workers if they cannot be managed otherwise. These face to face visits should currently occur if needed, for example to meet the person's specific communication needs, safeguarding concerns or if there additional concerns about the persons human rights.
- When deciding whether or not to visit in person, professional visitors should work closely with care homes to decide if visiting in person is appropriate, and how to do this safely. Visiting practitioners should understand and respect their local visiting policies. Visitors must follow important local infection control policies in the setting that they visit, which are based on national government and local guidance.

Communication and the relationship between the Local Authority and the Provider is key to ensuring positive outcomes for the person in need of care and support. This is increasingly important, especially if there is any reduction in visiting to a care home due to additional restrictions. This must be balanced by an increase in communication and engagement with families, and the care home demonstrating what they have done to mitigate the impact of reduced visiting.