Visitors to Clients in Isolation: Managing

What is Managing Visitors to Clients in Isolation?

Managing visitors to clients in isolation (i.e., on isolation precautions, which are infection-control measures used in addition to standard precautions to prevent transmission of infectious agents) involves balancing efforts to support client-visitor interaction with the need to prevent transmission of pathogens, maintain clients’ safety, and support client care. This function has become particularly critical with the spread of organisms that have limited treatment options (e.g., carbapenem-resistant *Enterobacteriaceae* [CRE]) and with the increased awareness that many hospital-associated infections are preventable. Current policies are directed toward use of isolation precautions guided by the specific pathogen, the endemicity of the microbe in the hospital and surrounding community, the benefit of imposing the isolation precaution on specific visitors (e.g., family members who have been exposed to the symptomatic individual), and the practicability of enforcement of the precautions.

- **What**: The management of clients’ visitors is generally guided by facility visitation policies, which are established to protect the safety of clients and healthcare personnel (HCP) and promote optimal client care, in accordance with the guidelines for isolation precautions issued by the U.S. Centers for Disease Control and Prevention (CDC). Generally, the CDC guidelines support placing a client with a contagious disease in an environment that permits contact with others only if certain personal protective equipment (PPE) is worn. This *Social Work Practice & Skill* will provide an overview of adhering to isolation precautions in the context of client visitation. For more detailed information on specific isolation precautions, see individual topics in the *Social Work Practice & Skill* series on types of isolation (i.e., contact, airborne, and droplet precautions).

- **How**: Managing visitors to clients in isolation involves the following:
  - Adhering to facility/unit-specific visitation policies (e.g., enforcing visiting hours and restrictions, such as number and age of visitors; confirming visitor badges are worn)
  - Screening visitors for illness (e.g., coughing, fever) and precluding visitation for these individuals
  - Discerning the appropriateness of visitation (e.g., based on the client’s wishes and/or clinical condition)
  - Enforcing visitor adherence to infection-control policies (e.g., standard precautions, isolation precautions)
  - Educating and instructing visitors about the purpose of visitation and infection-control policies; explaining the importance of restricting visitor movement within the facility to client care area and immediately adjacent waiting room for visitors to clients with highly virulent diseases
  - Respecting the client’s ethnic, cultural, and/or religious principles and individual needs

- **Where**: Managing visitors to clients in isolation occurs in all inpatient settings where isolation precautions are used, including acute and long-term care facilities.

- **Who**: The client’s nurse is typically responsible for determining the appropriateness of visits and managing visitors in accordance with facility/unit-specific policies. However, it is important that all healthcare workers be aware of facility protocols for patient visitation, infection control, and hospital safety.
What is the Desired Outcome of Managing Visitors to Clients in Isolation?
› The desired outcome of managing visitors to clients in isolation is to prevent the transmission of pathogens, maintain clients' safety, and promote optimal client care, while supporting the client’s needs for social contact with family and friends.

Why is Managing Visitors to Clients in Isolation Important?
› Client visitation can be an important part of a client’s mental well-being because hospitalization is often emotionally and psychologically distressing, and meeting with friends and family can provide clients with support and social interaction. Clients who are being cared for under isolation precautions are especially at risk for adverse psychological effects such as depression, anxiety, and anger. However, in managing visitation, the nurse clinician must balance the client’s psychological need against the increased risk of disease transmission due to the virulent nature of organisms that typically require isolation.

Facts and Figures
› Researchers who examined the rates of compliance with contact precautions in a large academic medical center and an affiliated Veterans Administration hospital reported low rates at both facilities, 7% and 22%, respectively. Lack of effective hand hygiene prior to room entry was the most common reason cited for incomplete compliance (Yanke et al., 2015).
› Investigators at a large tertiary care center surveyed visitors to clients in contact isolation and found that visitors had an overall positive perception and understanding of the need for infection precautions, which was attributable to the communication and education provided by HCP (Roidad & Khakoo, 2014).

What You Need to Know Before Managing Visitors to Clients in Isolation
› Prior to managing visitors to clients being cared for under isolation precautions, the social worker should be familiar with the following:
   • Recommendations regarding visitors to clients in isolation published in 2015 by the Society for Healthcare Epidemiology of America (SHEA), which are designed to balance visitor and clients' safety and the potential for pathogen transmission against the psychological implications of client isolation and the practicability of enforcement. The following recommendations are intended for endemic pathogens in non-outbreak situations (i.e., an outbreak is the occurrence of cases of a disease or pathogen in excess of what is normally expected in a defined community, geographic area, or season).
     Isolation precautions should be enforced for all visitors in cases of outbreak situations or if a novel pathogen (e.g., Ebola virus, Middle East respiratory syndrome coronavirus [MERS-coV], severe acute respiratory syndrome [SARS], coronavirus 2019 [SARS-CoV-2]) is suspected:
     – Hand hygiene prior to and immediately after leaving a client’s room
     – Consider elimination of isolation precautions for visitors with extended stays (e.g., parents, guardians) due to the impracticability and reduced effectiveness—the frequency with which PPE should be changed for visitors is unknown
     – Consider elimination of isolation precautions for visitors who have become carriers or who have developed immunity due to prior extensive documented exposure (i.e., household contacts) to the symptomatic client
     – In areas where methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant enterococci (VRE) are endemic, contact isolation precautions may not be necessary (due to prevalence in community) for routine circumstances—isoaltion precautions comparable to those used by HCP should be followed by visitors who participate in client care. Consider special circumstances (e.g., limiting/precluding visitation, use of gloves/gowns) for immunocompromised visitors and individuals who are unable to practice adequate hand hygiene
       - MRSA is extremely contagious and is spread by direct contact with skin infection, indirect contact with a vector that has been in contact with the skin infection (e.g., towel, benches in gyms), or through aerosolized droplets from a client with MRSA pneumonia
       - Visitors who interact with multiple clients should follow the same isolation precautions used by HCP
     – Visitors to clients who are colonized or infected with the following pathogens (which are not yet widely prevalent in most regions of the United States) should follow contact precautions similar to those used by HCP:
       - Gram-negative organisms (e.g., CRE and Klebsiella pneumoniae carbapenemase [KPC])
       - Intestinal pathogens (e.g., Clostridium difficile and norovirus)
     – Pathogens that are spread by droplet or airborne transmission should be considered harmful to all because this is one of the few scenarios in which visitors have been proven to have initiated or been involved in nosocomial outbreaks in the acute care setting. Visitors to clients under droplet (e.g., pertussis) or airborne precautions (e.g., tuberculosis) should wear surgical masks unless the visitor has had extensive documented exposure to the symptomatic client—the exception is made due to presumed immunity or the probability the visitor is already in the incubation period. For clients whose
condition requires that HCP wear an N-95 particulate respirator or higher respiratory protection, visitation should be restricted to individuals who have been fit tested with an N-95 respirator
– Individuals who are ill (e.g., active cough, fever) should be restricted from visitation
• The standard of care for clients placed on isolation precautions is delineated in guidelines published by the CDC, accessible online at https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
• General visitation guidelines established by hospitals or individual nursing units are developed with the following issues in mind:
  – Visitors present a potential safety hazard. Restricting visiting hours to the daytime or early evening can help protect clients and staff because the facility is more heavily staffed with personnel who can identify and respond to potential safety hazards
  – It is essential to maintain order in the nursing unit and to prevent the disruption of care, particularly in ICUs and other critical care areas
  – Individuals who are ill need rest. Unrestricted visitation could potentially result in a continuous stream of visitors, which could impair recovery
  – The spread of communicable diseases must be controlled
  – Visitors should not be present during aerosol-generating procedures
• Importance of using individual judgment in deciding if or when to permit visitation when following facility or unit guidelines for visiting hours. For example, allowing visits outside of the normal visiting hours might be considered
  – if the client has recently been admitted
  – if the visitor has traveled a long distance
  – if the client is nearing the end of life
  – in light of the client’s cultural, ethnic, or religious background; for example, if
    - culture strongly emphasizes family presence during illness
    - the family desires to offer prayers or rituals
    - the family is distrustful of Western medicine and family members want to verify their loved one is safe
  – if the client is a child or developmentally challenged adult
› Providing education and instruction to visitors of clients in isolation is critical to promote understanding of and adherence to infection-control policies. Higher rates of compliance and overall satisfaction with healthcare performance are observed when visitors understand the rationale behind restrictions. Nurse clinicians are responsible for communicating information about how to follow standard precautions in addition to the prescribed type of isolation precautions: contact, droplet, or airborne. Social workers should reinforce education that was provided by medical personnel
• Standard precautions include
  – hand hygiene (performed either by scrubbing hands with soap and warm water for 15 seconds or applying a facility-approved antimicrobial handrub)
  – wearing PPE if exposure to body fluids/secretions is anticipated
  – adhering to respiratory hygiene/cough etiquette practices (e.g., covering the mouth/nose when coughing and sneezing, proper disposal of soiled tissues, and hand hygiene after tissue disposal; sitting at least 3 ft/1 meter away from someone who is coughing) as an infection-control measure to minimize the spread of respiratory diseases
• Contact precautions are intended to prevent transmission of infectious agents that are spread by direct physical contact with a person or by indirect contact with contaminated items. Gowns and gloves are required. If exposure to potentially contaminated body fluids such as respiratory secretions or vomitus is possible, a face mask can also be appropriate
• Droplet precautions are instituted for infectious agents that are capable of traveling short distances (i.e., 3 ft/1 meter) through the air within large respiratory droplets (e.g., seasonal influenza virus) after being expelled by the client (e.g., by coughing, sneezing, or during clinical procedures such as suctioning and bronchoscopy). PPE requirements include a mask (sometimes with an eye shield) if within 3 ft/1 meter of the infectious client. Special air handling and ventilation are not required because the identified pathogens do not travel long distances in the air. CDC guidelines indicate that 3 ft/1 meter is viewed as an example of a “short distance” and suggest it can be prudent to don a mask when within 6–10 ft/2–7 meters of the client or upon entry into a client’s room if exposure to highly virulent pathogens is likely. The CDC has recommended additional studies be performed to increase understanding of droplet transmission under various circumstances (e.g., velocity and mechanism by which respiratory droplets are propelled, density of secretions, environmental factors of temperature and humidity, pathogen viability over long distances). Pathogens for which droplet precautions are indicated include Bordetella pertussis (the bacterium that causes pertussis, also known as whooping cough), adenovirus, rhinovirus, Mycoplasma pneumoniae, SARS-associated coronavirus, group A streptococcus, Neisseria meningitides, and seasonal influenza virus
Airborne precautions prevent transmission of infectious agents that are known to travel over long distances when suspended in the air (e.g., measles, chickenpox). Airborne precautions involve placing the affected individual in an airborne infection isolation room (AIIR). An AIIR is a type of private room that has specialized air handling and ventilation capacity, including monitored negative air pressure relative to the surrounding area, 6–12 air exchanges per hour, and either an air exhaustion system that delivers contaminated air directly outside of the facility or use of high-efficiency particulate air (HEPA) filtration to remove contaminated particles from the air before recirculation indoors. HCP must wear a NIOSH-approved respirator rated N-95 or greater when entering the client’s room.

Preliminary steps that should be performed before managing visitors to clients in isolation include the following:
- Review facility/unit-specific visitation policies, security protocols, and infection-control practices
- Review the client’s medical record to determine if the client has been placed on isolation precautions by the treating physician, including the rationale for isolation
- Gather all necessary supplies and equipment (e.g., gloves, gown, eye protection, face mask)
- Verify that PPE and hand hygiene supplies are available to visitors at an appropriate location

Social Work Responsibilities in Regards to Managing Visitors to Clients in Isolation

- Reinforce visitation policies, including
  - policies limiting times or duration of client visits
  - the need for visitors to wear identification badges, if applicable
  - restrictions regarding the number of visitors permitted at one time
  - restrictions limiting visits by young children, if applicable
  - infection-control policies and procedures
- Advise of the importance of adhering to standard precautions and the specific requirements of the infection-control isolation precaution in place for the client to be visited; indicate that visitation can be restricted if visitors are unable or refuse to comply with precautions
  - Remind visitors to follow standard precautions for visitors (e.g., hand hygiene, respiratory hygiene/cough etiquette), as necessary (Munoz-Price et al., 2015)
  - Remind visitors to follow standards specific to the client’s type of isolation, as necessary (Munoz-Price et al., 2015)
    - to perform hand hygiene prior to entering and immediately upon leaving the client’s room
    - to follow directions for the use of PPE while visiting and to discard PPE prior to exiting the room
    - to ask permission prior to bringing items into and removing items from the client’s room
    - to refrain from eating from the client’s tray or using his or her telephone and restroom
    - for the client to remain inside the room
- Discern the appropriateness of each client visit; notify nursing staff if
  - the client does not wish to be visited or becomes distressed during the visit
  - the visitor is argumentative or disruptive
  - risk of disease transmission is unacceptably high (e.g., client or visitor is unable or refuses to comply with isolation precautions)
- Consult with nurse if allowances for client visits outside of the normal visiting hours are requested in response to the client’s special circumstances, cultural or religious background, or individual needs
- Monitor clients in isolation for mental distress, including depression, anxiety, loneliness, and boredom; provide emotional support to clients and family members, as necessary
- Document client visits in the client’s medical record, including
  - frequency and quality of visits
  - client’s response to visits
  - client/family teaching about visitation guidelines
  - any problems that arose and how they were remedied
- Social workers should practice with awareness of and adherence to the social work principles of respect for human rights and human dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles (IFSW, 2018), as well as the national code of ethics that applies in the country in which they practice. For example, in the United States, social workers should adhere to the National Association of Social Workers (NASW) Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to visiting clients in isolation and practice accordingly (NASW, 2017).
Other Interventions that May be Necessary Before or After Managing Visitors to Clients in Isolation

› There are no other interventions that are necessary for the social worker to conduct before, during, or after the implementation of contact precautions

What Social Work Models are Used with Managing Visitors to Clients in Isolation?

› Client visits are conducted in accordance with facility policies and infection-control guidelines
› Any established social work model can be used with a client who is in isolation

Red Flags

› Consider alternative methods of communication between family members/contacts and clients such as video conferencing if visitation must be restricted
› In order to be effective, hand hygiene should be performed both before donning gloves and after discarding gloves; effective hand washing involves vigorous scrubbing of all hand surfaces for a minimum of 15 seconds
› Clients in isolation are at increased risk for social isolation and mental distress, including depression, anxiety, loneliness, and boredom. Interactions with family, friends, and clinical staff provide important social and emotional support for isolated clients (Cates et al., 2018)
› WHO recently issued interim guidance in response to the COVID-19 outbreak advising that individuals suspected of having COVID-19 should be screened and isolated immediately upon arrival at a healthcare facility. Contact and droplet precautions should be used when a client is suspected or confirmed to have COVID-19; airborne precautions are also required during aerosol-generating procedures (WHO, 2020)

What Do I Need to Teach the Client/Client’s Family?

› Inform clients and family that while visits can play an important role in the client’s care, visitation policies are also important to promote client and clinician safety
› The social worker should refer the client and/or family back to the treating medical professional for additional information about visiting the isolated client
› Communicate respectfully with clients and families, recognizing and adapting to differences in religion, culture, and individual needs

References