Public Health England

Protecting and improving the nation's health

PHE NW COVID-19 Template Resource Pack for Care Homes

Version 8

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About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Contents

Please note that, as COVID-19 is a rapidly evolving situation, guidance may change with little notice. Therefore, we advise that, in addition to familiarising yourself with the content of this document, you refer to the relevant national guidance (links provided in Section 10).

Section 1: Local Contacts

Community Infection Prevention and Control Teams	
Infection Prevention and Control Team **Available 8am – 5pm**	01744457314 or 01744 457312
Public Health England North West Health Protection Team	
Monday – Friday (0900 – 1700)	0344 225 0562
Out of Hours PHE Contact:	
Public Health England first on call via the Contact People	0151 434 4819

Report a suspected case of COVID-19 by telephone to:

Monday to Friday 8am – 5pm: local Community Infection Prevention and Control Team

After 5pm/weekends/bank holidays: Public Health England, NW Health Protection Team on 0151 434 4819 (ask to speak to the dedicated on-call for COVID-19)

Section 2: COVID-19 Key Messages

2.1 COVID-19 Disease Characteristics & Exclusion Periods

Symptoms	The main symptoms of COVID-19 are: new continuous cough and/or fever (temperature of 37.8°C or higher) anosmia (loss of the sense of smell and/or taste) Other symptoms that may indicate COVID-19 in care home residents include: new onset of influenza like illness worsening shortness of breath delirium, particularly in those with dementia A laboratory detection of COVID-19 would fulfil the definition of a case of COVID-19
Infectious period	From 48 hours before onset of symptoms (or test date if asymptomatic) until 14 days after symptom onset (or test date**) for care home residents.** OR until 10 days after symptom onset (or test date) **for staff** Please see current guidance: https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance
Modes of transmission	• Respiratory droplets during close unprotected contact • Contact with contaminated surfaces • Likely faecal oral
Exclusion periods	**Residents** should be isolated for 14 days from onset of symptoms (or positive test date) **Staff** should isolate for 10 days from onset of symptoms (or positive test date) and be fever free (temp <37.8c) for 2 days before returning to work **Staff and residents** that are contacts of a confirmed case of COVID-19, should be isolated for 14 days from the last date of contact with the ill resident.

2.2 Basic Infection Prevention Messages

Prevention is the most effective method of stopping transmission and outbreaks of COVID-19. Stringent infection prevention and control measures should be in place in all care homes during the COVID-19 pandemic.

Infection prevention and control measures will vary depending on context and settings should be directed to the relevant GOV.uk guidance for detailed information. The following principles should be applied

- **Hand Hygiene - r**einforce education about hand and respiratory hygiene to staff and residents and display posters widely. Ensure infection control policies are up to date, read and followed by all staff. Staff, residents and any visitors should wash hands regularly and use tissues for coughs and sneezes.

- **Facilities** - ensure liquid soap and disposable paper towels are available at each wash hand basin and sink, and alcohol-based hand rub (at least 70%) is available throughout the home, in every bathroom, communal and work areas, and stocks are adequately maintained.

- **Personal Protective Equipment (PPE)** - ensure PPE is available where required. This may include disposable gloves, aprons, and surgical masks, plus eye protection for procedures that may generate splashback. Where staff are being asked to use PPE, they should be trained in donning and doffing. Ensure the setting follows national guidance on when PPE should be used as per setting specific guidance. Additional PPE is required for aerosol generating procedures.

- **Cleaning** - clean surfaces and high touch areas frequently. Clean common equipment regularly. If there are suspected or confirmed cases all areas should be cleaned at least twice daily. Locations where symptomatic people have been should be cleaned wearing appropriate PPE (see section 6).

- **Social Distancing and Shielding**- Care home providers should follow social distancing measures for everyone in the care home, wherever possible, and the shielding guidance for the extremely vulnerable group.

Those who are at increased risk of severe illness from COVID-19 are:

  - Aged 70 or older (regardless of medical conditions)
  - Under 70 with an underlying health condition (i.e. anyone instructed to get a flu jab as an adult each year on medical grounds)

Section 3: COVID-19 Preparedness in Care Home Settings

3.1 General Advice

There is currently sustained transmission of COVID-19 across the UK

Even if your care home does not have any suspected or confirmed cases of COVID-19 it is important that infection control measures are still followed in order to best protect residents and staff

The guidance for working safely in care homes should be followed and be made available to all staff

Regular whole home testing is being rolled out for all residents and staff, regardless of symptoms. It is advised that staff are tested for coronavirus weekly, while residents receive a test every 28 days to prevent the spread of coronavirus in social care. This is in addition to intensive testing in any care home facing an outbreak, or at increased risk of an outbreak (see section 5 for more detail). A PHE North West pathway for COVID-19 Testing in Care Home Outbreaks is in place to support this

3.2 Advice for Management

- Managers should review sick leave policies and occupational health support for staff and support unwell or self-isolating staff to stay at home as per PHE guidance
- Managers should review their list of residents, and ensure that it is up to date, including levels of support and any clinical procedures that residents require.
- Managers should have up to date business continuity plans
- Ensure that sufficient personal protective equipment (PPE) is available for staff, and that they are trained in its use and disposal.
- Reinforce education of staff and residents about hand and respiratory hygiene.
- Make sure there is sufficient time/staff numbers on rounds to enable good infection, prevention and control (IPC).

- Increase the frequency and intensity of cleaning for all areas, focusing on shared spaces.

- Where care homes are part of a group, try to limit staff movement between facilities.

- If possible, consider limiting staff movements within facilities, e.g. individual care staff to only work on one floor of a facility.

- If possible separate staff to work with cohorted asymptomatic residents, those with COVID-19 symptoms and confirmed COVID-19 cases.

- Shift managers may consider proactively asking staff if they are symptomatic at the beginning of a shift.

- Consider staff mental health and wellbeing. Having a workforce with good mental health and wellbeing is beneficial both for your staff and the people they are caring for. The Every Mind Matters website provides expert advice and practical tips, and has a specific section relating to COVID-19.

- Managers should make sure that they and their staff are familiar with the contact definitions and isolation periods for the Test and Trace programme (see section 4.2) so that any contacts of a confirmed COVID-19 case (in either a resident or staff member) can be quickly identified and appropriately isolated.

3.3 Advice for Staff

- While at work staff should follow social distancing measures to the best of their ability, including in staff spaces such as break rooms.

- Staff should check that they have adequate supplies of PPE and are familiar with the guidelines and instructions for use and disposal (see section 6 and section 10 links)

- Staff should check they have access to adequate supplies of hand sanitizer or liquid soap, and disposable paper towels and other cleaning products

- Staff with a symptomatic household member should isolate while the household member arranges testing. If the household member tests negative, no isolation is required, but if positive, the staff member must continue isolating for 14 days from the first day the household member developed symptoms. **This is irrespective of any subsequent negative test results for the staff member in this 14-day period.**

- Staff identified as having contact with a confirmed case via Test and Trace should isolate for 14 days from date of the last contact. **This is irrespective of any subsequent negative test results for the staff member in this 14 day period**

3.4 Advice Regarding Residents

- Admissions from hospital should be tested for COVID-19 prior to admission (see Section 9). Appropriate isolation of positive cases should take place immediately on arrival.

- Residents should follow social distancing measures. Residents should be kept >2m apart where possible. This might include limiting movement of residents between floors or restricting the number of residents in communal areas at any one time.

- Tissues and handwashing facilities should be available throughout your facility to enable residents to wash their hands regularly and to use tissues for any coughs or sneezes.

- Management should assess each resident twice daily for the development of a fever (≥37.8°C), cough or shortness of breath and record symptoms (see appendix 1).

Section 4: Management of Suspected Cases and Outbreaks in Care Home

When to suspect a COVID-19 case?

An individual in the home has
a new persistent cough
AND/OR
an oral or tympanic temperature of >37.8
AND/OR
anosmia (loss of taste and/or smell)

When to suspect a COVID-19 outbreak?

Two or more cases which meet the above clinical case definition OR lab confirmed cases, arising within the same 14-day period in people who live or work in the care home

PUBLIC HEALTH ACTIONS SHOULD NOT BE DELAYED WHILE AWAITING CONFIRMATORY TEST RESULTS

4.1 Actions for Symptomatic (Possible) or Confirmed (Positive Test) Cases

4.1.1 Residents

- Isolate resident for 14 days from symptom onset (or date of test) from rest of care home population – if it is not possible to care for individuals in single occupancy rooms then cohorting of residents should be considered (see section 4.3)

- Ensure that anyone displaying symptoms or with a positive test receives appropriate clinical assessment via GP/111/A&E (depending on the severity of symptoms).

- If a possible case arrange COVID-19 testing for the resident (see section 5 below).

- Provide appropriate supportive management in accordance with advice provided by the supporting clinician.

4.1.2 Staff

- If a member of staff develops symptoms during a shift, they should go home as soon as possible, arrange for testing and be advised to contact NHS 111 if unwell.Their household contacts should self isolate for 14 days if they subsequently test positive

- Any staff with symptoms of COVID-19 should isolate for 10 days from onset of symptoms (or positive test date if tested when asymptomatic) and be fever free (temp <37.8c) for 2 days before returning to work. A cough and loss of taste and smell are known to persist for a longer period therefore should not be used as a basis for remaining in isolation. Local testing pathways should be followed (see Section 5 below).

- Agency staff working in the home when a case is identified should not take employment in any other health or care setting until 14 days after their last shift in the affected home. They can continue to work in the affected home and, when the outbreak is over in the care home, they can work elsewhere as normal.

4.2 Actions for Contacts

- The infectious period of a case is 48 hours before onset of symptoms (or test if asymptomatic) until 10 days after for staff and 14 days after for residents

- Managers should identify if, during the infectious period, there are any resident or staff contacts in the care home: (https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings)

- **Resident contacts**: Any resident that meets one of the following criteria:
    - lives in the same unit or floor as a confirmed case (e.g. shares the same communal areas)
    - has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact
    - has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact
    - has spent more than 15 minutes within 2 metres of a confirmed case

- **Staff contacts**: Any staff member that has had the following contact **while not wearing appropriate PPE** or who has had a breach in their PPE:
    - has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact
    - has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact

- has spent more than 15 minutes within 2 metres of a confirmed case
- has cleaned a personal or communal area of the home where a confirmed case has been located (note this only applies to the first time cleaning the personal or communal area)
- has been notified by Test and Trace that they are a contact of a COVID-19 case.

Advise any resident or staff contacts to self-isolate for 14 days as per national guidance https://www.gov.uk/government/publications/guidance-for-contacts-of-people-with-possible-or-confirmed-coronavirus-covid-19-infection-who-do-not-live-with-the-person

4.3 Cohorting Residents

- Cohorting is where a group of residents, all confirmed cases or with COVID-19 symptoms or contacts of the same confirmed case, are housed in the same room or unit; it is an effective infection prevention and control strategy for the care of large numbers of unwell people (and where it is not possible or safe to use single room isolation).

- Residents with **suspected COVID-19** should be cohorted only with other residents with **suspected COVID-19**
- Residents with **suspected COVID-19** should ***not*** be cohorted with residents with **confirmed COVID-19**
- Suspected or confirmed residents should not be cohorted next to **immunocompromised residents**

- Any resident contacts could also be cohorted together, if isolation in single rooms is not possible
- This approach can also be used to keep residents who have not had any contact with a symptomatic case separate – i.e. if possible all asymptomatic residents who are not contacts could be housed separately in another unit within the home away from the cases and resident contacts
- Extremely vulnerable residents should stay in a single room and should not share bathrooms with other residents.
- Separate staff should be allocated to cohort areas to prevent wider infection spread across the home. IPC and PPE guidance should be followed.

4.4 "Wandering" Residents and Isolation

In some situations, it is very difficult to effectively isolate residents – in these scenarios cohorting can be very beneficial, where it is possible:

- A designated 'symptomatic unit/area' – where symptomatic wandering residents can walk around (whilst keeping symptomatic residents separate from confirmed cases).

- A closed off/separate 'asymptomatic unit/area' for those unaffected

Where possible, care homes should seek advice and support from local community mental health and dementia teams on behavioural modifying approaches for 'wandering' residents

Guidance is available from NIHR to assist with the management of wandering residents during COVID-19.

4.5 What Local Support Can Care Homes Expect?

Your local Community Infection Control teams will liaise directly with PHE NW to provide information about what is happening in your home. In some instances, PHE NW may contact you directly.

4.6 Key Actions for Care Home Management During COVID-19 Outbreak

1. Ensure there is a named COVID-19 co-ordinator on every shift

2. Maintain adequate PPE supplied

3. Maintain accurate records of residents with COVID-19 symptoms and supply these to CICNs as requested. See Appendix 1. **The completion of these datasets are crucial for surveillance**

3. Instigate a minimum of twice daily symptom checks for all residents and staff (NB – additional observations may be required as directed by local teams)

4. Appropriate signage to be displayed across the home. As a minimum, this should include:

- Notice of outbreak at all entrances including exclusion information for anyone (staff or visitors) displaying symptoms

- Infection control notices outside rooms of symptomatic residents

5. Enhance cleaning across all affected units of the home

6. Limit visits by health and care staff to essential care/work only (see Section 8 for further details about visitors).

Section 5: Testing

5.1 Testing in care homes that do not have outbreaks – routine whole care home testing (Pillar 2/DHSC testing pathway)

Care homes without outbreaks are eligible for weekly testing of staff and testing of residents every 28 days

Staff include bank and agency staff. DHSC are developing guidance about who is included in the definition of visiting staff (social workers and allied health professionals) and how they will be tested.

Homes must register and order tests though the online digital portal https://www.gov.uk/apply-coronavirus-test-care-home

Enough kits for one month of testing (4x staff population and 1x resident population) will be sent to the home each time an order is placed.

The week the kits are received all staff and residents should be tested. Care homes can test over multiple days within the week if necessary, but will need to book their couriers for each day that they carry out testing. For the next three weeks, staff only should be tested.

Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Staff and Residents	Staff	Staff	Staff	Staff and Residents	Staff	Staff	Staff

This testing process is available 7 days a week and care homes are encouraged to use this on the weekends where possible.

Care homes will need to reorder testing in time to be able to carry out their next month of testing and will receive an email reminder to prompt them to reorder

If a single, positive case is identified then a risk assessment should be undertaken to determine actions (see section 5.2 and figure 1). If 2 or more suspected or confirmed cases are identified, then the testing regimen moves to that in an outbreak setting (see section 5.3 and figure 2).

Pillar 2 weekly testing of care home staff can continue during an outbreak.

Any queries regarding Pillar 2/ DHSC should be directed to the national helpline on 119

5.2 Single Positive Result from Pillar 2/DHSC Testing Pathway

Staff

If an asymptomatic staff member tests positive during pillar 2 testing, they should self-isolate for 10 days and return to work on day 11 if they remain asymptomatic.

If they subsequently develop symptoms, they must self-isolate for 10 days from symptom onset date.

Their household contacts should also self-isolate for 14 days.

Resident

If an asymptomatic resident tests positive during pillar 2 testing, they should be isolated within their own room whilst the risk assessment is carried out and re-tested via pillar 2 within 24 hours (see figure 1).

Resident contacts of the case should be isolated, whilst the risk assessment is carried out.

As figure 1 highlights, the result should be treated as a true positive and the appropriate public health actions undertaken if:

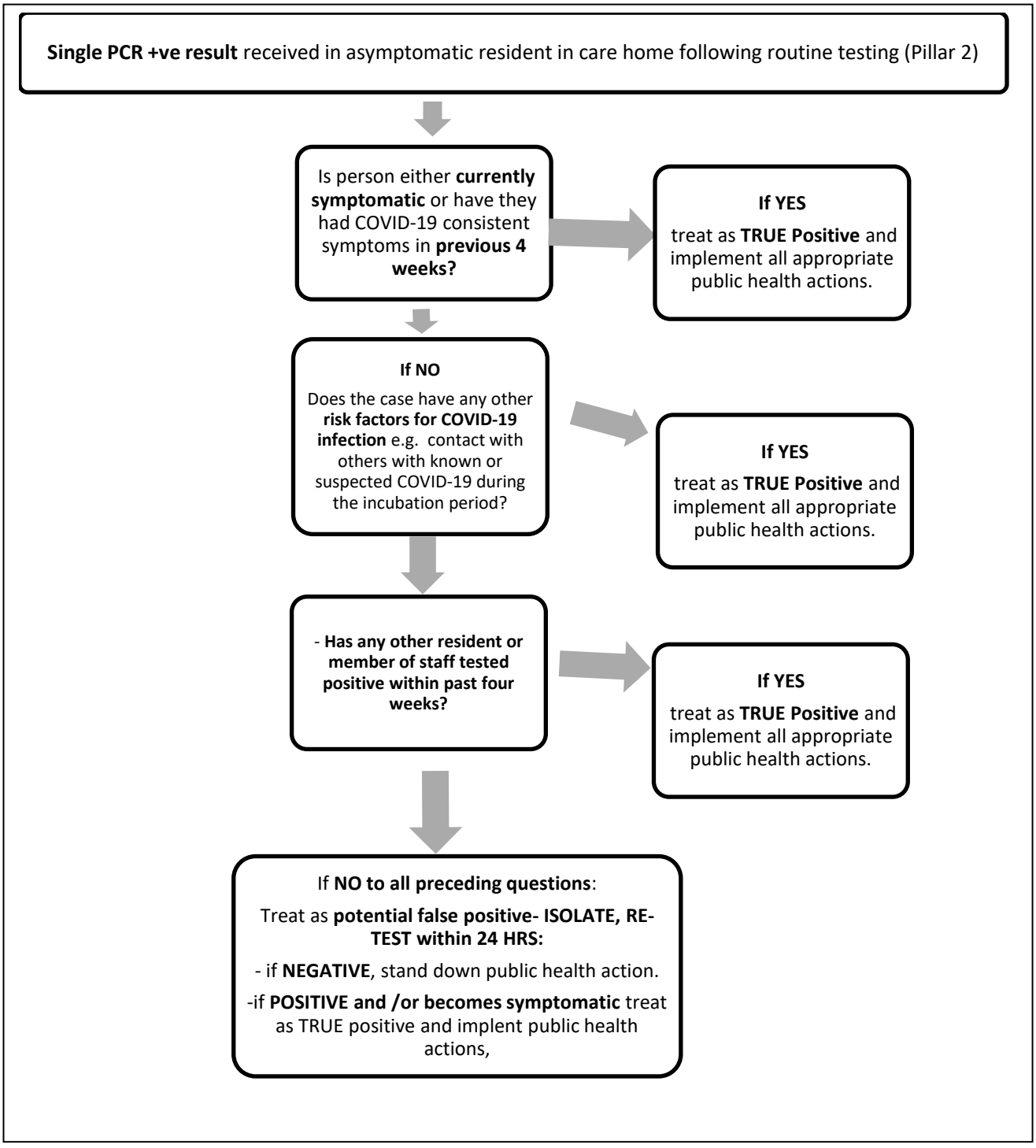
- The resident has COVID-19 symptoms or has had symptoms in the previous 4 weeks.
- The resident has had contact with a known or suspected COVID-19 case during the incubation period.
- Or another resident or staff member in the home has tested positive in the previous 4 weeks.

If the resident remains asymptomatic and the repeat test result is negative and there is no other reason to suspect COVID-19 cases in the home, the resident can be treated as a negative case on the assumption that this result could be a false positive. In this case, the resident no longer requires isolation but standard infection prevention and control measures should continue across the care home.

If the second test is positive, or the individual becomes symptomatic they should continue to be managed as a true positive case.

If there is a single symptomatic positive case detected from pillar 2 testing, a local risk assessment should be conducted to determine if there is likelihood of further cases within the setting. Decisions to activate Pillar 1 whole home outbreak testing based on a single confirmed case should be discussed with the PHE Heath Protection Team before activating the pathway.

Figure 1: Management of Care Home Resident with Positive Test



5.3 Testing in care homes where an outbreak is suspected (PHE rapid testing pathway)

Testing in outbreaks will be arranged via your local Community Infection Control Team or the PHE Health Protection Team (out of hours) depending on your usual arrangements.

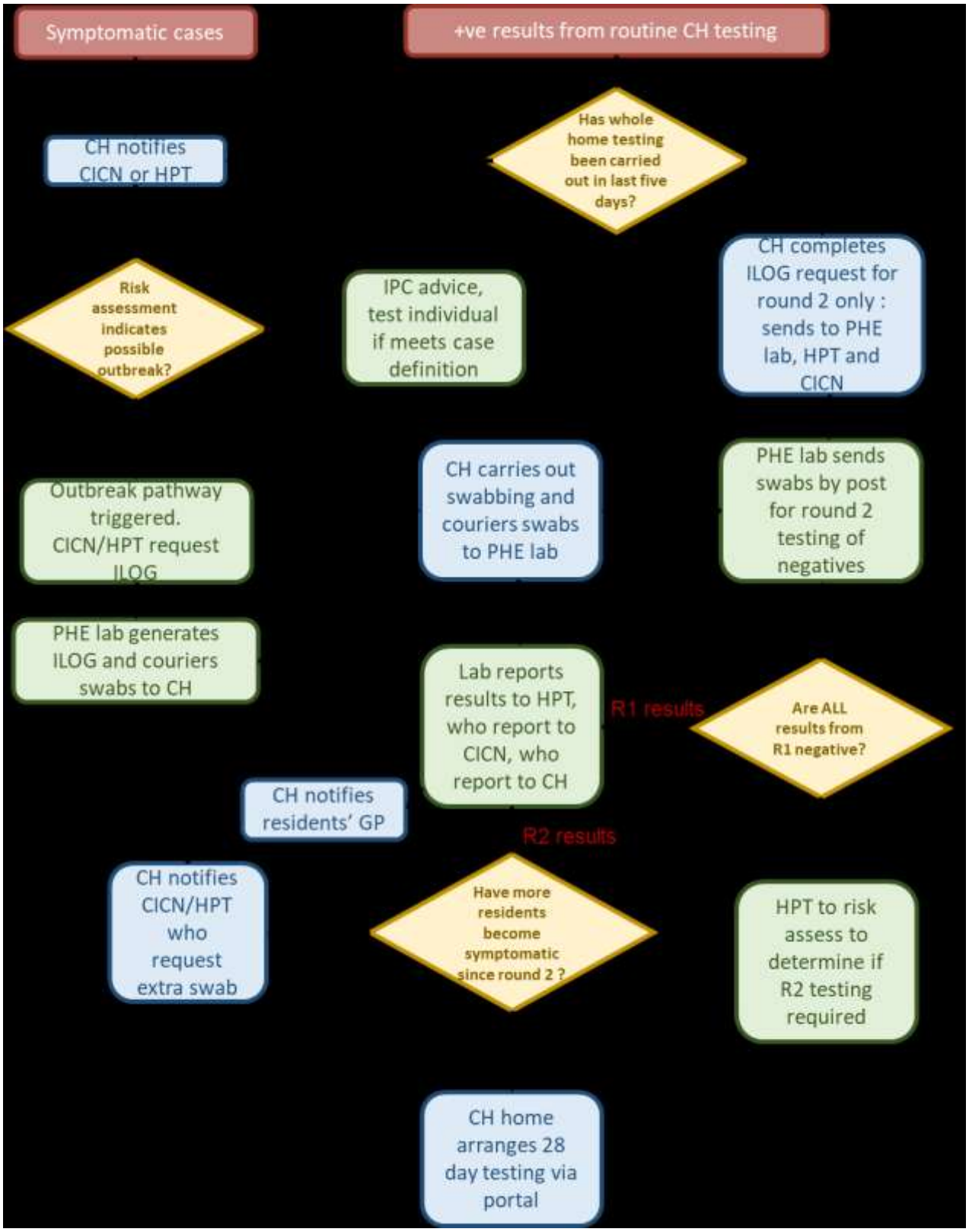
All symptomatic or positive cases in residents or staff members should be reported to the CICN (in-hours) or PHE HPT (out of hours or as per usual arrangements). A local risk assessment will then determine what testing is required and the CICN/PHE HPT will activate the appropriate pathway.

5.4 Declaring an Outbreak Over

Care homes that have had no new symptomatic cases or positive results in residents or staff for 28 days are recovered. The Infection control nurses will continue monitoring your home unitl then.

At this point whole home testing should be carried out via pillar 2. The care home will need to order the tests in advance from the DHSC portal.

Figure 2: Testing Flow Chart



5.5 Isolation Guidance for Residents and Staff with Repeatedly Positive Results

In some individuals, there is a long tail of PCR positivity lasting several weeks which may not be indicative of infectiousness. PHE recommends that you do not re-swab an individual who has had a PCR positive result for at least six weeks. If staff or residents are repeatedly tested, the following guidelines apply

- Care home staff or residents with COVID-19 symptoms should isolate for 10 days (14 days for residents) from onset of symptoms (or positive test date if tested when asymptomatic).

- False negative tests for COVID can occur, particularly when staff are new to taking the swabs. For those residents where there is a strong suspicion of COVID-19 based on clinical findings, residents should stay in isolation for the full period of 14 days, even if they have a negative swab.

- Those who test COVID-19 positive when asymptomatic but go on to develop symptoms in isolation should isolate for 10 days from the onset of symptoms (14 days for residents).

- Staff or residents must have been fever free (temp <37.8c, without taking paracetamol or other fever reducing medication) for 2 days before ending isolation.

- A cough and loss of taste and smell are known to persist for a longer period therefore should not be used as a basis for remaining in isolation

If a resident has already been tested within six weeks of their onset of symptoms (or first positive test if asymptomatic), then a second positive test within 6 weeks of symptom onset (or 1st positive test if asymptomatic) should not result in exclusion, unless the positive test has been preceded by two or more negative tests (see Table 1 for example scenarios).

- **Cases that test positive more than 6 weeks after the initial positive result should be managed as a new case.**

- **Cases that test positive after two successive negative tests should be managed as a new case.**

- **Regardless of prior test results, staff or residents who become symptomatic or whose symptoms worsen should self-isolate and be tested again.**

Asymptomatic immunosuppressed residents who test positive after 2 weeks isolation should be isolated for a further week as a precaution. If the test result after the third week is still positive but the resident has no symptoms, they should be allowed to come out of isolation as long as IPC measures are maintained.

Specific examples to aid interpretation of positive results are given in tables 1-3

RESIDENTS	Routine testing schedule (weeks)								
		W1	W2	W3	W4	W5	W6	W7	W8	W9
Repeated positive results A resident develops symptoms and/or tests positive and is excluded for 2 weeks. They are tested 1 month later (week4) and are still positive. As long as they have no new symptoms, no exclusion is necessary. If they remain positive the next month (week 8) they should be managed as a new case and excluded.	E.g. 1	+ve	O	O	+ve	O	O	O	+ve	O
Repeated positive results with negative results between them A resident develops symptoms and/or tests positive and is excluded for 2 weeks. If they are subsequently tested more frequently than monthly (e.g. at hospital) and they have both positive a negative results, if a positive result is up to 6 weeks after the initial positive, no isolation is required as long as the resident is asymptomatic (example 2). However, if a positive result follows two or more successive negative results at any time, they should be excluded and treated as a new case (example 3).	E.g. 2	+ve	O	+ve	-ve	O	+ve	O	+ve	O
	E.g. 3	+ve	O	-ve	-ve	+ve	O	O	O	O
Immuno-suppressed residents* An immunosuppressed care home resident tests positive and is managed as a new case. If they are tested at end of their isolation and are negative they can come out of isolation (example 4). If still positive they should be isolated for a further week (example 5). If the 4 week test is positive they do not need to isolate, but if they remain positive the next month they should be treated as a new case.	E.g. 4	+ve	-ve	O	+ve	O	O	O	+ve	O
	E.g. 5	+ve	+ve	O	+ve	O	O	O	+ve	O

Table 1: A table to aid interpretation of repeated positive test results as part of routine monthly screening for determining isolation of care home residents

Red shaded squares indicate that the resident is in isolation for 14 days from symptom onset (or date of test if asymptomatic). +ve = positive test result, -ve = negative test result, **O** = not tested, D=Day, W=Week

* Those on active cancer treatment and those with HIV, bone marrow transplant, and solid organ transplant patients who are taking certain immunosuppressive drugs; those with inherited diseases that affect the immune system. Also, those who are on oral or intravenous corticosteroids or other medicines called immunosuppressants that lower the body's ability to fight some infections (e.g., mycophenolate, sirolimus, cyclosporine, tacrolimus, etanercept, rituximab).

STAFF	Routine testing schedule (weeks)						
	Week	W1	W2	W3	W4	W5	W6
Repeated positive results After an initial positive test and isolation, a staff member is tested weekly (example 1) or intermittently (example 2) and continue to test positive. If asymptomatic, no exclusion is necessary unless it has been over 5 weeks since the initial result.	Example 1	+ve	+ve	+ve	+ve	+ve	+ve
	Example 2	+ve	+ve	O	+ve	O	+ve
Repeated positive results with negative results between them A staff member develops symptoms and/or tests positive and is managed as a new case. After the initial exclusion period they are tested and have positive and negative results. Even if it within 6 weeks of the initial test, if a positive result follows two or more successive negative results they should be excluded and treated as a new case.	Example 3	+ve	-ve	+ve	-ve	-ve	+ve
	Example 4	+ve	-ve	-ve	+ve	-ve	-ve
	Example 5	+ve	O	-ve	O	-ve	+ve

Table 2: A table to aid interpretation of repeated positive test results as part of routine weekly screening for determining isolation of care home staff

Red shaded squares indicate that the positive test result would lead to the exclusion of the individual for 7 days from symptom onset (or date of test if asymptomatic). +ve = positive test result, -ve = negative test result, **O** = not tested, D=Day, W=Week

OUTBREAK TESTING	Day/Week	D1	D4	W2	W3	W4 (D28)	W5	W6
After activation of the rapid testing pathway an individual tests positive on day 1, or day 4 after re-testing. They are re-tested on day 28 and are still positive. No isolation is required. However, if still positive at week 6, they should be isolated and managed as a new case.	Example 1	+ve	O	O	O	+ve	+ve	+ve
	Example 2	-ve	+ve	O	O	+ve	-ve	-ve
Any individual that was negative on both initial screens (D1&D4) and tests positive at day 28 should be managed as a new case. This would mean that the outbreak is still ongoing.	Example 3	-ve	-ve	O	O	+ve	+ve	+ve

Table 3: A table to aid interpretation of test results as part of rapid whole home outbreak testing for residents and staff

Red shaded squares indicate that the positive test result would lead to the exclusion of the individual for 7 (14 for a resident) days from symptom onset (or date of test if asymptomatic). +ve = positive test result, -ve = negative test result, **O** = not tested, D=Day, W=Week. The same principles as described in Tables 1&2 again apply.

Section 6: Personal Protective Equipment (PPE)

6.1 PPE Requirements

National guidelines on the PPE requirements for care home workers in the context of sustained UK transmission can be found **here.** Full infection prevention and control (IPC) and PPE guidance can be found **here**.

Summary PPE Guidance for Care Homes				
	All staff when in care home and at a distance of 2 metres or more away from residents	When performing a task requiring you to be within 2 metres of resident(s) but no direct contact with resident(s) (i.e. no touching)[1]	Providing personal care which requires you to be in direct contact with any resident or within 2 metres of a resident who is coughing	Swabbing
Disposable Gloves (single use)	NO	NO	YES	YES
Disposable Apron (single use)	NO	NO	YES	YES
Surgical Mask[2]	YES[1]	YES[1]	Fluid-resistant surgical mask	Fluid-resistant surgical mask
Eye Protection[3]	NO	Risk Assess[3]	Risk Assess[3]	YES

[1] Please check usual PPE requirements for the task that you are undertaking (i.e., food handling, cleaning etc.)
[2] A fluid-resistant surgical mask may be needed where there is high risk from respiratory droplets (e.g. when undertaking prolonged tasks close to residents who are repeatedly coughing). Use of fluid-repellent masks should be considered in line with national guidance and be informed by a risk assessment in your care home.
[3] Risk Assessment: Eye protection may be needed for certain tasks where there is risk of contamination to the eyes from respiratory droplets or from splashing of secretions (e.g. when undertaking prolonged tasks near residents who are repeatedly coughing or may be vomiting). Use of eye protection should be discussed with your manager and be informed by a risk assessment in your care home. Eye protection can be used continuously while providing care until you take a break from duties.

6.2 Putting on (Donning) and Taking off (Doffing) PPE

All staff should be trained on donning and doffing PPE. Posters and video guidance are available.

6.3 When to Change PPE – Single and Continual Use

- Gloves and aprons are single use PPE. They should be disposed of after each episode of care or resident contact

- Surgical masks can be used continuously while providing care, unless you need to remove the mask from your face (e.g. to drink, eat or take a break from duties).

- You should not touch your face mask.

- You should remove and dispose of the mask if it becomes damaged, soiled, damp or uncomfortable to use. If removed, you would then need to use a new mask when you start your next homecare visit.

- After removing any piece of PPE, hand hygiene should be practiced and extended to exposed forearms. All staff must be bare below the elbows, apart from single 'wedding' band. Staff should not wear nail varnish or use false nails.

6.4 Aerosol Generating Procedures (AGPs)

If an AGP is to be undertaken specific PPE is required, which is described **here.** A list of AGP procedures can be found **here**

6.5 Providing Care to People with Learning Difficulties or Autism

The publication **Coronavirus (COVID-19): guidance for care staff supporting adults with learning disabilities and autistic adults** sets out general issues in providing care for people with learning disabilities and/or autism. It provides a number of links to resources to help with this.

Some people with learning disabilities or autism may be distressed or anxious to see their care staff in PPE. Specific guidance concerning the use of PPE when carers are looking after individuals with learning disabilities and/or autism can be found **here (section 3)** For these people, Care England suggests:

- Introduce masks by making them in an art session. This will be useful if residents need masks when going out. Have a choice of colours or fabric designs.
- Try to normalise the wearing of masks around the care home; if there are soft toys around perhaps provide masks for these.
- Play a game trying to guess what expression people are making behind masks.
- Use Makaton or BSL or possibly develop shared non-verbal signals for the expressions usually read from faces.
- Develop a matching pairs game with pictures of people with and without masks.
- Praise people when they ask questions about the masks. Answer clearly and honestly using their preferred communication method.
- Consider changing existing staff photos on activity boards or staff boards to photos of the staff wearing masks.
- Consider graded exposure approaches with the aim of making the PPE acceptable.

A small number of individuals may reject their carers wearing of PPE in all circumstances. There should be a comprehensive risk assessment for each of these people identifying the specific risks for them.

- **The risk assessment needs to determine whether the risks involved in wearing masks (forceful outbursts with potential injury, or unsafe mask removal, or the serious impact on the physical and mental wellbeing from the inability to communicate, or to follow habitual routines) are greater than those involved in not wearing them.**
- **A multidisciplinary group involving external professionals and the local authority should undertake the assessment**

Under no circumstances should this assessment be applied to a whole care setting

6.6 Social Care PPE Distributors

If you are experiencing PPE supply issues from your usual routes, PPE can be sourced from the following:

Careshop	coronavirus@careshop.co.uk Tel: 01756 70 60 50
Blueleaf Care	Tel: 03300 552288 emergencystock@blueleafcare.com
Delivernet	kevin.newhouse@delivernet.co.uk
Countrywide Healthcare	Tel: 01226 719090 enquiries@countrywidehealthcare.co.uk
The National Supply Disruption line (If you have immediate concerns over your supply of PPE)	Tel: 0800 915 9964 Email: supplydisruptionservice@nhsbsa.nhs.uk
PPE – local arrangements	Through the dailylisting or COVID19@warrington.gov.uk

Section 7: Environmental Cleaning with Suspected or Confirmed Cases

This lays out general principles for cleaning in care homes during the COVID-19 outbreak. Guidance for cleaning in non-healthcare settings can be found here.

General Principles

- Cleaning of all areas should take place at increased frequency (at least twice per day)
- Cleaning locations where symptomatic residents are, or have been, should be carried out wearing a fluid-resistant surgical mask, plastic apron and gloves with a risk assessment for facial protection[3]

Communal areas (symptomatic residents)

- Public areas where a symptomatic individual has passed through and spent minimal time, such as corridors, but which are not visibly contaminated with body fluids can be cleaned thoroughly as normal.
- All surfaces that the symptomatic person has come into contact with must be cleaned and disinfected.

Symptomatic residents' rooms or cohort areas

- Domestic staff should be advised to clean the isolation room(s) or cohort areas after all other unaffected areas of the facility have been cleaned. Ideally, isolation room/area cleaning should be undertaken by staff who are also providing care in the isolation room.
- Any disposable items that have been used for the care of the patient should be bagged as clinical waste.
- Disposable cleaning items should be used where possible (e.g. mop heads, cloths)
- Use a detergent product to clean. Then disinfect using a disinfectant containing 1000 parts per million (ppm) of available chlorine. Alternatively, a combined detergent / chlorine releasing product can be used (chlorine must still be at 1000 ppm). Clean any re-usable non-invasive care equipment, such as thermometers or glucometers prior to their removal from the room.
- When items cannot be cleaned using detergents/chlorine or laundered, for example, upholstered furniture and mattresses, steam cleaning should be used. For items that can't be steam cleaned, use an alternative product for that item as per the manufacturers instruction.
- Non disposable cleaning items such as mop handles should be cleaned and disinfected (with chlorine 1000ppm) after use. Cleaning trolleys should not be brought into affected areas.
- Your Community Infection Prevention and Control team can provide further guidance on any aspect of cleaning.

Waste Disposal

Where care homes provide nursing or medical care guidance on safe management of healthcare waste must be followed.
All waste from possible cases, or from cleaning areas where possible cases have been:

- Should be put in a plastic rubbish bag, double bagged and tied.
- Should be labelled and stored securely for 72 hours, before disposing along with normal waste
- If from a suspected case, and the case subsequently tests negative, waste can immediately be disposed of along with normal waste.
- If storage for 72 hours is not appropriate arrange for collection as Category B infectious waste.
- Waste such as urine and faeces can be disposed of normally.

Laundry for confirmed or suspected cases

Guidance on decontamination of linen must be followed. Basic principles are described below:

- Any towels or other laundry used by a confirmed or suspected case should be treated as infectious.
- PPE should be worn for handling dirty or contaminated laundry.
- Laundry should be handled with care to avoid spread of the virus.
- Laundry should be placed in a red-water soluble bag and then placed in an impermeable nylon or polyester bag for transport to the laundry, which must be labelled as “infectious linen”. Place the unopened red-water soluble bag in the washing machine and launder on an appropriate cycle as per the above guidance. Dispose of the polythene bag as waste, launder the nylon bag on an appropriate disinfection cycle.

Staff uniforms

- Uniforms should be transported home in a disposable plastic bag.
- Uniforms should be laundered
    - separately from other household linen,
    - in a load not more than half the machine capacity,
    - at the maximum temperature the fabric can tolerate and dried completely.

Section 8: Visitors

Updated guidance on visiting care homes can be found **here.** Visiting in care homes should be based on a risk assessment taking into consideration a number of things including local epidemiology, and the risk and benefits of the visit.

If considering allowing visitors, the care home should contact their local infection control team who will liaise with the DPH to undertake a dynamic risk assessment.

However, there may be situations, particularly relating to end of life, where family and friends request a visit when the home remains closed to vistors. Where this occurs, it is advised that the following principles apply:

- An individual risk assessment by the care home manager should be undertaken in the event of a request for a visit, e.g. end of life visits.
- Visitors should be instructed in the correct donning and doffing procedures for relevant PPE on their arrival. Visitors should use the same PPE as per staff requirements outlined above.
- The visit should be limited to two visitors at any one time.
- The manager should clearly specify the length of time for the visit taking into consideration individual circumstances.
- Arrangements should be made for visitors to enter the home through the nearest door to the resident's room (this might include using fire doors).
- All visitors entering the care home should wash their hands immediately on arrival, during their stay and upon leaving for 20 seconds with warm water and soap; wear masks, i.e. in addition to observing 2 meters distance (if possible and practical) and exercise stringent respiratory hygiene.
- The visit should be supervised by a member of staff at all times to ensure infection prevention measures are adhered to.
- Safe exit from the care home should also be supervised.

After death, the infection control precautions described continue to apply whilst a person who has died remains in the care home. This is due to the ongoing risk of infectious transmission via contact, although the risk is usually lower than from those living.

Section 9: Transfers In and Out of the Home During an Outbreak

During the COVID-19 response it will not be possible for care homes to visit a potential resident in hospital to assess their care needs. A Discharge to Assess (D2A) model is in place to streamline the discharge process and the assessment of care needs will be undertaken by hospital discharge teams, in collaboration with Trusted Assessors.

Guidance on transfers is available here. The local CICNs and PHE can provide specific advice if you require it.

Government policy also recommends testing all residents prior to admission to care homes.

Residents being discharged from hospital or iterim care facilities to a care home and new residents admitted from the community should be isolated within their own room for 14 days.

Residents visiting hospital for outpatient appointments do not require a test to return to the home and do not need to self isolate on return, so long as IPC precautions were in place during the hospital visit.

Section 10: National Guidance Documents

This local guidance document has been based on national PHE, NHS and government guidance. Hyperlinks to key national guidance are displayed here for reference (click on the link to be taken to the relevant guidance/information online).

Social distancing for different groups

- Stay at home: guidance for households with possible coronavirus (COVID-19) infection
- Guidance on social distancing for everyone in the UK: English language version
- COVID-19: guidance on social distancing for everyone in the UK and protecting older people and vulnerable adults: non-English language and easy-read versions
- Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19: English language version
- COVID-19: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable: non-English language and easy-read versions

Infection prevention and control

- COVID-19: infection prevention and control (IPC) (Includes detailed tables on PPE in health and care settings and guidance on routine decontamination of reusable equipment)
- 5 moments for hand hygiene: with how to hand rub and how to handwash posters
- Catch it. Bin it. Kill it poster
- COVID-19: putting on and removing PPE – a guide for care homes (video)
- COVID-19: management of exposed healthcare workers and patients in hospital settings

Care home specific guidance and policy

- Admission and care of residents during COVID-19 incident in a care home
- COVID-19: our action plan for adult social care
- How to work safely in care homes
- Information from CQC

Cleaning and waste management

- Safe management of healthcare waste
- Decontamination of linen for health and social care
- COVID-19: cleaning in non-healthcare settings

APPENDIX 1 – Daily Log Template (list of residents with suspected / confirmed COVID-19 infection)

In the event of a COVID-19 outbreak, the table will ensure that important information is recorded in one place and is easily accessible

Room number	Name	NHS number	Date of onset of symptoms	Symptoms *	Date GP informed	Date swabbed (if swabbed)	Date CIPCN informed

Symptoms * T = Temp (>=37.8 C), C = Cough, NC = Nasal Congestion, ST = Sore Throat, W = Wheezing, S = Sneezing, H = Hoarseness, SOB = Shortness of Breath, CP = Chest Pain, AD = Acute Deterioration in physical or mental ability (without other known source