Public Health England

Protecting and improving the nation's health

PHE NW Acute Respiratory Illness (ARI) Template Resource Pack for Care Homes

Version 1.2

(Version for local adaptation by partners)

3 December 2020

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 this is a specific resource for care homes and national COVID-19 guidance is available for other settings, such as supported living and domiciliary care.

As Acute Respiratory Illness, particularly 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

Cumbria Infection Prevention and Control Team at :
IPC@cumbria.gov.uk

7 DAY SERVICE 9 to 5pm
or
Head if Health Protection - Fiona McCredie
07900668648
IPC Practitioner - Diane Watson
07341110095
IPC Practitioner - Samantha Woolveridge
07425 637164

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 acute respiratory illness by telephone to:

9am-5pm the local IPC team at IPC@cumbria.gov
After 5pm/bank holidays: Public Health England, NW Health Protection Team on 0151 434 4819

Section 2: Acute Respiratory Illness Key Messages

The most commonly identified causes of acute respiratory illness in care homes are influenza (flu) viruses, as well as non-influenza viruses such as respiratory syncytial virus (RSV), rhinovirus, adenovirus, parainfluenza and human metapneumovirus (hMPV) and more recently COVID-19.

Symptoms are difficult to distinguish between COVID-19, flu and illness caused by other respiratory viruses. It is anticipated that COVID-19, flu and other respiratory illnesses will need to be investigated and managed simultaneously. Consequently, acute respiratory illness in care homes should initially be managed by immediate implementation of the more stringent infection control measures required for COVID-19 until laboratory testing confirms it is not COVID-19.

2.1 Disease Characteristics & Exclusion Periods

	COVID-19	Influenza-like illness (ILI)
Symptoms	The main symptoms are: • New, persistent cough (coughing for >1 hour, or ≥3 coughing episodes in 24 hours) AND/OR • Fever (temperature of 37.8°C or higher) AND/OR • 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 ILI • 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	The main symptoms are: • Fever (Oral (mouth) or tympanic (ear) temperature of 37.8°C or higher) AND • New onset of one or more respiratory symptoms: - Cough (with or without sputum) - Hoarseness - Nasal discharge or congestion - Shortness of breath - Sore throat - Wheezing - Sneezing OR • An acute deterioration in physical or mental ability without other known cause Whilst it is recognised that older people may not always develop a fever with influenza, fever is necessary to define ILI[1].

[1] The World Health Organisation (WHO) defines ILI as an acute respiratory infection with fever (38.0 °C or higher) and cough, while the US Centers for Disease Control and Prevention (CDC) defines ILI as fever (37.8°C or higher) with a cough and/or sore throat. The PHE case definition is consistent with these approaches.

		A laboratory detection of influenza virus would fulfil the definition of a case of flu. Other common respiratory viruses include: • Rhinovirus • Adenovirus • Parainfluenza • Respiratory syncytial virus (RSV) • Human metapneumovirus
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	From 24 hours before onset of symptoms until symptoms have resolved. For flu specifically, it is generally assumed that people are infectious from the onset of symptoms and whilst they have symptoms.
Modes of transmission	• Respiratory droplets during close unprotected contact • Contact with contaminated surfaces • Likely faecal oral	• Respiratory droplets during close unprotected contact • Contact with contaminated surfaces
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. If the test date is more than 5 days after date of symptom onset, isolation should be extended to be 5 days from date of test. **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 case.	**Residents** should be isolated for a minimum 5 days after the onset of symptoms until feeling well. For suspected or confirmed flu, there may be occasions where individuals are recommended to isolate for a longer time period, until all symptoms have cleared. E.g. individuals with long-term conditions or impaired immune system* and those given antiviral therapy >48 hours after symptom onset or not at all or remaining symptomatic after 5 days of antivirals. **Staff** should isolate for 5 days from onset of symptoms and not return to work until fully recovered. **Contacts** of flu cases do not need to self-isolate but should remain vigilant for symptoms.

* E.g. cancer, chronic lung disease, renal disease, heart disease, liver disease, stroke, systemic corticosteroid use, chemotherapy, organ or bone marrow transplant, advanced HIV/AIDS infection and pneumonia diagnosis

2.2 Basic Infection Prevention Messages

Prevention is the most effective method of stopping transmission and outbreaks of acute respiratory illness. There is currently sustained transmission of COVID-19 across the UK and cases and outbreaks have occurred within care homes. Co-circulation of COVID-19 and flu is probable and it is difficult to distinguish between the disease symptoms and those caused by other respiratory viruses (see section 2.1). Consequently, it is important that if the presence of COVID-19, with or without flu or other respiratory virus, is a possibility, then stricter infection prevention and control measures should be adhered to.

Infection prevention and control measures will vary depending on context. Settings should be directed to the relevant GOV.uk guidance for detailed information. Even if your care home does not have any suspected ARI cases, it is important that infection prevention and control measures are still followed in order to best protect residents, staff and visitors. The following principles should be applied:

- **Hand Hygiene** - reinforce 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 their hands regularly and use tissues for coughs and sneezes.

- **Facilities** - ensure liquid soap and disposable paper towels are available at each hand wash basin and sink, alcohol-based hand rub (at least 70%) and tissues are 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 care home follows national guidance on when PPE should be used as per care home 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 ARI 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 2-metres 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 vaccination as an adult each year on medical grounds)

2.3 Impact of ARI Outbreaks

ARI outbreaks can have severe impacts on care home residents because:

- Care home residents are more likely to be more vulnerable to respiratory viruses due to their older age or underlying medical conditions.
- Elderly residents are more likely to suffer with severe symptoms or complications of ARI and therefore are more likely to require hospitalisation or die.
- Care home residents and staff are likely to spend significant periods of time together; therefore, respiratory viruses can spread rapidly in care homes, particularly if stringent infection prevention and control measures are not implemented.

They also impact on care homes and related services:

- Greater resources are required to implement infection control recommendations.
- The potential for having to close the care home to new admissions.
- The potential impact on the reputation of the care home, particularly where there are severe cases or deaths and any concerns over whether duty of care was met by the care home management and staff.

Section 3: Acute Respiratory Illness 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 acute respiratory illness 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.

Flu vaccination is a vital tool to prevent flu. People who have both flu and COVID-19 are more likely to have poorer outcomes. Each winter different types of the flu virus circulate, so people need to be vaccinated every year. Therefore, this winter, flu vaccination is even more important in protecting staff and residents and also in reducing staff absences from work.

Regular whole home COVID-19 testing is being undertaken 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 enable early identification of COVID-19 cases and prevent the spread of coronavirus in social care. This is in addition to additional testing in any care home facing an ARI outbreak, or at increased risk of an outbreak (see section 5 for more detail). A PHE North West Pathway for Testing in Care Home ARI 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 have a duty of care to protect their staff and residents from flu and should ensure ALL staff and residents have received their free seasonal flu vaccine in partnership with the GP Practice/Community Pharmacy BEFORE any ARI outbreaks.

- 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.

- Managers should ensure care home infection control policies are up to date, read and followed by all staff.

- Managers should nominate staff members to act as acute respiratory illness coordinators and manage working practices and care home environment on every shift.

- Managers should ensure that sufficient personal protective equipment (PPE) is available for staff, and that they are trained in its use and disposal.

- Managers should reinforce education of staff, residents and visitors about hand and respiratory hygiene.

- Managers should make sure there is sufficient time/staff numbers on rounds to enable good infection, prevention and control (IPC).

- Managers should increase the frequency and intensity of cleaning for all areas, focusing on shared spaces and ensure appropriate linen management and clinical disposal systems are in place.

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

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

- If possible, managers should separate staff to work with grouped/cohorted asymptomatic residents, those with ARI symptoms, confirmed flu and confirmed COVID-19 cases.

- Shift managers should proactively ask staff if they are symptomatic at the beginning of a shift.

- Managers should 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 COVID-19 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

- All staff involved in resident care (including pregnant women) should be vaccinated for seasonal flu to protect residents from flu, particularly those who may have a poor response to their own vaccination.

- While at work staff should follow 2-metres social distancing measures to the best of their ability, including in staff spaces such as break rooms and offices. Appropriate social distancing should also be maintained outside of work.

- 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 tissues, hand sanitiser or liquid soap, disposable paper towels and other cleaning products and materials (e.g. disposable cloths, detergent).

- Staff with a symptomatic household member should isolate while the household member arranges COVID-19 testing. If the household member tests negative, no further 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 COVID-19 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.

- Identify residents aged 65 years and above and those in a clinical risk group that are eligible for the seasonal flu vaccine and ensure ALL have been vaccinated e.g. those with chronic respiratory, cardiac, kidney, neurological disease including learning disabilities, pregnant women, morbid obesity, immunocompromise, diabetes.

- Maintain a central record of all residents' flu vaccination status and latest kidney function test to support antiviral prescribing in the event of a flu outbreak. A template is attached for care homes to use (appendix 1).

- Management should assess each resident twice daily for the development of a fever (≥37.8°C) and respiratory symptoms and record symptoms (see appendix 2).

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

In view of the probable co-circulation of COVID-19 and flu this winter, and the difficulties in distinguishing between symptoms, cases and outbreaks of acute respiratory illness should be investigated for COVID-19, flu and other respiratory infections simultaneously.

ARI outbreaks should initially be managed through immediate implementation of the stricter infection prevention and control measures required for COVID-19, including isolation of cases and contacts, until laboratory testing confirms otherwise.

Action cards for the management of cases and outbreaks of acute respiratory illness are provided in appendices 3 and 4. Suspected or confirmed outbreaks of acute respiratory illness should be immediately notified to your local Community Infection Prevention Control Team (CIPCT) in hours and the PHE Health Protection Team out of hours (see section 1).

Within the 'flu season' (when declared by the Chief Medical Officer) or outside the 'flu season' when influenza is known to be circulating locally, the use of antivirals should be considered for outbreaks judged to be due to flu, either through laboratory confirmation or a risk assessment undertaken by the PHE Health Protection Team in partnership with the care home, CIPCT and relevant GP.

<table>
<tr><th>ILI Case Definition</th><th>COVID-19 Case Definition</th></tr>
<tr><td>An individual in the home has an oral or tympanic temperature of > 37.8°C
AND
One or more new respiratory symptoms: Cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing
OR
An acute deterioration in physical or mental ability without other known cause

Whilst it is recognised that older people may not always develop a fever with influenza, fever is necessary to define ILI</td><td>An individual in the home has a new persistent cough
AND/OR
An oral or tympanic temperature of > 37.8°C
AND/OR
Anosmia (loss of taste and/or smell)
OR
Other symptoms that may indicate COVID-19 in care home residents include new onset of ILI, worsening shortness of breath and delirium, particularly in those with dementia</td></tr>
<tr><th colspan="2">Definition for an Acute Respiratory Outbreak</th></tr>
<tr><td colspan="2">Two or more cases that meet the clinical case definition of ILI or COVID-19 (above) arising within the same 14-day period in people who live or work in the care home, without laboratory confirmation.</td></tr>
<tr><th>Definition for a Confirmed Flu Outbreak</th><th>Definition for a Confirmed COVID-19 Outbreak</th></tr>
<tr><td>At least one laboratory confirmed flu case and one or more cases that meet the clinical case definition of ILI arising within the same 48-hour period in people who live or work in the care home.</td><td>At least one laboratory confirmed COVID-19 case and one or more cases that meet the clinical case definition of COVID-19, arising within the same 14-day period in people who live or work in the care home.</td></tr>
<tr><th colspan="2">PUBLIC HEALTH ACTIONS SHOULD NOT BE DELAYED WHILE AWAITING CONFIRMATORY TEST RESULTS</th></tr>
</table>

4.1 Public Health Actions for Symptomatic or Confirmed Cases

4.1.1 Residents

- Arrange testing for the symptomatic resident(s) (see section 5).

- Isolate suspected or confirmed COVID-19 residents 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).

- For COVID-19 negative residents with other respiratory infections, including flu, isolate for a minimum five days from symptom onset until fully recovered in a single room or appropriate cohorting (see section 4.3). This is particularly important for immunocompromised residents who are at higher risk of shedding the virus for long periods of time, who should be isolated until they are completely recovered, with no ongoing fever or respiratory symptoms.

- **If there is any doubt as to infection with COVID-19 or co-infection with COVID-19, isolation should be maintained for 14 days after onset of symptoms.**

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

- If flu is clinically suspected or detected, with or without other respiratory viruses, prompt treatment with antivirals should be undertaken, ideally within 48 hours of symptom onset in accordance with the advice from the prescriber. Antiviral therapy can be prescribed as treatment for cases and post-exposure prophylaxis (PEP) for residents in at-risk groups, regardless of their vaccination status.

- The risk assessment and laboratory results will inform the choice of antiviral used and potentially enable the targeting of antivirals to a specific sub-group of the care home e.g. single unit or floor. **There is no evidence to date to indicate that antivirals adversely impact on someone who is co-infected with flu and coronavirus.**

- Ensure seasonal flu vaccination of all unvaccinated residents to provide protection from future infection from other flu strains.

- Provide appropriate supportive treatment and management in accordance with advice from the clinician, including prompt administration of prescribed medications, including antivirals.

4.1.2 Staff

- If a member of staff develops ARI during a shift, they should go home as soon as possible, get tested for COVID-19 as a minimum and be advised to contact NHS 111 if unwell.Their household contacts should also self isolate whilst they await the test results.

- If COVID-19 is confirmed, they should isolate for 10 days from the 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. If the test date is more than 5 days after the date of symptom onset, isolation should be extended to be 5 days from date of test. Their household contacts should also self isolate for 14 days from the date of last exposure. 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).

- If staff members test negative for coronavirus and have ARI symptoms, or are confirmed as having flu, they should remain off work for a minimum of five days after the onset of symptoms and not return until fully recovered. Symptomatic agency staff should also not work in other health and care settings.

- If flu is clinically suspected or detected, with or without other respiratory viruses, antiviral prophylaxis and treatment should be considered for staff who have not had the seasonal flu vaccination (at least 14 days previously) and are in an at-risk group for flu, including pregnancy.

- Unvaccinated staff should be encouraged to have the seasonal flu vaccination to provide protection from future infection.

- A risk assessment should be undertaken with staff members at risk of complications if they become infected with COVID-19 or flu e.g. pregnant or immunocompromised individuals, to determine if they should avoid caring for symptomatic patients.

- Agency and temporary staff who are exposed during the flu outbreak should not work in any other health or care settings until 2 days after their last shift in the affected home. They can continue to work in the affected home once exposed and when the outbreak is over they can work elsewhere as normal.

- Agency staff working in the home when COVID-19 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 per normal arrangements.

4.2 Actions for COVID-19 Contacts

- The infectious period of a COVID-19 case is 48 hours before the onset of symptoms (or positive 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.

- **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) with a confirmed case, including being coughed on, having a face-to-face conversation, having skin-to-skin physical contact or travelled in a small vehicle with a case
    - 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 (please note this only applies to the first-time cleaning of the area)
    - has spent significant time in the same household as a suspected or confirmed case. This includes living and sleeping in the same house, sharing a kitchen or bathroom, or sexual partners.
    - has been notified by Test and Trace that they are a contact of a COVID-19 case.

Any person who maintained >2m social distancing or used appropriate PPE would not be classed as a contact

Advise any resident or staff contacts to self-isolate for 14 days as per national guidance

- **Only close contacts of COVID-19 cases need to self-isolate. If there is a case of another respiratory virus, including flu, close contacts do not need to self-isolate.**

4.3 Cohorting Residents

- Cohorting is where a group of residents, such as all confirmed cases or with ARI symptoms or contacts of the same COVID-19 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).

- If there is co-circulation of COVID-19, flu or other respiratory virus, consider **separate cohorting of residents with different viruses** if possible. If this is not possible, prior to

testing and laboratory confirmation, symptomatic residents with compatible symptoms should be cared for in separate areas (e.g. units or floors) from residents without symptoms.

- Residents with **suspected flu** should ***not*** be cohorted with residents with **confirmed flu or confirmed COVID-19**.

- Residents with **suspected COVID-19** should ***not*** be cohorted with residents with **confirmed COVID-19 or confirmed flu**.

- Suspected or confirmed ARI residents should not be cohorted next to **immunocompromised residents**.

- Any resident **COVID-19 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 COVID-19 contacts could be housed separately in another unit within the home away from the cases and resident COVID-19 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. Only consider using staff vaccinated against flu at least 14 days beforehand to care for symptomatic patients with suspected flu. IPC and PPE guidance should be followed, regardless of vaccination status.

4.4 Walking with Purpose 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 walking with purpose 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 walking with purpose residents.

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

4.5 What Local Support Can Care Homes Expect?

In Cumbria there is a multi agency Outbreak Control Team which meets daily Monday to Saturday and by exception on Sundays. Each care setting with an outbreak or a suspected outbreak situation is discussed and measures agreed to support the setting and limit the impact of COVID-19.

The Cumbria Infection Prevention and Control Team (IPC) offers support to care homes through the provision of infection prevention and control advice, collecting information relating to contact tracing for positive staff, arranging local swab testing for symptomatic residents and for asymptomatic residents during an outbreak. The team supports the arrangements for swab testing of people living in the community prior to admission to a care home and provides training in infection prevention and control for care sector staff..

The local team do not arrange pillar 2 staff testing and cannot obtain results on the behalf of care homes

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 ARI Outbreak

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

2. Maintain adequate PPE supplies.

3. Maintain accurate records of residents with ARI symptoms and share these with CICNs/PHE as requested. See Appendix 2. **Accurate information is essential for outbreak investigation.**

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

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

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

    b. Infection control notices outside rooms of symptomatic residents.

6. Adhere to all infection prevention and control measures, including stringent hand and respiratory hygiene for staff, residents and visitors, enhanced cleaning across all affected units of the home, particularly focusing on frequently touched sites or points.

7. The frequency of infection control audits should be increased to weekly.

8. Implement Social Distancing measures for everyone, wherever possible and the shielding guidance for the extremely vulnerable group.

9. Limit visits by health and care staff to essential care/work only, discourage visits from the elderly, very young or pregnant women and exclude symptomatic visitors (see section 8 for further details about visitors).

10. Arrange testing of residents and staff (see section 5).

11. Consider closure of the home to new admissions, supported by a risk assessment and discussion with social care commissioners and hospital discharge team (see section 9)

4.7 Management of Flu, COVID-19 and Other Respiratory Virus Outbreaks

The full algorithm outlining the investigation and management of acute respiratory illness in care homes is detailed in appendix 5. A key overview of the management of flu or Covid-19 care home outbreaks, either exclusively or together, and other respiratory outbreaks (flu and COVID-19 negative), following laboratory testing is outlined in Figure 1. If laboratory testing does not identify a causative organism, consider re-testing the five most recent resident cases with symptoms. Negative test results should not result in local infection prevention and control measures being lifted, as sustained community transmission of COVID-19 continues.

Figure 1: Key Actions for Flu, COVID-19 and Respiratory Outbreaks

Laboratory Results*	**Actions**					
	Antivirals	**Resident Cases****	**Staff Cases****	**Contacts**	**Pillar 2 COVID-19 Testing*****	**Declare End of Outbreak**
Flu Only	Consider use of antiviral treatment for symptomatic cases and prophylaxis for vulnerable contacts	Isolate for at least 5 days after symptom onset and feeling well	Exclude from work for at least 5 days after symptom onset and feeling well	Isolation not required	Continue with regular testing	5 days after onset of symptoms in most recent case
COVID-19 Only	Consider stopping if already started	Isolate for 14 days after onset of symptoms/ positive test date and 2 days fever-free	Isolate for 10 days after onset of symptoms/ positive test date and 2 days fever-free	Isolate for 14 days from date of exposure to case	Continue weekly testing of staff. Resident testing at day 28 after most recent case	28 days after onset of symptoms in most recent case

Flu and COVID-19	Consider use of antiviral treatment for symptomatic cases and prophylaxis for vulnerable contacts	Confirmed COVID-19: Isolate for 14 days after onset of symptoms/ positive test date and 2 days fever-free Confirmed Flu: Isolate for at least 5 days after onset of symptoms and feeling well	Confirmed COVID-19: Isolate for 10 days after onset of symptoms/ positive test date and 2 days fever-free Confirmed Flu: Exclude from work for at least 5 days after symptom onset and feeling well	Isolate for 14 days from date of exposure to case	Continue weekly testing of staff. Resident testing at day 28 after most recent case	28 days after onset of symptoms in most recent case
Other Respiratory Virus (Flu and COVID-19 negative)	Consider stopping if already started	Isolate for at least 5 days after onset of symptoms and feeling well	Exclude from work until feeling well	Isolation not required	Continue with regular testing	5 days after onset of symptoms in most recent case

* An outbreak is 2 or more cases. ** Both confirmed and suspected cases
*** Every 7 days for staff and every 28 days for residents

Section 5: Testing

5.1 COVID-19 testing in care homes that do not have outbreaks – routine whole care home testing (Pillar 2/DHSC testing pathway)

Regular COVID-19 testing of care home staff and residents is important in order to identify infection quickly and take action to limit transmission. Current arrangements remain that care homes without outbreaks are eligible for weekly PCR testing of staff and PCR testing of residents every 28 days. The only exception is staff and residents that have previously tested positive for coronavirus, and completed isolation, should not rejoin asymptomatic testing for 90 days from their initial symptom onset (or test date if asymptomatic), unless they develop new possible COVID-19 symptoms (see section 5.6).

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 COVID-19 case is identified then a risk assessment should be undertaken to determine actions (see section 5.3). If 2 or more suspected or confirmed COVID-19 cases are identified, then the testing regimen moves to that in an outbreak setting (see section 5.4 and figure 2). Pillar 2 weekly testing of care home staff can continue during an outbreak.

Any queries regarding Pillar 2/ DHSC testing should be directed to the national helpline on 119 (open 7am-11pm daily)

5.2 COVID-19 Lateral Flow Testing (LFT) in care homes that do not have outbreaks (DHSC testing)

The following section is based on the most recent information and guidance issued by DHSC at the time of writing.

The COVID-19 Winter Plan sets out plans to further increase testing in care homes. All care home staff are now offered weekly testing and this will be increased to twice weekly. Resident testing started in April and all care home residents have been offered monthly testing since July. This will be increased to weekly testing.

Lateral Flow Device (LFD) kits will be rolled-out for use in care homes in December 2020. Details on the delivery of LFT kits will be confirmed with care homes directly. LFD testing involves processing a throat and nasal swab sample and if COVID-19 has been detected, a coloured strip will appear on the test. However, all positive results obtained through this mode of testing will require a further test (using a PCR test kit) to confirm the results.

Care homes will be sent LFT kits, universal PCR test kits and supplementing kit. To log the test results with the NHS Test & Trace Service, care homes will be given a mobile device with an app and/or access to a web platform. Care homes will receive further information from DHSC on how to order more kits

LFD Testing of Visitors

Care homes should offer testing in line with the local visiting policy as advised by the DPH and Community Infection Prevention and Control Team. Regular testing of visitors, should be combined with other infection prevention and control measures to support visiting in care homes not experiencing an ARI outbreak. Visitors will need to be tested every time they visit, and the result will be given in 30 minutes. Each care home will be allocated kits to test up to 2 visitors per resident, twice a week (4 per resident).

However, in the event of an ARI outbreak, visits and visiting LFD testing should be stopped, apart from exceptional situations such as end of life (see section 8)**.**

The care home should inform all visitors of the LFT guidance in advance of their visit and schedule each visit in line with the time it takes to test each visitor (approximately 45-60 minutes). The care home should prepare a designated LFT area, with clear signage, which includes a check-in area for residents to put on PPE and complete the test registration and a place to conduct testing and await results, without entering other parts of the home. Separate clean and dirty entrances should be used for the testing area, if possible. Care home managers should ensure the testing area has enough space to allow visitors to maintain 2-metres social distancing before, during and after the test, including the waiting area and operates a one-way system. The area should comply with fire safety regulations and have hard, non-porous flooring that can withstand chlorine cleaning agents. Visitors should have ready access to hand hygiene and the area should be well ventilated with fresh air, either by appropriate ventilation systems or by opening windows and doors.

It is recommended to have two staff members to support each visitor LFD testing session – to check visitors in, to process the tests and to record the results. It is mandatory for all staff undertaking LFD testing to complete the NHS online training and assessment. Each care home will receive access to the training portal via testertraining@dhsc.gov.uk

DHSC has sent guidance and instructions for LFD visitor testing directly to care homes ('Care Home Visitors COVID-19 Testing Guidance. Lateral Flow Test Kits'). The process is summarised below:

1. Each visitor should be provided with PPE (gloves, apron and surgical fluid resistant face mask) when they first enter the care home and advised how to correctly put it on and take it off by a member of staff. Visitors should continue to wear the same PPE throughout the duration of their visit, unless it is contaminated and needs to be changed.
2. Visitors should be advised to maintain 2-metres social distancing with anyone outside their household/bubble throughout the testing process and duration of visit.
3. A member of staff confirms the visitor does not have COVID-19 symptoms. If the visitor has COVID-19 symptoms they will be asked to leave.
4. The visitor is asked to sign a consent form for testing and give permission to share their personal information with the NHS Test & Trace Service.
5. The visitor registers the test online, using the device and LFT kit bar codes provided by the care home. A staff member should help visitors to register, with their formal consent, where required.
6. The visitor is given a throat and nose swab and asked to self-swab. A staff member should advise the visitor how to self-swab and supervise the process.
7. The visitor is asked to wait for the test result, which takes around 30 minutes.
8. A member of staff processes the swab, interprets the result and logs the result with the NHS Test & Trace Service using the device/platform provided.
9. The care home verbally gives the visitor their result and the NHS Test & Trace Service also sends the result to the visitor via a text message or email. This will be one of three options:
    - **Positive** –The visit can no longer go ahead, and the visitor should undertake a 2nd confirmatory PCR test onsite and register it online using the 'testing at home' instructions. The care home should schedule a courier to pick up the test kit. The visitor should immediately go home (wearing a mask and avoiding public transport if possible) and self-isolate whilst they await the 2nd result, which is usually within 72 hours. If it is positive, the NHS Test & Trace Service will contact the visitor to

undertake contact tracing. The visitor should continue to isolate until day 11 and all contacts should isolate for 14 days from the date of last contact.

- **Inconclusive** – the visitor is asked to do a 2nd LFT test in the care home. If it is inconclusive, the care home should decide whether the visit can go ahead.
- **Negative** – the visit can go ahead, as long as stringent IPC measures are adhered to as the test result is not 100% accurate and does not guarantee the visitor does not have COVID-19. The visitor should only enter the designated visiting area, wear PPE at all times, undertake 2 metre social distancing, wash their hands regularly and follow any guidance the care home provides on physical contact with the person they are visiting (see section 8).

10. The testing area should be stringently cleaned in-between visitor tests.

All test providers have a legal duty to notify the results of a valid Point of Care Test (POCT) for COVID-19 to Public Health England. Further information about the POCT notification process can be found **here**. Care homes should ensure that all test results are logged with the NHS Test & Trace Service as per instructions in the guidance sent out from DHSC.

Any queries regarding DHSC LFD testing should be directed to the national helpline on 119 (open 7am-11pm daily)

5.3 Single Positive COVID-19 Result from Pillar 2/DHSC Testing Pathway

Staff

If an asymptomatic staff member tests COVID-19 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 COVID-19 positive during pillar 2 testing, they should be isolated within their own room for 14 days.

Resident contacts of the case should also be isolated for 14 days.

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.

5.4 Testing in Care Homes Where an ARI Outbreak is Suspected (PHE Testing Pathway)

Testing in care home outbreaks (2 or more symptomatic cases/laboratory positives, within 14 days in residents or staff) will be arranged via your local Community Infection Prevention and Control Team (in-hours) or the PHE Health Protection Team (out of hours) depending on your usual arrangements.

All symptomatic or positive acute respiratory illness 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). They will use this information to undertake a local risk assessment, which will then determine what testing is required and the CICN/PHE HPT will activate the appropriate pathway.

The recommendations for testing are under review and may change over the course of the winter. The current arrangements are outlined below:

At the point at which an ARI outbreak is suspected then whole home outbreak testing should be conducted for all residents and staff (see figure 2). From 1st December 2020, as we enter flu season, the first round of outbreak testing will include an offer of wider respiratory testing for up to five residents (please select those five residents who have developed their symptoms most recently, within 5 days of onset of illness) for flu A and B, in addition to COVID-19. These five test kits will arrive in a separate bag and be clearly labelled 'influenza and COVID-19 testing'. Please follow the instructions sent out by the laboratory for these swabs and return in the separate labelled bag to allow easy identification by the laboratory. **Please note that this testing is for care home staff and residents only. Other settings should follow the appropriate nationally or locally agreed testing pathways.**

If Point of Care testing (POCT) for influenza and COVID-19 is carried out in the care home, please follow your local protocols, ensuring that an additional swab is taken for each individual so that laboratory confirmation and other respiratory virus testing can still be undertaken where indicated. All test providers have a legal duty to notify the results of a valid POCT for influenza virus to Public Health England within 7 days. Further information about the POCT notification process can be found **here**.

5.5 Declaring an Outbreak Over

Flu and Other Non-COVID-19 Respiratory Infection

An outbreak of flu or other non-COVID-19 respiratory infection should not be declared over until no new symptomatic cases or positive results have occurred in residents or staff in a minimum of 5 days after the appearance of symptoms in the latest case.

If there are risk factors for the prolonged infectiousness of cases remaining symptomatic e.g. residents with long-term conditions or impaired immune systems (see section 2.1), infection control measures, including isolation, should be maintained for longer than 5 days until residents have fully recovered, with no on-going fever or respiratory symptoms.

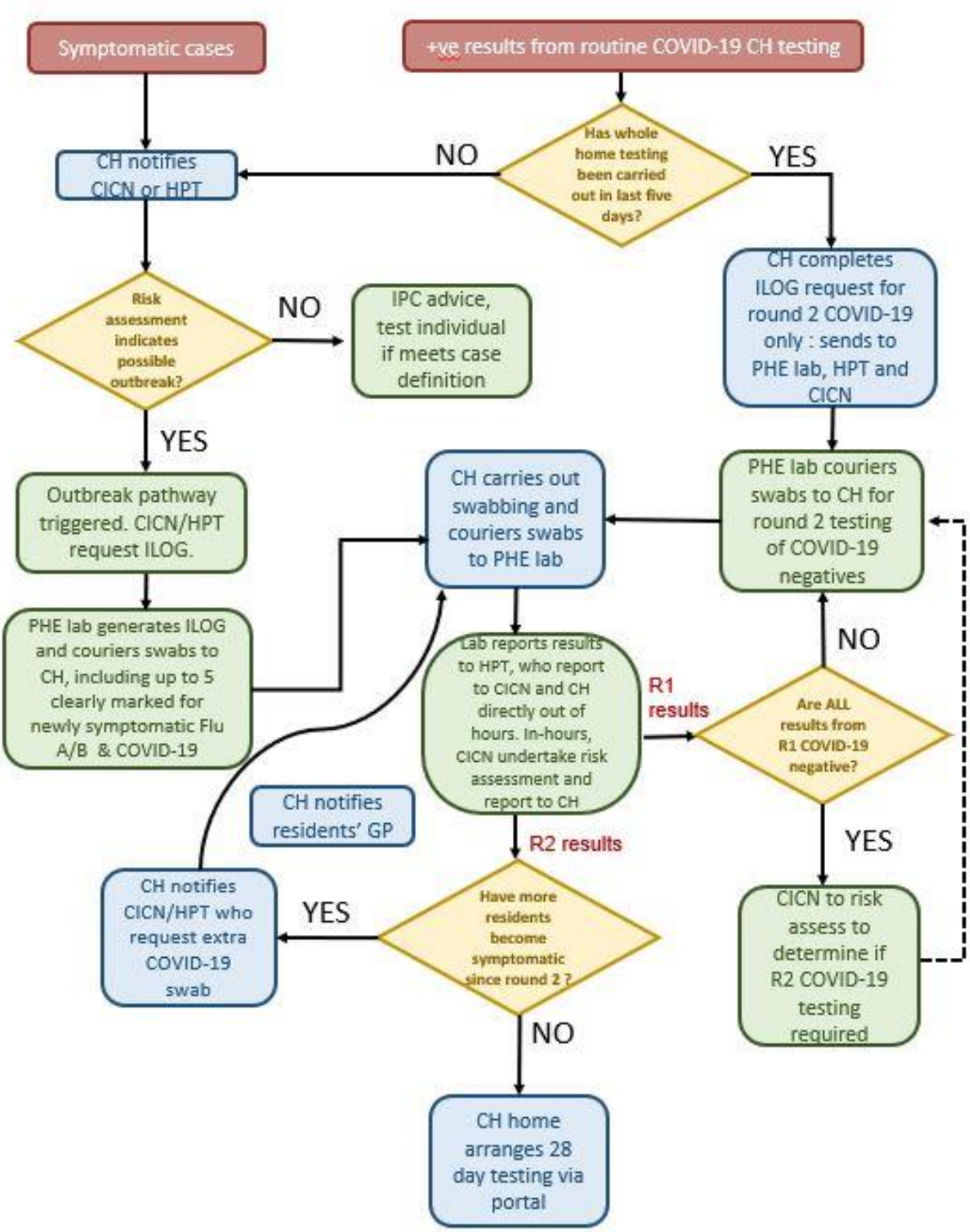
COVID-19

Care homes that have had no new symptomatic cases or positive results in residents or staff for 28 days since onset of symptoms/test date in the most recent case are recovered. 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.

When there have been no new cases of COVID-19 in either residents or staff within the care home in the 14 days since the appearance of symptoms, or a positive swab result in the most recent case, the Outbreak Control Team will agree that the care home has moved into the recovery stage of the outbreak. The care home will be advised of this by Cumbria County Council Strategic Commissioning Team, on completion of a terminal clean and checklist by the local IPC team the home will be advised that they reopen to admissions

Figure 2: COVID-19 Testing Flow Chart



Please note - if wider respiratory testing is required outside of this pathway, this should be discussed with the PHE NW Health Protection Team (HPT), a risk assessment will be completed, and laboratory requests will be submitted by the HPT.

5.6 Isolation Guidance for Residents and Staff with Repeatedly Positive COVID-19 Results

In some individuals, there is a long tail of COVID-19 PCR positivity lasting several weeks which may not be indicative of infectiousness. DHSC recommend that staff and residents that have previously tested PCR positive for COVID-19 and completed their isolation period should be exempt from being retested for 90 days from their initial symptom onset (or test date if asymptomatic), unless they develop new COVID-19 symptoms. The following guidelines apply to staff and residents:

- 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, and infection prevention and control measures should continue.

- 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 staff member or resident develop new possible COVID-19 symptoms within 90 days from their initial symptom onset (or first positive test if asymptomatic), they should self-isolate and be tested again as this could be a new infection.

Staff and residents that test positive more than 90 days after the initial positive result should be managed as a new case.

Asymptomatic, immunosuppressed residents who test COVID-19 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.

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)[2]	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[3]	YES[1]	YES[1]	Fluid-resistant surgical mask	Fluid-resistant surgical mask
Eye Protection[4]	NO	Risk Assess[3]	Risk Assess[3]	YES

Please note that appropriate mask wearing is essential for reducing risk. Alternatives such as clear masks are not considered to be appropriate PPE for COVID-19 and would not automatically exclude an individual from being considered a contact.

[2] Please check usual PPE requirements for the task that you are undertaking (i.e., food handling, cleaning etc.) The effectiveness of using face masks cannot be guaranteed in settings other than the provision of direct care with residents, such as a staff rooms, and will not automatically exclude an individual from being considered a close contact. Maintenance of effective IPC measures and 2 metre social distancing in these areas is therefore imperative.

[3] 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.

[4] 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. Ensure that the face mask is well secured to avoid the need for adjustment while wearing.
- 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 Email: 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

Local Arrangements:	• The expectation is social care providers should have registered with this service before contacting the Council for additional support. https://www.gov.uk/guidance/ppe-portal-how-to-order-emergency-personal-protective-equipment • In an emergency the first option should be: National Supply Disruption Response (NSDR) via the 24/7 helpline: 0800 915 9964 (Freephone number in the UK) or email: supplydisruptionservice@nhsbsa.nhs.uk • In an emergency providers can contact the Council's MAST team on 0800 783 1967, this is only intended as a short term emergency supply.

Section 7: Environmental Cleaning with Suspected or Confirmed Cases

This outlines general principles for cleaning in care homes during the ARI 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 eye protection.

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 and other work clothing should be laundered at work if there are facilities for this.

- Uniforms should not be worn between home and work. They should be transported home in a disposable plastic bag.
- Uniforms should be laundered at home:
  - 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

The following section is based on the most recent information and guidance issued by DHSC at the time of writing.

Guidance on 'Visiting care homes during COVID-19' can be found **here.** Care home visiting during sustained community COVID-19 transmission is legal and is an exemption to restrictions regarding indoor gatherings as set out by the Health Protection (Coronavirus, Local COVID-19 Alert Level) (Very High) (England) Regulations 2020 (SI 2020/1105). From 2 December 2020, there will be national roll-out of asymptomatic COVID-19 testing of care home visitors (see section 5.2). Care homes will need to make their own assessments and may develop further policies to ensure the safety of the residents they care for and their staff. Care home managers are best placed to decide how visits should happen in their own setting. However, care homes should work within any local care home visitor testing policies and arrangements (including any local testing requirements) which may be advised by the DPH and community infection control team.

In order for visits to happen, the care home needs to assess and balance the risk of residents contracting COVID-19 with the benefits of visiting through a dynamic risk assessment, which must formally consider the advice of the local DPH. It may be appropriate or necessary for care homes to apply different visiting rules for different residents or categories of resident. The DPH may choose to provide advice through a dedicated care home outbreak management team or group, often in partnership with local social care commissioners and community infection control team. This considers a number of factors including the:

- Circumstances of the individual care home e.g. size and staffing capacity, COVID-19 results of weekly staff testing and monthly resident testing, readiness of the care home to respond to a COVID-19 case and outbreak status.
- Local epidemiology such as the transmission risk, community testing and infection rates and outbreaks.
- Risks and benefits of visiting in terms of levels of resident wellbeing and vulnerability, including shielding risks.
- The layout and facilities of the care home, including the rooms in which visiting will take place, where and how visitors might be received on arrival at the home to avoid mingling with other visitors, staff or residents etc.
- How the visitor testing arrangements operate.

- The IPC precautions taken to prevent infection during visits, including PPE use, hand washing and social distancing.

8.1 Visiting in Care Home

The following principles apply for all visits:

- An individual risk assessment will need to be undertaken for each visitor by the care home manager.
- The care home should follow robust IPC measures.
- **Visits should only take place indoors where the visitor has been tested and received a negative COVID-19 result.**
- **Care home managers should ensure visitors understand that testing does not completely remove the risk of infection associated with visiting; and that it is essential that the visitor wears appropriate PPE (gloves, apron and surgical fluid resistant face mask), observes 2-metres social distancing in general and follows good hygiene throughout the visit.**
- Outdoor and 'screened' visits can be provided for visitors who have not been tested in line with the following principles:
    - Visits should take place in the open air wherever possible, in an outdoor visiting pod, drive-through in car parks (through car window), gardens (under an awning, gazebo or open-sided marquee, weather permitting) or at a window. Where this is not possible, a dedicated room such as a conservatory with a floor to ceiling screen between the resident and visitor can be used.
    - The visitor and resident must remain at least 2 metres apart at all times.
    - Chairs and tables should be pre-placed in the visiting area to assist social distancing.
    - Doors and windows should be kept open in indoor visiting areas to ensure good ventilation.
    - Consider using speakers or assisted hearing devices to avoid the need to raise voices and reduce transmission risk.
    - The visitor should enter the area from the outside wherever possible and at a different time to the resident to ensure 2-metre social distancing. Consider using a one-way system.
    - Visiting spaces should only be used by one resident and visiting party at a time, and an appropriate time interval should be left between visits to stringently clean the area.
- The visit should always be supervised by a member of staff to ensure PPE use, social distancing and infection prevention measures are adhered to.
- All visits should be pre-booked in advance for a fixed length of time and limited to a single, constant visitor wherever possible, with a maximum of 2 constant visitors per resident. Children should not visit.
- All visitors should be screened for symptoms of acute respiratory infection before entering the home and no one with symptoms in the previous 10 days or who is a contact of a COVID-19 case should be allowed to enter.
- The home should develop a safe visitor code and share with visitors in advance of visits. This should advise visitors of the local testing guidance and to:
    - Travel by private vehicle, walk or cycle to the home and not to travel on public transport.
    - Check in with home prior to the visit and be symptom-free for 10-days prior to the visit.
    - Wear appropriate PPE as advised.
    - Wash their hands thoroughly or use hand sanitiser on entering and leaving the home and use tissues for coughs/sneezes.
    - Only bring gifts that can be sanitised e.g. a box of chocolates.

- The care home should keep a temporary record of the visit date, the name, address and telephone number of all visitors and visiting staff and their arrival and departure time for a minimum of 21 days to assist contact-tracing.
- The care home should also offer alternatives ways of communicating between residents and their families/friends, particularly in the event of visiting restrictions e.g. telephone calls or provision of digital devices for virtual visits.

In the event of an ARI outbreak, the care home should stop visiting and cancel any pre-booked appointments, to protect vulnerable residents, staff and visitors. Once the outbreak is over, visiting may be restarted with stringent IPC measures.

However, there may also be situations, particularly relating to end of life or severe deterioration in a resident's physical or mental wellbeing, 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; observe 2 metre distancing and exercise stringent respiratory hygiene.
- The visit should be supervised by a member of staff at all times to ensure social distancing and 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.

8.1 Visits Out of the Care Home

Guidance for visits out of the care home can be found **here**. In view of the significantly greater risks of COVID-19 for older people, outward visits should only be considered for residents of working age, other than in exceptional circumstances, such as visiting a friend or relative at the end of their life. Outward visits should only happen in agreement with the care home manager, after completion of a risk assessment both for the individual resident, and the whole care home. Two-weeks prior to the visit, the individuals the resident is visiting should minimise their potential exposure to COVID-19 by limiting the number of people they meet.

All visits should be pre-booked in advance and adhere to the tier system rules of the local area. Both the resident and all of the members of the household hosting the visit must be tested for COVID-19 and have a negative result immediately before the visit. The test could be taken

when the individuals go to the care home to collect the resident for the visit. **If any of the individuals have a positive result the visit should not go ahead** (see section 5.2).

During the visit the resident and those they are visiting should maintain 2-metres social distancing, wash their hands regularly, let plenty of fresh air into rooms by opening windows and doors and consider wearing a face covering.

Following the visit, the resident will need to self-isolate for 14 days to protect other residents and staff. If any individuals in the household have COVID-19 symptoms or test positive during the visit, the resident should self-isolate in the visit setting. If this is not possible, the care home must be notified before the resident returns so that appropriate precautions are put in place to care for the resident as a contact of a COVID-19 case.

In the event of an ARI outbreak, outward visits should stop and any pre-booked visits cancelled to protect vulnerable residents and staff.

Section 9: Transfers In and Out of the Home During an ARI 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 Cumbria admissions oversight group can provide specific advice if you require it.

Government policy also recommends testing all residents prior to admission to care homes. Test results should be included in discharge documentation. Where a test result is still awaited, the person will be discharged and pending the result, isolated in the same way as a COVID-positive resident. A flowchart on the application of COVID-19 guidance on testing and discharge for hospital inpatients being discharged to care homes is outlined in Figure 3.

Residents being discharged from hospital or interim care facilities to a care home and new residents admitted from the community should be isolated within their own room or a designated, safe admission suite for 14 days. This should be the case unless they have already undergone isolation for a 14-day period in another setting, and even then, the care home may wish to isolate new residents for a further 14 days. If new residents are admitted part way through an isolation period, they should as a minimum complete the remaining isolation period within their own room in the care home.

People being discharged with a COVID-positive status will also need to be isolated until they complete their 14-day recommended isolation period. Some care providers can accommodate these individuals through effective isolation strategies or cohorting policies. However, if this care is not available by the home, the individual's local authority will be asked to secure alternative appropriate accommodation and care for the remainder of the required isolation period.

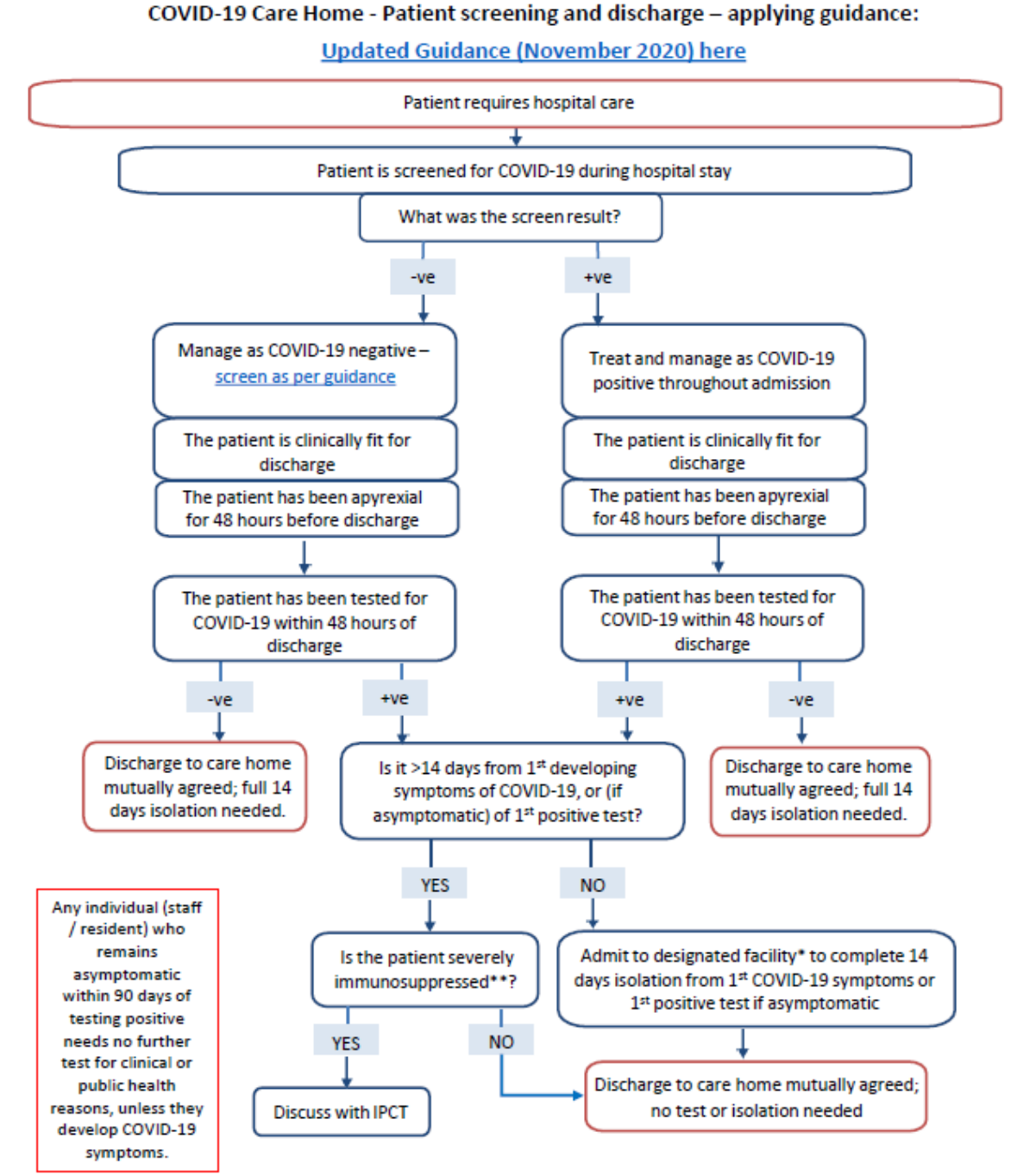
Residents visiting hospital for outpatient appointments do not require a test to return to the home and do not need to self isolate on return, so long as IPC precautions were in place during the hospital visit.

Once an ARI outbreak is identified, closure of the home wholly, or in part, to new admissions and suspension of transfers should be considered by the care home manager in partnership with the social care commissioners and hospital discharge team. Visits to acute medical facilities should be based on medical necessity and the destination facility should be warned in advance about the infection risk. Home closure should be informed by a joint risk assessment that considers:

- The number of staff and/or residents affected and their location within the home.
- Whether symptomatic residents can be effectively isolated.
- Cohorting possibilities for staff.
- Staffing levels
- Availability of PPE
- Ability of the home to comply with all required infection control measures.

A care home may re-open to new admissions once the outbreak is over, provided all IPC measures are implemented. This corresponds to 5 days after the onset of symptoms in the last case for flu and other non-COVID-19 infections, and 28 days from the onset of symptoms in the last case for COVID-19.

Figure 3: Flowchart on the application of COVID-19 guidance on testing and discharge for hospital inpatients being discharged to care homes



* Designated facility: CQC approved care home, or hospital if agreed locally by relevant body

** Immunosuppression:
Examples of persons with weakened immune systems include those on active cancer treatment and those with HIV, bone marrow transplant, and solid organ transplant patients who are taking certain immunosuppressive drugs; and those with inherited diseases that affect the immune system (e.g., genetic immune deficiencies). The list of immunosuppressed people also includes 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)

For any individual who is severely immunocompromised, a test-based plan may be considered in consultation with an Infection Prevention Control or Infectious Disease expert.

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).

Influenza-Like Illness

- Influenza-like illness (ILI): managing outbreaks in care homes guidance
- To order flu leaflets and posters
- Algorithm for outbreaks of acute respiratory infection in care homes poster
- The Flu vaccination, who should have it and why leaflet
- The Flu vaccination, who should have it and why leaflet (Braille version)
- Guide to having your flu vaccination (jab) during the coronavirus pandemic (Easy Read leaflet for people with learning disabilities)

Social Distancing

- Stay at home: guidance for households with possible coronavirus (COVID-19) infection
- COVID-19 social distancing
- COVID-19 shielding guidance

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 hand wash posters
- Catch it. Bin it. Kill it poster
- COVID-19: putting on and removing PPE – a guide for care homes (video)
- COVID-19: personal protective equipment use for aerosol generating procedures
- 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
- Adult social care: our COVID-19 winter plan 2020 to 2021

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: Care Home and Resident Information Template - Complete Prior to ARI Season

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

Name of Care Home	Type Residential / Nursing	Manager of Care Home	Name of ARI Coordinator	Name of Person Completing Template	Date Completed	Date Updated

Room	Full Name	DOB	NHS Number	Medical Conditions	GP Practice	Flu Vaccine Given Y/N Date	Kidney Function (eGFR)/Creatinine Clearance/Serum Creatinine Date of Last Blood Test	Weight

Room	Full Name	DOB	NHS Number	Medical Conditions	GP Practice	Flu Vaccine Given Y/N Date	Kidney Function (eGFR)/Creatinine Clearance/Serum Creatinine Date of Last Blood Test	Weight

Appendix 2 – Daily Log Template (list of residents with suspected / confirmed ARI infection)

In the event of an ARI 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*	Flu Vaccine Yes/No	Kidney Function	Date GP informed	Date Swabbed**	Date Anti-virals Commenced	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

**If Swabbed

Appendix 3: Action Card to respond to a single case of Acute Respiratory Illness

1. Ensure symptomatic resident is assessed by a GP/111/A&E (depending on severity of symptoms) and provide supportive treatment and management (rest, keep warm, plenty of fluids) in accordance with advice from clinician, including prompt administration of prescribed medication.

2. Ensure all infection control measures are in place. Key actions include:

- Isolate symptomatic resident in a single room. A resident with confirmed **COVID-19** should be isolated for **14 days** from symptom onset (or positive test date). A COVID-19 negative resident with **flu/other respiratory infection** should be isolated for a minimum of **5 days** after onset of symptoms until feeling well.
- **If there is any doubt as to infection or co-infection with COVID-19, maintain isolation for 14 days after symptom onset.**
- If the suspected case is a member of staff, exclude from work and arrange COVID-19 testing. Their household contacts should also self-isolate whilst they await test results. A staff member with confirmed COVID-19 should self-isolate for **10 days** from symptom onset (or positive test date) and be fever free (temp <37.8 C) for 2-days until they return to work. COVID-19 negative staff with flu/other respiratory infection should remain off work for a minimum of **5 days** after onset of symptoms until feeling well.
- Identify any close contacts of a confirmed COVID-19 resident/staff member and advise to self-isolate for **14 days** from date of last exposure to case.
- Ensure stringent hand and respiratory hygiene for staff, residents and visitors.
- Maintain adequate Personal Protective Equipment (PPE) for staff and visitors.
- Undertake enhanced cleaning, focusing on frequently touched sites/points.
- Implement 2-metres social distancing measures for everyone and shielding guidance for extremely vulnerable individuals.
- Display signage on resident's door informing of infection control measures.
- Agency staff working in a home with an identified COVID-19 case should be advised not to work in other health/care settings until 14 days after last shift in the home.

3. Arrange testing of resident in accordance with advice from clinician and support the collection of respiratory swab(s).

4. If flu is clinically suspected or detected, undertake administration of antivirals, ideally within 48 hours of symptom onset for both treatment of case and post-exposure prophylaxis for exposed residents/staff in at-risk flu groups or those not vaccinated for seasonal flu, in accordance with advice from prescriber.

5. If case is not vaccinated for seasonal flu, arrange vaccination to provide protection from future infection.

Appendix 4 Action Card to respond to a suspected or confirmed outbreak of Acute Respiratory Illness (2 or more cases linked by time and place)

1. Ensure all symptomatic residents are assessed by a GP/111/A&E (depending on severity of symptoms) and provide supportive treatment and management in accordance with advice from clinician, including prompt administration of prescribed medications.

2. Inform your local Community Infection Prevention Control Team (**in hours**) and PHE Health Protection Team (**out of hours**) of the situation immediately.

3. Ensure all infection control measures are in place. Key actions include:

- Isolate symptomatic residents in single rooms or cohort if appropriate whilst awaiting test results. Confirmed **COVID-19** residents should be isolated for **14 days** from symptom onset (or positive test date). COVID-19 negative residents with **flu/other respiratory infection** should be isolated for a minimum of **5 days** after onset of symptoms until feeling well.
- **If there is any doubt as to infection or co-infection with COVID-19, maintain isolation for 14 days after symptom onset.**
- If possible, cohort residents with different viruses separately. If not possible, prior to testing and laboratory confirmation, symptomatic residents should be cohorted in separate areas from those without symptoms. Separate staff should be allocated to different cohort areas.
- Exclude symptomatic staff from work and arrange COVID-19 testing. Their household contacts should also self-isolate whilst they await test results. Staff with confirmed COVID-19 should self-isolate for **10 days** from symptom onset (or positive test date) and be fever free (temp <37.8 C) for 2-days until they return to work. COVID-19 negative staff with flu/other respiratory infection should remain off work for a minimum of **5 days** after onset of symptoms until feeling well.
- Identify close contacts of confirmed COVID-19 residents or staff and advise to self-isolate for **14 days** from date of last exposure to case.
- Ensure named ARI coordinator on every shift.
- Ensure stringent hand and respiratory hygiene for staff, residents and visitors.
- Maintain adequate Personal Protective Equipment (PPE) for staff and visitors.
- Undertake enhanced cleaning, focusing on frequently touched sites/points.
- Increase frequency of infection control audits to weekly.
- Implement 2-metres social distancing measures for everyone and shielding guidance for extremely vulnerable individuals.
- Limit visits by health and care staff to essential care/work only, discourage visits from elderly, young and pregnant women and exclude symptomatic visitors.
- Display signage informing about outbreak and infection control measures.
- Agency staff exposed during a flu outbreak should be advised not to work in any other health/care settings until 2 days after last shift in the home.
- Agency staff working in a home with identified COVID-19 cases should be advised not to work in other health/care settings until 14 days after last shift in the home.

4. Arrange testing of residents and staff with the local community infection prevention and control team or PHE health protection team and support the collection of respiratory swabs.

5. Undertake twice daily symptom checks of all residents and staff and keep a daily log of cases (appendix 2)

6. If flu is clinically suspected or detected, undertake administration of antivirals, ideally within 48 hours of symptom onset for both treatment of cases and post-exposure prophylaxis for exposed residents/staff in at-risk flu groups or those not vaccinated for seasonal flu, in accordance with advice from prescriber.

7. Ensure seasonal flu vaccination of all unvaccinated residents and staff to provide protection from future infection.	
8. Consider the need for partial or whole home closure to new admissions and suspension of transfers with social care commissioners and hospital discharge team, supported by a risk assessment.	
9. An outbreak of flu or other non-COVID-19 respiratory infection is usually declared over once no new cases have occurred in the 5 days since the appearance of symptoms in the most recent case. COVID-19 outbreaks are declared over once no new cases have occurred for 28 days since the onset of symptoms in the most recent case. Discuss with your local community infection prevention and control team.	
These actions should be completed throughout the course of the outbreak	Completed by

Appendix 5: Algorithm for ARI Outbreaks in Care Homes