Lancashire Resilience Forum

Care Settings Admissions Policy Statement

18th January 2021 (revised from 16th December 2020 version)

In light of the ongoing Coronavirus COVID 19 pandemic, the Adult Social Care Cell (the ASC Cell, a sub Cell of the Lancashire Resilience Forum (LRF)) has produced this care settings admission policy statement on behalf of Lancashire County Council, Blackburn with Darwen and Blackpool Councils (the Upper Tier Councils of Lancashire).

This document has been produced to support and enable, as far as possible, safe admissions to residential care homes for older people and to residential settings such as supported living accommodation for people with a learning disability and/or mental health need (in this document the collective term for all of these types of settings will be referred to as 'care settings').

It is acknowledged that people who move into a supported living type of setting do so, in the main, from a community setting rather than directly from a hospital or emergency department. For the purposes of this paper 'admittance' to a care setting will cover people who move into a setting from the community as well people who are discharged into a setting from a hospital or following an assessment in an emergency department.

This statement has been developed in conjunction with the Lancashire Integrated Care System (ICS) and for clarity, Cumbria County Council have produced their own Admissions Protocol.

Introduction/Context

There are a number of guidance documents and plans (national and local) currently in circulation which have a bearing on care setting (mainly focussed on older people's care homes) discharge policies and practice in relation to the ongoing management of the Coronavirus COVID 19 pandemic. Most if not all of the guidance changes on a regular basis and often at short notice.

In the interests of brevity this document does not repeat verbatim all relevant guidance. It has been produced with the intention of supporting providers to undertake safe admissions in to care settings as opposed to facilitating discharges from a hospital setting. It is kept under regular review by the Adult Social Care Cell (ASC) Cell.

By way of context, the emerging national and international research into the virus suggests that it is present in a significant number of people who display no symptoms, it is likely to be being brought unwittingly into care settings by staff and

other visitors, by the time Infection Prevention Control teams are alerted to an outbreak there is likely to be some degree of transmission already, and the effectiveness of testing undertaken is only about 70% reliable. The increase in whole home testing is resulting in an increase in positive test results for asymptomatic residents and staff and also an increase in the numbers of people who continue to test positive (repeat tests) long after any symptoms have ceased.

Care providers are requested to maintain their vigilance over the winter period and to continue to undertake regular testing of both staff, residents and any designated visitors. They are also reminded to obtain winter flu vaccinations for their residents and staff, and note that a 7 day period must be observed prior to the first or after the final dose of any Covid 19 vaccination.

The emphasis of this admissions policy statement was originally focussed on the prevention of infection occurring in care homes for older people, which at the start of the pandemic saw high infection and death rates occurring across these settings. As the pandemic has continued it has become clear that people with a learning disability have been disproportionately impacted and therefore this admissions policy also needs to incorporate care settings for this group.

Our aim is to keep as many care settings as possible free from COVID 19 (we refer to these as 'cold' homes), and where infection has already occurred (we refer to these as 'hot' homes), keeping the virus under control and prevented from spreading further.

For clarity, the latest guidance from PHE defines an outbreak in a care setting as 2 or more suspected or confirmed cases of COVID 19 in either staff or residents over a 14 day period, with a period of outbreak recovery from the end of the 14 days to day 28, and the end of the outbreak declared at day 28 or at a point within the 14 to 28 day recovery period if a risk assessed deep clean (approved by IPC team) has been undertaken (see below). The definition of outbreak does not include designated visitors who may test positive as part of the testing that will be undertaken as part of the safe visiting process agreed by the LRF. This is on the basis that the designated visitor upon testing positive should not be permitted to enter the care setting/undertake the visit.

A decision was taken at the Health Protection Board on 11th November 2020 that admissions to care settings following an outbreak of COVID 19 must follow national guidance to remain closed to admissions until the end of the outbreak at day 28.

However where urgent admissions are required the care setting can offer an admission during the 14-28 day recovery period following an outbreak but must comply with the following conditions:

1. A deep clean MUST be completed during the recovery period (day 14 onwards) prior to any admission taking place

2. A risk assessment MUST be completed by the care setting provider with input and approval from the respective local authority Infection Prevention Control Team prior to the admission.

This advice also applies to local hospices.

The risk assessment process must take account of and is subject to available resource/capacity within the local authority Infection Prevention Control Teams.

This Admissions Policy and the principles set out apply equally to admissions to care settings as a result of a hospital discharge from a ward or following an assessment in an Accident and Emergency (A&E) department.

The LRF is now in a position to report a positive position in relation to the roll out of the Covid 19 vaccination programme across Lancashire and South Cumbria for people in the top 4 priority groups as set out in the government's Covid 19 Vaccines Delivery Plan published on 13th January 2021. These four priority groups include people who are 80+, older people's care home residents and staff, people with an extreme clinical health vulnerability and front line health and social care workers.

By the end of January 2021 all older people's care homes in Lancashire will have received at least one visit from an NHS vaccination team to deliver vaccines to the residents in the home (some homes who are in outbreak may have their first visit postponed). Each home will then follow a 4 week repeat visit programme to ensure that every resident in the home has been vaccinated. It is anticipated that these visits will take place over a 4 month period to ensure that all first and second doses are administered.

In the event that a care home resident has not received a vaccine for whatever reason eg was a Covid positive person at the time of a vaccination team visit or is a recent non vaccinated new admission, the care home manager is requested to contact the person's GP to request the vaccine. The vaccination teams are very mindful that they do not want to undertake more visits than is necessary.

The LRF are aware that residents of care homes that do not fall into the older person's care home category are not part of the top 4 priority groups, unless they are a person with an extreme clinical health vulnerability or are aged over 70. The LRF has determined that people with a learning disability and/or autism are a priority for vaccination and work is underway to identify people who are living in supported accommodation to receive the vaccine as soon as possible.

Principles to Support Safe Admissions in to Care Settings

Managers of care settings are obviously primarily concerned about the health and wellbeing of residents, families and staff, and in these very challenging times they have faced and are continuing to face some incredibly difficult and distressing situations.

We know from our close and regular contact with care setting managers and other staff that, despite the regular changes in guidance, care settings have been consistently applying the following best practice principles in order to maintain the safest care services as possible, which this statement endorses and supports:

- There is an expectation that all residents (current and new) will be swabbed/tested for COVID 19 prior to any hospital discharge where a person is being admitted to a care setting

- All people being discharged from a hospital and being admitted to a care setting should be tested 48 hours prior to the admittance, and the result should be relayed to the care setting prior to the admittance. This does not apply for people who are being discharged from hospital and who have tested PCR positive 14 days prior to the discharge. These people are deemed to have completed their 14 day isolation period whilst in the hospital and unless they are showing new Covid 19 symptoms do not require a further PCR test prior to discharge (and will not require another PCR test for 90 days after the first PCR positive test/onset of symptoms).

- It is considered best practice that all residents (current and new) discharged into a care setting should be isolated i.e. cared for separately/away from other residents, or appropriately 'cohorted', with effective infection control measures in place, for a period of 14 days regardless of a swab test result. This has been reinforced in the latest guidance however it is acknowledged that many residents in care settings have regular appointments in hospital settings and the requirement to continue to keep these residents in isolation on return to their care setting on a long term/ongoing basis is not, in most circumstances, either practicable for the setting or helpful for the wellbeing of the person and their family. Care settings are asked to take a pragmatic approach in liason with health and other professionals and with the person and their family. Of course strict adherence to IPC measures and appropriate use of PPE, social distancing and adherence to visiting guidance should be maintained.

- As a first principle care settings should only accept discharged residents (current and new) with a confirmed negative test swab.

- Care settings that are willing and able to accept Covid 19 positive residents can do so if they are able to safely and appropriately cohort/isolate the person for the remainder of their 14 day isolation period. Where a care setting is unable/unwilling to accept a Covid 19 positive person then a Designated Setting can be utilised for the remainder of the person's 14 day isolation period, prior to the person then being able to be admitted to the care setting.

- In the minority of cases where a test result is not available at the point of discharge and alternative discharge accommodation is not available a resident can be admitted to a care setting if the care setting is willing and able to safely and appropriately isolate/'cohort' the resident until the negative result is provided or for 14 days (or the balance of) if the result is positive.

- In hospital several COVID-19 tests may be performed due to the hospital being involved with epidemiology surveillance. If a patient has repeated positive swabs the date of the first positive PCR test is taken as the start of isolation. Subsequent positive swabs are to be expected and will not extend the period of isolation required. The resident may need to be isolated for 14 days on admission to a care setting and be retested in the Whole Home Testing PCR testing 90 days following the last positive test (unless they become symptomatic).

- In hospital a patient may be a contact of COVID-19 positive patients, but may not be positive themselves. Whilst in hospital every effort will be made to minimise risk and ensure separation of Covid 19 positive and Covid 19 negative people separate. On admission to care settings these residents should ideally be isolated for 14 days and be included in the next round of PCR Whole Home Testing.

- As a first principle care settings should only accept discharged residents (current and new) if they are asymptomatic on admittance. Any symptomatic residents (current and new) should be isolated/cohorted within the care setting for the remainder of the 14 days isolation period.

- This isolation period should apply unless the person has already undergone isolation for a 14 day period in another setting, and even then, the care setting may wish to isolate new/readmitted residents for a further 14 days. However this must be balanced within the context of overall health of wellbeing in relation to extended periods of isolation (see below for isolation procedures)

- Care settings which contain a mix of symptomatic and asymptomatic residents must ensure that symptomatic residents are isolated/'cohorted' away from asymptomatic residents.

- Any staff who are working in a care setting must follow the latest guidance in relation to effective infection prevention measures and all staff, including agency workers, should not work in another setting until 14 days after the last case has tested negative

- Any staff who need to self isolate (either through their own positive test result or because they have been identified as a 'contact' via track and trace) should do so immediately. They should not seek alternative employment during their isolation period. Care providers must continue to pay staff their full wages for their period of isolation and should use the Infection Prevention Control grant monies for this purpose. This is important for maintaining staff income levels and removing their need to seek alternative work in order to substitute for lost wages, which in turn reduces the spread of infection. It will also encourage staff to take part in testing and not fear the wage related consequences of isolation. In some local lockdown areas the government is offering additional welfare payments to provide further financial assistance for staff who are self isolating. In a limited number of circumstances the Local Authority may be able to challenge the track and trace requirement to self isolate. Such circumstances would be where there is clear evidence that the 'contact' was during a period where the staff member was wearing full and appropriate PPE and complying with all relevant IPC and other requirements, for example if they were a contact whilst at work.

Staff and residents who have previously tested positive and completed isolation should not re-join asymptomatic PCR testing for 90 days from their initial symptom onset (or test date if asymptomatic), unless they develop new possible COVID-19 symptoms. If a repeat PCR test is positive within the 90 days the staff member does not need to be excluded from work unless they have had previous negative tests or if they are displaying symptoms, in which case they should isolate for 14 days.

- Where a Covid positive person is being discharged from a designated setting into a care setting (new or returning) and has already completed their 14 day isolation period then a further PCR Covid test is not required in order to enable the person to be admitted/readmitted to the care setting. The person does not need to be isolated/cohorted and does not need to be PCR retested for Covid for 90 days following the first PCR test unless they display symptoms. A PCR test can only detect presence of the virus not whether the person is infectious.

- To support the person's discharge from the designated setting into a care setting a Lateral Flow Test (LFT) should be used. This test will detect infection as opposed to a PCR test which can only test for presence of the virus. If the person tests negative using the LFT then the person can be admitted/readmitted into a care setting without the need for further isolation unless they then display further symptoms.

- This position has been agreed by the Lancashire DPHs via the Lancashire Clinical Oversight Group.

In the circumstances where a person has received a Covid positive test result and is being discharged from a hospital setting before their 14 day isolation period has expired the person may return to their care setting if the setting is willing to receive the returning resident and can ensure appropriate and effective isolation/cohorting and has all IPC and other appropriate arrangements in place. In these circumstances the person does not need to be admitted to a Designated Setting to complete their isolation period prior to returning to their care setting. If the care setting is unable or unwilling to receive a returning resident the person will be admitted to a Designated Setting to complete their isolation period prior to returning to their care setting.

PHE give the following explanations for some positive PCR tests:

- In some individuals, there is a long tail of positivity lasting several weeks which may not be indicative of infectiousness

- Cases that test positive more than 90 days after the initial positive PCR 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

If a resident has already been PCR tested within 90 days of their onset of symptoms (or first positive test if asymptomatic), then a second positive PCR test within 90 days of symptom onset (or 1st positive test if asymptomatic) should not result in isolation, unless the positive test has been preceded by two or more negative tests.

- If a trusted assessment is not complete the care setting will need all information that is felt to be required/relevant prior to admittance

- Current guidance is for all residential (including dementia) care home staff (including appropriately identified visiting staff) to be PCR tested every 7 days, and all residents every 28 days. Some care settings are now included in the mass testing programme and if included in that programme will be tested using a rapid testing method such as a Lateral Flow device on a twice weekly basis. This is currently in addition to the Whole Home/PCR Testing programme.

- Care settings should take account of the latest national and local guidance in relation to maintaining safe visiting procedures for all staff and family members/friends. Please see the latest LRF ASC Cell Visiting guidance available on the LCC Care Provider Engagement portal website.

These principles apply equally to any person who is being admitted to a care setting (current and new) as a result of a hospital discharge or following an assessment in an emergency department (see below for A&E testing procedures).

Some residential settings may feel able to be more flexible in relation to some of these principles in circumstances where they can accept discharged residents in a safe and proper manner, in particular

- Symptomatic, asymptomatic or recovering residents may be accepted by a care setting prior to the completion of 14 days isolation, with or without swab results, where isolation/'cohorting' can safely be achieved within the setting

- Some limited incomplete information in a trusted assessment may be acceptable to permit discharge, however it is vital that discharge documentation is as complete and accurate as possible to ensure safe and effective ongoing care

The above principles **in the main** reflect current guidance at this point in time, and they are intended to support and enable care settings in Lancashire to manage the health and wellbeing of their residents and staff in these extremely challenging times to the best of their ability.

It is acknowledged that the above principle in relation to care settings only accepting discharged residents following the confirmation of a negative test result is a way of working that many settings have adopted in an understandable effort to reduce the risk of COVID cases amongst their residents but is *not strictly in line* with current guidance. A number of settings have been able to accept residents who are still awaiting a test result but are deemed medically fit in order to assist the discharge process by applying effective isolation/'cohorting' methods. (As stated above, not all residents will require a test result prior to discharge if they have PCR tested Covid 19

positive 14 days prior to discharge and are therefore deemed to have completed their 14 day isolation period whilst in the hospital and are not showing new symptoms.

People with dementia, autism or a learning disability, and people experiencing serious mental ill health are likely to experience particular difficulties during the pandemic. This could include difficulty in understanding and advice on social distancing, and increased anxiety. They may need additional support to recognise and respond to symptoms quickly, and in some cases may be at greater risk of developing serious illness from COVID.

Please see the flow chart and table at Annex A below which sets out a summary of the discharge procedures to be followed for people who have tested Covid 19 positive. It was issued to providers on 15th January 2021 and reflects the updated national discharge guidance published on 13th January 2021.

Testing procedures within Emergency Departments

At the start of the pandemic, A&E departments established a 2 hour turn around testing procedure which was aimed at providing care settings with the confidence to safely readmit their residents following an A&E assessment i.e. the person was deemed medically fit to return home with no need for admittance to a hospital ward.

As the pandemic has progressed and A&E departments have come under additional pressures and are returning to more BAU the ability for some A&E departments to turn test results around within 2 hours is currently not always practicable.

In these circumstances the A&E department may undertake a test prior to the person leaving the department and will provide the readmitting care setting with the test result as soon as possible. The care setting can readmit their returning resident on the basis that the resident should be treated as COVID positive with all relevant IPC procedures observed ie isolation/cohorting and appropriate use of PPE until a test result is provided.

It is also possible that the A&E department may not be able to undertake any test whilst the person is in their care. The readmitting care setting will therefore be expected to treat the returning resident as positive and undertake safe and appropriate isolation/cohorting for 14 days. This lack of a test, whilst a missed opportunity to identify asymptomatic people, should not be a barrier to readmitting the person (safely) back to their home.

Isolation Procedures within Care Settings

PHE NW have published some interim guidance in relation to local queries about how long people who have repeatedly tested positive should remain in isolation. It is included below by way of assistance in relation to decisions on discharge into care settings. PHE NW have raised the issues with national PHE and further guidance is expected.

The following advice in relation care setting residents has been produced due to the challenges local care settings are facing with managing significant numbers of residents in isolation for a longer period, including some with challenging medical conditions such as dementia. This is local interim guidance whilst awaiting a national response:

For care setting residents, the following categorisation has been developed:

1) symptomatic residents 2) asymptomatic residents 3) asymptomatic 'immune suppressed' residents:

1. Symptomatic residents

Residents may come out of isolation 14 days after the onset of symptoms provided they are symptom and fever free for 48 hours (without taking paracetamol or other fever reducing medication). 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 they were positive and tested again and remained positive what matters is the symptoms, not the second test, to make a decision about ending isolation. As long as they remain well and fever free after 48 hours and infection prevention control measures are followed, they should not be isolated. However, if they develop symptoms again they need to be isolated ASAP, as for a new possible case, and tested accordingly. If the resident is not known to be immunosuppressed, then as long as they remain asymptomatic there is no need for repeat testing.

2. Asymptomatic residents

Asymptomatic residents who have tested positive initially, after they have been isolated for two weeks and they remain asymptomatic and are not immunosuppressed, then the current holding advice is not to continue with isolation irrespective of subsequent test results. However, if they develop symptoms they need to be isolated ASAP, as for a new possible case, and tested accordingly.

3. Asymptomatic immunosuppressed residents

Asymptomatic immunosuppressed residents who have tested positive after two weeks should be retested after a further week in isolation. 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. Please note: People with weakened immune systems are at higher risk of getting severe illness from SARS-CoV-2 infection, the virus that causes COVID-19. They may also remain infectious for a longer period of time than others with COVID-19.

This interim PHE NW guidance will be helpful in assisting a more proactive and positive approach in relation to people who have repeatedly tested positive for COVID 19 and are requiring admission to a care setting. This advice will assist care settings in the requirements for appropriately isolating/cohorting such people.

All of the above principles are based on care settings having an appropriate number/skill mix of staff in place, have an appropriate amount/mix of compliant PPE, are observing correct infection control practices and measures, are able to operate

within appropriate Mental Capacity Act and Deprivation of Liberty protocols, and feel that they have the appropriate support and guidance from GPs, local authority and health professionals.

Summary

The Upper Tier Lancashire Councils will keep this document under regular review in light of changing guidance and partner and care setting manager feedback, and will amend/update as necessary.

It is recognised that applying the 14 day isolation period will potentially have an impact on the ability of health services to meet the new obligations in relation to timely discharges from hospitals. This will become more of an issue as the pressure on hospital capacity increases over time. The Upper Tier Lancashire Councils will endeavour to continue to work with NHS services to identify appropriate settings to enable safe and efficient discharge, including mutual aid.

Particular issues affecting timely and safe discharges at the present time are the delays in receiving test results, and the current guidance which states that any re-testing of symptomatic residents can only be done after 7-10 days of a previous test. This is causing particular problems where residents need to be moved from one setting to another.

There is obvious demand for asymptomatic residents to be discharged in to settings reporting no COVID cases ('cold' homes). At present the majority of Lancashire settings are COVID free. Ensuring the protection of these settings is an obvious priority and the subject of a separate and linked LRF testing policy statement, however it is acknowledged that the desire to protect these settings may restrict the quantity of available care beds to discharge to if in future the infection rates within settings starts to rise again.

The financial viability of some settings may become more of a pressing issue in the months ahead and work is being done across the system to assess and appropriately support care settings in relation to finance pressures.

The Upper Tier Lancashire Councils continue to support the discharge of more residents at weekends and 'out of hours' and welcome additional support from NHS community services during these periods to enable effective and timely decisions to be made, and encourage the principle of 'home first' wherever possible. The use of 'step down' facilities is currently under review. Additionally they also support further work being done in relation to the development and adoption of a consistent approach to how placements are made.

Grateful thanks are extended to all care providers in Lancashire, and care setting providers in particular, for the hard work, diligence, resilience and above all else, care and compassion that they continue to show for their residents and staff. There will be a lasting impact of this pandemic on residents and staff and the Upper Tier Councils of Lancashire alongside NHS services will continue to provide as much support as possible in a respectful, pragmatic and proportionate way.

Annex A

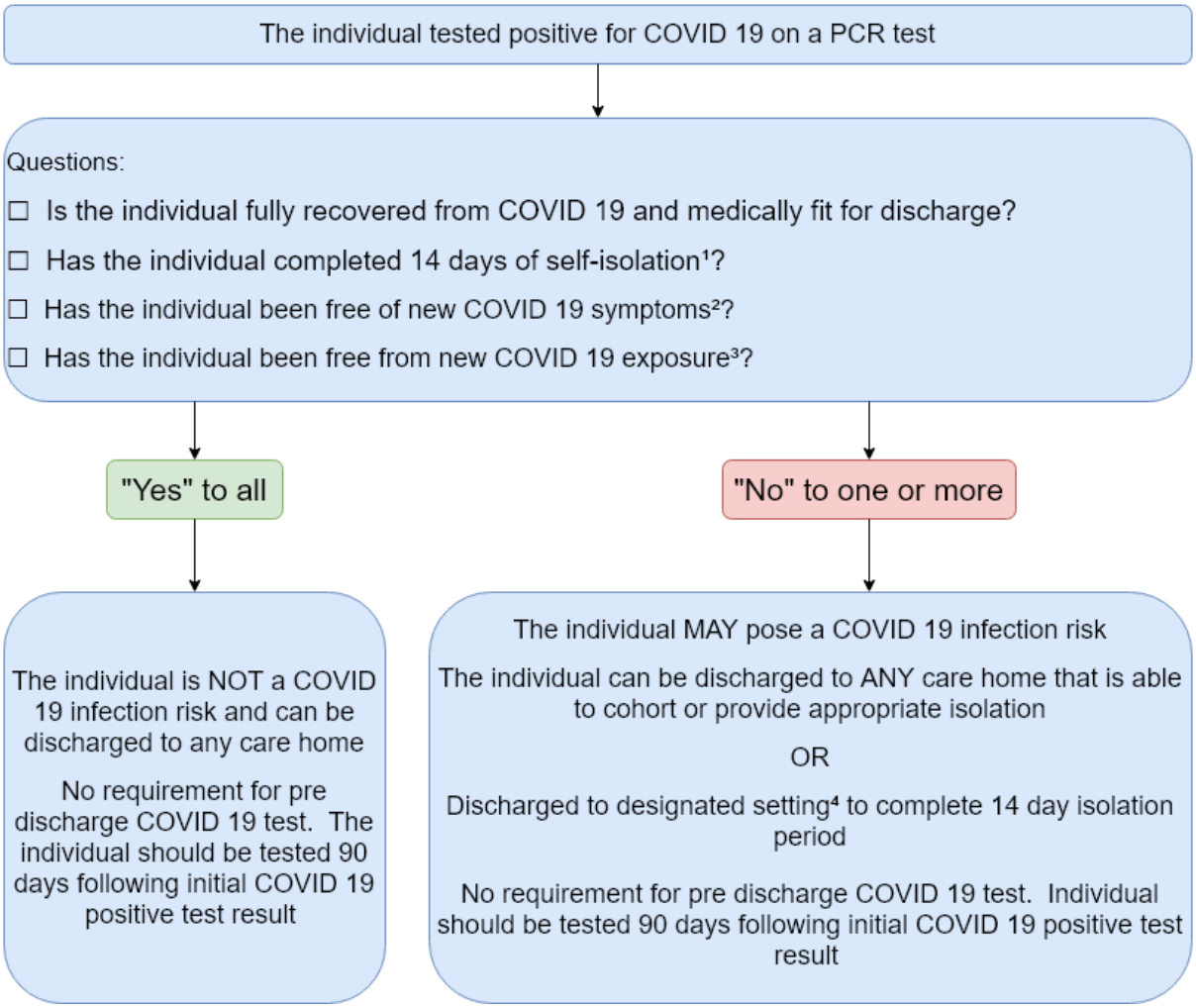
DISCHARGE INTO CARE HOMES FOR PEOPLE WHO HAVE TESTED POSITIVE FOR COVID 19: NOTE AND FLOWCHART FOR CARE HOMES.

Date of issue: 15th January 2021

This note and flowchart has been created for care homes to simplify and clarify existing national guidance on discharge into care homes (published in December), particularly in relation to people who have tested positive for COVID-19.

Key roles of care homes	Key roles of hospitals (in the context of interacting with care homes)
Care home manager has the absolute discretion to accept or decline a resident depending on their local context and subsequently whether to isolate that individual on admission.	**Hospital discharge team** must not put undue pressure on a care home to accept a resident.
Care home manager should review the discharge summary information, in conjunction with NHS clinical support to care homes if required, to satisfy themselves that due process has been followed in the clinical assessment and decision-making.	**Clinical team** should ensure that the time-stamped reported COVID-19 test result of the individual is included in the discharge summary information.
If any information in the discharge summary information is missing or unclear, the **care home manager** should seek clarification from the hospital before accepting a resident.	**Clinical team** should provide detailed information about the clinical assessment and decision-making in the discharge summary information. This should state clearly whether or not the person is considered infectious and therefore whether or not it is necessary to discharge them to a designated setting. It should also include details of the individual's previous COVID symptomology (including date of onset of symptoms) and severity.
Care home manager should ensure the care home follows its own infection prevention and control procedures.	
Care home manager must ensure that the care home is operating within the margins of its organisation's indemnity insurance.	

DISCHARGE INTO CARE HOMES FOR PEOPLE WHO HAVE TESTED POSITIVE FOR COVID-19: FLOWCHART FOR CARE HOMES



[1] Self Isolation – Click Here for more information

[2] New COVID 19 symptoms – Click here for more information

[3] COVID 19 Exposure – Click here for more information

[4] Designated setting – Click here for more information