UK Health Security Agency

Acute Respiratory Infection Resource Pack for Care Homes (Interim)

Version 1.0

(Adapted by Lancashire County Council 17th November 2021)

About the UK Health Security Agency

The UK Health Security Agency is an executive agency, sponsored by the Department of Health and Social Care.

www.gov.uk/government/organisations/uk-health-security-agency

Version 1.0

Prepared by: UKHSA North West Health Protection Team
For queries relating to this document, please contact: ICC.NorthWest@phe.gov.uk

Contents

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

COVID-19, is a rapidly evolving situation, and guidance may change with little notice

This pack will be updated when national guidance for adult social care settings is published. Once published, updated guidance will **immediately supersede** this resource pack**.**

Always refer to the latest guidance: Coronavirus (COVID-19): adult social care guidance & ILI: Managing Outbreaks in Care Homes

Sign up to receive Social Care updates here

Section 1: Local Contacts

Community Infection Prevention and Control Team (CIPCT)

Infection Prevention and Control Team
Lancashire County Council

Monday – Friday 8am – 5pm

infectionprevention@lancashire.gov.uk

Please use this email address as the main contact for the team.

http://www.lancashire.gov.uk/practitioners/health/infection-prevention-and-control.aspx

For out of hours please contact UKHSA on 0151 4344819

UKHSA North West Health Protection Team

Monday – Friday 9am – 5pm	0344 225 0562
Out of Hours	0151 434 4819

Reporting Outbreaks of suspected / confirmed Acute respiratory infection (ARI)	
Monday to Friday 9am – 5pm	Local Health Protection Team: 0344 225 0562
Weekends/Bank Holidays 9am – 5pm	Local Health Protection Team: 0151 434 4819
After 5PM	Refer to this resource pack and follow-up the next day with Health Protection Team

Section 2: Acute Respiratory Infection Key Messages

The most commonly identified causes of acute respiratory infection (ARI) 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 SARS-CoV-2 virus, which causes COVID-19.**

Symptoms are difficult to distinguish between COVID-19, influenza, and other, influenza-like illness (ILI) viruses. COVID-19, influenza, and other influenza-like illnesses will need to be investigated and managed simultaneously. Therefore, acute respiratory infection in care homes should initially be managed with the more stringent infection control measures needed 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]. A laboratory detection of influenza virus would fulfil the definition of a case of influenza.

[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.

	COVID-19	Influenza-like illness (ILI)
		Other common respiratory viruses include: • Rhinovirus • Adenovirus • Parainfluenza • Respiratory syncytial virus (RSV) • Human metapneumovirus
Infectious Period	From 2 days 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** - *increased to 14 days, <u>if hospitalised</u>* Please see current guidance	From 24 hours before onset of symptoms until symptoms have resolved. For Influenza 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	• Respiratory droplets during close unprotected contact • Contact with contaminated surfaces
Exclusion Periods	**Resident CASES** should be isolated for 14 days from onset of symptoms (or positive test date) **Staff CASES** should isolate for 10 full days from onset of symptoms (or positive test date) <u>and</u> be fever free (temp <37.8C) for 2 days before returning to work. Isolation period should be extended to 14 days for any Staff who are hospitalised with COVID **Resident CONTACTS** of a confirmed COVID-19 case should isolate for 14 days from the most recent date of, unless exempt** **Staff CONTACTS** of a confirmed COVID-19 case should be isolated for 10 full days from the most recent date of contact with the case, unless exempt** NB: The most recent date of contact counts as “Day 0”, and contacts need to isolate for **10 full days** after that	**Resident CASES** should be isolated for a <u>minimum</u> 5 days after the onset of symptoms and until feeling well. For suspected or confirmed Influenza, there may be occasions where individuals are recommended to isolate for a longer period, until all symptoms have cleared e.g. individuals with long-term conditions or impaired immune systems* and those given antiviral therapy >48 hours after symptom onset or not at all, or remain symptomatic after 5 days of antivirals. **Staff CASES** should isolate for 5 days from onset of symptoms and not return to work until fully recovered. **CONTACTS** of Influenza 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
** Refer to Guidance

2.2 Basic Infection Prevention Messages

Prevention is the most effective method of stopping transmission and outbreaks of ARI. COVID-19 cases and outbreaks continue to occur within care homes in the UK. Co-circulation of COVID-19 and Influenza is likely and it is difficult to distinguish between the two diseases and those caused by other respiratory viruses (see section 2.1). Therefore, it is important to apply the stricter infection prevention and control measures needed for COVID-19 whenever an ARI case or outbreak is suspected.

Infection prevention and control measures will vary depending on context. Settings should refer 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 guidance for working safely in care homes should be followed and made available to all staff. The following principles should be applied:

- **Hand Hygiene** - reinforce education about hand and respiratory hygiene to staff and residents and display posters throughout the setting. 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, bathrooms, 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, doffing and correct disposal. Ensure the care home follows national guidance for when PPE should be used as per care home specific guidance. Additional PPE is required for aerosol generating procedures (AGP).

- **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. Appropriate PPE should be worn when cleaning locations where symptomatic people have been (see section 6).

Section 3: Acute Respiratory Infection Preparedness in Care Home Settings

3.1 General Advice

The COVID-19 and influenza vaccinations offer the best protection against the viruses for staff and residents. From 11th November 2021, everyone working in care home will need to vaccinated against COVID-19 unless exempt. Different types of influenza can circulate each winter, which is why people need to be vaccinated every year.

Regular whole home COVID-19 PCR testing is being undertaken for all residents and staff, regardless of symptoms. Staff should be PCR tested for COVID-19 weekly, and residents tested every 28 days to enable early detection of COVID-19 cases and prevent transmission in social care settings. In addition to the weekly PCR test, staff should also have twice weekly Lateral Flow Device (LFD) tests - see section 5 for more detail.

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 UKHSA guidance.

- Managers have a duty of care to protect their staff and residents from influenza and COVID-19 and should ensure ALL staff and residents have received their free seasonal influenza vaccine in partnership with the GP Practice/Community Pharmacy and a full dose of COVID-19 vaccinations. COVID-19 booster vaccinations will also be offered as per national guidance.

- Managers should review their list of resident details, and ensure it is kept up to date, and includes the level 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 their ARI 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 safe 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 shifts 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 and waste management 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 movement within setting, e.g. individual care staff to only work on one floor/unit.

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

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

- The Every Mind Matters website provides expert advice and practical tips for wellbeing, 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, if not meeting exemption criteria.

3.3 Advice for Staff

- All staff involved in resident care (including pregnant women) must be fully vaccinated against COVID-19 by 11th November 2021 and encouraged to have a seasonal Influenza vaccine to protect both themselves and their residents, who may have a poor response to their own vaccination.

- Staff should check that they have adequate supplies of PPE and are familiar with the guidelines and instructions for its correct use and disposal (see links to guidance in sections 6 and 10)

- Staff should check they have access to adequate supplies of tissues, hand sanitiser and liquid soap, disposable paper towels and other cleaning products and materials (e.g. disposable cloths, detergent).

- Fully vaccinated staff identified as being a contact of a confirmed case of COVID-19 should refer to guidance to assess whether or not they are exempt from self-isolation.

3.4 Advice Regarding Residents

- Admissions from hospital should be PCR tested for COVID-19 prior to admission, unless exempt, and cases found to be COVID-19 positive should be managed as per guidance.

- 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 50 years and above, and those in clinical risk groups eligible for the seasonal influenza vaccine and ensure all have been vaccinated. People most at risk include those with chronic respiratory, cardiac, kidney, neurological disease including learning disabilities, pregnant women, morbid obesity, immunocompromise, diabetes.

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

- During an outbreak of ARI. Management should assess each resident twice daily for 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

Due to the potential for co-circulating COVID-19 and influenza this winter, and the difficulties distinguishing between the two, cases and outbreaks of acute respiratory infection should be investigated for COVID-19, influenza and other respiratory infections simultaneously.

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

Checklists for the management of single cases and outbreaks of ARI are provided in Appendices 3 and 4. Suspected or confirmed outbreaks of ARI should be immediately notified to your UKHSA Health Protection Team.

Within the 'influenza season' (*as declared by the Chief Medical Officer*) or outside the 'influenza season' where influenza is known to be circulating locally, antivirals should be considered for any outbreaks where influenza is either suspected or confirmed and following a risk assessment undertaken by the Health Protection Team in partnership with the care home, CIPCT and relevant GP (not all teams may be involved in each outbreak assessment).

COVID-19 Case Definition	Influenza Like Illness Case Definition
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	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
Definition for an Acute Respiratory Outbreak	
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.	
Definition for a Confirmed COVID-19 Outbreak	**Definition for a Confirmed Influenza Outbreak**
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.	At least one laboratory confirmed influenza 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.
PUBLIC HEALTH ACTIONS SHOULD NOT BE DELAYED WHILE AWAITING CONFIRMATORY TEST RESULTS	

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 if asymptomatic) from other residents – 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 influenza, must isolate in a single room or appropriately cohort (see section 4.3) for a minimum five days from symptom onset until fully recovered. This is particularly important for immunocompromised residents who are at higher risk of shedding the virus for longer periods and should therefore be isolated until fully recovered.

- **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 influenza is clinically suspected , known to be circulating in the local area or confirmed, with or without other respiratory viruses, prompt treatment with antivirals should be considered following risk assessment undertaken by the Health Protection Team in partnership with CIPCT, GP and care home, 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 influenza and COVID-19.**

- 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 symptoms during a shift, they should go home as soon as possible, get tested for COVID-19, and be advised to contact NHS 111 if unwell.

- If COVID-19 is confirmed, staff should isolate for 10 full 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. Any staff hospitalised with COVID-19 should extend their isolation/exclusion period to 14 days. 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 COVID-19 and have ARI symptoms, or are confirmed as having influenza, 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 not work in other health and care settings.

- If influenza is clinically suspected, known to be circulating in the local area or confirmed, with or without other respiratory viruses, antiviral prophylaxis and treatment should be considered for staff who have not had their seasonal influenza vaccination (at least 14 days previously) and are in an at-risk group for influenza, including pregnancy, via their GP.

- A risk assessment should be undertaken with staff members at risk of complications if they become infected with COVID-19 or influenza 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 influenza 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

- Cases of COVID-19 are considered infectious from 2 full days before the day of onset of symptoms (or positive test if asymptomatic) until 10 full days after for staff and 14 days after for residents

- Managers should identify if there are any resident or staff contacts in the care home.

- **Resident CONTACT definition**:

    - lives in the same unit or floor as a confirmed case (e.g. shares the same communal areas)

    - anyone who has had any of the following types of contact with someone who has tested positive for COVID-19:
        - face-to-face contact including being coughed on or having a face-to-face conversation within one metre
        - been within one metre for one minute or longer without face-to-face contact
        - been within 2 metres of someone for more than 15 minutes (either as a one-off contact, or added up together over one day)
        - travelled in the same vehicle

- **Staff CONTACT definition** (*without appropriate PPE **or** where a PPE breach occurred*):

    - anyone who lives in the same household as another person who has COVID-19 symptoms or has tested positive for COVID-19

    - anyone who has had any of the following types of contact with someone who has tested positive for COVID-19:
        - face-to-face contact including being coughed on or having a face-to-face conversation within one metre
        - been within one metre for one minute or longer without face-to-face contact
        - been within 2 metres of someone for more than 15 minutes (either as a one-off contact, or added up together over one day)
        - travelled in the same vehicle

Any person who maintained >2m social distancing or used appropriate PPE *or* only had interations through a Perspex screen (or equivalent) would not be classed as a contact (this does not include Perspex facial visors)

Staff identified as contacts should self-isolate for 10 full days from their last contact with the infectious case, unless they meet the exemption, as per national guidance. If exempt, staff can return to work if the following apply:

- the staff member should not have any COVID-19 symptoms
- the staff member should immediately arrange for a PCR test*, either through their workplace arrangements or via the NHS Test and Trace service, and the result of this PCR test should be negative prior to returning to work
- following the negative PCR result, the staff member should undertake an LFD antigen test every day for the 10 days following their last contact with the case (even on days they are not at work)
- *if a staff member has had a COVID-19 infection in the past 90 days, they should not have a PCR test and should only undertake the daily LFD antigen tests
- on days the staff member is working, the LFD antigen test should be taken before starting their shift, and the result should be negative
- the staff member should comply with all relevant infection control precautions and PPE should be worn properly throughout the day
- if the staff member works with patients or residents who are highly vulnerable to COVID-19 (as determined by the organisation), a risk assessment should be undertaken, and consideration given to redeployment during their 10 day self-isolation period

Additional mitigations may be put in place by employers in different settings for fully vaccinated staff who are identified as household contacts. Refer to organisational guidance as necessary.

Only close contacts of COVID-19 cases may need to self-isolate. Contacts of other respiratory viruses, including influenza, do not need to self-isolate but should be closely monitored for symptoms.

4.3 Cohorting Residents

- Cohorting is where a group of residents, with the same infection or exposure are housed together in the same room or unit. This can be an effective infection prevention and control strategy for the care of large numbers of unwell people where it is not possible or safe to use single room isolation.

- If there is co-circulation of COVID-19, influenza, or other respiratory viruses, consider **separate cohorts 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 influenza** should ***not*** be cohorted with residents with **confirmed influenza or confirmed COVID-19**.

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

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

- Resident **COVID-19 contacts** can 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. Consider using staff vaccinated against influenza at least 14 days beforehand to care for symptomatic patients with suspected influenza. IPC and PPE guidance should be followed, regardless of vaccination status.

ALWAYS consider whether residents have any other potentially transmissible conditions, before cohorting cases of the same ARI together

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 beneficial, where possible create:

- 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?

The IPC team at Lancashire County Council will provide general and bespoke IPC advice to the care home on a home by home basis.

IPC advice and support:

- To apply national and local guidance into good practice;
- To facilitate safe hospital discharges and re admissions into care homes;
- To manage outbreaks until they are confirmed as over;
- To sign post to other relevant professionals and services;
- To manage bespoke COVID-19 situations and issues during multi-disciplinary team meetings.

The IPC team at Lancashire County Council will liaise directly with PHE NW, if required, to provide information about what is happening in your home. In some instances, PHE NW may contact you directly.

UKHSA Health Protection Team (HPT) will liasie with your local Community Infection Control teams to provide information about what is happening in your home. Local IPCT will in some instances, contact you directly to provide specialist support

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/HPT 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. Limit close contact with other people especially during an outbreak, or when spending prolonged periods of time with a vulnerable individual. This can help reduce your risk of catching or spreading COVID-19, and other ARI.

9. Limit visits by health and care staff to essential care/work only or in exceptional circumstances e.g. end of life. Discourage visits from older people, very young or pregnant women and exclude any symptomatic visitors (see section 8 for further details about visitors).

10. Arrange COVID-19 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)

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 vital 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 immunocompetent staff and residents that have tested positive for COVID-19 within the last 90 days and completed their self-isolation period. These individuals, should not be retested 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).

DHSC also request care homes undertake twice weekly LFD testing of staff, in addition to their weekly PCR testing (Figure 1), ideally at the beginning of the shift. One LFD test should be taken at the same time/day as the weekly PCR test and a second LFD test taken 4-5 days after.

Staff that have worked elsewhere in another health or care setting since their last shift in the care home or are returning from annual leave and have missed their weekly PCR test will need to undertake a LFD test immediately before starting their shift.

Any staff who have a positive LFD test should undertake a confirmatory PCR test onsite, go home immediately before any significant contact with other staff members and residents and self-isolate whilst they await the PCR result. If it is positive, they should continue to isolate until day 11. If the confirmatory PCR is negative, and the staff member does not have symptoms, they can return to work.

LFDs can also be used for visitor testing, including visiting professionals who are not part of a regular testing programme (see section 5.2).

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

For further information: https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested#care-home

If a single, positive COVID case is identified, a risk assessment should be undertaken to determine actions (see section 5.3). Staff should be tested daily with an **LFD** as close to the beginning of their shift as possible **for 7 days.** If any staff are found to be positive as part of the 7-day LFD testing they should undertake a confirmatory PCR test onsite, go home immediately and self-isolate whilst awaiting the result. Daily staff LFD testing should continue until 5 days without any further cases being identified.

If there are 2 or more positive COVID-19 cases contact your Community Infection Control Team weekdays, or Health Protection Team weekends and Bank Holidays (9am-5pm) to carry out a risk assessment.

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 Device (LFD) testing in care homes

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

Lateral Flow Device (LFD) kits have been in use in care homes since December 2020. Care homes have been sent LFT kits, universal PCR test kits and supplementing kit. To log the test results with the NHS Test & Trace Service, care homes have been given a mobile device with an app and/or access to a web platform. Care homes have been given further information from DHSC on how to order more kits

Any queries regarding DHSC testing should be directed to the national helpline on 119

LFD Testing of Visitors

Care homes should ensure:

- there is a separate area for people being tested to complete a self-assisted swab and await results, maintaining social distancing
- your staff schedule is planned accordingly to allow time for testing
- you have prepared written consent forms for all people being tested in line with your normal policies and procedures
- devices are set up for registration and the unique organisation number (UON) is visible for registering online
- if you have received a handheld scanner for easier registration: make sure you have set it up and familiarised your staff with how to use it, see guidance
- you are prepared to have a clear record of which device matches which individual's result
- you have a mirror, timer, permanent markers, hand sanitiser and health care waste bins in the testing area

Where testing will be fully or partly conducted on site, care home managers will need to set up a testing area. Care home managers should ensure the testing area has enough space

to allow visitors to maintain social distancing before, during and after the test, including a waiting area and a one-way system.

The area should comply with fire safety regulations that govern deployment sites and 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. Care managers should also consider storage implications for testing.

Visitors who have recently tested positive for COVID-19 by PCR test should not routinely be retested within 90 days unless they develop new symptoms. This means that some visitors will not need to be tested regularly because they will still fall into this 90-day window. These visitors should use the result of their positive PCR result to show that they are currently exempt from testing until the 90-day period is over following their period of self-isolation. Once the 90-day period is over, visitors should continue to be tested. Visitors should continue to follow IPC measures, including limiting close contact, maintaining good hand hygiene, and wearing PPE.

Actions for specific LFD test results in visitors:

- **Positive** – If a visitor tests positive they must immediately self-isolate following government guidance for households with possible or confirmed COVID-19 infection. If the test has been taken away from their own home, they should return home, avoiding public transport, where possible and wearing a face mask. Visitors should also complete a confirmatory PCR test which should be provided to them by the care home if testing on-site, or ordered from the government portal or by calling 119. If the confirmatory PCR comes back positive, their contacts may also need to self-isolate. If the follow-up PCR test result is negative, *and* this PCR test was taken within 2 days of the positive rapid lateral flow test, self-isolation is not necessary.
- **Inconclusive** – the visitor is asked to do a second LFD test in the care home. If it is inconclusive, an indoor visit is not recommended, and the care home should consider an outdoor or screened visit (see section 8).
- **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, wash their hands regularly and follow any guidance the care home provides on physical contact with the person they are visiting (see section 8).

Care homes do not need to retain records of proof. All tests done both at the care home and when self-testing at home should be reported to the unique organisation number (UON) of the care home and managers should ensure visitors are aware of their UON and the legal duty to report the result. This will support NHS Test and Trace and public health teams to better support care homes to understand the transmission of COVID-19 and prevent outbreaks.

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 LFD Testing Pathways

PCR Positive Staff

If an asymptomatic staff member tests **PCR** COVID-19 positive, they should self-isolate for 10 full 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.

If staff cases of COVID-19 are hospitalised they should extend their self-isolation until 14 days after onset of symptoms/test date

Their household contacts will be required to self-isolate, unless exempt as per national guidance

PCR Positive Resident

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

NB: **A single PCR positive case in a care home (resident or staff) will trigger 7-day daily rapid LFD testing of all staff.**

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

Two or more symptomatic cases/positive tests, within 14 days in residents or staff should be risk assessed by your local Community Infection Prevention and Control Team (in-hours) or UKHSA Health Protection Team (out of hours) depending on your usual arrangements. They will use this information to undertake a local risk assessment, which will then determine what testing is required and the CICN / UKHSA HPT will activate the appropriate testing pathway.

The recommendations for testing are under review and may change over the course of the winter.

The current NW arrangements are outlined below:

- The CIPCN (weekdays) or UKHSA HPT (weekends) remain the first point of contact for the care home to report a symptomatic resident or residents with ARI and lead the risk assessment, provide case or outbreak management and infection prevention and control advice to the care home.

- CIPCN/LA (in-hours) or HPT (out of hours) will advise COVID-19 testing for the whole home via DHSC National Testing Service (formally known as “pillar 2”) when care homes first notify of a resident or residents with symptoms compatible with ARI, to support immediate public health action. Testing of up to 5 of the most recently symptomatic residents for influenza A and B can also be organised separately by CICNs/UKHSA through the UKHSA Laboratory Manchester if influenza is suspected.

- Requests for influenza-like illness testing, including influenza A and B, will be processed by CICN or UKHSA HPT(as per local arrangements) by sending an iLOG request form to the UKHSA Laboratory Manchester. On receipt of the request, the laboratory will create a unique iLOG number for identification and tracking of results.

- **The UKHSA laboratory will arrange for a courier to deliver the necessary swab kits for use by the care home. The laboratory will contact the care home to arrange a time slot within a 5-hour window for the courier. The courier will drop the test kits off at the home, wait for 30 minutes while swabs are taken, packaged and returned to the courier.**

  Swabbing instructions will be included with these test kits. **It is important that only swabs from the UKHSA laboratory are used for testing via this pathway. DHSC or "pillar 2" testing uses a different swab, which cannot be substituted for testing through the UKHSA laboratory.**

- Results of the UKHSA respiratory virus testing will be initially provided to the CICN (in hours) or HPT (out of hours), who will inform the care home. **The care home should not contact the laboratory directly for results.**

- Where an ARI outbreak is suspected and influenza testing requested through this pathway, it is also essential that whole care home COVID-19 testing is organised through the DHSC National Testing Service.

- All COVID-19 testing in care homes is coordinated by the DHSC National Testing Service (formally known as "pillar 2") and accessed through registering with the online portal: https://www.gov.uk/apply-coronavirus-test-care-home

- **All enquiries regarding DHSC Pillar 2 PCR testing and LFD testing should be directed to the national helpline on 119.**

- Negative test results should not result in local infection prevention and control measures being lifted. These measures should continue due to the current national situation of sustained transmission of COVID-19 in the community. CIPCN systems should ensure IPC measures are being implemented as appropriate.

If Point of Care testing (POCT) for influenza 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 UKHSA within 7 days. Further information about the POCT notification process can be found here.

Refer to national guidance on testing which includes:

- Summary of available COVID Testing for Adult Social Care
- Onsite LFD Testing in Adult Social Care
- Step-by-Step Guide to Self-testing by LFD for Adult Social Care
- Visitors: reporting rapid LFD tests at home
- Care Home Specific COVID Testing

Sign up for regular adult social care home testing webinars HERE

Figure 1: Routine COVID Testing in Care Homes without outbreaks

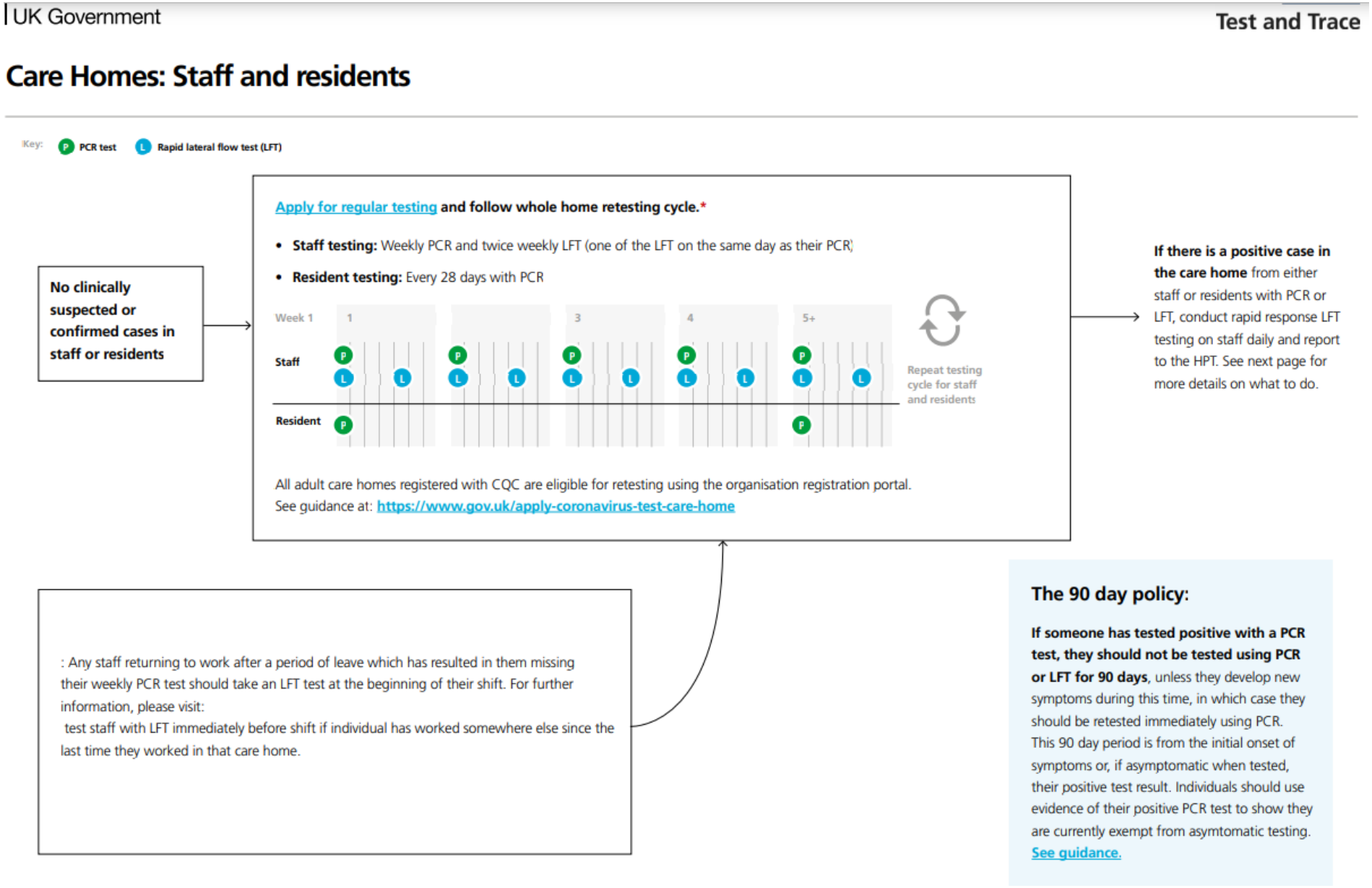
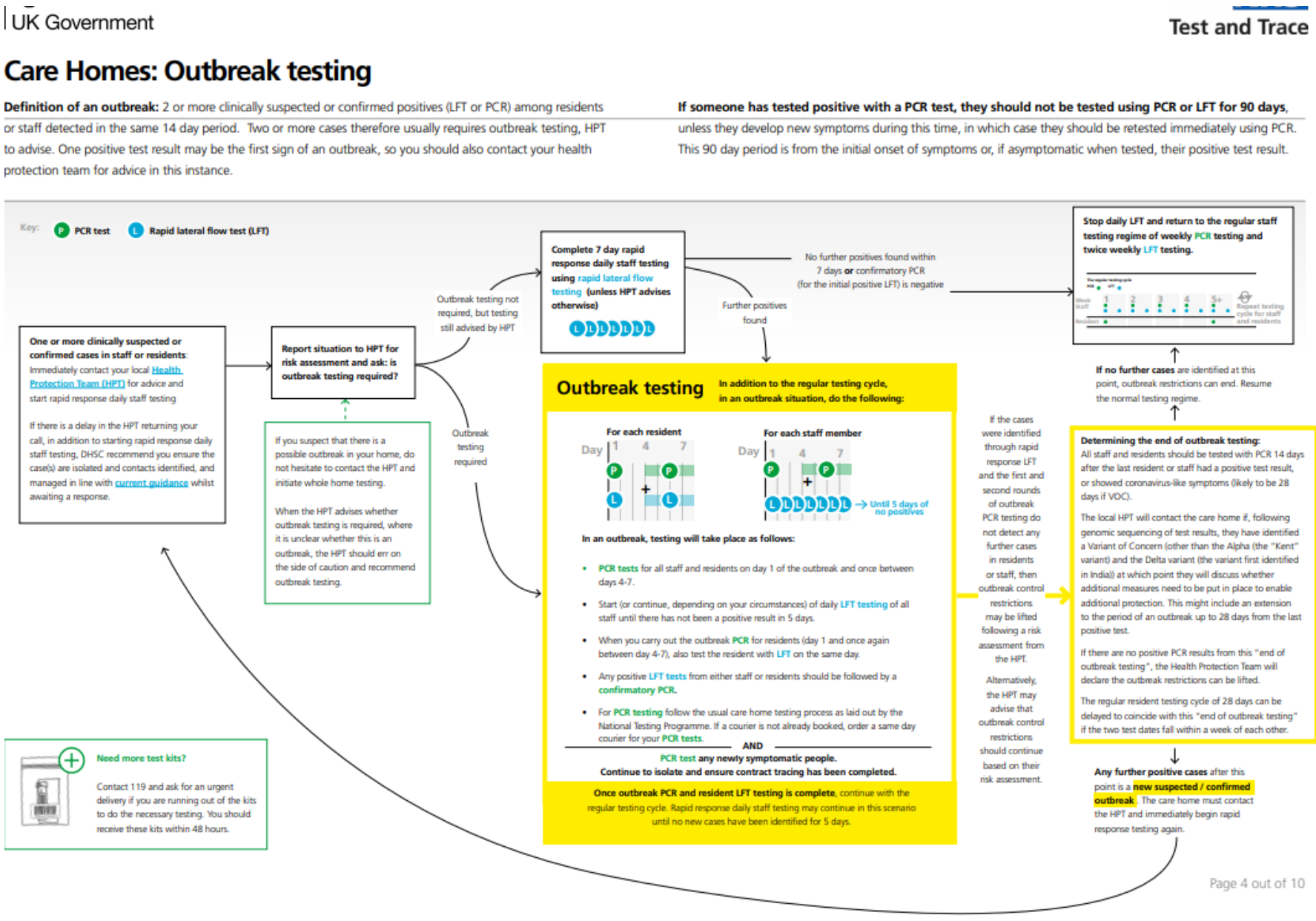


Figure 2: Outbreak COVID testing in Care Homes



1 5.5 Declaring an Outbreak Over

Influenza and Other Non-COVID-19 Respiratory Infection (COVID-19 negative)

An outbreak of influenza 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 for a minimum of 5 days after onset of symptoms in the last 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

For care homes that have had no new symptomatic cases or positive results in residents or staff for 14* days from onset of symptoms/test date in the most recent case, whole home testing should be carried out via DHSC. This is known as recovery testing. The care home will need to order the tests in advance from the DHSC portal. Only once all recovery testing results are back and negative, can lifting of outbreak restrictions be considered.

***28 days if certain variants of concern (VOC) are identified**

The IPC team will review the outbreak once the recovery testing results are returned.

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

In some cases, COVID-19 PCR positivity can last several weeks after the infectious period. This is due to the sensitivity of PCR tests, which can detect fragments of inactive virus in nose and throat samples long after a person has completed their isolation period and is no longer infectious. **DHSC recommend that immunocompetent 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**.

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 can be found HERE**.** Full infection prevention and control (IPC) and PPE guidance can be found HERE.

PPE	Disposable Gloves	Disposable Plastic Apron	Single Use Fluid-repellent surgical mask (Type IIR)	Eye Protection
Carrying out direct care within 2m of resident with COVID19 and/or isolating	YES	YES	YES	YES
Carrying out direct care within 2m of resident with risk of contact with respiratory symptoms and or body fluids	YES	YES	YES	YES

Carrying out direct care within 2m of asymptomatic resident, negative for COVID	YES	YES	YES	**NO**
Within 2m of an individual but NOT carrying out personal care	**NO**	**NO**	YES	**NO** – *unless there is a risk of splashing of either body fluids or cleaning products*
NB: The IPC precautions for COVID and ILI are the same and additional PPE is required for any Aerosol Generating Procedures (AGP). Refer to National Guidance				

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

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. Once a mask has been removed, it cannot be re-used and will need to be replaced with a new one.
- 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, plain 'wedding' band. Staff should not wear nail varnish or false nails.

6.4 Aerosol Generating Procedures (AGPs)

If an AGP is to be undertaken specific additional PPE is required, 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. 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 Ordering PPE in Social Care

PPE can be sourced from the PPE portal: how to order COVID-19 personal protective equipment (PPE)

The National Supply Disruption line (If you have immediate concerns over your supply of PPE)	Tel: 0800 915 9964 Email: supplydisruptionservice@nhsbsa.nhs.uk

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 not be steam cleaned, use an alternative product for that item as per the manufacturer's 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 for safe management of healthcare waste must be followed. Also refer to section on waste in guidance

- Waste does not need to be segregated unless an individual in the setting shows symptoms of or tests positive for COVID-19.

- Dispose of routine waste as normal, placing any used cloths or wipes in 'black bag' waste bins. You do not need to put them in an extra bag or store them for a time before throwing them away.

Laundry for Confirmed or Suspected Cases

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

- Any towels or other laundry items used by a confirmed or suspected case should be treated as potentially infectious.
- PPE should be worn when handling dirty or contaminated laundry.
- Potentially infectious or soiled 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 sealed 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.
- Wash items in accordance with the manufacturer's instructions.
- Use the warmest water setting for the fabric and dry items completely.
- Dirty laundry that has been in contact with an unwell person can be washed with other people's items.
- To minimise the possibility of dispersing virus through the air, do not shake dirty laundry prior to washing.
- Clean and disinfect anything used for transporting laundry with your usual products, in line with the cleaning guidance above.

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

- For advice and guidance regarding visitors to the care home, refer to the Guidance on care home visiting and Visits out of care homes
- Visiting policies should be in line with local and national restrictions and guidance
- For further information on visitor testing and reporting of test results see see Section 5.2 above and Coronavirus (COVID-19) testing for adult social care settings
- Testing does not completely remove the risk of infection associated with visiting and it is essential that visitors wear appropriate PPE, observe social distancing, and follow good hygiene throughout their visit.
- Each care home must complete a dynamic risk assessment in relation to both whole care home visiting and visiting for each individual resident, which formally considers the advice of the local Director of Public Health.
- **In the event of an ARI outbreak, visits in and out of the care home should be stopped, apart from exceptional situations such as end of life or for nominated essential care givers (See 8.1)**
- Please contact the IPC team for any queries concerning visiting: infectionprevention@lancashire.gov.uk

8.1 Visits in exceptional circumstances / by nominated essential care givers

For visits in exceptional circumstances, 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
- Visitors should have had a negative LFD test on the day of the visit
- 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; limit direct contact and exercise stringent respiratory hygiene.

- The visit should be supervised by a member of staff at all times to infection prevention measures are adhered to.
- Safe exit from the care home should also be supervised.

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

Once an outbreak of ARI is identified, closure of the home to new admissions should be considered. It may also be advisable to suspend transfers to other care homes during the outbreak period. The decision to restrict admissions and transfers sits with the care home manager in discussion with their commissioners and will depend on the joint dynamic risk assessment.

- Care homes should carry out a risk assessment prior to all admissions to the home
- Government guidance for admission and isolation of residents describes the isolation and testing requirements for residents being admitted to care homes from different settings and under different circumstances
- Residents being transferred from another interim care facility or transferring from another care home may not need to isolate if they meet the criteria as advised in guidance
- Residents discharged from hospital following unplanned, emergency admissions will need to isolate in a single room for 14 days on arrival at the care home.
- Residents who test positive for COVID-19 prior to their transfer should be discharged to a designated setting as per guidance.
- Residents being transferred from an overnight elective stay do not need to self-isolate if they meet the following criteria as advised in guidance
- 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, provided IPC precautions are undertaken.
- Residents admitted from the community may not be required to self-isolate if they satisfy the necessary requirements
- Immunocompetent patients who have received a positive PCR test for COVID-19 within 90 days of their initial illness onset/positive test date should be assessed to determine if all of the criteria as documented in guidance has been met to decide whether discharge should be to a care home or designated setting.

No care home should be forced to admit a new resident to the care home if they cannot safely care for the resident, in self-isolation, for the full isolation period. If the care home is unable to do so, the manager should ask the resident's local authority to secure appropriate alternative accommodation.

Refer to Guidance

- Admission and care of residents in a care home during COVID-19
- COVID-19: guidance for stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings

Section 10: National Guidance Documents

This local guidance document has been based on national UKHSA, 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 Influenza leaflets and posters
- Influenza Vaccine: Who should have it? **Leaflet**
- The Influenza vaccination, who should have it and why leaflet (Braille version)
- Guide to having your Influenza vaccination (jab) during the coronavirus pandemic (Easy Read leaflet for people with learning disabilities)

National COVID-19 Guidance

- Stay at home: guidance for households with possible or confirmed coronavirus (COVID-19) infection
- COVID-19: How to stay safe and prevent the spread
- COVID-19 guidance on shielding and protecting people previously defined on medical grounds as extremely vulnerable

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 of Hand Hygiene" Poster
- 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 staff and exposed patients or residents in health and social care settings

Care Home Specific Guidance and Policy

- Admission and care of residents in a care home during COVID-19
- How to work safely in care homes

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

Name of Care Home	Type: Residential/Nursing etc…	Manager of Care Home	Name of ARI Coordinator	Name of person completing form	Date Completed	Date Updated

Room	Name	DOB	NHS No.	Medical Conditions	GP Practice	Date of 1st COVID Vaccine	Date of 2nd COVID Vaccine	COVID Booster Date	Date of Flu Vaccine	Kidney Function: Date & result of most recent eGFR	Weight (Kg)
In the event of an outbreak, this table will ensure that important information is recorded in one place and is easily accessible											

Appendix 2: Daily Log of Residents with suspected / confirmed ARI **Template**

Room	Name	Age	NHS No.	Date of symptom onset	Symptoms*	COVID Vaccines 1st? 2nd? Booster?	Flu Vaccine Yes/No	Date GP informed	Date swabbed**	Date Antivirals commenced	Date CICN 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: Checklist for **Single Case** of ARI - **Actions**	**Date, time & sign when action completed**
1. **Clinical assessment** and management by doctor - GP/111/A&E	
2. **Infection Prevention and Control (IPC) measures:** *Isolate symptomatic resident in a single room using IPC precautions, as recommended for COVID-19. Isolate for 14 full days after symptom onset. Duration of isolation can be re-assessed once test results available*	
3) **Exclude symptomatic staff from work**. If COVID-19, provide advice re: COVID-19 testing and self-isolation of household contacts.	
4) **For COVID-19: identify close contacts** of confirmed COVID-19 resident/staff member and adhere to isolation/exclusion advice for contacts who do not meet the exemption criteria	
5) **Hand and respiratory hygiene** for staff; residents and visitors. *Ensure access to tissues, handwashing facilities with liquid soap, disposable paper towels and alcohol-based hand rub* *Reinforce education:* ***"Catch it! Bin it! Kill it!"***	
6) **Personal Protective Equipment (PPE)** for staff *and* visitors. *Adequate PPE worn as per national guidance. All staff should be trained in donning and doffing. Ensure PPE is changed between residents (gloves and aprons) or worn sessionally (masks and eye protection). Additional PPE required for aerosol generating procedures.*	
7) **Enhanced Cleaning** *Clean surfaces and high touch areas frequently. Clean shared equipment between residents, e.g. hoists, aids, showers. If suspected or confirmed cases, all areas should be cleaned at least twice daily. Locations where symptomatic residents have been should be cleaned wearing PPE.*	
8) Segregate **Linen and Waste** appropriately *Ensure linen management and clinical waste disposal systems are in place. Additional guidance is available for managing waste and laundry from people with COVID-19 Link*	
9) IPC **Signage** on resident's door. *Display appropriate signage as a prompt to ensure correct IPC & isolation precautions followed*	
10) Limit close contact	
11) If COVID-19, **agency staff** should not work in any other health/care settings until 10 days after last shift in affected home.	
12) For COVID-19, commence all **staff LFD testing** for 7 days, ideally at the beginning of their shift. *If no further positives are identified in the seven days, then the normal testing regime can be re-established.*	
13) *If* **flu outbreak** clinically suspected/detected, antivirals to be arranged and prescribed within 48 hours of symptom onset to case and exposed residents in at-risk flu groups and any staff in at risk groups and those who are unvaccinated against flu.	

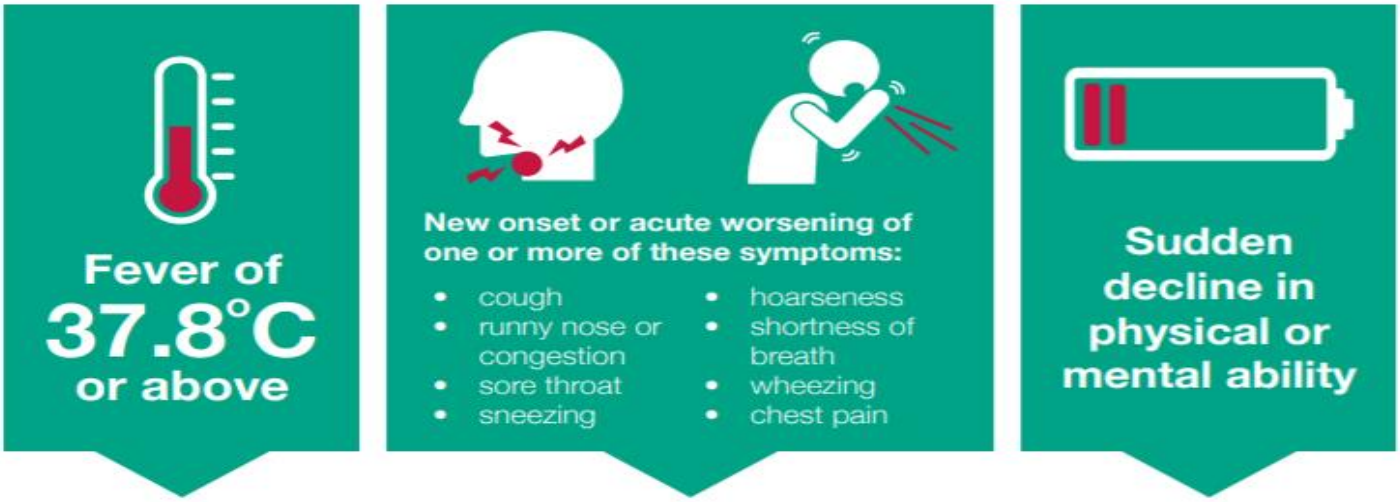
Appendix 4 (Part 1**):** Checklist for **2 or more Cases** of ARI **- Actions**	**Date, time & sign when action completed**
1) **Clinical assessment** and management by doctor - GP/111/A&E	
2) **Communicate** – Immediately inform the UKHSA Health Protection Team (HPT)	
3) **IPC measures** are in place. Key actions include: **a.** Identify and isolate symptomatic residents in single rooms, preferably with en suite. IPC measures as per COVID-19 infection and isolate for 14 full days after symptom onset. *Duration of isolation can be reviewed once all results back.* **b.** If **cohorting** is required, only cohort residents together who have the same virus e.g. a resident positive for Flu A can only be cohorted with other residents who have tested positive for Flu A and not with cases of Flu B. Likewise, residents with COVID-19 can only be cohorted with other cases of COVID-19. *ALWAYS consider whether residents have any other potentially transmissible conditions before cohorting cases of the same respiratory virus together e.g. Diarrhoea, MRSA* - Asymptomatic and symptomatic residents should be cohorted in separate areas. - Separate staff should be allocated to work in a cohort area on each shift. Movement of staff between different cohorts / resident groups should be restricted as far as possible. - Access to communal areas should be restricted. **c. Exclusion of symptomatic staff** from work. *If* COVID-19, provide advice re: COVID-19 testing **d.** For **COVID-19: Identification of close contacts** of confirmed COVID-19 resident/staff member and adhere to isolation/exclusion advice for those individuals who do not meet exemption criteria.	
4) Named **ARI Co-ordinator** to be allocated on every shift. This staff member would ensure they have up to date information re: the care home situation & outbreak in anticipation of liaison with CIPCT, HPT, GP	
5) **Twice-daily symptom checks** of all residents/ staff and daily log of cases to be completed and shared with HPT/CIPCT if required.	
6) **Hand and Respiratory Hygiene** for staff; residents and visitors. Ensure access to tissues, handwashing facilities with liquid soap, disposable paper towels and alcohol-based hand rub Reinforce education: “Catch it! Bin it! Kill it!”	
7) **Personal Protective Equipment (PPE)** for staff and visitors. Adequate PPE worn as per national guidance. All staff should be trained in donning and doffing. Ensure PPE is changed between residents (gloves and aprons) or worn sessionally (masks and eye protection). Additional PPE is required for aerosol generating procedures.	

Appendix 4 (Part 2**):** Checklist for **2 or more Cases** of ARI **- Actions**	**Date, time & sign when action completed**
8) **Enhanced Cleaning** Clean surfaces and high touch areas frequently. Clean shared equipment between residents, e.g. hoists, aids, showers. If suspected or confirmed cases, all areas should be cleaned at least twice daily. Locations where symptomatic residents have been should be cleaned wearing PPE.	
9) Segregate **Linen and Waste** appropriately Ensure linen management and clinical waste disposal systems are in place. Additional guidance is available for managing waste and laundry from people with COVID-19 *Link*	
10) **Outbreak & IPC Signage** to be displayed. Display appropriate signage as a prompt to ensure correct IPC & isolation precautions followed to prevent onwards transmission of infection.	
11) **Health/care staff visits limited** to essential care only and visitors to be excluded (except for in exceptional circumstances e.g. End of Life).	
12) Use of **Agency Staff** ***If a flu outbreak***, agency staff should not work in other health/care settings until 2 days after last shift in home. ***If a COVID-19 outbreak***, agency staff should not work in other health/care settings until 10 days after last shift in home.	
13) **Commence Outbreak Testing** regime ***For COVID-19***: a. In addition to the whole home PCR testing (via Pillar 2), all staff and residents should also undertake immediate LFD tests. b. Start daily LFD testing of staff for 7 days until no further positive cases (in residents or staff) are detected for 5 days. c. Repeat PCR (via Pillar 2) and LFD testing of all residents and staff who test negative on the first round of testing or who missed testing should be undertaken on between 4-7 days after the first round of whole home PCR outbreak testing (this may coincide with a regular cycle of testing). ***If ARI:*** Where influenza is clinically suspected, residents who have developed recent symptoms and/or those with symptoms most indicative of influenza should be tested for influenza and other respiratory viruses	
14) **If flu outbreak** clinically suspected/detected, **antivirals** to be arranged and prescribed within 48 hours of symptom onset to cases and exposed residents/staff in at-risk flu groups/unvaccinated for flu.	
15) **Vaccination** Consideration of seasonal flu (and COVID-19 vaccination if unvaccinated/booster dose outstanding) of all unvaccinated residents and staff, supported by risk assessment.	
16) Consideration of partial or whole **care home closure** to new admissions and suspension of transfers, supported by a risk assessment.	
17) Discuss with HPT/CIPC as to **when outbreak can be declared over**. This will depend on the cause of the outbreak (influenza, COVID-19, or another respiratory virus).	

Appendix 5. Care Home: When to suspect an ARI Outbreak

UK Health Security Agency

Do 2 or more residents or staff have the following symptoms?



If you notice 2 or more residents or staff meeting these criteria, occurring within 14 days, in the same area of the care home **you might have an outbreak.** Consider influenza or COVID-19 as an alternative diagnosis in residents with suspected chest infection or fever or cough

Isolate symptomatic resident & send throat/nose swab for COVID-19 PCR test
Exclude symptomatic staff & advise testing through online portal or 119

Do not wait for results but call the UKHSA North West Health Protection Team

Monday – Friday 9am – 5pm 0344 225 0562

Out of hours 0151434819

UKHSA North West Health Protection Team can arrange testing for other respiratory viruses e.g. Flu A, Flu B, RSV
Antivirals for Flu are most effective if given with 48 hrs of symptom onset. HPTs can arrange antivirals to treat and to prevent flu