UK Health Security Agency

Acute Respiratory Infection Resource Pack for Care Homes (Interim)

Version 2.0

(Adapted by Lancashire County Council 16th November 2022)

15 November 2022

About the UK Health Security Agency

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

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

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Contents

List of Abbreviations

AGP	Aerosol Generating Procedures
ARI	Acute Respiratory Infection
CDC	Centres for Disease Control and Prevention
CIPCT	Community Infection Prevention Control Team
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
FLU	Influenza
Hmpv	Human Metapneumovirus
HPT	Health Protection Team
ILI	Influenza-like illness
IPC	Infection Prevention and Control
LA	Local Authority
LFD	Lateral flow device
NIHR	National Institute for Health and Care Research
PCR	Polymerase Chain Reaction
PEP	Post-exposure prophylaxis
POCT	Point of care testing
PPE	Personal Protective Equipment
RSV	Respiratory syncytial virus
UKHSA	UK Health Security Agency
WHO	World Health Organisation

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 on the management of outbreaks of influenza-like illness (ILI) in care homes 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 & Influenza-like Illness (ILI): Managing Outbreaks in Care Homes

Sign up to receive Social Care updates here

Section 1: Local Contacts

Infection Prevention and Control Team (IPCT)	
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: Infection prevention and control - Lancashire County Council	**For out of hours please contact UKHSA: 0151 4344819**

UKHSA North West Health Protection Team (HPT)	
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	Infection Control Team (IPCT)
Weekends/Bank Holidays 9am – 5pm (or after 5pm for urgent queries)	Local UKHSA Health Protection Team (HPT): 0151 434 4819
After 5PM	Refer to this resource pack and follow-up the next day with either Infection Control Team (weekdays) or UKHSA Health Protection Team (weekends)

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 stringent infection control measures as per guidance, prompt testing is recommended to confirm the diagnosis.

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: • Worsening shortness of breath • Delirium, particularly in those with dementia NHS: https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/ 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 UKHSA case definition is consistent with these approaches.

	COVID-19	Influenza-like illness (ILI)
Infectious Period	2 days before onset of symptoms (or 2 days before test date if asymptomatic) up to 10 days after onset of symptoms (or 10 days after test date if asymptomatic) 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 NB: Aerosol Generating Procedures (AGP) will cause infectious particles to become airborne	• Respiratory droplets during close unprotected contact • Contact with contaminated surfaces NB: Aerosol Generating Procedures (AGP) will cause infectious particles to become airborne
Exclusion Periods	**Resident CASES** should be isolated for 10 days from onset of symptoms (or positive test date). They may be able to end isolation after receiving 2 consecutive negative tests 24 hours apart from day 5, see guidance. **Staff CASES** should not attend work until they have had 2 consecutive negative lateral flow test results (taken at least 24 hours apart, from day 5), they feel well and they do not have a high temperature, see guidance. Risk assessment should be undertaken if they work with people who are at higher risk of becoming seriously unwell with COVID-19, including consideration for redeployment** **Resident CONTACTS** of a confirmed COVID-19 case are no longer advised to isolate nor undertake additional testing, see guidance for further advice** **Staff CONTACTS** of a confirmed COVID-19 case can continue working but should comply with all relevant infection control precautions and PPE, no additional	**Resident CASES** should be isolated for a minimum 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.

	COVID-19	Influenza-like illness (ILI)
	testing needed. Risk assessment should be undertaken if they work with people who are at higher risk of becoming seriously unwell with COVID-19, including consideration for deployment**. If staff contacts develop symptoms, they should follow the guidance.	

* 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 clinically distinguish between the two diseases and those caused by other respiratory viruses (see section 2.1). Therefore, it is important to apply infection prevention and control measures as per guidance whenever an ARI case or outbreak is suspected.

Settings should refer to the Infection prevention and control: resource for adult social care for detailed information. This resource contains general infection prevention and control (IPC) principles to be used in combination with advice and guidance on managing specific infections; such as COVID-19 supplement to the infection prevention and control resource for adult social care and Guidelines on the management of outbreaks of influenza-like illness (ILI) in care homes. Even if your care home does not have any suspected ARI cases, it is important that infection prevention and control measures are still followed in order to best protect residents, staff and visitors. The following principles should be applied:

- **Hand Hygiene** - reinforce education about hand and respiratory hygiene to staff and residents and display the hand hygiene poster 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.

- **Respiratory and cough hygiene** - Good respiratory hygiene reduces the transmission of respiratory infections. Being alert to people with respiratory symptoms is important as this may indicate infection, see Catch it. Bin it. Kill it poster.

- **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, see PPE guide for non-aerosol generating procedures. Ensure the care home follows national guidance for when PPE should be used, see Infection prevention and control: resource for adult social care and COVID-19 PPE guide for adult social care services and settings. 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. To minimise risk to people who receive care and support, health and social care providers should encourage and support all their staff to get a COVID-19 vaccine and a booster dose as and when they are eligible, as well as a vaccine for seasonal influenza. Providers can do this by putting in place arrangements to facilitate staff access to vaccinations, and regularly reviewing the immunisation status of their workforce in line with immunisation against infectious disease ('the Green Book').

Everyone eligible can either book their first dose, second dose and booster dose of a COVID-19 vaccination online via the national booking service, or can attend a walk-in centre.

For more information on symptomatic, rapid response and outbreak testing processes in adult social care services see Coronavirus (COVID-19) testing for adult social care services.

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 national 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 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, quick guide here.
- 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.

- 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.

Note: Care services are not normally required to limit staff movement between sites or services. However, they may be asked to limit staff movement by the local Director of Public Health or UKHSA HPT if, for example, there is high prevalence of COVID-19 or ILI locally or in an outbreak.

- Managers to encourage anyone who has symptoms of a respiratory infection and has a high temperature or does not feel well enough to work to stay at home and avoid contact with other people. Residents and staff to follow the advice regarding testing and isolation if they develop symptoms of COVID-19.

- If an outbreak is suspected, the UKHSA HPT or IPC team should be informed (refer to contact details on Page 6). A risk assessment should be undertaken with the HPT or other local partners to see if the clinical situation can be considered an outbreak and if outbreak management measures are needed.

- The every mind matters website provides expert advice and practical tips for wellbeing, and has a specific section relating to COVID-19.

3.3 Advice for Staff

- All staff involved in resident care are encouraged to have a COVID-19 and 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).

- Staff contacts of a confirmed case of COVID-19 can continue working, they should refer to guidance for details of the relevant measures to take, see section 4.2 below.

- Staff contacts of a confirmed case of influenza are not required to isolate. Antiviral prophylaxis and treatment should be considered for staff who have not had the seasonal influenza vaccination (at least 14 days previously) and are in an at-risk group for influenza (including pregnancy), as defined in the UKHSA antivirals guidance.

3.4 Advice Regarding Residents

- Admission of care home residents from a care facility or the community, including urgent admissions and discharge from hospital into a care home should be managed as per guidance which includes COVID-19 testing requirements, see section 9 below which includes ARI outbreaks.

- 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.

- Residents in long-stay residential care homes are eligible for influenza vaccinations. For more information on eligible groups please see guidance.

- 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).

- Maintain a central record of all residents' COVID-19 vaccination, see the COVID-19 vaccination: guide for adults for advice on who is eligible for, and where to book vaccines.

- 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 clinically distinguishing between the two, cases and outbreaks of acute respiratory infection should be investigated for COVID-19, influenza and other respiratory infections simultaneously.

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 Infection Prevention Control Team (IPCT) in hours and the UKHSA HPT out of hours (see section 1).

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 in partnership with the care home, IPCT, relevant GP and UKHSA HPT.

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	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,

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	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 COVID-19 testing for the symptomatic resident(s) (see section 5). They should isolate until they have two negative LFD results from:
  - A lateral flow test as soon as they develop symptoms (day 0)
  - If first test is negative, carry out another lateral flow test 48 hours after the first test (day 2)

- All residents who test positive for COVID-19 with either lateral flow or PCR tests, regardless of whether they are symptomatic or asymptomatic, should isolate in the care home for 10 days from when the symptoms started, or from the date of the test if they did not have symptoms, see guidance for further details. The care home manager should inform the resident's GP and should:
  - Closely monitor the resident's symptoms.
  - Consider if the resident is eligible for COVID-19 treatments including antivirals or monoclonal antibodies.

- Individuals who test positive for COVID-19 should take part in daily lateral flow testing from day 5 (counting the day of the original positive test as day 0). They can end isolation after receiving 2 consecutive negative tests 24 hours apart, or after 10 days' isolation.

- Any individual who is unable to test should be isolated for the full 10 days following a positive test.

- Isolation should only be stopped when there is an absence of fever (<37.8°C) for 48 hours, without the use of medication.

- For support caring for care home residents who test positive for COVID-19 see guidance. They should still be supported to:
  - Receive one visitor.
  - Go into outdoor spaces within the care home grounds through a route where they are not in contact with other care home residents – this should be supported where safe and possible given its importance in rehabilitation and to minimise the deconditioning impact of isolation.

- Residents with other respiratory infections, including influenza, must isolate in a single room or appropriately cohorted (see section 4.3) for a minimum 5 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.

- 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 in partnership with IPCT, GP, care home and UKHSA HPT, 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 (as per antiviral guidance), 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; complete a COVID-19 test see eligible for free testing for COVID-19, and be advised to contact NHS 111 if unwell.

- Staff members who receives a positive lateral flow or PCR test result should follow the advice regarding staying at home and avoiding contact with other people from the day they test positive or develop symptoms (day 0). There is no need to take a PCR test after a positive lateral flow test result.

- **Staff cases** should not attend work until they have had 2 consecutive negative lateral flow test results (taken at least 24 hours apart, from day 5).To determine when staff can return to work and the various risk assessment and considerations, please see guidance for details.

- If staff members test negative for COVID and have symptoms of or are confirmed as having influenza, they should remain off work for a minimum of 5 days after the onset of symptoms and until feeling well.

- 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.

- Care services are not normally required to limit staff movement between sites or services. However, they may be asked to limit staff movement by the local Director of Public Health or UKHSA HPT if, for example, there is high prevalence of COVID-19 locally or in an outbreak.

4.2 Actions for COVID-19 Contacts

- Care home residents who are close contacts of a COVID-19 case are no longer advised to isolate nor undertake additional testing. Instead, it is advised that they:

- Minimise contact with the person who has COVID-19.

- Avoid contact with anyone who is at higher risk of severe COVID-19 infection especially those whose immune system means that they are at higher risk of serious illness, despite vaccination; (see guidance, the risk assessment section of 'IPC considerations for people receiving care').

- Follow the advice regarding testing and isolation if they develop symptoms of COVID-19.

- Staff who are contacts of confirmed cases can continue working. They should comply with all relevant infection control precautions and PPE should be worn properly throughout the day. They no longer need to undertake any additional testing, and instead should continue their usual testing regime.

- If the staff member develops symptoms, they should follow the guidance for staff with symptoms (see 4.1.2 above).
- If the staff member works with people who are especially vulnerable to COVID-19 (seek clinical advice as necessary), a risk assessment should be undertaken, and consideration given to redeployment during the 10 days following their last contact with the case.
- Consideration should be given to how to ensure staff can deliver safe care during the 10 days after being identified as a close contact of someone who has tested positive for COVID-19. This includes applying the measures known to reduce risk such as distancing, maximising ventilation, PPE and cohorting. This should be built into providers' general risk assessments for responding to infectious diseases and ensuring safe staffing levels are maintained.

Note: Close contacts of a resident with a respiratory virus other than COVID-19 do not need to self-isolate.

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**.

- Where possible suspected or confirmed ARI residents should not be cohorted next to **immunocompromised residents**.

- 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.

- Please see guidance for people previously considered clinically extremely vulnerable from COVID-19 and guidance for people whose immune system means they are at higher risk for details.

- 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?

In Lancashire (Lancashie County Council (LCC) footprint) and Blackburn with Darwen (BwD) footprint, the process described in the Acute Respiratory infections (ARI) in Care Homes (NW document) differs from the standard arrangements, as follows (agreed by LCC IPCT and UKHSA Cumbria and Lancashire):

If the Care Home calls the acute response cell (ARC)
UKHSA will give initial advice and then refer the situation to LCC IPCT with an email notification (the standard notification) – LCC IPCT will follow up as appropriate.

If the Care Home calls LCC IPCT
IPC will give the initial advice and follow up as appropriate. UKHSA will be informed of the situation via a weekly summary from LCC IPCT.

For COVID notifications to LCC IPCT
LCC IPCT will gather the numbers staff and/or residents involved in the outbreak and advise UKHSA as appropriate.

For non typical Covid

- Full details/minimum data set (*MDS) and information for risk assessment is required and it should be dealt with as a possible flu case/outbreak.

- UKHSA will arrange testing and Anti Viral provision as required and deal with the results.
- Completion of the MDS will be carried out by UKHSA if required.

*If MDS is required this will be completed by UKHSA

Hospital discharges awaiting admission to a setting in COVID-19 outbreak

LCC IPCT will review risk assessments for hospital discharges awaiting admission to a social care setting that are in an ARI outbreak.

Please contact infectionprevention@lancashire.gov.uk for a copy of the risk assessment.

4.6 Key Actions for Care Home Management During an 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 IPCTs/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. Display appropriate signage 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. Increase the frequency of infection control audits 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. Some forms of visiting should continue if individual risk assessments are carried out. 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). Other ARI testing may be required following discussions with the local IPCT.

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 regimes in care homes

The guidance for routine and outbreak testing in care homes is available here. Care homes should keep enough test kits to prepare for symptomatic testing, rapid response testing following a positive test or outbreak testing where applicable. See guidance for how to order COVID-19 tests for your organisation.

5.1.1 Symptomatic testing for staff and residents

Symptomatic lateral flow device (LFD) testing is available for all staff and all residents in care homes. For details of COVID-19 symptoms and when symptomatic testing is needed, as well as testing after a positive result, see section above and the COVID-19 supplement to the infection prevention and control (IPC) resource for adult social care.

As far as possible, residents should be offered the choice to either self-administer the tests or to have the tests administered by a suitable member of staff.

5.1.2 Asymptomatic staff testing

At this time, national guidance does not routinely recommend regular asymptomatic staff testing. Some staff without COVID-19 symptoms may be asked to undertake testing as part of rapid response testing or as part of outbreak testing in care homes (see information below).

Care homes enrolled in the Vivaldi study may be asked to undertake additional asymptomatic testing to support ongoing research and surveillance in the sector. Care homes that participate in this study should follow any separate guidance they receive.

At this time, it is not recommended that staff should conduct any further asymptomatic testing beyond these situations.

5.1.3 Rapid response testing in care homes

If one or more positive cases (staff or resident) are found in a care home, then daily rapid LFD testing should be conducted for 5 consecutive days for all staff working on those days. This testing period is not extended if further positive cases are found within the 5 days. Only the staff working in the setting over the 5-day rapid response testing period need to be tested; those not working during this period do not need to be tested. You should not bring people into work to get tested on their non-working days.

5.1.4 Outbreak testing in care homes

On receiving 2 or more linked positive COVID-19 test results in the same setting within a 14-day period, care homes should contact their IPCT (weekdays 9am-5pm), or UKHSA HPT

(weekends and Bank Holidays) to carry out a risk assessment. They should not delay contact as interventions are more effective the earlier they are started.

Once contacted, IPCT or UKHSA HPT will conduct a risk assessment including whether the cases are likely to be linked. Following this, they may advise whole home outbreak testing.

If the care home is advised to initiate whole home outbreak testing, in addition to completing rapid response testing for staff, all staff and residents should conduct both an LFD test and a PCR test on day 1 of the outbreak and another LFD test and PCR test between days 4 and 7. The LFD test will allow the identification and isolation of the most infectious cases immediately whilst awaiting PCR results, therefore reducing the risk of the virus spreading.If an individual has tested positive for COVID-19 in the last 90 days they should not conduct a PCR test.

If either test is positive, it is highly likely that the individual has COVID-19.

After the first week of outbreak testing has been completed, staff do not need to do any further testing unless they become symptomatic or unless requested as part of any outbreak recovery testing. Outbreak recovery testing should be conducted once there have been at least 10 days with no new linked cases occurring due to likely spread within the care home (see section below).

UKHSA HPT will advise should a different approach be more appropriate.

Care home outbreak testing for COVID-19 flowchart: staff and residents is available in figure 1 below.

5.1.5 Outbreak recovery testing in care homes

Outbreak recovery testing is undertaken to confirm that transmission of COVID-19 within the care home has ended, and therefore allowing outbreak measures to be lifted.

Apart from those who have tested positive in the last 90 days, all staff and residents should do a PCR test at least 10 days after the last case of COVID-19 in the care home in either staff or residents. This should be 10 days from the last symptom onset date (where symptoms are confirmed as COVID-19 by testing), or 10 days from the last positive test if asymptomatic.

- If there are no positive PCR results from outbreak recovery testing, outbreak measures can be lifted.

Note: If 2 or more linked positive cases are subsequently identified, this should be classed as a new outbreak and the care home should contact the HPT again.

- If there are further positive results identified, the new cases could be linked to the original outbreak. Care homes should seek advice from UKHSA HPT or IPCT for this assessment on when it might be reasonable to lift outbreak measures.

- If this assessment finds that the further cases are likely part of the same outbreak, the care home should wait another 10 days with no positive results to conduct another round of outbreak recovery testing. The care home should not do any further rounds of whole home testing in this period.

- UKHSA HPT will contact the care home if they have identified a particular variant of concern or variant under investigation which requires additional actions or measures. They will discuss whether additional measures need to be put in place to enable additional protection and how this impacts the testing required. This might include delaying the whole home outbreak recovery testing until 28 days from the latest case.

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

5.2 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 IPCT (in-hours) or UKHSA HPT (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 IPCT / 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 IPCT (weekdays, in-hours) 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.

- IPCT (in-hours) or HPT (out of hours) may 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.

- 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.

- **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. CIPC systems should ensure IPC measures are being implemented as appropriate.

- Testing of up to 5 of the most recently symptomatic residents for wider respiratory viruses including influenza A and B can also be organised separately by UKHSA HPT, through the UKHSA Laboratory Manchester if influenza is suspected.

- Requests for ILI testing, including influenza A and B, will be processed by 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 to the care home at the earliest available opportunity. The laboratory will inform UKHSA HPT if a same day courier has been arranged, who will then communicate this to the care home. If a same day courier cannot be arranged, it will be arranged for the next day. The courier will take the test kits to the home, wait for 30 minutes while swabs are taken, packaged and returned to the courier.**

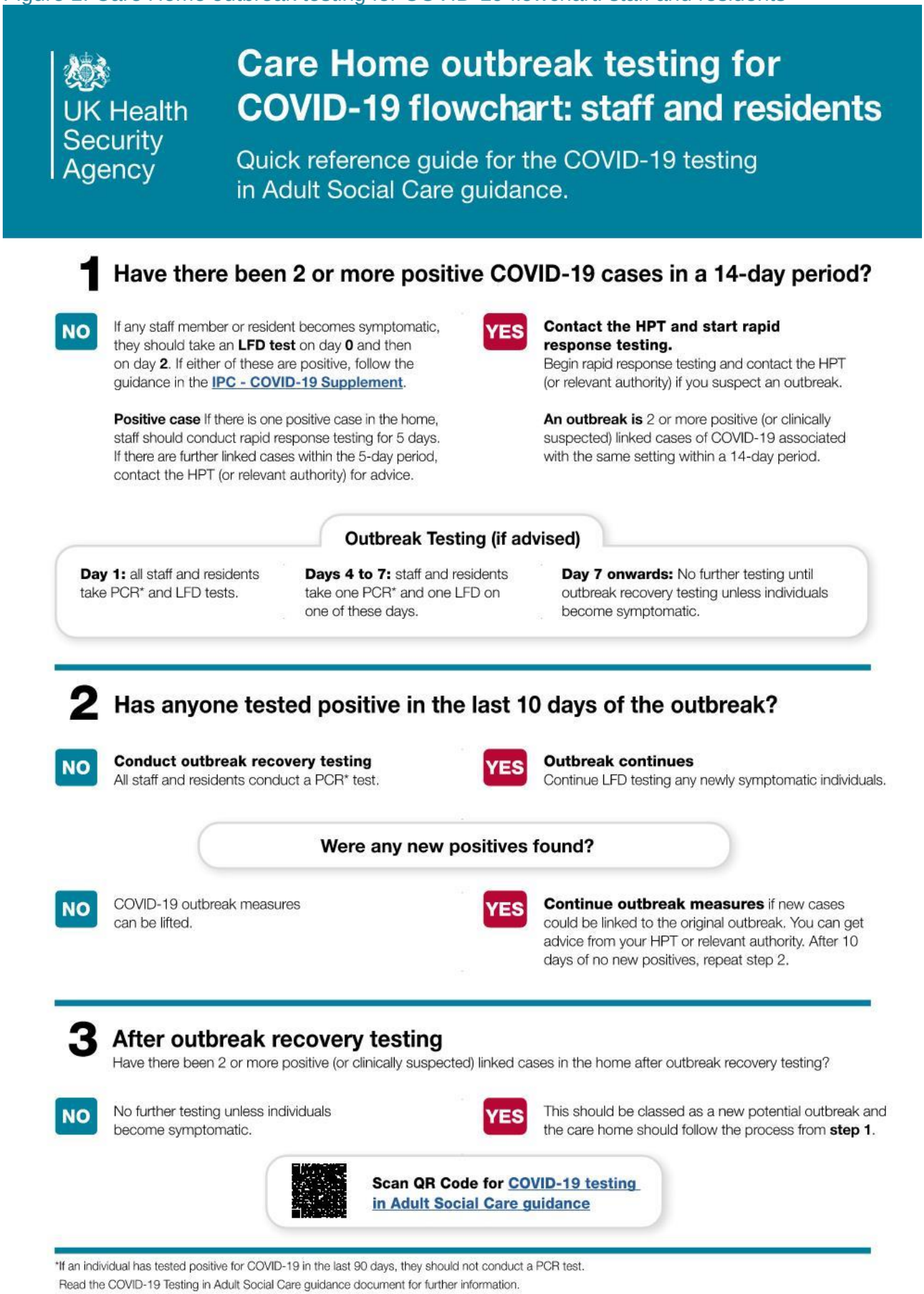
  Swabbing instructions will be included with these test kits. **It is important that only swabs from the UKHSA laboratory are used for testing via this pathway. DHSC or 'Pillar 2' testing uses a different swab, which cannot be substituted for testing through the UKHSA laboratory.**

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

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 positive POCT for influenza virus to UKHSA within 7 days. Further information about the POCT notification process can be found here.

Sign up for regular adult social care home testing webinars HERE

Figure 1: Care Home outbreak testing for COVID-19 flowchart: staff and residents



5.3 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 10* days from onset of symptoms/test date in the most recent case (***28 days if certain variants of concern (VOC) are identified)**, whole home testing should be carried out via DHSC. This is known as recovery testing. See section 5.1.5 above on recovery testing.

It is important to maintain infection prevention and control measures *at all times* even when there are no cases. IPC precautions should be maintained even after the declaration of the end of an outbreak in line with relevant guidance.

Please report your recovery testing results to the IPCT and the team will review the outbreak status of the setting: infectionprevention@lancashire.gov.uk

*If the results are received at the weekend please inform UKHSA and email the IPCT - a response will be returned during working hours. If these results have all returned negative, you are able to remove outbreak restrictions, once a deep clean has been completed.

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

Fragments of inactive virus can be persistently detected by PCR tests in respiratory tract samples following infection, and for some time after a person has completed their isolation period and is no longer infectious.

- Asymptomatic staff and residents who do not have severe immunosuppression, and who have previously tested positive for COVID-19 by LFD or PCR test should be exempt from testing by PCR within 90 days from the initial illness onset or test date. **This does not apply if they develop new COVID-19 symptoms.**

This exemption includes patients without severe immunosuppression, who require testing within 48 hours prior to discharge to a care home.

- This exemption **does not** apply to LFD testing. LFD tests can be conducted within 90 days of a positive COVID-19 test result. If staff or residents are tested with an LFD test within 90 days of a prior positive LFD or PCR test and the result is positive, residents

should start a new period of self-isolation and staff should stay away from work as per isolation section above, unless a clinical or risk assessment suggests that a re-infection is unlikely. This risk assessment should inform subsequent action including whether isolation is required.

- If an individual is re-tested by PCR within 90 days of initial illness onset or prior positive COVID-19 test and the PCR test result is positive, a clinical risk assessment should be used to decide whether a new infection ('reinfection') is a possibility and to inform subsequent action including whether isolation is required.

The advice of an infection specialist should be sought to inform clinical risk assessment.

In regards to staff:

- A positive lateral flow test in the absence of a high temperature after 10 days is unlikely. If the staff member's lateral flow test result remains positive on the 10th day, they should continue to take daily lateral flow tests. They can return to work after a single negative lateral flow test result.

- The likelihood of a positive lateral flow test after 14 days is considerably lower. If the staff member's lateral flow test result is still positive on the 14th day, they can stop testing and return to work on day 15. If the staff member works with people who are at higher risk of becoming seriously unwell with COVID-19 (seek clinical advice as necessary), a risk assessment should be undertaken, and consideration given to redeployment.

Managers can undertake a risk assessment of staff who test positive between 10 and 14 days and who do not have a high temperature or feel unwell, with a view to them returning to work depending on the work environment.

Section 6: Personal Protective Equipment (PPE)

6.1 PPE Requirements

Appropriate PPE should be worn by care workers and visitors to residential care settings, subject to a risk assessment of likely hazards such as the risk of exposure to blood and body fluids.

Guidance on the use of PPE for non-aerosol generating procedures (APGs) in adult social care settings can be found here. This guidance covers the donning (putting on) and doffing (taking off) of PPE for droplet precautions and the PPE for standard infection control procedures.

Guidance on donning and doffing PPE for aerosol generating procedures (AGPs) is available here.

The personal protective equipment section on the COVID-19 supplement guidance provides information on the type of PPE that is recommended, to help protect care workers and care

recipients and prevent the transmission of infectious diseases, with particular advice regarding care of people suspected or confirmed to be COVID-19 positive.

Please see COVID-19 PPE guidance for adult social care services and settings. Guidance should be used in conjunction with local policies. It shows which PPE to wear depending on where and how you are working and how to use your PPE safely to help protect staff and residents.
See also:

- Infection prevention and control in adult social care settings
- COVID-19 PPE guide for unpaid carers

The tables below detail some common scenarios in care and the appropriate PPE to be worn.

Table 1: PPE requirements when caring for a person not known or suspected to have COVID-19

Activity	**Face mask**	**Eye protection**	**Gloves**	**Apron**
Social contact with clients, staff, visitors	Yes – universal masking for source control Sessional use of type I, II or IIR (see note)	No	No	No
Care or domestic task involving likely contact with blood or body fluids (giving personal care, handling soiled laundry, emptying a catheter or commode)	Yes – universal masking for source control Sessional use of type I, II or IIR (see note) Type IIR if	Risk assess if splashing likely	Yes	Yes

Activity	Face mask	Eye protection	Gloves	Apron
	splashing likely			
Tasks not involving contact with blood or body fluids (moving clean linen, tidying, giving medication, writing in care notes)	Yes – universal masking for source control Sessional use of type I, II or IIR (see note)	No	No	No
General cleaning with hazardous products (disinfectants or detergents)	Yes – universal masking for source control Sessional use of type I, II or IIR (see note) Type IIR if splashing likely	Risk assess if splashing likely	Risk assess	Risk assess
Undertaking an AGP on a person who is not suspected or confirmed to have COVID-19 or another infection spread by the airborne or droplet route	Yes – type IIR to be used for single task only	Yes	Yes	Yes (consider a gown if risk of extensive splashing)

For people with an infectious illness other than COVID-19, follow the above principles and any additional advice for the specific infection.

Note: sessional use of masks applies to communal care settings only.

Table 2: PPE requirements when caring for a person with suspected or confirmed COVID-19

Activity	**Face mask**	**Eye protection**	**Gloves**	**Apron**
Giving personal care to a person with suspected or confirmed COVID-19	Yes – type IIR Remove on leaving the area	Yes	Yes	Yes
General cleaning duties in the room where a person with suspected or confirmed COVID-19 is being isolated or cohorted (even if more than 2 metres away)	Yes – type IIR Remove on leaving the area	Yes	Yes	Yes
Undertaking an AGP on a person who is suspected or confirmed to have COVID-19 or another infection spread by the airborne or droplet route	Yes – FFP3 RPE to be used for single task only	Yes – goggles or a visor should always be worn If there is a risk of contact with splash from blood or body fluids and the FFP3 is not fluid resistant this needs to be a full-face visor (which covers the eyes, nose and mouth area)	Yes	Yes (consider a gown if risk of extensive splashing)

Activity	Face mask	Eye protection	Gloves	Apron
For tasks other than those listed above, when within 2 metres of a person with confirmed or suspected COVID-19	Yes – type IIR Remove on leaving the area	Yes	Risk assess (if contact with blood or body fluids likely)	Risk assess (if contact with blood or body fluids likely)

COVID-19 symptoms may include coughing, sneezing, diarrhoea, vomiting, shortness of breath, temperature – see People with symptoms of a respiratory infection including COVID-19.

6.2 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
Lancashire County Council (if you cannot source PPE from the above routes)	Please email infectionprevention@lancashire.gov.uk

Section 7: Environmental Considerations

The Infection prevention and control quick guide for care workers details general IPC principles including cleaning, ventilation, uniforms and workwear and is to be used in combination with guidance on managing specific infections such as the COVID-19 supplement.
The national specifications for cleanliness guidance can be found here.
Guidance on decontamination of linen must also be followed.

7.1 Ventilation

In addition to standard precautions, particular attention should be given to how ventilation can be improved. Ventilation is an important control to manage the threat of COVID-19. Letting fresh air into indoor spaces can help remove air that contains virus particles and prevent the spread of COVID-19.

Where possible, rooms should be ventilated after any visit from someone outside the setting, or if anyone in the care setting has suspected or confirmed COVID-19. This is because ventilation is particularly important in spaces which are shared with other people for longer periods of time.

The comfort and wishes of the person receiving care should be considered in all circumstances, for example balancing with the need to keep people warm. Rooms may be able to be repurposed to maximise the use of well-ventilated spaces.
Further information regarding ventilation can be found in Infection prevention and control: resource for adult social care and Ventilation of indoor spaces.

7.2 Waste management

In addition to standard precautions the following should be observed:

- In a care home, waste generated when supporting a person with confirmed COVID-19 should enter the hazardous waste stream (usually an orange bag)
- Waste visibly contaminated with respiratory secretions (sputum, mucus) from a person suspected or confirmed to have COVID-19 should be disposed of into foot-operated lidded bins which should be lined with a disposable waste bag

- If there is not access to a hazardous waste stream, such as waste generated in people's own homes, this should be sealed in a bin liner before disposal into the usual waste stream

Where care homes provide nursing or medical care guidance for safe management of healthcare waste must be followed.

Section 8: Visitors

8.1 Visiting arrangements and precautions

For advice and guidance regarding visitors to the care home, refer to the visiting arrangements in care home section of the Infection prevention and control in adult social care: COVID-19 supplement. Contact with relatives and friends is fundamental to care home residents' health and wellbeing and visiting should be encouraged. There should not normally be any restrictions to visits into or out of the care home. The right to private and family life is a human right protected in law (Article 8 of the European Convention on Human Rights).

- In the event of an outbreak of COVID-19 or influenza, each resident should be able to have one visitor at a time inside the care home. This visitor does not need to be the same person throughout the outbreak. They do not need to be a family member and could be a volunteer or befriender.

- It is important that any visitor follows the IPC processes put in place by the care home, such as practicing hand hygiene and wearing appropriate PPE. Please see the section on outbreak handling in guidance for further details on flexibility in visiting arrangements during outbreaks, such as for end of life visits.

- Visitors should not enter the care home if they are feeling unwell, even if they have tested negative for COVID-19, are fully vaccinated and have received their booster. Transmissible viruses such as flu, respiratory syncytial virus (RSV) and norovirus can be just as dangerous to care home residents as COVID-19. If visitors have any symptoms that suggest other transmissible viruses and infections, such as cough, high temperature, diarrhoea or vomiting, they should avoid the care home until at least 5 days after they feel better.

- Visitors should be encouraged to wear a face mask when visiting a care home, particularly when moving through the home. Individual approaches may be needed as the wearing of face masks may cause distress to some residents, see guidance.

- Visitors providing personal care to residents are no longer required to test before visiting a care home. However, care homes should ask all visitors to wear face masks, in addition to other PPE if they are providing personal care, to ensure visits can happen safely. This should be based on individual assessments, taking into account any distress caused to residents by use of PPE or detrimental impact on communication.

- Children under the age of 11, who are visiting a care home, may choose whether to wear face masks. However, they should be encouraged to follow the IPC guidelines such as practising hand hygiene.

- Care home residents should not be asked to isolate or take a test following high-risk visits out of the care home including following emergency hospital stays (unless the hospital is in active outbreak – in which case, follow the advice below on discharge from hospital into a care home).

- In the event of an outbreak, each care home must complete a dynamic risk assessment with the support of the local IPCT(UKHSA HPT out of hours) to consider proportionate changes to visiting in line with guidance.

8.2 Visiting professionals

- Health, social care and other professionals may need to visit residents within care homes to provide services.

- Visiting professionals should follow the same advice as in the section above on visiting precautions.

- PPE usage is recommended in line with section 6 above.

- NHS staff and Care Quality Commission (CQC) inspectors also have access to symptomatic testing and should follow the same guidance as staff about staying away from work if they test positive.

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.

A risk assessment should be informed by the number of residents and/or staff affected, their location within the home, whether symptomatic residents can be effectively isolated, cohorting possibilities for staff, staffing levels, availability of PPE and the ability of the home to comply with all required infection control measures. Decisions around potential closure are not straightforward and the care home should discuss this with the hospital discharge team and commissioning authority.

- Care homes should carry out a risk assessment prior to all admissions to the home.

- Care homes should follow discharge and testing guidance.

9.1 Admission of care home residents from a care facility or the community

Residents should take both of the following:

- a PCR test within the 72 hours before they're admitted (or a lateral flow test if they have tested positive for COVID-19 in the past 90 days)
- a lateral flow test on the day of admission (day 0)

These tests should be provided by the care home. If an individual tests positive on either of these tests and continues to be admitted to the care home, they should be isolated on arrival and follow the guidance on care home residents who are symptomatic or test positive for COVID-19.

9.2 Urgent care home admissions from the community

For urgent admissions to a care home from the community, the care home manager should find out whether the resident being admitted has had a lateral flow or PCR test and, if so, when and what the result was.

If the individual has taken a lateral flow or PCR test within 72 hours of the urgent admission into the care home, the care home manager should share the result with the relevant and responsible person. This may be a delegated responsibility.

If a PCR or lateral flow test has not been taken or was taken more than 72 hours before urgent admission, the individual should be tested again by the care home, with a lateral flow test. If

the test result is positive, the individual should isolate in the care home and follow the guidance below on care home residents who are symptomatic or test positive for COVID-19.

9.3 Discharge from hospital into a care home

The NHS will do a PCR test within 48 hours prior to an individual's discharge into a care home, or a lateral flow test if the individual has tested positive for COVID-19 in the last 90 days.

The test result should be shared with the individual themselves, their key relatives or advocate, and the relevant care provider, before the discharge takes place.

- If an individual tests positive prior to discharge, they can be admitted to the care home, if the home is satisfied they can be cared for safely.

- If an individual returning or being admitted to a care home has tested positive for COVID-19, they should be isolated for a total period of 10 days from the day symptoms started, or the day of the positive test, if asymptomatic (counting the day of symptom onset or the original positive test as day 0). This isolation period should include days in the hospital, so when entering a care home, they only need to isolate for the remainder of the 10 days since symptoms or positive test.

- However, if an individual who is isolating can participate in testing, they may undertake daily lateral flow testing from day 5 (counting the day of symptom onset or the original positive test as day 0). They can end isolation after receiving 2 consecutive negative tests 24 hours apart.

- Any individual who is unable to test should be isolated for the full 10 days following symptom onset, or a positive test if asymptomatic. Isolation should only be stopped when there is an absence of fever (< 37.8°C) for 48 hours, without the use of medication.

- If an individual tests negative for COVID-19 and has no symptoms of COVID-19 and is being discharged to a care home from a location in the hospital where there was an active outbreak, they should be isolated for 10 days from the date of admission to the care home, regardless of whether their overnight hospital stay was planned (elective) or unplanned. This is to prevent possible introduction of infection into the care home.

- If a new patient is waiting to be discharged from hospital to a care home in COVID-19 outbreak, please email LCC IPC and ask for a risk assessment. The team will review the risk assessment on an individual basis.
  Please contact infectionprevention@lancashire.gov.uk for a copy of the risk assessment.

- Information about hospital outbreak status should be provided as part of the discharge process.

- Individuals who are isolating for this reason and who are able to participate in daily testing may have lateral flow testing from day 5 (counting the day of admission to the care home as day 0). They can end isolation after 2 consecutive negative tests 24 hours apart, or after 10 days' isolation, if they remain asymptomatic.

- During isolation, residents should be enabled to receive one visitor at a time (this does not need to be the same visitor throughout the isolation period) and have access to outside space to assist rehabilitation if possible.

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.

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
- Guidance on how to manage influenza (flu) using anti-viral agents
- To order influenza leaflets and posters
- Flu vaccination: who should have it this winter and why
- Influenza Vaccine: Who should have it? Leaflet
- Guide to having your influenza vaccination (jab) during the coronavirus pandemic (Easy Read leaflet for people with learning disabilities)

National COVID-19 Guidance

- Guidance for people with symptoms of a respiratory infection including COVID-19, or a positive test result for COVID-19
- Guidance for people aged 12 and over whose immune system means they are at higher risk of serious illness if they become infected with coronavirus (COVID-19)
- Guidance for living safely with respiratory infections, including coronavirus (COVID-19)
- People with symptoms of a respiratory infection including COVID-19
- Guidance for people previously considered clinically extremely vulnerable from COVID-19
- COVID-19: guidance for people whose immune system means they are at higher risk
- COVID-19: information and advice for health and care professionals
- Coronavirus (COVID-19) testing for adult social care services

Infection Prevention and Control

- National infection prevention and control
- Infection prevention and control in adult social care settings
- Infection prevention and control in adult social care: COVID-19 supplement
- ‘5 Moments of Hand Hygiene’ poster
- ‘Catch it. Bin it. Kill it’ poster
- GermDefence
- COVID-19: personal protective equipment use for aerosol generating procedures
- COVID-19 PPE guide for adult social care services and settings
- COVID-19 PPE guide for unpaid carers
- PPE guide for non-aerosol generating procedures
- Standard Infection Control Precautions - Literature Reviews

Cleaning and Waste Management

- Safe management of healthcare waste
- Decontamination of linen for health and social care

Other

- CQC: Adult social care: information for providers

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-19 Vaccine	Date of 2nd COVID-19 Vaccine	COVID-19 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-19 Vaccines 1st? 2nd? Booster?	Flu Vaccine Yes/No	Date GP informed	Date swabbed**	Date Antivirals commenced	Date CIPCT 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*

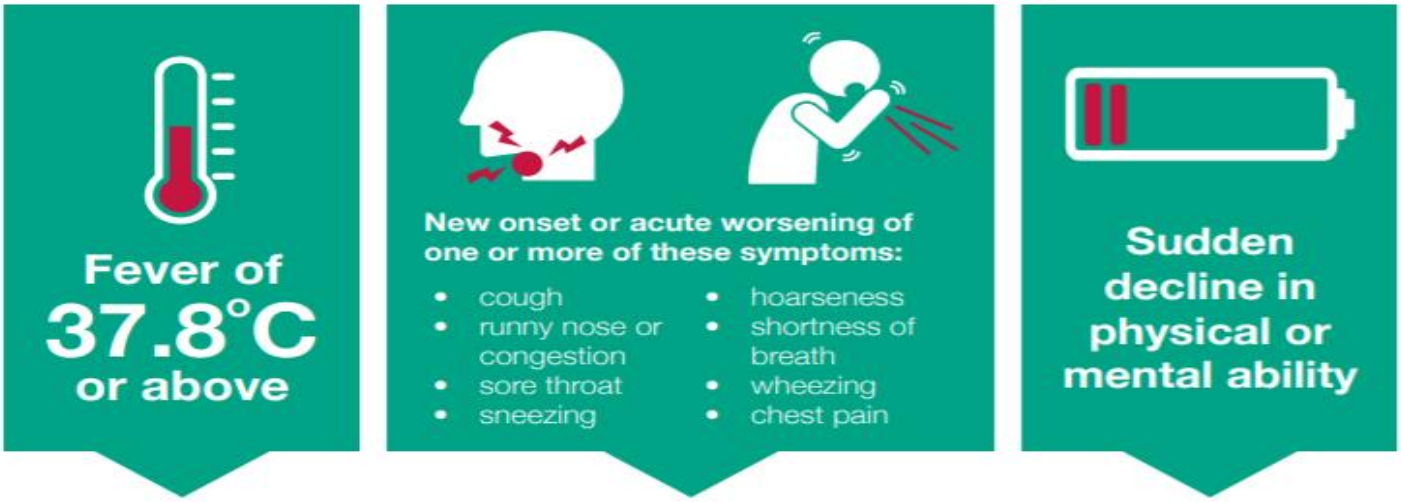
Appendix 3: Checklist for **Single Case** of ARI - **Actions**	**Date, time & sign when action completed**
1) **Clinical assessment** and management by clinician - GP/111/A&E	
2) **Testing** • *Test for COVID-19 as per guidance.* • *If single case of confirmed COVID-19, conduct rapid response testing for staff for 5 days.* • *If there are further linked cases, contact CIHPT/UKHSA HPT for advice and refer to outbreak checklist.*	
3) **Management of resident cases** • *If COVID-19, isolate resident cases for 10 days from onset of symptoms (or positive test date). They may be able to end isolation early, see guidance.* • *If ARI (non COVID-19), isolate resident cases for a minimum 5 days after the onset of symptoms and until feeling well.*	
4) **Management of staff cases** **Exclude symptomatic staff from work**. *If COVID-19 positive isolate and follow staying at home guidance. Staff should not attend work until they have had 2 consecutive negative lateral flow test results (taken at least 24 hours apart), from day 5, see guidance.* *If negative for COVID-19 and have symptoms of or are confirmed as having influenza, they should remain off work for a minimum of 5 days after the onset of symptoms and until feeling well.*	
5**) Management of contacts** **For COVID-19:** *Resident contacts of a confirmed case are no longer advised to isolate nor undertake additional testing, minimise contact with case and avoid contact with anyone at higher risk of COVID-19 infection.* ***Staff contacts** of a confirmed case can continue working, but should comply with all relevant IPC and PPE, no additional testing needed. Risk assessment should be undertaken if they work.* ***Contacts of Influenza** do not need to self-isolate but should remain vigilant for symptoms.*	
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 required for aerosol generating procedures.*	
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 cleaned wearing PPE.*	
9) Segregate **Linen and Waste** appropriately *Ensure linen management and clinical waste disposal systems are in place. See guidance for managing waste and laundry from people with COVID-19.*	
10) IPC **Signage** on resident's door. *Display appropriate signage as a prompt to ensure correct IPC & isolation precautions followed.*	
11) Limit close contact.	
12) Consider restriction of movement of staff providing direct care to avoid 'seeding' of outbreaks between different settings supported by risk assessment.	
13) *If* **flu is** clinically suspected/detected, antivirals may need to be arranged within 48 hours of symptom onset for the case and within 48 hours of exposure for resident contacts and any staff in at risk groups who are unvaccinated against flu. Discuss with CIPCT /UKHSA HPT.	

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 clinician - GP/111/A&E.	
2) **Communicate** – Immediately inform the Community Infection Prevention & Control Team (CIPCT) weekdays, and UKHSA Health Protection Team (HPT) weekends/Bank Holidays (9-5pm). Outside of these hours, refer to Resource Pack and inform the CIPCT or UKHSA HPT the next day.	
3) **Commence Outbreak Testing** ***For COVID-19***: Commence outbreak testing as per guidance:- Day 1: all staff and residents take PCR and LFD tests. Day 4 to 7: staff and residents take one PCR and one LFD on one of these days. Day 7 onwards: no further testing until outbreak recovery testing unless individuals become symptomatic. **Wider respiratory testing:** Where influenza is clinically suspected and/or COVID-19 testing is negative, wider respiratory testing may be advised.	
4) **Management of cases and contacts** a) **Isolation of cases** • *If COVID-19, isolate resident cases for 10 days from onset of symptoms (or positive test date). They may be able to end isolation early, see guidance.* • *If ARI (non COVID-19), isolate resident cases for a minimum 5 days after the onset of symptoms and until feeling well.* • If **cohorting** is required, only cohort residents together who have the same virus. *ALWAYS consider whether residents have any other potentially transmissible conditions before cohorting 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. b) **Exclusion of symptomatic staff** from work. • *If COVID-19 positive, isolate and follow staying at home guidance. Staff should not attend work until they have had 2 consecutive negative lateral flow test results (taken at least 24 hours apart), from day 5, see guidance.* • *If negative for COVID-19 and have symptoms of or are confirmed as having influenza, they should remain off work for a minimum of 5 days after the onset of symptoms and until feeling well.* *c)* **Contacts** • For **COVID-19:** *Resident contacts of a confirmed case are no longer advised to isolate nor undertake additional testing, minimise contact with case and avoid contact with anyone at higher risk of COVID-19 infection.* • ***Staff contacts** of a confirmed case can continue working, but should comply with all relevant IPC and PPE, no additional testing needed. Risk assessment should be undertaken if they work.* • ***Contacts of influenza** do not need to self-isolate but should remain vigilant for symptoms.*	
5) 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, UKHSA HPT, GP	
6) **Twice-daily symptom checks** of all residents/ staff and daily log of cases to be completed and shared with CIPCT.	
7) **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!”	

Appendix 4 (Part 2**):** Checklist for **2 or more Cases** of ARI **- Actions**	**Date, time & sign when action completed**
8) **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.	
9) **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.	
10) Segregate **Linen and Waste** appropriately. Ensure linen management and clinical waste disposal systems are in place. See guidance for managing waste and laundry from people with COVID-19.	
11) **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.	
12) **Visitors** In the event of an outbreak, each care home must complete a dynamic risk assessment with the support of the local CIPCT (UKHSA HPT out of hours) to consider proportionate changes to visiting in line with guidance. Visitors including professionals should follow the visiting precautions in guidance.	
13) Consider restriction of movement of staff providing direct care to avoid 'seeding' of outbreaks between different settings supported by risk assessment.	
14) If **flu is** clinically suspected/detected, antivirals may need to be arranged within 48 hours of symptom onset for the case and within 48 hours of exposure for resident contacts and any staff in at risk groups who are unvaccinated against flu. Discuss with CIPCT /UKHSA HPT.	
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 and discussion with social care commissioners and hospital discharge team.	
17) Discuss with CIPCT as to **when outbreak can be declared over**. This will depend on the cause of the outbreak (influenza, COVID-19, or another respiratory virus).	

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

If any staff member or resident becomes symptomatic, they should isolate and take a COVID-19 LFD test as per guidance.

Do not wait for results but call the UKHSA Cumbria & Lancashire (C&L) Health Protection Team

Monday – Friday 9am – 5pm 0344 225 0562

Out of hours 0151434819

UKHSA C&L Health Protection Team can arrange testing for other respiratory viruses if appropriate e.g. flu A, flu B, RSV
Antivirals for flu are most effective if given with 48 hrs of symptom onset. After risk assessment, UKHSA HPT may recommend the use of antivirals to treat / prevent flu.