Corona Virus – COVID -19

Information Sheet

Last updated 1 February 2021

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Finding information in this document.

If you have a query please review this guidance in the first instance to see if the answer is here. We have tried to make this as comprehensive as possible so that you have the necessary information at your fingertips.

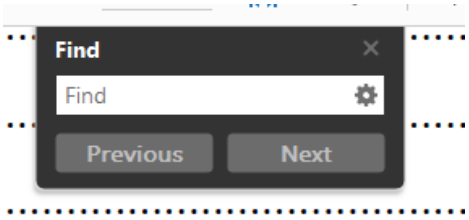
Please also encourage your teams to read this so that they are kept up to date.

Searching by index or heading. (on computer only).

The index as shown above contains hyperlinks to the relevant parts of this guidance. If you hover over the index you wish to go to and press the Ctrl button and click with the mouse. You will automatically be taken to that part of the guidance.

Searching by word (on computer only)

If you wish to find a particular work in the guidance, press right click on your mouse and select the 'Find' option. Enter the word or phrase you wish to find into the box and click 'Next'.



You will be taken to the next time this word appears in the guidance. If the word appears more than once, you can fast forward through the guidance by clicking 'Next' until you reach the section you need.

If the word or phrase is not in the guidance you will see message to say 'No matches were found'.

It is often worth trying a similar word or the first part of the word. You will be shown any matches, which can be worked through by clicking 'Next'

1. Introduction

HCMS has prepared this information sheet about the Corona virus - COVID-19 to provide guidance for staff in our homes. This information sheet summarises and explains the government guidance. It is updated each time new information is issued. The date at the top show the last time this guidance was updated.

This guidance has been prepared by the COVID Action Team at HCMS which is constituted from members of the senior management team. The COVID Action Team review the guidance published by the Government for the UK and each of the devolved nations to carefully consider how best to implement across our homes.

This guidance forms part of the Company's policies and procedures for the duration of this pandemic. Any instructions from health care professionals to implement practice that is not consistent with this guidance must be checked with one of the Operations Directors or a member of the COVID Action Team before implementation.

This information should be shared with staff via daily briefings and by availability in the staff room. It is best viewed electronically as it provides links to web pages that are frequently being updated.

2. The COVID 19 Virus

A coronavirus is a type of respiratory virus. Coronaviruses are common across the world. COVID-19 is a new strain of coronavirus that was first identified in Wuhan City, China in January 2020.

Transmission of COVID-19 occurs mainly through respiratory droplets generated by coughing and sneezing, and through contact from droplets on contaminated surfaces. These droplets infect people by coming into contact with the mouth, nose or eyes.

The incubation period of COVID-19, is between 1 to 10 days. We now know that people can be infectious prior to the onset of symptoms. In most cases, individuals are usually considered infectious while they have symptoms; however, we now know that many people with the virus are asymptomatic – do not have any symptoms, or may only have mild symptoms.

New strains of the virus have been identified in the UK and over the 2020/2021 winter period. Whilst these appear to transmit more easily the important information to remember is the precautions to prevent transmission and infection of others **remains the same**.

a. Symptoms of the virus

The main symptoms of the virus are fever and a cough, but guidance on recognising the virus in older people now advises that older people and younger adults with learning disability or autism may not present with the typical symptoms and may not be able to report a loss of taste or smell. Guidance issued on 19th June reinforces the need for residents to be checked twice a day for the following symptoms:

- Fever – 37.8°C+ NB this will not be the main symptom for people where a pre-existing condition such as a spinal injury prevent their body from developing a temperature to fight infection. OR
- New persistent / continuous cough,
- Difficulty in breathing, shortness of breath, reduced oxygen saturation levels
- Being off food,
- Loss of appetite or sense of taste or smell,
- Vomiting and diarrhoea,
- Fatigue, excessive sleepiness or reduction in alertness,
- New onset of confusion or increased confusion or delirium.

Any resident or member of staff with the symptoms should be assumed to have the virus and will need to be isolated and tested without delay.

An easy read version of information about the COVID 19 virus for residents is available.

b. How the virus infects others

There are 2 main routes by which people can spread COVID-19:

- infection can be spread to people who are nearby (within 2 metres), if infected droplets can be inhaled into the lungs

- it is also possible that someone may become infected by touching a surface, object or the hand of an infected person that has been contaminated with respiratory secretions and then touching their own mouth, nose, or eyes (such as touching door knob or shaking hands then touching own face).

The current understanding is that the virus doesn't survive on surfaces for longer than 72 hours.

If a person does not have the virus 10 days after contact with someone with confirmed coronavirus, there is no evidence they will have the virus. This time period is extended to 14 days for older people in care homes as some have weakened immune systems due to their age

The average time from symptom onset to clinical recovery for mild cases is approximately 2 weeks and is 3 to 6 weeks for severe or critical cases.

The table below helps to distinguish between the virus and other winter infections. A poster is available on portal to display in homes.

Symptom	Coronavirus	Flu	Cold
Fever	Common	Common	Common
Fatigue	Common	Common	Uncommon
Loss of smell or taste	Common	No	Due to blocked nose
Cough	Common	Common	Common
Short of breath	Common	No	No
Sneezing	Sometimes	No	Common
Aches & pains	Sometimes	Common	Common
Runny/ stuffy nose	Sometimes	Common	Common
Sore throat	Sometimes	Common	Common
Diarrhoea	Sometimes	Sometimes	No
Headaches	Uncommon	Common	Common

c. Progress of the COVID-19 virus

After 12 months of the pandemic, we now have a robust vaccination programme being rolled out in the UK. This is very positive and means there is an end in sight.

It is very important to communicate the message to all staff, residents and those we interact with, that vaccination does not protect people from the virus straight away.

The vaccine will help to reduce transmission, but until we have the majority of the population protected **it is vital that we keep to ALL of our infection control measures,** especially as we have yet to find out how the new mutations of the virus will behave and how much of a risk they will pose. So, we must keep going to protect ourselves and those around us.

3. Vaccinations

a. Flu Vaccination Campaign 2020/2021

We are committed to preventing the spread of all infections, the infection control measures that we have in place will help to reduce transmission of the flu and should continue to be prioritised and monitored to ensure they are being implemented correctly.

Our flu campaign launched in the autumn strongly encourages all staff to have the flu vaccination. As part of our incentive, we are offering all homes that achieve 100% uptake a £500 reward to be spent on the staff team or home in the way they choose.

We are aware there were some issues with supply of the flu virus in the early months of the winter but understand these have now been resolved.

To date we have had 2 successful care homes who achieved 100% - Old Raven, Dungate Manor. We heartily congratulate the efforts of the teams in these homes to achieve the target and encourage others to continue with their efforts.

We know that a person can be infected with flu and the COVID 19 virus at the same time, and physically vulnerable people would be expected to be very poorly if this were to happen, and may not survive.

Letters have been provided to Home Managers to take to pharmacy or their GP as proof of eligibility for care home staff to access a free vaccination.

The NHS Public Health clinicians advise there should be a 7-day gap between flu and COVID vaccinations

b. COVID 19 vaccination

In December 2020, the Pfizer COVID vaccine was approved for use in the UK by the MHRA. The Astra Zeneca and Moderna have also now been approved for use and will be rolled out by the NHS. The MHRA is the body with responsibility for assessment of medicines safety.

Responsibility for providing information and obtaining consent for administration of the vaccine is with GPs and Public Health working under a Patient Group Direction (PGD). The PGD sets out the specific responsibilities and accountabilities for the administration of the vaccine.

Current advice is that the COVID vaccine is promoted to everyone except those who:

- Are pregnant.
- Have had a significant anaphylactic / allergic reaction with the need to use or carry an EpiPen.
- Has a fever on the day.

The clinicians leading on administering the vaccines have clear guidelines to follow and will clinically assess the appropriateness of each person before they administer the vaccination. This means there may be some people who have consented to the vaccine but who do not receive it.

Home Managers should:

- Raise awareness with staff, residents.
- Compile a list of staff and residents.
- Identify which residents have capacity to consent, and which have a power of attorney.
- For residents that do not have capacity and where a valid power of attorney for health and welfare is not in place you will need identify who should be contacted to agree what is in their best interests.

A log is being maintained on portal for both staff and resident vaccinations to assist with progress and tracking follow up doses.

Members of the staff team who do not wish to accept the vaccine, must continue with weekly testing and PPE to minimise the risks to themselves and to others, until Public Health advise this is no longer necessary.

The Government have announced that care home residents and staff are the highest priority for vaccination once it has been approved by the MHRA for use in the UK.

Please ensure you forward all communications of this nature to the COVID Action Team to ensure the appropriate response is provided and all the appropriate governance and consent processes are in place.

c. Resident Vaccinations

Vaccination teams have instructions to minimise the number of unnecessary visits to care homes.

The guidance as to whether one or two doses and the spacing between doses may vary but will be between 3-12 weeks. Please follow the instructions from your local vaccination team who will be following the latest instructions. Follow up visits may be needed until mass population coverage has been achieved, so you may be asked to agree an ongoing rolling process to make sure all staff and residents are vaccinated due to turnover.

The vaccination team should plan their visits with you and are very likely to ask for assistance from the care home team in preparing consent and supporting administration of vaccinations on the day. Such as preparing an area, organising residents etc.

The Chair of the Social Care Sector, Medical Director of Primary Care, and Deputy Chief Medical Officer has also produced this video to answer questions about the vaccine for the care sector. This will be shared with Care Home Managers via the WhatsApp's group. Managers are encouraged to share with their staff and relatives or others who may have questions.

https://www.youtube.com/watch?wp-linkindex=16&utm_campaign=Coronavirus_social_care_update_17.12.20&utm_content=dhsc-mail.co.uk&utm_medium=email&utm_source=Department_of_Health_and_Social_Care&v=e6UHLCmC1vo&feature=youtu.be

d. Consent and mental capacity for care home residents

You can expect to be asked to assist those coordinating the vaccination programme by using their knowledge of their residents to complete assessments and group residents into three categories:

- Those who are likely to have mental capacity to consent
- Those who have or may require a Legal Power of Attorney (LPA) to consent on their behalf
- Those who may require a best Interest decision made on their behalf.

Consent discussions

The vaccinations teams should provide information about the vaccine that will be administered. Residents may need some support to ensure they have understood and be able to give informed consent.

For residents who lack capacity the Care Home will contact the Power of Attorney or arrange for forms to be sent to next of kin to inform best interests' decisions. We have prepared a checklist to assist with best interests' decisions for COVID vaccinations.

Relevant consent forms, other supporting forms and associated information can be found on the GOV.UK website and HCMS portal. We will also send these to homes.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/941477/PHE_11843_Covid-19_Consent_form_care_home_resident_able-self.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/941478/PHE_11843_Covid-19_Consent_form_care_home_resident_attorney.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/941794/PHE_11843_Covid-19_vaccination_relatives_view_form.pdf

e. Residents with capacity who refuse COVID-19 vaccinations

Where vaccination has been refused by a resident with capacity to make that decision, a risk assessment will be completed to reflect the risks this presents, and a care plan devised to mitigate the identified risks. This will be done in conjunction with the resident to provide the opportunity for discussion and questions. This will be reviewed regularly to provide the resident with the opportunity to reconsider their decision.

If appropriate key members of their family or other health care professionals involved in their care may discuss the decision with the resident to explain the balance of risks and benefits in relation to the decision not to have the vaccination.

f. Refusal of COVID-19 vaccination in the best interests of a resident without capacity

Where vaccination has been refused by others in the best interest of the resident, the Home Manager will revisit the best interest's decision to ensure:

- The decision was made correctly in accordance with relevant legislation,
- By persons with appropriate authority or responsibility,

- After consultation with those who would reasonably be expected to participate in such a best interest's decision, - knowing the residents wishes and the expected pros and cons of the decision,
- The decision-making process and outcome have been properly documented.

A risk assessment will be completed to reflect the risks this presents, and a care plan devised to mitigate the identified risks. This will be done in conjunction with, or communicated to those who acted in the best interests of the resident to provide the opportunity for discussion and questions. This will be reviewed regularly to ensure the decision remains in the best interests of the resident.

g. Care home staff vaccinations

Both care home staff and residents are eligible for a vaccination as they are in priority group 1 and therefore our staff should be scheduled for vaccinations as well as residents where ever possible. Where it is not possible for staff to have the vaccination at the same time as residents, the vaccination team will be able to advise which locations in the area are offering appointments.

NB Please make sure your teams know there are scams emails circulating that ask for bank details to confirm your identity when applying for the vaccine. The vaccination teams will contact staff when offering the vaccine and they will NEVER ask for bank details.

All homes have now commenced vaccination. This will be an ongoing process due to new admissions, and recruitment of new staff.

Progress for completion of vaccinations for residents and staff in each home is being tracked on HCMS PORTAL. Home Managers will be responsible for submitting information to keep progress log on portal up to date, and for liaising with the vaccination teams to allow ongoing access to the home.

Home Managers in England who have not been visited should email covidvaccineasc@dhsc.gov.uk. to ensure vaccinations can be offered as soon as possible.

4. Admission to Care Homes

All hospitalised care home residents who have previously tested PCR negative as part of routine screening or the investigation of a recent illness should be tested for SARS-CoV-2 again 48 hours prior to discharge and the result of this repeat test relayed to the receiving organisation. Immunocompetent residents who have tested positive within the previous 90 days, and remain asymptomatic, do not need to be re-tested.

Any resident who tests positive and is being discharged within their 14-day isolation period should only be discharged to a designated setting.

All residents being discharged from hospital or interim care facilities and new residents admitted from the community, or another social care facility, who were not in hospital due to COVID virus should be isolated for 14 days within their own room.

If new residents are being admitted to the care home part way through an isolation period, they

should as a minimum complete the remaining part of their isolation period in their own room in the care home. This should be the case unless they have already completed their isolation period in another setting, and even then, the care home may wish to isolate new residents for a further 14 days.

The Local Authority should be alerted when a home is asked to take an individual from hospital with a positive test result. No care home will be forced to admit an existing or new resident to the care home if they are unable to cope with the impact of the person's COVID-19 illness for the duration of the isolation period.

A small number of people may be discharged from hospital within the 14-day period from the onset of COVID-19 symptoms needing ongoing social care, but no longer needing in-patient care. They will have been COVID-19 tested and have confirmed COVID-positive status.

Most care providers will be able to accommodate these individuals through effective isolation strategies or cohorting policies. If appropriate isolation/cohorted care is not available with a local care provider, the individual's local authority will be asked to secure alternative appropriate accommodation and care for the remainder of the required isolation period. This will be in a 'designated setting' that has been approved for step down care for COVID positive discharges from hospital.

Test results should be included in discharge documentation. Residents who have tested positive are not being retested within a 90-day window, as it is very likely to show a positive result even though they have completed the isolation period, and so may not be retested on discharge from hospital. They will need to be isolated until they complete their 14-day recommended isolation period, and should be retested if they develop new symptoms.

In Scotland Covid-19 patients discharged from hospital to a care home should have completed the required isolation period and have given two negative tests at least 24 hours apart and preferably within 48 hours before discharge, unless there are overriding clinical reasons why this is not appropriate. The isolation period for COVID-19 patients is 14 days.

In Wales anyone leaving hospital to be discharged to a care home will have 14 days from last positive test or onset of symptoms and free from fever for 3 days. Those who are infectious but no longer need acute care will be moved to a COVID infectious step down faciality. For those with no evidence of COVID, the requirements for a negative test prior to discharge and a 14-day isolation period remain in place to address the risk of acquiring infection after the test was taken.

5. Preventing Infections

a. General Principles

The COVID 19 pandemic was recognised at the beginning of 2020. As increases in the virus have emerged the Governments of England Scotland and Wales have introduced a range of restrictive measures to target a reduction in the spread of the virus. This has resulted in different levels of restrictions across the UK at any one time.

All staff who work in care homes are identified as key workers. All Home Managers have been issued with key worker letters that they can provided to their staff if needed.

The following principles are important for all staff to follow as they are key to actions to prevent the spread of infection.

It is important that ALL staff take responsibility for implementing these practices and reminding others if they forget:

a) Ensure all staff are aware the uniform policy is strictly adhered to – **no sleeves, no false nails, no jewellery except for a wedding band, no wrist watches.** Failure to comply will be a disciplinary matter. Ongoing compliance will be monitored by Regional Managers & Quality Managers during their visits.
b) All staff will change into uniform or work clothes on arrival at work, and change out of work clothes before they return home.
c) **All staff uniforms must be laundered in house with NO exceptions.**
d) Make sure there are records of checks of staff temperatures and enquires about new staff coughs, for staff coming on shift.
e) All staff, including agency staff, will be checked each day to see if they have a temperature above 37.8C or a new continuous cough.
f) Wash hands thoroughly with soap for the time it takes to sing happy birthday twice. Dry with a disposable paper hand towel or dryer and dispose of hand towel in the bin. This is the most effective method of hand hygiene when done properly.
g) Use a hand sanitiser if you cannot wash your hands – using a product with not less than 60% alcohol. Take care with alcohol gel and naked flames as it can ignite, especially in cars when the weather is hot.
h) Wash hands every time you - leave home, use the toilet, prepare food, before eating any food or smoking, have used public transport, have shaken someone's hand, have sneezed or coughed, or get home.
i) Cough or sneeze into a tissue and dispose of the tissue into the bin. If you do not have a tissue then use the crook of your elbow.
j) Use disposable medicine pots when there is an outbreak in the home.
k) Make sure cleaning products and equipment – mops, buckets and cloths are allocated to units, not on trollies, for use across the whole care home.
l) Make sure there are records of cleaning and cleaning checks across the whole home.
m) Have documented routines for daily cleaning of all handles, rails, door panels, phones, switches and knobs, lift buttons, keypads, arms of chairs etc that are touched by various people throughout the day or night.
n) Make sure there are documented checks and competencies for use for PPE.
o) Have robust instructions to minimise traffic from staff and equipment in areas where there are symptomatic or positive tested residents.
p) Have regular checks to ensure all pedal bins are fully operational and do not need to be touched by staff.
q) Ensure information is displayed at the entrance to the Home to describe the visiting status in the home. A special permission may be granted by the Home Manager in exceptional circumstances such as end of life if visiting is restricted in the home.
r) Remind all those entering or leaving the home to use hand sanitiser or wash their hands.
s) All staff must report any illness, including a temperature or likely contact with a

person with the virus, to the Home Manager without delay. The Home Manager will take advice from the Regional Manager /local Health Protection Team.

t) Make every effort to cover shift vacancies with home staff rather than agency staff. Employees will be paid an additional £3 per hour to cover shifts in these circumstances, where they are working more than their contacted hours.

u) Homes have been given approval to use increased domestic hours to 10% above budget during this outbreak.

The Health & Safety Executive have produced posters for workplaces to display to confirm that risk assessments are in place and appropriate measures have been taken to promote a COVID safe workplace.

2 laminated posters have been sent to each home for display, these show the correct employer details and are signed by Lynn Fearn as Managing Director on behalf of each company. These posters are to be displayed in the Home entrance way and the staff room until further notice is issued through this guidance. Any home that has not received their posters should contact Frances Evans at Head Office.

b. Decorations for Celebrations and Festivities

We recognise that celebrations and festivities are a special time for everyone which generate the 'feel good' factor and improve wellbeing.

Our experience from Christmas 2020 has demonstrated it is possible to decorate your home to recognise celebrations and festivities as long as the decorations do not collect dust or prevent cleaning of surfaces, especially horizontal surfaces, and touchpoints. Key principles to follow are:

1. Decorations that hold dust, prevent cleaning or which cannot be easily wiped down or spray cleaned must **not** be used e.g., saw dust, spray snow, cotton wool.
2. Where possible there should be additional focus on outside decorations and lights that can be easily seen from rooms used by residents.
3. Avoid live trees, straw, and wood inside the home.
4. Decorations must be cleanable or disposable.
5. Electrical decorations should, where possible, be outdoor quality – so that they can be wiped down if necessary.
6. Decorations will be avoided on areas that need to be wiped down for decontamination purposes, to minimise additional time spent cleaning.
7. Edible decorations must not be used.
8. As far as possible table ware will be disposable – tablecloths, napkins, decorative place settings.
9. Table centres are permitted if they can be wiped down or sprayed.
10. Cards should be stored in card holders, **not pinned or stuck to walls**. Relatives can be approached to provide one for residents own rooms, so that surfaces can be easily cleaned.
11. Presents need to be wipeable OR a secure room should be identified – such as an empty bedroom, where gifts can be brought to the home and left for quarantine (min 72 hours). Please ensure gifts do not include perishable items and are well labelled so they can be directed to the correct person. If the room is on the ground floor or can be viewed from outside, please ensure that it is appropriately screened to minimise the risk of theft or a break-in.

c. Celebratory buffets and 'goodies'.

The following must be applied to meals, snacks, and confectionary as this is an area that poses a high risk of transmission of the Virus. The general principle is to minimise the number of people who touch edible items.

1. As far as possible, food served and/or displayed should be individually wrapped to minimise contact.
2. All food must be served by staff rather than for individual selection.
3. Blowing out candles on cake to be served to anyone other the person blowing out the candles is **NOT permitted**.
4. Buffet boxes will be available to order so that individual buffet teas can be prepared.
5. Confectionery should be individually wrapped.
6. Food and confectionary must not be in tins, jars or containers where people put their hand in to select an item, as this can lead to transmission of the virus.

d. Vitamin D supplements

The Department of Health is due to send a provision of vitamin D supplements to all care homes in England. This is planned to commence in January 2021.

Further guidance will follow shortly to ensure this is implemented in a person-centred way that complies with guidance for medicines management. If you receive stock in the intervening period PLEASE DO NOT ADMINISTER IT TO YOUR RESIDENTS UNLESS IT IS ACCOMPANIED BY A VALID PRESCRIPTION.

e. Infection Control Leads

Leadership and direction for infection control has been an important aspect of managing the pandemic.

This is now standardised across all our services. At a corporate level the infection control leads are:

- Lynn Fearn – Managing Director
- Helen Nethercott – Director of Quality & Clinical Practice.

At home level responsibility for infection control will be either Home Manager or the Clinical Lead. There may be other team members that assist with certain aspects, but responsibility for the following will sit with the infection control lead:

- All staff members will have up to date training on infection control, COVID 19, correct use of PPE.
- The home is following good infection control practices.

- Observation assessments for correct handwashing, use of sanitiser, correct use of PPE will be completed randomly on all staff.
- Ensuring there are systems in place to check competencies of all new and agency staff.
- Monitoring cleaning in the home and cleaning of frequently touched surfaces.
- Communicating information and updates to staff.
- Ensuring PPE stock is appropriate and timely ordering takes place to meet the needs of the home.

f. Cleaning

Regular cleaning of frequently-touched hard surfaces and hands will help to reduce the risk of infection. This includes phones, handrails, door handles, toilets, stair rails, phones, keyboards etc. Workstations should be cleaned each day by the employee that uses it.

Since the start of the pandemic all homes have been encouraged to make use of the 10% increase in cleaning hours. There must be at least daily checks and monitoring of the standard of cleanliness in all homes.

Records must be kept in the home of extra cleaning and extra hours that are being worked to ensure cleaning and how this is being monitored. Evidence of monitoring should be included in your COVID file.

All homes are expected to maintain regular cleaning and deep cleaning practices and records to evidence this. The Home Manager and Regional Manager must ensure there are suitable monitoring and checking systems to be assured all cleaning requirements to support infection control are in place.

Evidence shows the virus remains present on most surfaces for up to 72 hours.

The following are very important:

- Washing hands before going out, when you come in, before food, drinking, smoking etc.
- Maintaining social distancing – keeping 2 metres apart – not going out unless absolutely necessary
- Wearing PPE correctly
- Washing your hands after removing PPE
- Not touching your face and eyes,
- Cleaning of handles, switches, telephones, etc on regular basis.
- Keeping up to date with information sent out.
- Being aware of fake information on social media etc
- Using common sense.

Specific guidance is available to guide the appropriate cleaning of areas where there may have been a person infected with COVID-19.

All new admissions will be admitted to rooms that have been deep cleaned with antiviral products.

Deep clean guidance and record is available on PORTAL HK-FR-COVID-19 Deep Cleaning Guide for Care Homes.

g. Cleaning products

COVID- 19 is a virus and cleaning products must be antiviral. Antibacterial products are designed to eliminate bacteria which can cause many illnesses but is not effective in killing the COVID 19 virus, this will require an antiviral product. **Antiviral products are those tested to the British Standard BS EN 14476 & BS EN 14575** for antiviral properties.

Infection control advice includes wipe down with a chlorine-based product at a dilution of 1000 parts per million available chlorine.

The following products are available from Blue Leaf via your normal ordering processes. They are approved for use to kill viruses. A poster is available to laminate and display on cleaning trolleys, in cleaners' cupboards and with COSHH files to show the properties of these products. Always follow the manufacturer's instructions.

h. Disinfection spray machines

Homes will now have received a pneumatic disinfection system. This machine produces a fine disinfecting mist that can be used to assist with cleaning and reduce risk of transmitted the virus by contact with hard surfaces or items.

Decontamination can be used in areas of the home such as:

- Day rooms and other communal areas (at night when residents are not present).
- Arm chairs and soft furnishings.
- Visiting areas – between visits.
- Bedrooms between admissions or following an outbreak.
- Entrances and exits to cover touch points.
- Testing areas

Disinfection of frequently touched surfaces in communal areas such as dining furniture and table, arm chairs, settees, side tables, entrances and exits need to be completed daily. The virus can be transmitted by touching your eyes, mouth or nose after touching surface where infected droplets have landed or that have been touched by an infected person

The disinfection machine can disinfect these large areas more easily than other cleaning methods.

The disinfectant is designated non-toxic and non-irritant; however, we recommend the following to minimise any risks to staff or residents:

1. Do not spray over electrical items such as TV's, radios, fans, lights, switches. As a precaution they should be unplugged and left to dry if in a disinfection area.
2. Do not spray in rooms where residents are present. The spray is not harmful but ideally the room should be empty.
3. DO NOT spray toward the face.
4. Fish aquariums or other pets
5. Do not spay near food or drinks -. it is not toxic but this should be avoided.
6. The device should only be operated be a person who has clearly read and understood the operating instructions.

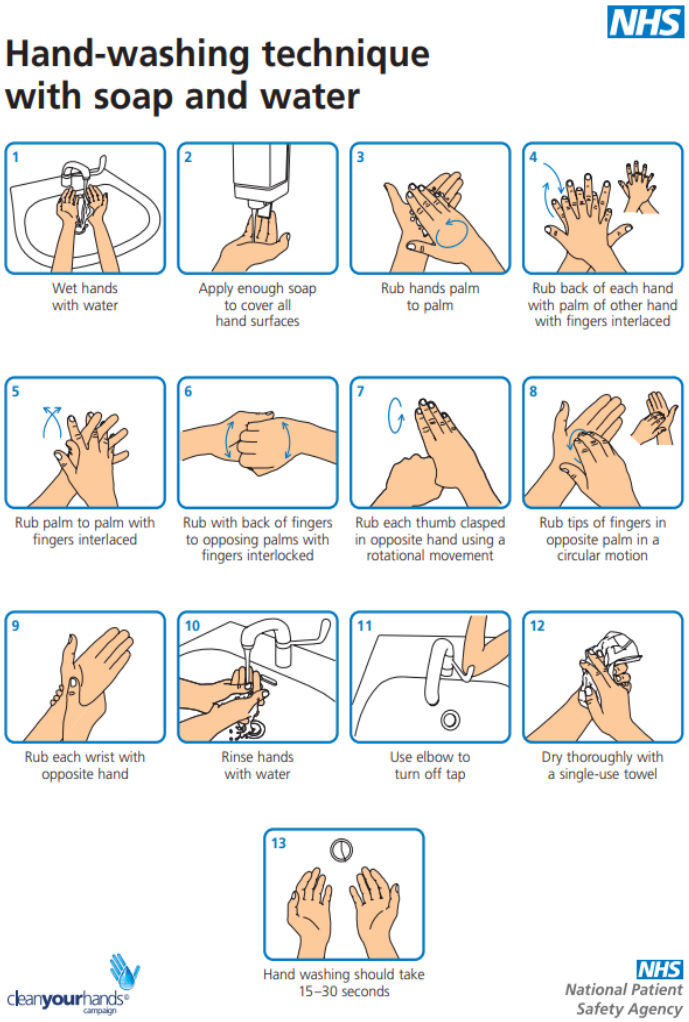
Members of staff using the machine should wear the following PPE: Face mask, gloves, apron and goggles in accordance with the risk assessment for use of the disinfection machine.

i. Hand Hygiene

Hand hygiene is essential to breaking the transmission of the virus. Everyone must wash their hands with soap and water for a minimum of 20 seconds:

- when they arrive at work
- before and after contact with the person being cared for
- before putting on and after removal of PPE
- after cleaning of equipment / environment
- before leaving the home

Please see instructions below. Posters can also be downloaded from PORTAL.



Where is it not possible to wash hands – alcohol sanitising gel should be used following the same principles as for hand washing.

Further principles for good hand hygiene are:

- **<u>Washing to forearms at the same time as washing hands to remove any respiratory droplets.</u>**
- Anyone delivering care must be bare below the elbow. This means no long sleeves, no hand or wrist jewellery/ wristwatch.
- Ensure fingernails are clean, short and that artificial nail products are not worn.
- Ensure all cuts/ abrasions are covered with a waterproof plaster/dressing.
- Alcohol hand rub can be used if hands are not visibly soiled
- Promote hand washing in the home and ensure clear posters displaying technique are displayed.
- Encourage all visitors to wash hands on entering and exiting the home.
- Handwashing should last for as long as it takes to sing Happy Birthday twice following the instruction on the diagram below.
- Where taps do not have levers – you should use a paper towel to turn off the tap. You

may also use the paper towel to open the door if necessary and dispose of the paper towels appropriately on leaving the toilet/room.

Hand washing and use of hand sanitiser observations and competencies are available from PORTAL – Care-FR-119 & Care-FR-120.

Home Managers should ensure they have appropriate numbers of hand sanitising dispensers in the relevant locations around the home. In areas of heavy use such as main entrances it may be appropriate to have more than one dispenser. Use of 5l litre bottles of hand sanitiser should now be reviewed and replaced with proper dispensers. These are available from Blue Leaf without charge.

Hand sanitising gel has a minimum 60% alcohol and must not be stored in large quantities as it poses a fire risk. Home Managers must ensure they do not have large stocks (more than 10 litres) of alcohol hand gel stored together in one place.

j. When to use a face covering or face mask.

All parts of the UK now expect the public to wear a face covering before entering an enclosed space or where they may not be able to maintain a 2m distance from others, and where they will come into contact with people they do not normally meet.

Face coverings are for members of the general public, and for care staff when they are not at work.

It is important to launder face coverings frequently, as when they are worn, they create a warm and moist environment in which bacteria can grow, and which can be inhaled by the wearer. If in doubt launder as frequently as underwear.

All face covering must cover both the mouth and nose and be laundered on a hot wash each time they are used. Ironing a cloth face covering after laundering is also recommended as it helps to disinfect the cloth. It is important to use face coverings properly and wash your hands before putting them on and taking them off.

Face coverings should not be used by children under the age of 3 or those who may find it difficult to manage them correctly.

Face coverings also need to be worn by staff or families sharing lifts to work as social distancing cannot be maintained in a car environment. It must cover both the nose and the mouth and they must keep it on until they leave unless there is a reasonable excuse for removing it.

A face covering should be removed if asked to do so by police officers and staff for the purposes of identification.

If you have symptoms of COVID-19 (cough, and/or high temperature, and/or loss of, or change in, your normal sense of smell or taste - anosmia), you and your household must isolate at home: wearing a face covering cannot replace the need for isolation at home.

A face covering is not the same as the surgical masks or respirators used by healthcare and other health and social care workers as part of personal protective equipment. These should continue to be reserved for those who need them to protect against risks in their workplace, such as health and care workers, and those in industrial settings, like those exposed to dust hazards.

When working in our homes, all care staff will follow guidance on the correct use of masks etc as personal protective equipment (PPE). This is provided to all staff following the assessment of risk and after consultation with government guidance as part of our compliance with Health and Safety legislation. There is a duty on all staff to wear PPE provided for their work, and to use it correctly.

6. Personal Protective Equipment - PPE

a. PPE guidance

Public Health England and the Department of Health have been designated the lead agencies on behalf of the UK for providing guidance across the 4 countries. It can be confusing when there is a raft of guidance that is essentially the same but portrayed slightly differently. We closely monitor the guidance issued by central government, and will update this guidance as soon as possible when it is updated.

Home Managers and Infection Control Leads will ensure all staff understand when PPE should be used, so that the supplies we have are not used inappropriately and will be available when needed. To support this we have provided, posters, information booklets, training, competency assessments for staff to clarify the correct use of PPE, and the correct equipment for clinical situations.

A template risk assessment for PPE is has been sent out for homes to use.

Note: PPE is only effective when combined with: hand hygiene (cleaning your hands regularly and appropriately); respiratory hygiene https://coronavirusresources.phe.gov.uk/hand-hygiene and avoiding touching your face with your hands, and following standard infection prevention and control precautions. www.nice.org.uk/guidance/cg139

b. PPE Supply from NHS

A small stock of PPE is held at Head Office as a contingency for emergency situations, but all Care Home Managers should make best use of PPE available from the PPE Portal as there may be times when PPE is not readily available through other suppliers, especially items such as nitrile gloves and FFP masks.

Access to NHS supplies of PPE relies on the Care Home **making a weekly order or request**. There is a limit on the amount of PPE that can be accessed in each country which is dependent on occupancy or the size of the home.

It is important that Home Managers make sure they take full advantage of the PPE that is available to them by making regular orders for their PPE. If they are not able, or are having difficulties with ordering free PPE for any reason they should contact the COVID supply line, who will be happy to help.

Scotland – NHS HUB PPE

In Scotland Home Managers must make a weekly request to the NHS Hub for PPE.

Wales – Local Authority PPE

In Wales a weekly order must be placed with the local authority for PPE.

England – PPE PORTAL

The Department of Health and Social Care operate portal for ordering PPE for social care. All Home managers in England must register to be able to order their allocation of PPE and complete the capacity tracker.

Free PPE will be available via the PPE portal until the end of June 2021. Home Managers are encouraged to order their full allocation from the portal.

Current guidance shows the ordering limits for residential homes are as follows:

Residential care homes: order limits

Residential care homes with fewer than 10 beds can order up to (per week):

- 300 IIR masks
- 500 aprons
- 1,000 gloves (500 pairs)
- 3 bottles of hand hygiene (usually 500ml)
- 200 visors
- 200 FFP masks*
- 200 gowns*

Residential care homes with between 10 and 24 beds can order up to (per week):

- 400 IIR masks
- 2,000 aprons
- 3,000 gloves (1,500 pairs)
- 5 bottles of hand hygiene (usually 500ml)
- 300 visors
- 200 FFP masks*
- 200 gowns*

Residential care homes with between 25 and 49 beds can order up to (per week):

- 700 IIR masks
- 3,000 aprons
- 5,000 gloves (2,500 pairs)
- 8 bottles of hand hygiene (usually 500ml)
- 300 visors
- 200 FFP masks*
- 200 gowns*

Residential care homes with between 50 and 99 beds can order up to (per week):

- 1,300 IIR masks
- 7,000 aprons
- 10,000 gloves (5,000 pairs)
- 10 bottles of hand hygiene (usually 500ml)
- 300 visors
- 200 FFP masks*
- 200 gowns*

c. PPE Instructions and PPE Stations

All homes will have clear instructions for use of PPE at the entrance to the home so that visitors and new staff are clear what is expected. This will include:

- Signing in sheet and symptoms check record.
- A supply of the appropriate PPE – with donning and doffing instructions,
- Directions to changing facilities,
- Directions to the nearest handwashing or hand sanitising stations
- A foot operated pedal bin for used PPE – with bin bag for incineration.

PPE stations and foot operated pedal bins will be provided at convenient locations around the home so that staff do not need to travel to locate PPE when entering a section of the home. This will assist with separation of staff with the principles of distinct areas of the building and grouping of staff and residents.

d. Using PPE in a warm working environment

We experience periods of hot weather during the summer; in colder weather, the heating is required in homes to provide a suitable environment for old and frail residents. It is important for staff to maintain hydration when working in a warm environment. Managers must make arrangements to support staff:

- By allocating breaks for the shift – possibly splitting breaks for shorter periods more often,
- Ensuring staff take their breaks as allocated,
- Ensuring there are 'hydration stations for both staff and residents.

The virus is less likely to be passed on in well ventilated buildings and outdoors. Try to leave

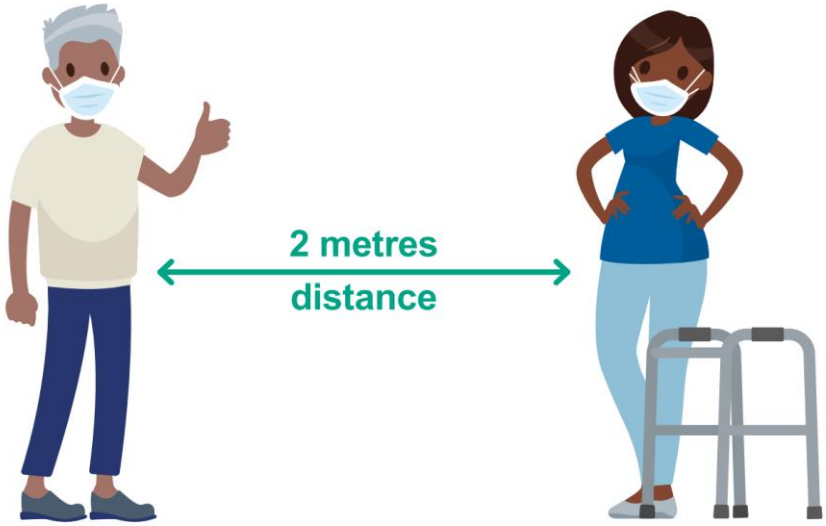
windows and doors open in areas where people come into contact if you can.

e. Sustained Transmission of COVID – 19

Sustained transmission means the infection is widespread and that for many people with the COVID 19 infection it is not yet possible to work out who or where they got it from.

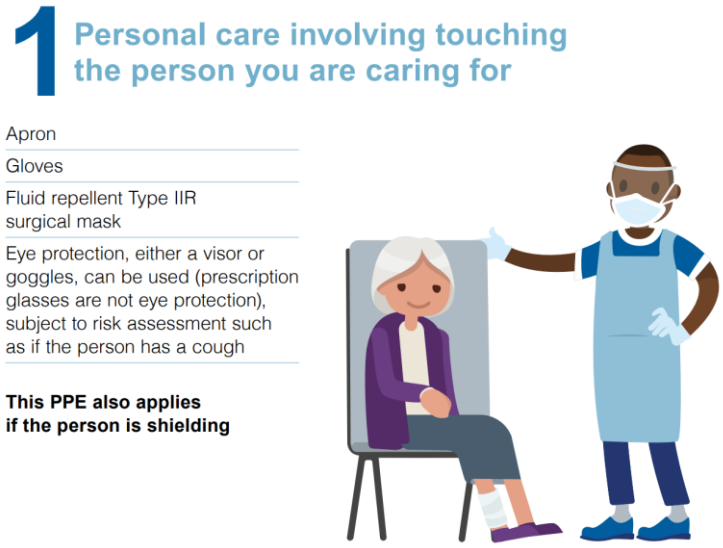
All care workers should assume they are likely to encounter people with the virus infection in their routine work. They are also likely to encounter people with the virus infection outside work and so it is important to maintain the basic principles of social distancing, hand hygiene and correct use of face masks.

f. PPE in the care home when none of the residents or staff have symptoms of COVID -19.



Government guidance states that because there is sustained transmission of COVID 19, use of PPE is required regardless of where or not residents in the home have symptoms. Staff must take precautions to protect their own health and to prevent passing on the infection to vulnerable people.

g. When providing personal care which requires you to be in direct contact with the resident(s) (e.g., touching) or within 2 metres of a resident who is coughing.



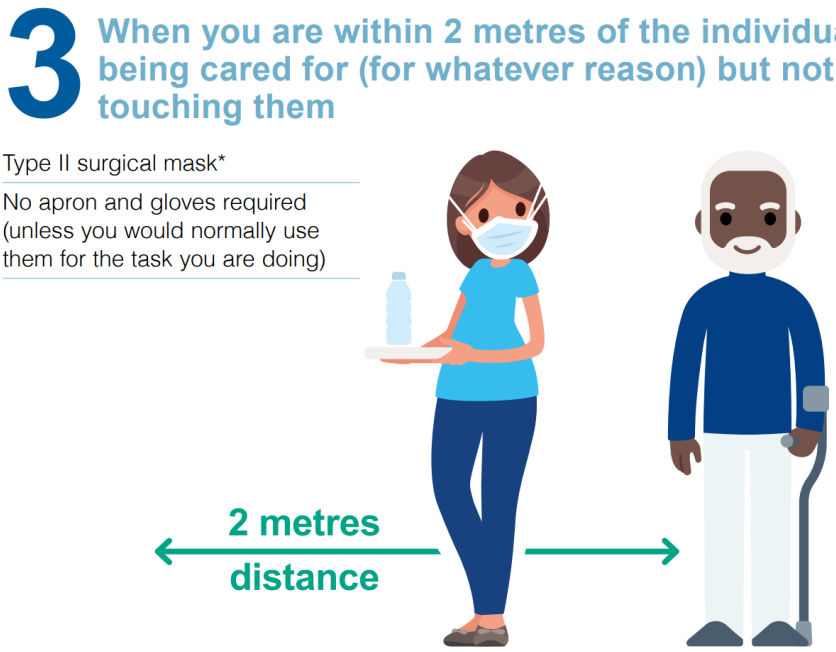
These rules apply:

- whether the resident you are providing personal care to has symptoms or not, and includes all residents including those in the 'extremely vulnerable' group undergoing shielding and those diagnosed with COVID-19
- whenever you are within 2 metres of any resident who is coughing, even if you are not providing personal care to them, eye protection will be subject to a risk assessment.
- to all personal care, for example: assisting with getting in/out of bed, feeding, dressing, bathing, grooming, toileting, applying dressings etc. and or when unintended contact with residents is likely (e.g., when caring for residents with challenging behaviour)
- whatever your role in care (i.e., applies to all staff, care workers, cleaners etc.)

These recommendations assume that care workers are not undertaking aerosol generating procedures (AGPs) see below.

Note: PPE is only effective when combined with hand hygiene (cleaning your hands regularly and appropriately); respiratory hygiene and avoiding touching your face with your hands and following standard infection prevention and control precautions.

h. When performing a task requiring you to be within 2 metres of resident(s) but no direct contact with resident(s) – no touching and there is no one within 2 metres who has a cough.



These recommendations apply:

- for tasks such as: performing meal rounds, medication rounds, prompting people to take their medicines, preparing food for residents who can feed themselves without assistance, cleaning close to residents
- when working in communal areas such as dining rooms, lounges, corridors with residents whatever your role in care (i.e., applies to all staff, care workers, cleaners etc.)

If practical, residents with respiratory symptoms should remain inside their room, they should be encouraged to follow good hand and respiratory hygiene.

Note: PPE is only effective when combined with: hand hygiene (cleaning your hands regularly and appropriately); respiratory hygiene and avoiding touching your face with your hands and following standard infection prevention and control precautions.

If practical, residents who are not required to be in isolation but who may have other symptoms which means they might spread droplets by a cough, dribble, spray when talking or other behaviours such as where they cannot safely contain or dispose of respiratory or oral fluids should remain inside their room. They should be encouraged and supported to follow good respiratory hygiene where possible. If unable to maintain 2 metre distance from a coughing resident, then follow recommendations above.

i. Residents who are High Risk – Clinically Extremely Vulnerable

* Type II masks are Fluid Repellent Surgical Masks which can be worn anywhere in a home.

There must be robust processes in each home to ensure staff are aware of those residents who are extremely vulnerable. As a minimum these residents must be cared for in a single room, ideally with their own ensuite, or commode if this is not possible. If they do not have an ensuite – there must be assessed arrangements in place for the resident to access a separate bath or shower if this is appropriate.

The clinically extremely vulnerable group include the following:

1. Solid organ transplant recipients
2. People with specific cancers:
   - people with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer
   - people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
   - people having immunotherapy or other continuing antibody treatments for cancer
   - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
   - people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD.
4. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell).
5. People on immunosuppression therapies sufficient to significantly increase risk of infection.
6. Women who are pregnant with significant heart disease, congenital or acquired.

j. Wearing facemasks Fluid Resistant Surgical Masks (FRSM) and Surgical Masks - FRSM

For the avoidance of doubt a fluid resistant surgical mask (Type II mask) and a surgical mask (Type 1 mask) is NOT the same as a FFP2 of FFP3 respirator. For details of these see below.

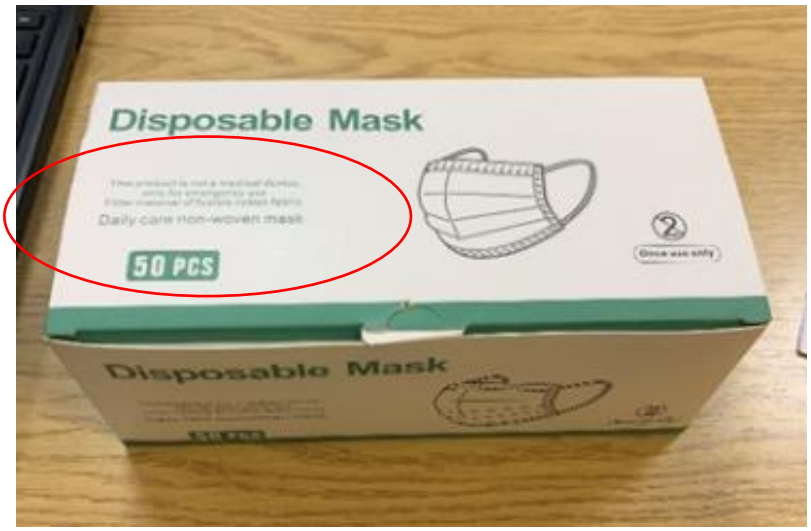
Masks provide protection against infected droplets reaching the inside of the mouth and/or nose.

Masks should:

- Cover both **nose and mouth**
- Not be allowed to dangle around the neck after or between each use
- Not be touched once put on
- Be changed when they become moist or damp – removing by straps.
- Be discarded after the procedure they have been used for and hand hygiene – including forearms performed immediately.

It has become more difficult to identify the different types of mask as they are being imported with labels in varying languages. The images below should help to identify the correct type of mask.

This is **a Type 1 mask**. The box is labelled 'This product is **not a medical device**, only for emergency use.



These masks are made to a lesser standard of materials which may be cloth or paper based. They provide a simple barrier to reduce the number of respiratory droplets expelled. They are not for use where residents are clinically unwell with a cough, sneeze or spraying saliva etc. They are to provide a barrier when moving around the home.

We will have phased out the supply of Type 1 masks as Type 2 / Type IIR masks are in more plentiful supply and the price has reduced compared with the Type 1 masks. NB Type 2 masks can be worn anywhere in the home and so can replace Type 1 masks as they run out.

This is a Fluid Resistant Surgical Mask FRSM – also referred to as a Type 2 or Type IIR mask

A fluid repellent surgical mask provides the wearer with greater protection against droplets, slashes or sprays of body fluids.

Fluid repellent surgical face masks will be worn at all times by staff providing care to residents or where 2m distance cannot be maintained.

k. Eye & Face Protection

A visor is not a replacement for a facemask. The facemask is to prevent the spread of respiratory droplets from the person who is wearing it and a visor does not perform this function. A visor can protect the eyes or face of the person wearing it from splashes.

Eye protection is recommended for care of some residents where there is risk of droplets or secretions from the resident's mouth, nose, lungs or from body fluids reaching the eyes (for example caring for someone who is repeatedly coughing).

Use of eye protection should be discussed with your manager and you should have access to eye protection (such as goggles or visors). Regular corrective spectacles are not considered adequate eye protection.

Eye and face protection can be achieved using any one of the following:

- surgical mask with integrated visor,
- full face shield or visor,
- polycarbonate safety spectacles or equivalent.

Eye protection can be used continuously while providing care until you need to take a break from duties. If you are provided with goggles or a visor that is reusable, then you should be given instructions on how to clean and disinfect following the manufacturer's instructions or local infection control policy and how to store them between duties. If eye protection is labelled as for single use then it should be disposed of after removal.

Visors are not widely available. They should be used in accordance with care plans for those with hearing difficulties or severe cognitive impairment to aid communication.

While performing AGPs, a full-face shield or visor is recommended – see AGPs below.

The same as for respirators and FRSMs, eye protection should: be well fitted; not be allowed to dangle after or between each use; not be touched once put on; be removed outside the patient room, cohort area or 2 metres away from possible or confirmed COVID-19 cases.

If your eye protection is reusable you should check and follow the manufacturer's instructions or local infection control policy on how to clean and disinfect between uses.

As a minimum, between uses you should clean with a neutral detergent wipe, allow to dry, disinfect with a 70% alcohol wipe and leave to dry; or use a single step detergent/disinfectant wipe, allowing the item to dry afterwards. You should store in a bag to avoid possible contamination after cleaning and disinfection is complete.

Do not put eye protection on until it is completely dry. Cleaning of reusable PPE items that have been provided to you is your responsibility. Do not smoke and avoid contact with flames whilst wearing eye protection.

l. Practicalities of wearing face masks and eye protection.

A face mask should be discarded and replaced and NOT be subject to continued use in any of the following circumstances:

- if damaged
- if soiled (e.g., with secretions, body fluids)
- if damp
- if uncomfortable
- if difficult to breathe through

Eye protection should be discarded and replaced (or decontaminated if the item is re-usable) and NOT be subject to continued use in any of the following circumstances:

- if damaged
- if soiled (e.g., with secretions, body fluids)
- if uncomfortable.

When removing and replacing PPE ensure you are 2 metres away from residents and other staff – see Donning of PPE video here. Face masks can be worn for up to 8 hours.

Government guidance states there is no evidence to suggest that replacing masks and eye protection between each resident would reduce risk of infection to staff. Instead, there may in fact be more risk to you by repeatedly changing your face mask/eye protection as this may involve touching your face unnecessarily. The recommendations are for you to use face masks and eye protection continuously until you leave for a break, both to reduce risk of transmission and also to make it easier for you to conduct your routine work without unnecessary disruption.

Homes have given excellent examples of ways to ensure staff are hydrated at the start of the shift

and planning breaks to make sure they stay hydrated. Straws have also been used successfully for ad hoc drinks.

When you take a break, you should remove your face mask and eye protection, a new mask should be used for the next duty period. Please see donning and doffing guidance. The period of duty between your breaks is the equivalent to what we refer to as a "session" in the main PPE guidance.

If the item is reusable, then you must ensure it is appropriately cleaned before reusing it. There may be circumstances that you would need to remove and replace your face mask or eye protection before the end of your shift, these are detailed above.

Where you need to remove your mask (e.g., to take a drink or eat) then you need to dispose of it safely or remove safely and store in a bag/ box for future use. Do not dangle your mask or eye protection around your neck. Hand hygiene must follow to prevent cross infection.

m. Face masks for staff with exceptionally sensitive skin.

Where a member of staff in unable to tolerate wearing PPE due to allergies or any other factors, the Home Manager should discuss this with the staff member to see if there are any obvious solutions.

Face masks have been used in hospitals for years, and very few staff experience problems. Most itchy rashes from masks will be something called an irritant contact dermatitis, which often clears with a topical steroid from the GP if necessary. Those with sensitive skin should use gentle cleansers, avoidance of irritants, and heavy moisturizers. Gently cleansing the face on removal of a face mask is also recommended.

A small supply of FFP2 masks is being kept at head office for use by staff who have exceptionally sensitive skin. It has been our experience that staff who have reactions to the FRSMs can often tolerate the FFP2 masks. These masks are much more expensive and are of a higher specification that FRSMs. Home Managers can request a supply of these masks for individual members of staff only. It is helpful for Home Managers to provide feedback on how effective these masks are in preventing a skin reaction for the member of staff. To date the feedback has been very positive.

This is an FFP2 – Filtering Face Piece 2

It is important that PPE is worn as prescribed until an agreement is reached for any alternative action. If a member of staff cannot tolerate wearing PPE at all they will not be able to work until the issue is concluded. Where an answer cannot easily be found due to an ongoing medical condition, HR should be contacted regarding referral for an Occupational Health Assessment. This advice in conjunction with a risk assessment will be used to determine the way forward with the member of staff.

n. Gloves

Disposable gloves are single use and you must dispose of them immediately after completion of a procedure or task and after each resident, and then wash your hands. You must take care not to touch your face, mouthy or eye when you are wearing gloves.

Gloves provide protection from picking up the COVID-19 virus from the environment (such as contaminated surfaces) or directly from people infected. The use of gloves may be based on a risk assessment of the task being carried out.

Vinyl gloves provide sufficient protection for the majority of duties in the care environment, providing the correct size of glove is chosen according to the wearer's hand size.

Nitrile gloves should be worn for personal care involving body fluids, if the task requires a high level of dexterity, or requires an extended period of wear. Managers must ensure nitrile gloves are not used for other purposes so that a continued supply remains available.

o. Aprons

Disposable plastic aprons must be worn to protect staff uniforms when providing direct care and when cleaning or decontaminating equipment.

They must be changed each time personal care is provided to a different resident.

NB We are not able to access blue aprons which are normally used when serving meals, snacks and drinks. We have good supplies of white aprons and these should be used until such time as blue aprons can be purchased again.

p. PPE for transportation

In all enclosed spaces with other people face coverings or masks must be worn. This includes car sharing or transportation to and from work.

q. Aerosol Generating Procedures (AGPs)

Aerosol Generating Procedures are much higher risk because they produce mists and spray of body fluids when providing care or treatments.

A 3-day supply of higher-level PPE for each of the residents using AGP should be kept securely in

all homes providing AGPs so that it can be used if an outbreak were to occur or the person using the AGP equipment showed signs of the virus. Staff need to know how to access and use the equipment if required. A risk assessment should be in place to support this.

PPE as described below must be worn where AGPs are being implemented and:

- The resident having AGP is suspected or confirmed positive for the virus the following, and /or
- There is an outbreak of the COVID virus in the home.

Guidance from the Association for Respiratory Technology and Physiology advises stopping CPAP/BIPAP/NIV for 14 days if the person using the AGP is COVID positive.

As part of the risk assessment and plan of care for all residents receiving AGP, advice should be sought from the Lead Consultant or Clinician overseeing the care and use of CPAP/BIPAP/NIV to seek their instructions on how to proceed if the resident becomes positive for COVID, as this may be to temporarily cease therapy thereby decreasing the risk in the home.

Home Managers must ensure all instructions are in writing and incorporated into the care plan and risk assessments for the resident once they are received.

If this happens contact Helen Nethercott Director of Quality for advice and support help to obtain appropriate PPE or find other resolutions for the issue.

A long-sleeved disposable fluid repellent gown (covering the arms and body) or disposable fluid repellent coveralls, a filtering face piece class 3 (FFP3) respirator, a full-face shield or visor and gloves are recommended during AGPs on possible and confirmed cases, regardless of the clinical setting.

DO NOT USE FANS in the room of a person using aerosol generating procedures as this circulates any infected droplets that may be in the air. Many public health teams are now implementing a blanket ban on the use of fans in care homes.

Where an AGP is a single procedure, PPE is subject to single use with disposal after each patient contact or procedure as appropriate.

Examples of Aerosol Generating procedures are:

- intubation, extubation and related procedures, for example manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)
- tracheotomy or tracheostomy procedures (insertion or open suctioning or removal)
- bronchoscopy and upper ENT airway procedures that involve suctioning
- upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract
- surgery and post-mortem procedures involving high-speed devices
- some dental procedures (for example, high-speed drilling)
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- induction of sputum (cough)

- high flow nasal oxygen (HFNO) oxygen delivered in conjunction with compressed gas at flow higher than normal oxygen therapy.

In a Care Home AGP are likely to be when a resident is receiving CPAP or BiPAP, or for care of tracheostomies. Having reviewed practice and the guidance this may include residents that require suctioning. All homes must ensure the PPE stock check is kept up to date with the levels of the relevant PPE in the home.

In anticipation of emergencies - homes are advised to have a small supply of fluid repellent surgical masks, eye protection, apron and gloves located with the suction machine.

Equipment when providing close care for a person using CPAP or BiPAP or Suctioning will be:

Long sleeve gown.

Long sleeve gown should be fluid repellent gowns. If fluid repellent gowns cannot be obtained, then non fluid repellent gowns are used and a plastic apron should be worn on top.

FFP3 – Filtering Face Piece 3 respirators or N95

These are used to prevent the inhalation of droplets from Aerosol Generating Procedures – All FFP3 masks must fit correctly to seal to the face of the wearer and a fit test must be completed by a competent person before they are used in care delivery care. See Fit Testing section.

This is an FFP3 – Filtering Face Piece 3

All respirators should:

- be well fitted, covering both nose and mouth
- for single use, unless providing uninterrupted care to a cohort of positive residents
- not be allowed to dangle around the neck of the wearer after use
- removed by holding the straps
- not be touched once put on
- be removed and disposed of outside the bedroom.

On 7th August 2020 the Government body NERVTAG (New and Emerging Respiratory Virus Threats Advisory Group) issued a statement following a review of the evidence of

cardiopulmonary resuscitation as an aerosol generating procedure (AGP) which stated that it

> "does not consider that the evidence supports chest compressions or defibrillation being procedures that are associated with a significantly increased risk of transmission of acute respiratory infections."

As such cardio pulmonary resuscitation should not be added to the list of aerosol generating procedures.

r. Fit Testing for FFP3 masks

Home Managers must ensure all staff who are likely to use FFP3 masks have been fit tested to ensure the masks fits correctly.

HSE guidance states that all staff who are required to wear an FFP3 respirator must be fit tested for the relevant model to ensure an adequate seal or fit (according to the manufacturers' guidance).

Fit testing must be completed by a person who has been properly trained and accredited to provide the training and do the checks. Once the mask has been correctly fitted, fit checking (according to the manufacturers' guidance) is necessary each time a respirator is donned to ensure an adequate seal has been achieved.

If your CCG, Health Board or Infection Control Team cannot provide 'fit testing' please contact the Training Department, and this will be arranged.

Those who have been trained to check the fit of FFP3 masks will have a fit test kit. Fit test checks will need to be undertaken for all new staff, and should the make of masks changes. Refreshers of fit test checking should be completed with other staff 6 monthly.

s. Nebulisers

A nebuliser is NOT an aerosol generating procedure. This is different and does not require the higher level of PPE because the mist that is made by the nebuliser is from the medicine being delivered to the resident and not their body fluids. However, care should be taken when the procedure is completed to remove and clean the mask in hot spay water and spraying with anti-viral spray whilst properly wearing gloves and an apron and washing hands after removal of PPE.

7. Outbreaks in Care Homes

a. Definition of an outbreak

An outbreak is defined as two or more confirmed cases of COVID-19 OR clinically suspected cases of COVID-19 among individuals associated with a specific setting, with onset dates within 14 days.

NB. If there is a single laboratory confirmed case, this would initiate further investigation and risk assessment. Care homes should seek advice from their local Health Protection Team (HPT) if they

have a single possible case of COVID-19.

In Wales a cautious approach has been taken so that it is treated as an outbreak if there is a single case in the residents or staff. Care homes should seek advice from their local Health Protection Team (HPT) if they have a single possible case of COVID-19.

Recovery from an outbreak of COVID-19 in a care home is defined by a period of 28 days or more since the last laboratory confirmed or clinically suspected cases was identified in a resident or member of staff in the home.

Scotland has now issued guidance to define the end of the outbreak for care homes in Scotland where there have been no new cases or symptoms for 14 days.

b. Meal times for residents who are symptomatic or have a positive result

Residents who are symptomatic or who have a positive test result will be served their meals and drinks served in their room.

Where the home has a dishwasher and not a rinser/sanitiser the home should continue to use normal crockery and cutlery and wash the used crockery and cutlery from the people who are COVID-19 positive separately and last of all. This will require identifying a separate quarantine area in the kitchen of these items to wait if the dishwasher is in use. This area must be separate and not allow for cross contamination to other items in the kitchen.

Where a home only has a rinser/sanitiser disposable plates, bowls, cups, beakers and cutlery should be provided along with small sachets of condiments. Care should be taken to ensure the resident can manage the disposable items and does not require adapted equipment or assistance.

Disposable items can be ordered from Blue Leaf, a small supply should be kept in the home in case they are needed at short notice.

Disposable napkins or clothes protectors should be worn, or the clothes protector should remain in the room and laundered with other clothes for the resident.

Meals and hot drinks will be transported to rooms on a trolley, and served as attractively as possible.

Transporting food and drinks on a trolley means a tray does not need to go into the room or need to be decontaminated. Food covers and the trolley should not enter the room to avoid items that require decontamination being returned to the kitchen or food preparation area.

At the end of the meal all disposable items should be deposited in the bin in the resident's room. The bin bag will be quarantined for 72 hours and then disposed of with normal rubbish.

If a resident has a celebration such as a birthday a small cup cake with a candle to blow out, should be provided if candles are required.

8. Limiting contact by cohorting / zoning and social distancing.

a. Principles for limiting contacts

- The guiding principle is to limit the number of contacts between people in the home.
- Working arrangements will be organised to limit, as far as possible, the number of people that a resident or a member of staff will meet during a shift.
- Use of any communal areas must be organised to that the principles of reducing contact and maintaining social distancing, as described in this section are maintained.
- The normal practice of keeping good records will be maintained or enhanced.
- Consideration should be given to ways in which residents can maintain social contact and physical activity to maintain their wellbeing, whilst keeping to the principles described above.
- All Managers are encouraged to be creative and share good practice within their colleagues and wider company via Managers WhatsApp Group, Manager conference calls etc.
- Proper use of PPE and effective handwashing must be maintained.

b. Staff with additional employment outside the home.

Government guidance emphasises that Care Home Managers must ensure that members of staff work in only one care home wherever possible. This includes staff who work for one employer across several homes, or members of staff that work on a part-time basis for multiple employers.

Members of staff who work in more than one setting will be required to undertake a LFD test before they commence their shift, if they have worked in another setting since their last shift in the home. This applies to both regular staff and agency staff.

c. Context of zoning

This guidance sits alongside the Business Continuity Plan for the home and all the information, systems, support mechanisms and risk assessments for the strategic management of the national pandemic. Each Home has a COVID file with all the documentation readily available.

Nationally care providers are facing unprecedented times during the Covid-19 pandemic. Care homes are particularly vulnerable to the devastating impact of the virus due to the complexity and levels of frailty of the people who reside in them.

The risk of outbreak and spread within care homes is further compounded where people who have a cognitive impairment need and space to walk and are therefore unable to isolate in their bedrooms. This increases the possibility of residents who do not have the virus being infected by those around them who have the virus.

We acknowledge the principle of zoning to reduce the risk of virus transmission, but we must also recognise and respect that people are entitled to feel safe and secure in their own familiar room, and whether it is ethically correct to remove a person from their own environment in the home.

This type of disruption of their normality brings with it significant risks that need to be weighed against the risk of contracting or spreading the virus. The effect on the staff group and the safe day to day care of the residents also needs to be carefully considered on a home-by-home basis.

We have standard operating procedures detailing what processes should be followed to keep people safe, including consideration of zoning the building into COVID-19 and non-COVID-19 areas. We also acknowledge that most of our care homes do not have the facility to provide separate designated areas for people who are positive for COVID-19 and those who are not.

We have considered in this guidance how we can provide safe operating procedures where a separate area/unit is not available or feasible considering people's rights and choices.

d. Shielding and protecting those who are clinical extremely vulnerable.

Where transmission of the virus is high, people who are clinically extremely vulnerable may receive a letter from Public Health, their consultant or their GP advising them to take additional precautions.

Residents who are shielding because they are clinically extremely vulnerable will have a risk assessment and care plan to ensure the appropriate precautions are taken to protect them from the virus.

This will include:

- PPE to be worn by staff.
- Placement in zone or cohort if appropriate.
- Visiting risk assessment.
- Additional precautions to be taken to prevent transmission.

There will also be a sign outside their room to remind staff that extra precautions to protectant the resident should be taken. Some homes have chosen rainbows or other images as the sign to protect the privacy and dignity of these residents.

e. Preparing for an outbreak

All residents will have a risk assessment and care plan specific to their individual needs.

It is very important to pre-plan for an outbreak in the care home. Prepare signs, complete risk assessments for the home, residents, visiting (including professional healthcare visitors) and staff, train staff and use the daily briefings, along with the attendance on the Managers COVID 19 action calls and circulation of the documentation provided including FAQ's.

All staff will have completed Infection Control and COVID 19 training with assessments of staff hand washing and donning and doffing PPE.

An outbreak checklist has been prepared. This is targeted to homes that may not have had an outbreak previously so that they can be sure they follow the correct procedures without delay should there be an outbreak. A copy should be kept in locations such as the staff roster folder, the diary, so that it is readily available to refer to, even if the Manager is not present in the service. See **Care-FR-125 Checklist for new COVID Outbreak.**

f. Zoning in a separate area

Where a service has a vacant area that can become a red zone to cohort residents, and they have staff that can be allocated to an area that is fully equipped and functional, the following should be considered and planned:

- Discussion with the COVID Action Team to review the feasibility of such a plan considering the logistics, people's safety, rights, and individuals concerned.
- Minimise the use of social areas including dining and sitting rooms
- If social areas must be used i.e., to support mental wellbeing, social distancing guidance should be followed by ensuring there is a minimum of 2 meters space between residents where possible

g. Red Zone Characteristics

- Non-essential footfall into red zones should be ceased.
- Residents in red zones should be asked to remain in bedrooms if possible.
- Residents symptomatic or positive for COVID 19 will be cared for in isolation in a single room (guidance on this is available and will be followed). The isolation period remains in line with government guidance.
- Designation of a bathroom where required, for people who are positive.
- Residents can be moved back into amber area after the isolation period, if they no longer have a high temperature for 48 hours.
- No visiting unless very essential / end of life.
- Staff working in red zones require to wear fluid resistant mask, gloves, apron. Eye protection should also be worn during direct resident contact if there is a risk of coughing etc (see infection control guidance). All guidance must be followed when donning and doffing PPE.
- Where possible supplies required for an individual in isolation should be available at the point of care to avoid staff leaving the room to access these. Where supplies cannot be left in the room then these will be collected before entering.
- All care homes should proactively review the environment and identify if there are potential areas that can be kept separate from the rest of the facility behind a locked door i.e., a locked unit or locking of fire doors to section off an area. This would provide a red zone area.
- Where possible, empty rooms should be reconfigured into the red zone prior to any cases so residents can be transferred quickly as and when required.

h. Zoning without a separate area

The principles for zoning will also be followed in all homes where zoning is implemented without the ability to use separate areas due to the design and layout of the service: -

All homes should adapt the ethos of red, yellow, and green areas.

- Red – areas/rooms with suspected or confirmed COVID resident
- Yellow – areas/rooms with residents without COVID-19 symptoms
- Green – staff only area

All areas within homes should be colour coded and zone signs should be clearly visible on doors.

i. Changing Zone Designation

Where they have been changes to the zones the Manager or senior designated person in charge will reprint the zone plan and colour code the rooms/areas again to reflect changes, the changes made will also be listed on the plan for ease of reference, this will be dated and signed and communicated to all staff.

j. Ethical considerations for zoning and cohorting

When residents are either moved to a red zone or their room is designated a red zone, they must be reassured and provided with information regarding this process, including what that means for them, and their belongings, their care, what staff will be wearing, what contact they can have with relatives, what assistance they need to access their interests and social interaction during this period.

Where a resident has moved room, they and their relatives must be provided with information about how long it is likely to last and what will happen when they no longer require isolation.

When a resident is in a designated red zone, this should not mean they receive less care as a result, especially for issues around hygiene and dignity (e.g., bathing). Residents in isolation are already in a stressful position, and not having access to basic hygiene will only add to that. For showering, there should always be a way to work around a situation (e.g., allocating certain bathrooms as red or amber and disinfecting between uses).

To care for residents with dementia is admittedly one of the most challenging circumstances. People with dementia may 'walk with purpose', which means that they may like to walk around purposefully and may become distressed if constrained, so this makes isolation particularly challenging.

There are added complications in that staff may have a tendency to remove all aspects of decision-making from the people living with dementia, rather than still trying to support them in making the decisions they are able to make, such as when to eat or when they would like to drink. So, it is important for the care home staff to ensure as much as possible, that people with dementia still have some ability to make decisions for themselves, whilst also being encouraged to follow infection prevention protocols.

The layout of some homes provides a particular wing for people with dementia (especially where they are suspected or confirmed as having COVID-19). Where they want to move outside their room,

such as to a small seating area, the ideal option for zoning may be to support this whilst restricting access to the wider home.

Where this is not possible, the only way is to understand the risks and adhere as consistently as possible to all the other infection prevention and control measures (e.g., strict hand hygiene, use of full PPE, handwashing after being in close contact with each person with dementia where touch has been needed, making sure that the essential visitors are doing the same, etc.). In general, if the whole care home has all these measures strictly in place, then the overall risk for everyone in the care home is a lot lower than it would otherwise have been. These measures would include:

- Testing for residents and staff,
- Enhanced cleaning schedules,
- Laundry and waste management procedures,
- Adherence to uniform laundering and changing into uniform on arrival and when leaving work,
- Adherence to guidance when staff are taking breaks,
- Regular hand hygiene and correct use of PPE throughout the home,
- PPE stations will be available,
- Maintaining social distancing.
- Guidance for PPE for aerosol generated procedures must be followed where this is required, and the corresponding risk assessments completed.

k. Staff Allocation during an outbreak

To limit the number of contacts on a shift and mitigate the risk of a high proportion of staff needing to self-isolate at any one time, homes will organise their workload and staffing based on cohorting or grouping.

It is not intended that additional agency staff are brought in, to cover this initiative as this will increase rather reduce contacts. The following may be ideas to consider:

- An additional carer on shift to free up the senior or nurse to be flexible across the home,
- Flexible or extended shifts for nurses or carers to cover busy periods at the start of the next or previous shift.
- In mixed nursing/residential homes with 2 floors, allowing medicines administration by nurse on one floor and senior carer on the other. With risk assessments in place and strict supervision or instructions for senior from nurse in the building to ensure nursing residents get safe care.
- Closing a floor/unit if appropriate.
- Grouping nursing funded residents together if not already done so.
- Where the layout of the building is complex or rambling and does not lend itself to grouping by floor, looking to reduce risks by going back to principles of reducing contacts and good infection control.

Where possible designated staff will work in red or yellow zones, this will be identified on the staff rota and a floor plan of the home will be available in each office with red, yellow and green

areas/rooms identified. **This plan will be dated and signed each day by the Manager or senior designated person in charge to confirm it has been reviewed and is still applicable.**

There should be limited changing of staff between red and yellow areas because this is a known method of cross infection in the home. Where there are staff that change area, this should be planned to allow tasks to be carried out in a planned way, for example, where a dressing is required for a service user who is positive this should be where possible co-ordinated with other care and support the service user requires and full change of PPE as per guidance will take place.

Where possible staff should continue to work in those zones every day when they come to work (rather than swapping over). Always try to maintain as much separation as possible between staff groupings.

If there are not enough staff to allocate shifts solely for amber or red rooms, or there are only a small number of residents that are symptomatic or confirmed as having COVID 19, then where staff must access both amber and red rooms in the same rotation, they should start with amber rooms first, then red rooms (but with PPE change between each individual room).

There must be a plan for organising cleaners for red zones, they need separate equipment etc and separate cleaners OR their work must be organised so they do green zones, then amber then red zone, this also applies to maintenance and laundry staff.

Meal delivery must be organised in order of green zone, amber zone then red zone or have a designated red zone person. This guidance already advises to deliver meals etc to the outside of the room on trolley and serve from there, no trays or food covers should go into room to avoid the need for decontamination.

Home Managers are responsible for ensuring a duty roster for the home is planned and available at all times that follows the cohorting guidance and allocates the staff team in the best way to manage this based on the design, layout and nature of their service.

It is the responsibility of the nurse or senior carer on shift to ensure cohorting of staff is followed.

Key principles of staff allocation are:

- Allocating a group of staff to work together as a team to provide care to a specific group of residents on a specific unit or floor for no less than 7 days at a time.
- Managers will ensure there is a clear rota on display and available for staff to show which staff team are allocated are allocated to each group of residents.
- Staff breaks must be covered by members of their own team, to minimise contacts on shift.
- Cigarette breaks will only be within allocated breaks.
- Social distancing must be maintained during break times.
- Staff rooms and changing areas will be reviewed and actions taken to minimise close contact of staff.
- Managers must ensure every reasonable effort has been made to cover shifts from the care home team, and reduce the presence of Agency staff to an absolute minimum. They will need to assess make a decision about the relative risks of covering part or a whole shift and introducing additional risk from agency staff. Especially in homes where block booked agency staff is not in place.

- Cleaners and activity staff will need to fit in with staff allocation arrangements.
- Maintenance work will need to be organised so that it fits with the principles of grouping e.g., grouping work together for units on separate days.
- Kitchen staff will work in teams. Where kitchen staff assist with serving, the possibility of a screen in the serving area may be considered.

l. Social distancing for residents without symptoms.

For Residents this means:

- Reviewing seating arrangements in lounges and dining rooms and removing furniture where necessary so that the ideal spacing of no less than 2 meters is achieved.
- Alternating mealtimes where possible.
- Putting tables together to create larger spaces for residents to sit together.
- Using garden space on fine days.
- Furniture in use must be of a material and design that makes it easy to clean.
- As a rule, use of communal areas should be on the basis of a risk assessment which considers the outbreak status of the home, the amount of space available generally, the ability of the home to prevent transmission.
- Having robust arrangements for residents without ensuite rooms to access baths and showers.
- Having robust arrangements for residents to undertake physical activity both inside and outside to maintain muscle tone in their legs etc.

m. Social distancing at meal and drink times

All meals and drinks must be served for individual persons. There must NOT be buffet style meals or platters where residents can pick food from a communal serving plates, bowls or dishes. All food must be served by staff with appropriate serving spoons or tongs.

Cakes, biscuits or sweets must be individually wrapped or served as described above.

Where dining rooms or other communal spaces or gardens are to be used at meal and drink times, this must be supported by a risk assessment. Managers are encouraged to have creative strategies such as reorganisation of furniture, or different times for meal sittings to ensure social distancing.

n. Social distancing for Visitors

We have already implemented the criteria below at the commencement of the pandemic.

- Visitors are no longer permitted unless special permission has been granted by the Manager.
- Keep in touch with family and friends using remote technology such as phone, internet, and social media.

o. Social distancing for Staff

For Staff this means:

- Use telephone or online services to contact your GP or other essential services.
- All staff being made aware of the principle of social distancing and be mindful this in both in the work place and outside.
- Being mindful of spacing between residents and the risks this may pose to them.
- Hold meetings in small numbers or larger spaces where spacing can be maintained.
- Avoiding car sharing,
- Wearing masks when in confined spaces and 2m distance cannot be maintained travelling to and from work.

It is important that staff maintain social distancing when they are having breaks etc. They should always ensure that whilst the virus is still circulating and social distancing is a key measure to prevent transmission of the virus, they:

- Take staggered breaks, have breaks in areas where space can be maintained.
- Do not share drinks or food, this includes gifts such as boxes of chocolates
- Make their own drinks,
- Use their own cutlery and crockery,
- Ensure appliances are cleaned in between usage – where possible put items through the dishwasher on a hot wash.
- Do not share changing rooms at the beginning or end of a shift (1 person at a time).

p. After an outbreak

All outbreaks will be investigated using **Care-FR-117 Review of COVID 19 Outbreak** document. This document will be submitted to the COVID Action Team for review and will be used for learning at home level.

It will be used to influence wider learning and inform any changes in decision making and policy for the company.

9. Residents with Symptoms or in Isolation

a. Residents with symptoms or positive test result

If a resident displays symptoms or signs consistent with COVID-19 in the 14 days after exposure then relevant diagnostic tests, including for SARS-CoV-2 (the virus which causes COVID-19), should be performed (see testing section above for more information). These residents should be isolated or cohorted with other suspected cases whilst results are pending if these measures are not already in place.

All residents will have their symptoms monitored and recorded at least twice per day. Any resident with a temperature above 37.8C and / or a new persistent/continuous cough and or difficulty in breathing should be promptly isolated in their room and tested. Staff should be vigilant to other changes to residents' presentation that may indicate covid-19 including lethargy, change in appetite, nausea, diarrhoea, drop in oxygen saturation and increased confusion.
See Section Monitoring of vital signs and for symptoms of the virus

All equipment must be cleaned between each use in line with the manufacturer's instructions.

The Residents Room must have a sign to alert staff that they are in isolation and to the need to wear PPE and take extra precautions. To maintain dignity and respect each home can use a poster with a symbol to communicate this to staff. Managers must ensure the symbols have been explained to staff. Some homes have used symbols such as Trees, or Rainbows to provide signage in this way.

Isolation should be in a single room with a separate bathroom where possible. If the design and capacity of the care home and the number of residents involved is manageable, it is preferable to isolate residents into separate floors or wings of the home – see section on cohorting/zoning.

Residents in isolation should not attend communal areas, including shared lavatories and bathrooms. Where residents need to share a bathroom or lavatory due to lack of ensuite facilities – the Home Manager will designate a bathroom for use by those who are in isolation because they have a had a positive test or have symptoms.

Designated bathrooms and toilets will be:

- clearly marked to show that it is different to the bathrooms for use by those who are not in isolation.
- in a suitable location so that it can be accessed easily by those who need to use it without travelling through the home.

They will be barrier nursed in line with our policy throughout this period to protect other residents from cross infection. This should continue until the 14th day or until they have not had a temperature for 48 hours (without the use of anti-pyrexia drugs) if symptoms persist past the 14 days of isolation.

If their symptoms worsen the person in charge must be informed who will seek medical advice either from the GP or telephone 111. The instructions provided by 111 or local Health Protection Teams MUST be followed as they are the lead agencies for advice in management of this outbreak of the virus.

Where a resident has persistent symptoms, a local risk assessment should be carried out taking advice from the GP. Following the clinical assessment and advice from the Public Health Team a plan will be devised for the resident to manage symptoms.

b. Supporting residents who may require hospital care

If you think a resident may need to be transferred to hospital for urgent and essential treatment, the care home may need to contact their local registered GP or the appropriate out-of-hours service for advice.

Consult the resident's advance care plan or treatment escalation plan and discuss with the resident and/or their family member(s) or health and welfare attorney and their GP as appropriate, following usual practice to determine if hospitalisation is the best course of action for the resident.

NEWS scores should be recorded and referred to when making contact with emergency services or other health care professionals, as this helps to assess urgency of the situation and symptoms.

If the condition of a resident deteriorates significantly whilst waiting for response or assessment the NEWS should be used to assist in assessing the deterioration and appropriate action taken depending on the score. If it becomes an emergency – dial 999.

If hospitalisation is required
If hospitalisation is required:

- follow infection prevention and control guidelines for patient transport.
- inform the receiving healthcare facility as early as possible that the incoming patient has COVID-19 symptoms.

If hospitalisation is not required
If hospitalisation is not required, follow infection prevention and control and isolation procedures and consult the resident's GP for advice on clinical management, using remote monitoring as needed.

Support with general health needs
If a resident requires support with general health needs:

- flag each resident who requires review by the weekly 'check in' with the aligned Primary Care Network (PCN) or GP practice.
- consult the resident's GP and community healthcare staff to seek advice.
- alternatively, contact NHS 111 for clinical advice.

Postpone routine non-essential medical and other appointments
Review appointments (medical and non-medical) that would involve residents visiting a hospital or other healthcare facilities and discuss with the healthcare provider whether these could be delivered remotely.

c. Residents without symptoms who have had contact with a possible or confirmed person with COVID 19.

Residents who are known to have been exposed to a person with possible or confirmed COVID-19 (an exposure similar to a household setting), should be isolated (or cohorted if not possible) with other similarly exposed residents who do not have COVID-19 symptoms until 14 days after last exposure.

A 'contact' is a person who has been close to someone who has tested positive for coronavirus (COVID-19) anytime from 2 days before the person was symptomatic up to 14 days from onset of

symptoms (this is when they are infectious to others).

Resident contacts:
Any resident that meets one of the following criteria:

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

or

- has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact

or

- has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact

or

- has spent more than 15 minutes within 2 metres of a confirmed case.

10. Isolation and Returning to work

a. Staff who have symptoms on arrival or at work.

All staff will be checked each day to see whether they have a temperature of 37.8C or above or a new persistent cough. A record of all temperatures will be maintained. There are no exceptions to this.

Staff with symptoms of a temperature above 37.8C and / or a new persistent/continuous cough and or difficulty in breathing should immediately isolate themselves in a room and access the NHS 111 online https://111.nhs.uk/covid-19/ for advice on the action they need to take.

The staff member must go home immediately and not stop off to talk to anyone or do shopping. The staff member must self-isolate for 10 days.

The HR Department must be notified of all staff who have symptoms or that are self-isolating for any reason.

If the staff member comes from an agency, the agency must be notified immediately that they have symptoms.

b. Staff with symptoms or a positive PCR for COVID-19

The precautionary 14-day contact-isolation period does not apply to care home or hospital staff contacts who should follow the legal requirement to isolate for 10 days.

If a health or social care worker develops symptoms of COVID-19:

- they should follow the stay-at-home guidance

- while at home (off-duty), they should not attend work and notify their line manager immediately
- while at work, they should put on a surgical face mask immediately, inform their line manager and return home
- comply with all requests for testing

A member of staff who develops symptoms, must be tested **to continue to receive pay during their isolation period.** They should be tested for SARS-CoV-2 without delay, there are no restrictions on access to tests for people who are symptomatic. Testing is most sensitive within 3 days of symptoms developing. Guidelines on who can get tested and how to arrange for a test can be found in the COVID-19: getting tested guidance.

If their symptoms do not get better after 10 days, or their condition gets worse, they should speak to their GP or NHS 111 online coronavirus service. If they do not have internet access, they should call NHS 111. For a medical emergency, they should call 999.

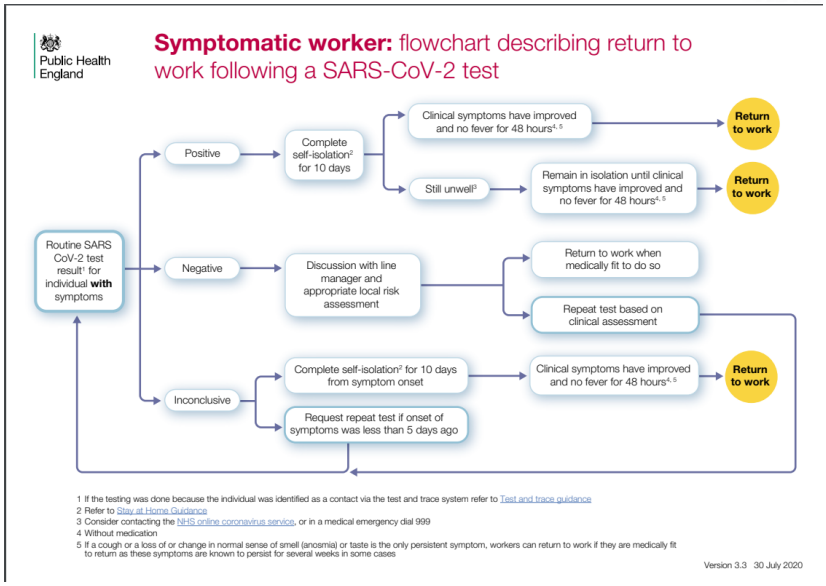
If, however, they have been admitted to hospital they should be isolated in hospital (or continue to self-isolate on discharge) for 14 days from their first positive PCR test result. This is because COVID-19 cases admitted to hospital will have more severe disease and are more likely to have pre-existing conditions, such as severe immunosuppression. For the same reasons, the 14-day isolation rule also applies to other (non-staff) COVID-19 cases admitted to hospital.

Staff who have tested positive for SARS-CoV-2 by polymerase chain reaction (PCR) in the community or at work should self-isolate for at least 10 days after illness onset. The isolation period includes the day their symptoms started (or the day their test was taken if they do not have symptoms) and the next 10 full days.

Symptomatic staff who test positive for SARS-CoV-2 or who have an inconclusive test result, and symptomatic staff who have not had a test, can:

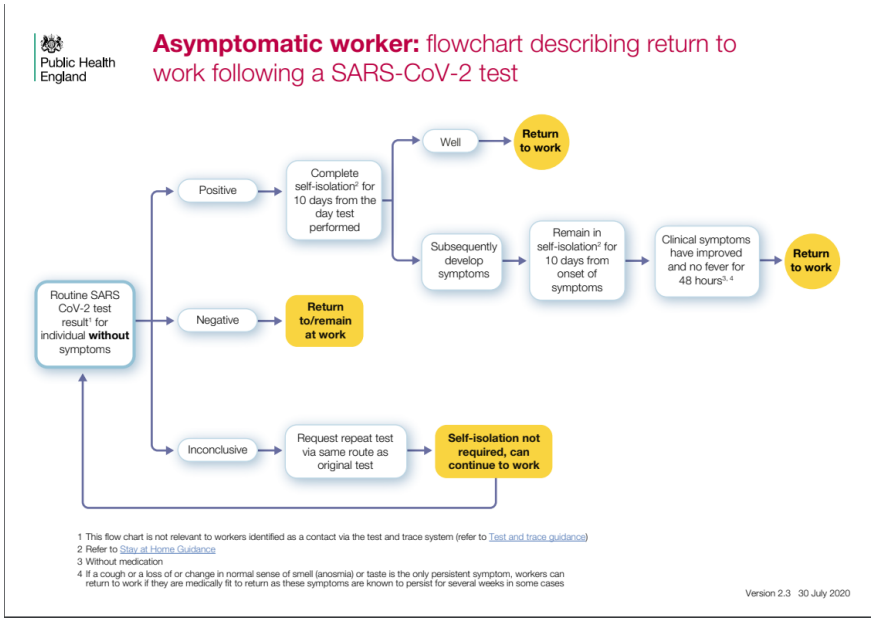
- return to work no earlier than 10 days from symptom onset, provided clinical improvement has occurred and they have been without a fever without medication for 48 hours and they are medically fit to return.

- if a cough or a loss of or a change in normal sense of smell (anosmia) or taste is the only persistent symptom after 10 days (and they have been without a fever for 48 hours without medication), they can return to work if they are medically fit to return (these symptoms are known to persist for several weeks in some cases).



Asymptomatic staff who have not been hospitalised and have tested positive for SARS-CoV-2, should self-isolate for 10 days following their first positive PCR test.

Staff who test negative for SARS-CoV-2 can return to work when they are medically fit to do so, following discussion with their line manager and appropriate local risk assessment, as long as they have not been identified as a close contact of a confirmed case. Interpret negative results with caution together with clinical assessment.



c. Staff who have a symptomatic household member

All members of a household shared with a symptomatic person should self-isolate for 10 days from

the day the individual's symptoms started.

If any household member develops symptoms of COVID-19, they should isolate for at least 10 days from the onset of their symptoms, in line with the stay-at-home guidance.

England - If all symptomatic household members test negative, the member of staff can return to work if they feel well enough to do so. If any member of the household tests positive, they must continue to isolate and follow the guidelines as above.

Staff with a household member who returns from abroad.

Where a member of staff has a household member who has returned from abroad and has to isolate will also have to isolate for 10 days.

Staff with a household member who has been told to self-isolate e.g., child sent home from school.

Where a member of staff has a household member who has been told to self-isolate, the rest of the household do not also need to isolate but extra care must be taken to follow the guidance on social distancing and handwashing and avoid contact within the household.

If, during the 10 days isolation, they develop symptoms, they must self-isolate for 10 days from the day of symptom onset. They can:

- return to work no earlier than 10 days from symptom onset, provided clinical improvement has occurred and they have been afebrile (not feverish) without medication for 48 hours and they are medically fit to return
- if a cough or a loss of or a change in normal sense of smell (anosmia) or taste is the only persistent symptom after 10 days (and they have been afebrile for 48 hours without medication), they can return to work if they are medically fit to return (these symptoms are known to persist for several weeks in some cases)
- All members of a household shared with the individual should self-isolate for 10 days from the day the individual's test was taken. However, if any household member develops symptoms of COVID-19, they should isolate for at least 10 days from the onset of their symptoms, in line with the stay-at-home guidance.

This advice must be should be followed regardless of the results of any SARS-CoV-2 antibody testing or vaccination status until government guidance is issued to provide specific advice.

d. Staff member who has had contact with a person who has tested positive or has symptoms.

If you are providing direct care to a resident with COVID-19 and are wearing the correct PPE in accordance with the current IPC guidance, you should not be considered as a contact for the purposes of contact tracing and isolation. You will also not be required to self-isolate for 10 days.

It is important to note that the effectiveness of the use of face masks, face coverings, or other PPE for prevention of transmission or acquisition of coronavirus infection cannot be guaranteed in settings other than the provision of direct care with residents. Therefore, the use of PPE in other settings, such as a staff room or canteen, will not necessarily exclude an individual from being considered a close contact.

In addition, if staff have been in contact with a COVID-19 case and are not following appropriate IPC, including wearing correct PPE, they will be considered as a contact for the purposes of contact tracing and isolation.

Staff contacts is defined as:
Any staff member that has had the following contact while not wearing appropriate PPE or who has had a breach in their PPE:

- has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact

or

- has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact

or

- has spent more than 15 minutes within 2 metres of a confirmed case

or

- has cleaned a personal or communal area of the home where a confirmed case has been located (note this only applies to the first time cleaning the personal or communal area)

or

- has been notified that they are a contact of a co-worker who has been confirmed as a COVID-19 case.

The Government guidance states if a health or social care worker is considered to be a contact, and the recommendation for them to self-isolate would have implications for the provision of the service, their employer will need to **escalate this for a risk- assessment to a Tier 1 contact tracer at the local Health Protection Team (HPT).** Advice about whether a risk assessment is needed may also be sought from the HPT. The risk assessment should take account of any PPE use (including its type and situational appropriateness) and other mitigating factors that may reduce the risk of infection transmission to such an extent that the individual identified as a contact does not need to self-isolate.

A risk assessment for exposure to a contact will consider the following:

- the severity of symptoms the patient/resident has
- the length of exposure
- the proximity to the patient/resident
- the activities that took place when the worker was in proximity (such as aerosol-generating procedures (AGPs), monitoring, personal care)
- whether the health or social care worker had their eyes, nose or mouth exposed

If the risk assessment concludes there has been a significant breach or close contact without PPE, the worker should remain off work for 10 days.

It is very unlikely that not wearing gloves for a short period of time or their gloves tore, and they washed their hands immediately, or if their apron tore while caring for a resident and this was replaced promptly will be considered a significant breach.

e. Staying safe and avoiding scams

We are aware there have been a number of contacts from people pretending to be from the test and trace service. Everyone must be vigilant to those who may try to pretend to be a member of the test and trace service to try and gain personal information or get money under false pretences.

The NHS guidance makes it very clear, if the NHS test and trace service contacts you, the service will use text messages, email or phone. All texts or emails will ask you to sign into the NHS test and trace contact-tracing website. All information you provide to the NHS test and trace service is held in strict confidence and will only be kept and used in line with the Data Protection Act 2018.

If NHS test and trace calls you by phone, the service will be using a single phone number: 0300 013 5000.

Beware texts or emails that invite you to apply for a vaccination, as we understand all vaccinations will be made by booking an appointment. Any contacts that ask for bank details to verify your identity will be a scam.

The NHS will NOT ask you to provide bank details as any part of test and trace or the vaccination programme.

Contact tracers will:

- call you from 0300 013 5000
- send you text messages from 'NHS'
- ask you to sign into the NHS test and trace contact-tracing website
- ask for your full name and date of birth to confirm your identity, and postcode to offer support while self-isolating
- ask about the coronavirus symptoms you have been experiencing
- ask you to provide the name, telephone number and/or email address of anyone you have had close contact with in the 2 days prior to your symptoms starting
- ask if anyone you have been in contact with is under 18 or lives outside of England

Contact tracers will never:

- ask you to dial a premium rate number to speak to us (for example, those starting 09 or 087)
- ask you to make any form of payment or purchase a product or any kind
- ask for any details about your bank account

- ask for your social media identities or login details, or those of your contacts
- ask you for any passwords or PINs, or ask you to set up any passwords or PINs over the phone
- disclose any of your personal or medical information to your contacts
- provide medical advice on the treatment of any potential coronavirus symptoms
- ask you to download any software to your PC or ask you to hand over control of your PC, smartphone or tablet to anyone else
- ask you to access any website that does not belong to the government or NHS.

f. Testing for antibodies to confirm a person has recovered from the COVID 19 virus

The antibody test is to determine which people have developed antibodies to the virus as a result of having the infection. There is not enough evidence as yet to be able to confirm that having antibodies to the virus will provide immunity to the virus, this is still being researched.

The test requires a specimen of blood. Home Managers should now start compiling a list of staff who wishes to be tested for antibodies for the virus, so that they are prepared when further instructions are issued.

11. Testing

a. Testing – types of testing available

PCR (polymerase chain reaction) testing is the swab test to determine whether a person has the virus. The swab must go to a laboratory for analysis and results are usually returned in 24 – 72 hours.

LFT (lateral flow test) is a swab test to determine whether a person has the virus. These are more accurate when a person has a lot of the virus in their body, meaning they are effective in identifying people who are infectious and most likely to transmit the disease. They are rapid turnaround tests that usually generate the result in around half an hour.

Government guidance states that 1 in 3 people with the virus are asymptomatic – (do not have any symptoms). The LFD test is being used as one of the key tools to quickly and easily identify those people who are infectious because they have a lot of virus in their body and need to isolate immediately to prevent further spread of infections.

LAMP (loop-mediated isothermal amplification) test is a swab test to determine whether a person has the virus. It only detects when the virus is present. They are rapid turnaround tests with results usual in 2 – 3 hours.

Antibody testing is a blood test to determine whether a person has antibodies to the virus because

of a pervious infection. The blood sample must be sent to a laboratory and results are usually returned in a couple of days.

b. National Guidance for care home testing

Following a significant rise in infections, attributed to the rapid spread of a new variant of coronavirus, the government updated the guidance on staff testing for all care homes in England & Scotland.

In addition to the current regular PCR testing regime, the new guidance advises all care home staff in all tiers to:

Undertake an additional two lateral flow device (LFD) tests per week, ideally at the beginning of the shift:

- One LFD test on the same day as the PCR test.
- One LFD test midweek between PCR tests. If any staff test positive, they will need to undertake a confirmatory PCR and then self-isolate at home immediately until they receive their result.
- Undertake an LFD test before beginning their shift if they've worked elsewhere since their last shift.

In addition to the above, if there are any positive cases found in a care home **in tier 4 areas** only, staff should also:

- Undertake daily LFD testing for 7 days, ideally at the beginning of the shift.
- If any staff test positive, they will need to undertake a confirmatory PCR and then self-isolate at home immediately until they receive their result. Homes do not need to keep testing daily indefinitely if more positive results are found in the 7 days. Any staff members who have tested positive should immediately take a confirmatory PCR, registered through the organisation route using the care home's UON and then self-isolate at home.

Please note that the confirmatory PCR is in addition to the weekly PCR test that all staff undertake, unless they tested positive on the day, they did their weekly PCR test.

NB Lateral Flow Tests are not being undertaken in care homes in Wales at this time. The new guidance issued in respect of visitors indicates that LFT's will be a requirement for visiting going forward. Further guidance will be provided as the situation becomes clearer.

Care homes should continue to follow existing outbreak management processes as per normal and notify their local Health Protection Team of any positive case.

Additional lateral flow kits can be requested when needed by calling 119.

HCMS policy for testing is CARE-PR-43b. Further guidance can be found at:

https://www.gov.uk/government/publications/coronavirus-covid-19-lateral-flow-testing-of-visitors-in-care-homes

A recording of a lateral flow testing webinar can be accessed at:

https://event.webcasts.com/starthere.jsp?ei=1408929&tp_key=d2a77c17e3

The NHS training, which all staff members who are carrying out lateral flow testing must complete, can be accessed at:

https://go.tessello.co.uk/TestDeviceTraining/

The token for this portal is: 3wkcVi4UTX

Please note that the token is not your password. Please follow the link, create your own username and password and then you will be prompted to add the token.

It is crucial that all lateral flow device tests are registered (whether positive, negative or void) to help us understand the prevalence of coronavirus in care homes.

Lateral flow tests should be registered at: https://www.gov.uk/report-covid19-result

Couriers should be booked at: https://test-kit-collection.test-for-coronavirus.service.gov.uk/

If you have booked a courier and you no longer need it, please call 119 to cancel the courier, so that your slot can be used by another care home. If your courier doesn't arrive, please call 119 the next morning to arrange an urgent courier.

c. General Principles for testing Care Home and Field Based Staff

All field-based staff will work within a dynamic risk assessment to determine the appropriateness of entering homes during the times of peak transmission until the pandemic is over.

Regardless of their role, no staff who are **symptomatic** should be tested in a home. Any staff member who is symptomatic should immediately go home to self-isolate, and should apply to be tested via the separate arrangements for testing symptomatic staff.

Where a member of staff is tested positive, they must isolate for 10 days, and members of their household for 10 days. If they develop symptoms after the test the 10 days will recommence on day 1 when they developed symptoms of the virus.

Where testing is available for an employee, it is company policy, and our expectation, that they will be tested for presence of the virus – PCR test.

Refusal to be tested for presence of the virus without a valid medical reason will be considered Gross Misconduct as it places staff and residents at increased risk of harm. The normal processes for management of gross misconduct will apply in these cases.

Line managers will, without delay take advice from the HR Director, and hold an investigatory meeting/conversation with any member of staff refusing to accept a test. The investigatory meeting can be held in person or telephone. Normal procedures will then be followed.

Antibody testing is a blood test to determine whether a person has been infected with the virus and developed antibodies as a result of this. The presence of antibodies does not guarantee

immunity to the virus and is confirmation of a historical event. It is therefore company policy that members of staff will determine whether they wish to take the antibody test

d. Testing new staff or staff in receipt of healthcare services.

New members of staff **must** be tested no longer that 48 hours before they start work in a home with an outbreak.

Any member of staff that has been in hospital or in receipt of healthcare services at home must be tested before they return to work.

Asymptomatic staff must still be tested. If they test negative, they can commence work. If they test positive, they must isolate for 10 days.

e. Testing of staff in homes.

The Governments in England, Scotland and Wales have issued guidance on mass testing in care homes. There are inconsistencies in the ways this has been implemented and each home should follow the advice from their local public health or health protection team.

This is in addition to intensive testing in any care home facing an outbreak, or at increased risk of an outbreak. It is essential for staff to participate in the weekly testing and to follow government guidance in order to reduce the transmission of the virus.

Our policy is that all staff will attend the home to be tested as the testing programme is implemented. Where they cannot attend the home on the day of testing, each member of staff will be responsible for making their own arrangements to be tested, this must not be less often than the frequency specified in the testing programme for the Care Home. We have agreed that staff who need to go to the home for testing in their own time will be paid and additional 1.5 hrs.

Where members of staff have been on leave or away from for other reasons that mean they cannot be tested, they will be expected to make every effort to have a test before returning to work.

Many homes are staggering testing across the week, as previous arrangements for testing with home kits or at drive through centres is only available for symptomatic people or targeted pilot studies.

Care home staff whose test is positive will be immediately excluded from work to self-isolate at home for a minimum of 10 days. They will be telephoned by the contact tracing team as described above.

f. Retesting of staff and residents in care homes – 90-day rule

Retesting following a positive test

There are different arrangements in England, Scotland and Wales for retesting.

England – latest guidance – Jan 2021

- **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/950192/Care_Home_Testing_Guidance_England_v06-01_3.pdf January 2021**

Members of **staff and residents**, who are not immuno compromised, who have **tested positive for COVID-19 by PCR or LFD test** should be exempt from routine re testing (for example whole home testing or testing prior to hospital discharge) **for a period of 90 days** from their initial illness onset or test (if asymptomatic), **unless they develop new symptoms of COVID-19.**

Scotland – latest guidance 15 Jan 2021

- https://www.nhsggc.org.uk/media/264167/lfdt-a-guide-for-healthcare-staff-nhsggc.pdf

Wales – latest guidance 15 Jan 2021

The Welsh Government announced on 4 December 2020 that LFD testing would be rolled out from 14th December, but no further announcements have been made.

Guidance issued on 23 December 2020 states no retesting for 90 days after a positive PCR positive test.

- https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-health-and-social-care/gui-001-covid-19-in-residential-care-settings/

In all countries, if it is necessary to do a PCR retest **within 90 days** from their initial illness onset or PCR test date and they are found to still be positive for COVID-19, advice from an infection specialist is required to interpret the results and the actions that need to be taken. This should be obtained via the Public Health Team.

Staff who have previously tested positive for SARS-CoV-2 by PCR in the past 90 days are exempt from government requirements to re-test.

Despite this advice, some staff may be offered and may accept an LFD antigen test as part of an asymptomatic staff testing programme. It is HCMS policy that LFD retesting will continue where tests are available to the home.

Should such re-tested staff be found to be LFD antigen positive within 90 days of a positive PCR test, they and their household should self-isolate and they should arrange to have a confirmatory PCR test. If this PCR test result is negative, they and their household can stop isolating and they can return to work. If this PCR test result is positive, then the possibility of SARS-CoV-2 re-infection should be considered – subsequent action should be guided by a clinically-led approach taking account the factors described below.

If a person is re-tested by PCR within 90 days from their initial illness onset or test date and is found to still be positive for SARS-CoV-2, a clinically-led approach, taking into account several factors, should be used to decide whether re-infection is a possibility and to inform subsequent action. Such factors include:

- COVID-19 symptoms
- underlying clinical conditions
- immunosuppressive treatments and conditions
- additional information such as cycle threshold values

Seek advice from an infection specialist as required.

If a person is retested **after 90 days** from their initial illness onset or test and is found to be positive, this should be considered as a possible new infection. If they have developed new COVID-19 symptoms, they will need to self-isolate again and their contacts should be traced.

All hospitalised care home residents who have previously tested negative as part of routine screening or the investigation of a recent illness should be tested for COVID-19 again 48 hours prior to discharge and the result of their repeat test communicated to the care home. Residents who are not immunocompromised who have tested positive within the 90 days, and remain asymptomatic, do not need to be retested.

Any resident who tests positive and is being discharged within their 14 days isolation period should only be discharged to a designated setting – a care home with an agreement to take COVID-19 positive residents.

g. Difficulty in obtaining testing for care home staff

Where the member of staff has risk factors which mean they are not able to obtain a test before they are due to return to work, and they are likely to have been exposed to risks which means they would be a risk to the wellbeing of the residents and staff in the service, the Home Manager will consult with the HR Department.

Each case will be reviewed individually to agree the most appropriate course of action to be taken.

Members of staff who obtain a test outside their work time will be paid 1.5 hours at their standard pay rate for attending for the test.

h. Testing for field-based staff

Field based staff who require access to testing will normally be able to access this through care homes, as access through walk in, and drive through centres do not normally allow for non-home-based staff to access tests.

If the staff member suspects they have been in contact with someone who has the virus in the 10 days prior to planning to enter a home, they must notify their line manager without delay and complete a risk assessment to determine the appropriate course of action.

Field based staff who have been on annual leave will access testing on their first day back and will not enter a care home until their negative test result has been received where their role means they cannot maintain 2m social distancing.

i. Testing Residents

Residents with capacity will be asked to sign a consent form once the procedure has been explained to them.

Some residents of care homes, including those being admitted from hospitals and the community, may lack the relevant mental capacity needed to make decisions about arrangements for their own care and treatment. For example, some people with dementia and learning disabilities may lack the relevant capacity to make these decisions and will fall under the empowering Mental Capacity legislation.

Duties and powers to comply with legislation for those who lack capacity still apply during this period. If care home staff think the person may lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before a decision about their treatment or a change of placement is made. During the emergency period, professionals may want to consider a proportionate approach to such assessments to enable timely discharge.

If a resident does not have relevant mental capacity, for example, to make necessary decisions (including care, treatment and residence decisions), staff will need to consider the legal, decision-making framework offered by the MCA. DHSC has issued guidance on the use of the MCA and DoLS during this emergency period.

SCIE provides guidance on implementing the Mental Capacity Act specifically to support care homes in undertaking this. It covers involving residents in the process, best interests' decisions, reviews, DoLS and includes a useful checklist for monitoring MCA implementation.

Care home staff will need to consider the MCA and this guidance, when making decisions for people who lack the relevant mental capacity to make them. This includes residents who cannot make their own decision about testing.

If a person lacks capacity to provide consent to be tested for COVID-19, the decision maker should where necessary make a 'best interests decision' under the MCA. When doing so, they must consider all the relevant circumstances and should make a record of their decision. This must be undertaken in relation to the individual and should never be determined in relation to groups of people. Additional time may be required to make the best interest's decision in these situations.

If a resident finds testing intrusive or painful or refuses consent, they should not be forced to undergo a test. If you have reasonable concerns about a resident's health or wellbeing or you suspect they have COVID 19 you should discuss this with their GP or other health care professional involved in their care and isolate the resident until there is confirmation of their status.

Residents who cannot be tested should be treated as if they were a possibly infected with the virus and isolated for 14 days, to minimise the risk to others as far as possible.

Residents who are known to have been exposed to a confirmed COVID-19 resident (an exposure similar to a household setting), should be isolated or cohorted only with residents who do not have COVID-19 symptoms but also have been exposed to COVID-19 residents, until 14 days after last

exposure.

If symptoms or signs consistent with COVID-19 occur in the 14 days after last exposure then relevant diagnostic tests, including for SARS-CoV-2, should be performed. If they have been cohorted with other individuals, the other residents' follow-up period recommences from the date of last exposure.

Where the resident is immobile or can be persuaded to remain in their room or area this should be implemented. However, where the resident is mobile and cannot be persuaded to restrict their movements, best efforts should be made to minimise their contacts with other residents and staff in the home. This could be by grouping with other residents who are mobile and whose movements are difficult to restrict. The main principle being got minimise the number of contacts with others.

Where a resident with capacity refuses to accept a test, staff should try to persuade them and may offer to enlist appropriate help. It may be that reassurance from a separate member of staff who can hold their hand during the procedure will allay the anxieties they may have to allow the test to proceed.

Residents without capacity to consent to testing will be tested in their best interests unless there is a medical reason for not testing such as:

- The resident being in the last days of life,
- A large tumour in the mouth/throat,
- Other relevant medical condition that would prevent testing.

j. Additional staff to support mass testing programmes in Care Homes

We will be issuing further guidance to support LFD testing in homes in the near future.

Where mass testing programmes are in operation, additional staffing for homes has been agreed in recognition of the time required.

Most homes are operating weekly testing and so additional hours will be per week, or tailored to the frequency in the area if different – e.g., 2 weekly.

Homes are allocated the following additional hours:

- Up to 40 beds
    - 8 hours Nurse/ Senior Carer
    - 8 Hours Admin
- Over 40 beds
    - 12 hours Nurse/ Senior Carer
    - 12 hours Admin

Home Managers must keep a log of all hours worked to assist in claiming additional costs back at a future date.

12. Test & Tracing Service

a. UK variations

The Tracing Service for those who were in contact with someone with symptoms of coronavirus is now in operation across the UK:

- On 28th May 2020 the NHS in England launched the **Test and Trace** service.
- On 26th May the Scottish Government announced its **Test and Protect** strategy.
- On 1st June 2020 the Welsh Government published its **Test, Trace and Protect** strategy.

These all have the same key features and are closely linked through databases to the testing.

b. Contact by the Test and Trace Service and Self Isolation

When someone has a positive test result, the NHS test and Trace Service will contact them to confirm they are isolating and to establish whether there is a risk of infection from a contact and to identify any further contacts. The test and trace service will ask:

- if you have family members or other household members living with you.
  In line with the medical advice, they must remain in self-isolation for the rest of the 10-day period from when your symptoms began
- if you have had any close contact with anyone other than members of your household.
  They are interested in in the 48 hours before you developed symptoms and the time since you developed symptoms.

Close contact can be:

- anyone who lives in the same household as someone with COVID-19 symptoms or who 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 with a PCR test:
  - 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
  - sexual contacts
  - 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 or a plane

The contact tracers will not consider the wearing of personal protective equipment (PPE) as a mitigation when assessing whether a recent contact is likely to have risked transmitting the virus. Only full medical-grade PPE worn in health and care settings will be considered.

Medical-grade PPE should not be purchased to circumvent self-isolation, as this risks disrupting critical supplies needed by the NHS and social care sector.

Contact tracers will ask for information about the names and contact details (for example, email address, telephone number) for the people you have had close contact with. As with your own details these will be held in strict confidence and will be kept and used only in line with data protection laws.

Staff who have been notified through the NHS test and trace service that they are a contact of a confirmed case of COVID-19 should inform their line manager and self-isolate for 10 days, in line with the NHS test and trace guidance.

The alert will usually come by text, email or phone call. They should then log on to the NHS test and trace website, which is normally the easiest way for the person and the service to communicate with each other – but, if not, a trained call handler will talk them through what you must do. Under-18s will get a phone call and a parent or guardian will be asked to give permission for the call to continue.

If the member of staff is due to be at work before they can speak a member of the tracing service, **they should not go to work**, as it may be discovered they are infected with the virus. The member of staff will be expected to demonstrate to the Home Manager when they were contacted and that they responded without delay.

If a care home is contacted the following information about residents, previous residents, visitors and staff may be requested at short notice:

For residents:

- name, and contact details of current residents.
- If a resident moves out of the care home, the care home should continue to keep a record
- of the resident, including:
- resident's name;
- a contact phone number;
- date of admission (if this took place within 21 days of their departure);
- date of departure/move to another setting.

For visitors:

- name (if there is more than one person, then you can record the name of the 'lead member' of the group and the number of people in the group as long as the lead visitors is able to support provision of more detailed information of their visiting group if needed);
- a contact phone number for each visitor, or for the lead member of a group of people;
- date of visit; and
- arrival time and, where possible, departure time.

For staff:

- the names of staff who work at the premises;
- a contact phone number for each member of staff; and
- the dates and times that staff are at work.

NHS Test and Trace will ask for these records only where it is necessary.

c. Government Apps to support tracing people with COVID-19

Apps have been developed by each of the UK nations to support tracing of people infected with COVID -19 and their contacts.

The App is stored on mobile phones and runs in the background. When the app finds another user, it will record the contact, the distance between your phones and the length of time the phone was near theirs. This is all done anonymously.

Once you've downloaded the app, it should be left on as much as possible. However, there are some specific workplace scenarios when you should pause the contact tracing feature. These are:

- when you are working behind a Perspex (or equivalent) screen
- if you are putting your phone in storage, such as in a work locker, and it will not be on your person
- **if you are a health or care worker practising infection prevention and control (IPC) working in a clinical setting**

Contact tracing can be paused within the app by moving the contact tracing toggle on the home screen. It's important you turn the contact tracing toggle back on as soon as you are not in one of the above scenarios, for example, when you retrieve your phone from your locker. To make it easier to remember to do this, you will be given the option to pause the feature for different time periods and you will then receive a reminder to turn the contact tracing feature back on.

If a person who has the App tests positive for coronavirus, they can choose to input the Test Code, provided by the contact tracer, into the app. This will automatically notify other app users that they have been in close contact with (within 2 metres for at least 15 minutes)

When another app user tests positive, and has inputted a Test Code, the app will notify contacts if it determines you may be at risk. If a member of staff is informed by an App, they must contact the Home Manager before they return to work.

We encourage all staff to participate in this **when they are not at work** to help to reduce the spread of the virus.

The App is available from the App Store or Google Play.

13. Visiting

a. General arrangements for visiting

The arrangements for visitors to the home are reviewed regularly by the HCMS COVID 19 task force. Our decisions have been updated in line with national guidance for visiting and a risk-based approach for the company.

Our **Dynamic Risk Assessment Process** assesses the risks for each locality on a home by home and

resident by resident basis, it will be updated as circumstances change

The dynamic risk assessment includes: -

- The risk level of the Locality assessed by central or devolved government and any instructions issued by the local **Director of Public Health**.
- The outcome of the Covid-19 Home Risk Assessment.
- Risk assessments of indoor and outdoor visiting arrangements.
- Risk assessments for individual residents.

Where internal visiting is unsafe appropriate window visits, pod visits, or other appropriate measures will be offered. Government and public health guidance state all visits should take place in the open air where possible.

Where a resident is unable to get out of bed, visits will be arranged in bedrooms using screens, full PPE and other measures as appropriate to the risk assessment for that individual.

A visiting matrix has been produced to assist Home Managers in identifying the options for residents to keep in contact.

Decisions around visiting in the home will be made using the following framework.

Stage 1 Assessment of whether the home is generally COVID-19 Safe.

The COVID-19 -19 Care Home Risk Assessment Tool & Plan Care-FR-111 which will take account of the following risk factors.

1. Locality status.
2. Lockdown directives may come from central Government or from the Local Director of Public Health in conjunction with the Local Authority.
3. Where there is a 'lockdown' in a nearby area the risk assessment and plan must consider which areas staff and visitors are likely to be travelling from, and whether this is in the 'lockdown area'.
4. Appropriate spaces for visiting to take place – see stage 2 below.
5. Appropriate areas and signage for hand hygiene and PPE.
6. Information for visitors – pamphlets etc.
7. Staffing managed to avoid using staff that also work in other homes / or areas of significant risk.
8. Testing for staff in accordance with local directions and arrangements.
9. Designated staff who know how to book, manage and escort visitors and deal with everyday queries. Their knowledge, skills and practice will have been checked and this will have been documented. Home Managers are advised to evidence assessment of each staff member's ability to undertake this correctly by recording the process on a staff supervision form.
10. Designated staff who know how to clean the visiting area and prepare for the next visits. Their knowledge, skills and practice have been checked and this has been recorded. A key component of managing risk to prevent cross infection as a result of visiting will be staff explanation to visitors of the arrangements in place for the visit and disinfection after the visit.
11. Appropriate members of staff are designated on the rota and at handover rota to

be responsible for visitors.

12. A central booking system for visits.
13. Visiting will be restricted to:
    - one named person per visit externally, but this does not need to be the same person each time.
    - a single named person for any visits inside the home. Limiting contact to one person is to reduce the number of contacts entering care homes.

Where a home is assessed as COVID-19 Safe then the indoor and outdoor risk assessments should be completed/updated to determine in more detail what, if anything, is required before visiting can be recommenced. If the Covid-19 Home Risk Assessment determines that there is an increased risk of transmission of the virus then the Indoor and outdoor visiting risk assessments should be completed along with the individual resident risk assessment to determine the next steps for each resident.

Guidance issued by the Department of Health to maximise the opportunities for visiting at times of increased transmission, emphasises the responsibility of the Home to balance the benefits of visiting with the safety of residents, and to make sure they are not put at avoidable risk of contracting COVID 19.

In all cases:

- visitor numbers should be limited to a single constant visitor wherever possible, with an absolute maximum of 2 constant visitors per resident. This, for example, means the same family member visiting each time to limit the number of different individuals coming into contact. This is in order to limit the overall number of visitors to the care home and/or to the individual, and the consequent risk of disease transmission from multiple different routes.
- appropriate PPE must be used throughout the visit, and around the care home building and grounds.
- social distancing (between visitors and residents, staff, and visitors from other households) must be maintained at all times – during the visit, and around the care home building and grounds.
- high quality infection prevention and control practice must be maintained throughout the visit and through the wider care home environment. (See section on infection control precautions in the wider care home environment).
- the home should have an arrangement to enable booking/appointments for visitors – ad hoc visits should not be enabled.
- **visiting spaces must be used by only one resident and visiting party at a time, and between visits there must be appropriate cleaning and an appropriate time interval.**
- **visits should happen in the open air wherever possible, recognising that for many residents and indeed visitors this will not be appropriate in the winter (this might include under a cover such as an awning, gazebo, open-sided marquee etc):**
    - the visitor and resident must remain at least 2 metres apart at all times.
    - the visit can take place at a window.

Some providers have used temporary outdoor structures – sometimes referred to as ‘visiting pods – which are enclosed to some degree but are still outside the main building of the home.

Where visiting pods are not possible, a dedicated room such as a conservatory (i.e., wherever possible, a room that can be entered directly from outside) can be used in both of these cases, providers must ensure that:

- the visiting space is used by only one resident and visiting party at a time, and is subject to regular enhanced cleaning between each visit.
- **the visitor enters the space from outside wherever possible.**
- **where there is a single access point to the space, the resident and visitor enter the space at different times to ensure that safe distancing and seating arrangements can be maintained effectively.**
- **there is a substantial (e.g., floor to ceiling) screen between the resident and visitor – designed to reduce the risk of viral transmission.**
- there must be good ventilation for spaces used (for example, including keeping doors and windows open where safe to do so and using ventilation systems at high rates but only where these circulate fresh air).
- **consider the use of speakers, or assisted hearing devices (both personal and environmental) where these will aid communication. This will also avoid the need to raise voices and therefore transmission risk**

If the Covid-19 Home Risk Assessment determines that there is a high risk of transmission of the virus then only essential visits will be permitted in order to safe guard both staff and residents and the Essential Home Visits Risk Assessment and Plan should be carried out and required actions completed as a matter of urgency to allow essential visits to go ahead.

An essential visit for residents is defined as:

- **One that is necessary to prevent immediate and ongoing deterioration in a person's health or wellbeing – such as a person in distress or losing weight.**
- **Healthcare professional visits to address wellness or welfare issues – a chiropodist may be essential to prevent pain or prevent falls.**
- **A visit to witness a Power of Attorney.**
- **Immediate family at the end of life.**
- **A religious or spiritual representative.**

The COVID-19 -19 Home Risk Assessment and plan must be reviewed by the Regional Manager and submitted to the Operations Director for sign off before visiting can commence.

Stage 2

Where the home risk assessment indicates garden visiting is appropriate, a garden visiting plan will be completed using HS-FR-03a

Arrangements for garden visiting using must be set out in a plan for the home and take account of the following:

1. Visiting will take place outside in the fresh air. A gazebo (open sided tent) or other suitable structure will provide shelter from the weather. This must allow for circulation of fresh air and should not be an enclosed space.
2. Furniture must be comfortable but easily cleaned.
3. Visits will be on an appointment only basis and will last for a maximum of 1 hour.
4. No more than 1 visitor is allowed – over 18 years of age.

5. The plan must specify the maximum number of visits must be specified at any one time to allow for a member of staff to supervise and assist where necessary.
6. Social distancing of 2m must always be maintained.
7. PPE must always be worn.
8. Visitors will be checked to ensure they do not have symptoms – temperature, new cough or loss of sense of smell/taste.
9. There will be an agreed route for visitors to the home that avoids contact with residents and staff and minimises footfall through the home.

Stage 3 Visiting Plan for Internal Visiting

Where the home risk assessment indicates internal visiting is appropriate, an internal visiting plan will be completed using HS-FR-03a.

Arrangements for internal visiting must be set out in a plan for the home and take account of the following:

1. Visiting will normally take place in a designated visiting area. The visiting area will be prepared and will allow for visits with:
    - 2m social distancing.
    - A pleasant environment.
    - Comfortable furniture that is easy to clean between visits.
    - Surroundings that are easy to clean between visits.
    - Be well ventilated
    - Appropriate route from the entrance that does not access resident areas.
    - Ideally have a one-way system from entrance to exit.

2. Visits for those who are completely bed bound will take place in the resident's room. The bedroom will be prepared and may need some adjustment to allow for visiting with:
    - 2m social distancing as far as possible.
    - Comfortable furniture that is easy to clean between visits.
    - Be well ventilated
    - Appropriate route from the entrance that minimises access resident/communal areas.
    - Ideally have a one-way system from entrance to exit.
3. Visits will be on an appointment only basis and will last for a maximum of 1 hour.
4. No more than 1 visitor is allowed – over 18 years of age.
5. The plan must specify the maximum number of visits at any one time to allow for a member of staff to supervise and assist where necessary.
6. Social distancing of 2m must always be maintained.
7. PPE must always be worn.
8. Visitors will be checked to ensure they do not have symptoms – temperature, new cough or loss of sense of smell/taste.
9. There will be an agreed route for visitors to the home that avoids contact with residents and staff and minimises footfall through the home. The fire zone plans may be a useful template to designate/identify routes through the home.

Stage 4 Risk Assessment & Visiting Plan for Each Resident

A risk assessment Care-FR-114 and visiting plan Care-FR-115 will be completed for each resident

that takes account of:

1. Who does the resident wants to visit them?
2. Where the visit will take place?
3. How often they will be visited – max 1 hr visit per week for each resident at the current time, unless the visit qualifies as an essential visit?
4. What the risks are for the resident such as capacity, distress, whether they are High Risk – Extremely Clinically Vulnerable, assistance they may need?
5. When is the best time of day to fit with the resident and visitors needs and the ability of the Home to be able to support their wishes?

Where a resident wishes to leave the Care Home for a visit to the community a specific risk assessment will be completed.

Residents with capacity will be fully involved in making decisions about their visiting arrangements, the staff will provide explanation of the risks and benefits to assist with informed decision-making. Residents without capacity will have their best interests determined in line with existing rules.

As the risk of introducing the virus increases with greater contact in the community residents will asked to agree to visits away from the care home only where this is necessary to maintain their wellbeing and where virtual communications and visits within the care home are not enough to support good mental health.

Residents, or their Power of Attorney, or Representative will be asked to agree to and comply with the following:

1. Residents will not go to areas where the community is in lockdown, or there are concerns about rising numbers of cases.
2. Residents will only visit away from the care home with one other household. This is to minimise the close contacts they may have whilst away from the home.
3. All external visits will be prearranged and based on an individual risk assessment. Adequate time must be allowed for discussion and arrangements to be made.
4. Escorting relatives or friends will be asked to confirm they will comply with all relevant guidance and not expose themselves or the resident to any avoidable risk.
5. Travel arrangements must be in a private vehicle or taxi where the occupant must wear a face covering/mask as they cannot maintain 2m social distancing whilst in the vehicle.
6. If anyone involved in the visit is contacted by track and trace or has signs of the virus, the visit will be postponed.
7. Residents will be collected from and returned to the outside the home, to avoid additional contacts entering the home.
8. Residents will complete hand hygiene as they enter or leave the home and at appropriate intervals in between.
9. Residents will be checked for signs of a new cough, temperature or other significant symptoms at exit and entry to the building.
10. Residents will be provided with appropriate PPE for use while way from the home.
11. On return, Escorts will be asked to confirm whether the resident has been exposed to any possible risk of COVID.
12. On return the Resident can only bring into the home items that can be sanitised. All residents and visitors will be asked to comply with social distancing and hand hygiene.

Stage 5 Maintaining a Dynamic Risk Assessment Process

All Home Managers will be responsible for ensuring the risk assessment and plan is up to date and reflects the current circumstances for all the risk factors in and associated with the home.

The risk assessment and plan will be reviewed at least weekly and as circumstances change for the home.

The Regional Manager will monitor reviews and will sign off any updates for the risk assessment and plan.

Where there are **significant changes** to the risk assessment or plan, a copy of the revised risk assessment and plan must be singed off the Operations Director before implementation. The risk assessment will form the foundations for the plan for visiting for each home, with individual risk assessments and care plans for residents then being completed.

Visitors are only permitted to bring in food that is in the original sealed packaging that can be wiped down and which is not perishable.

Pamphlets and a Code of Conduct for Visitors have been produced to assist visitors in understanding the approach being taken to keep people safe.

In Scotland additional guidance has been issued and plans for visiting are to be signed off by the local public health team before visiting can commence.

Other rules around visiting have NOT changed at this time.

End of Life Visiting

Visiting at very end of life is a necessary part of providing the Resident with a “good death” and is vital in supporting families to come to terms with their loss.

- The Manager must ensure that the risk of increased footfall through the home is managed whilst not placing arbitrary restrictions on numbers of visitors. If there are active cases of the virus in the home the risks MUST be clearly explained to visitors and that must be recorded in the resident’s care records.
- No children under school age
- No children who are not a family member of the Resident
- No children of any age who are not able to follow the requirements of the home regarding PPE, handwashing, and social distancing.
- No one with symptoms of Covid19.
- Outer wear must be removed at the entrance to the home.
- Strict handwashing protocols must be followed.
- For those in isolation PPE must be worn throughout the visit.
- The visitor will be accompanied to the resident’s room by a member of staff and must not leave the room unaccompanied for any reason.
- Social distancing of 2 meters from staff must be respected.

Visiting will not take place during an outbreak in the home. This is to protect residents, staff and

visitors.

b. Residents wishing to leave the care home

Residents are not being prevented from leaving the home but are subject to the same restrictions as the rest of the population. Where carers are assisting residents in taking a period of exercise or fresh air outside the home, such as in the garden, they must ensure the principles of social distancing are being followed and ensure there is sufficient resource left in the home.

We are not encouraging residents to leave the care home to visit their relatives. This is due to the level of risk this poses to the resident themselves and the other residents and staff on their return.

Home Managers must ensure residents with capacity, and those with Power of Attorney for those who do not have capacity who wish to leave the care home to visit their family and friends over the Christmas period are aware of the risks this may pose to them, and the need for the resident to isolate for 14 days on their return.

We have prepared a letter to explain the process where residents wish to leave the care home to explain the risks and support the decision-making process.

Home Managers are asked to advise Lynn Fearn, Alison Boote, Heidi Davies or Helen Nethercott, by email, where residents are going out into the community during the outbreak so that the situation can be monitored.

c. Testing visitors for COVID-19

There has been much publicity over the winter months about the availability of testing for visitors to care homes.

We have been assured that testing of visitors in care homes is outside the requirements for registration where it is being undertaken in accordance with instructions from the Government – HM Government, Welsh Ministers or Scottish Government.

Initial instructions from local authorities and public health indicate they expect visitors to undertake a test before each visit; the care home will be expected to organise this and provide assistance to visitors as needed.

Testing may only commence once all part so the Testing policy Care-PR-43b can be implemented.

d. Alternatives to visiting

Some families are choosing to leave ‘goodies’ at the door to the home, this is to be encouraged but please ask them not to leave perishable items.

Some homes have implemented activities such as send a post card to send a drawing to the home from family members. This is to be encouraged as an innovative way to keep in touch. There have

been queries about whether this can transmit the virus. Transmission is unlikely. If anyone has concerns due to illness in their family at the time of making drawing etc then they should be advised not to send for 72 hours.

e. Changes to arrangements for visiting

Arrangements for visiting will be paused/changed if any of the risks identified for visiting outweighs the benefits. This will be in accordance with Government and Public Health advice and will usually be due to an outbreak in the local community, or an outbreak in the home, but there may also be other triggers that will be assessed on a case-by-case basis.

Any changes to the visiting status for each home must be signed off by the Regional Manager.

f. Visiting External Healthcare Professionals & Regulators

We have developed a policy statement to support visiting by external healthcare professionals, regulators, and commissioners.

For the duration of the pandemic, the following criteria will need to be met for permission to access the home.

- All visits need to be deemed essential.
- All visitors will have their temperature checked and recorded and asked if they have any new symptoms that may be symptoms of the virus.
- Everyone will perform hand hygiene as they enter and leave the building.
- They will always be expected to implement social distancing.
- They will always wear a mask in areas of the service where staff or residents are circulating and wear other PPE as appropriate.
- Donning and doffing of PPE and the associated hand hygiene should take place at the PPE station at the entrance to the service and not in vehicles or before they get to the service.
- Those who are visiting the service, rather than a specific resident will not be permitted to enter residents' bedrooms.
- A separate room will be allocated to regulators to allow them to review evidence and coordinate the visit.

Chiropody is an essential service to keep residents' feet healthy and comfortable.
Where there are no contra indicating factors, a chiropodist cannot be contacted to attend in a timely manner, and a suitable set of nail clippers is available, nurses or carers can trim fingernails and toenails for residents. Nails should be filed if the skin is sore or fragile.

g. Paramedics

Paramedics are expected to don their PPE prior to enter the scene of an emergency. They will therefore normally have prepared their PPE and the equipment they are likely to require for the emergency before they enter the home.

It will still be appropriate to take their temperature on entering the building, and ask them to

confirm they are not experiencing any symptoms of the virus.

When the paramedics need to take a casualty from the home to the hospital, they will remove the PPE once they have delivered the casualty to the team at A&E. As such they will not normally change PPE on leaving the home.

If they do not need to transport a casualty away from the home, then it will be appropriate for them to remove PPE on leaving the home and performing hand hygiene. This will help to keep the ambulance free from contamination.

h. Hairdressers & Beauticians

Following a risk assessment, each Home Manager can put forward a proposed plan for reintroduction of hairdressers.

Any part of the UK in 'lock down' will not be expected to have hairdresser or beauticians visiting the home.

For all other areas there must be a risk assessment and plan that includes the following:

a) Choice of hairdresser to evidence they are minimising their contacts with the community and other care homes and thereby minimising risk of introducing the virus into the home.
b) The hairdresser will have a negative test in the 7 days prior to coming into the home – accessed as an essential worker in a care home, or with the rest of the staff when they are having tests.
c) The hairdresser will have temperature test, change clothes and follow same rules as other staff working in the home.
d) Evidence that number of people with the virus in the local area is low.
e) Home free from outbreak for 28 days.
f) Preparation of an area where social distancing can be maintained as far as possible.
g) Full PPE to be worn by the hairdresser including a mask, ensuring they have completed the training for donning and doffing PPE.
h) Consideration of selection of residents based on vulnerability and need for shielding.
i) Completion of a risk assessment.
j) Submission of the plan to manage the risks.
k) To be signed off by the Regional Manager before commencement of service.

i. Visiting HCMS Staff

We have developed a policy statement and risk assessment to support visiting by internal support staff.

All support staff from HCMS visiting homes – Executive Team, Operations Directors, Quality Managers, Regional Managers, Facilities Managers, Regional Administration Team, Trainers, etc will change their clothing when entering the service and again when leaving a service.

Hand hygiene must also be performed at regular intervals and as appropriate depending on work being undertaken.

Non-surgical face masks must always be worn when in communal areas of the home. All staff must be mindful not to touch their face or the mask. If additional masks are required, please contact Ashley Groombridge.

HCMS staff that are expecting to be able to maintain a 2m distance between themselves and other staff, residents and visitors are not expected to maintain regular testing to be able to enter the home to complete their work.

In these circumstances staff are expected to comply with all the rules to prevent cross infection such as changing clothes on entering/leaving the home, wearing PPE appropriately, good hand hygiene etc.

If the staff member suspects they have been in contact with someone who has the virus in 10 days prior to planning to enter a home, they must notify their line manager without delay and complete a risk assessment to determine the appropriate course of action.

HCMS staff who cannot maintain 2m social distancing in the home will be responsible for organising their own testing and should be organised around the work plan for the week. Where a member of staff is very likely to be involved in providing care or will be less than 2m from other staff or the residents in the home testing is expected to be completed every 7 days, or in the timescales agreed locally by the Director of Public Health.

j. Contractors

Closure of the home to visitors does NOT include contractors on site to remedy or maintain anything that is required for compliance with health and safety or regulatory requirements.

Any contractor on site for essential maintenance and repairs can continue, provided the trades person is well and is maintaining a 2-metre distance from anyone in the home. No work should be carried out by trades people who have symptoms however mild. All trades people coming to the home will:

- Have their temperature checked by a member of staff. They will be asked if they have a new continuous cough. It they have a high temperature 37.8C + or new cough they will not be permitted to enter the home.
- Wash their hands before entering and leaving the main part of the home in line with all other professional visitors.
- Have a change of clothes or have a disposable protective covering for their clothes while in the home.
- If a contractor has to go into a room where the resident is classed as ‘extremely vulnerable’ and has been shielding, the contractor should wear a fresh disposable apron and gloves, which must be removed on leaving the room.
- Contractors who are within 2 metres of a resident / staff but are not touching them will only be required to wear a mask and coverall unless their risk assessment advises the need for other PPE.
- Be asked to always maintain a 2-metre distance whilst in the home.

When the contractor needs to enter parts of the home where residents may be present, the route through the home and associated work plan MUST be planned before work commences.

Where possible contractors should not go into areas where residents are present, but there may be urgent circumstances where this is required. If contractors have to visit any areas where residents are present, the following priority order of work should be followed and a plan for the visit agreed with the Home Manager or Person in Charge at the time: -

1. First - Areas where residents are extremely vulnerable and continue to shielding – because these people need protecting the most. The contractor will also need to wear apron and gloves in the vicinity as additional protection **for** the resident.
2. Then - Communal and other areas in the home.
3. Last - Areas where resents are coughing but not in isolation. Then areas where resident are in isolation. These areas are last as they could be the highest risk. The Contractor will need to wear additional PPE as protection **from** the resident. This is intended to be the last work before they leave the home and take off their PPE, therefore not posing any additional risk of cross infection to others in the home.

A risk assessment has been provided to homes to support this approach. Contractor businesses have been advised of these requirements.

k. Visits to view homes on the market.

Visits to view homes will only be by appointment and authorisation of Lynn Fearn, and the Operations Directors.

Any part of the UK with high levels of virus transmission will not normally be expected to support visits from potential purchasers to view homes on the market.

14. Caring for a person with symptoms or tested positive for COVID 19.

Any resident presenting with symptoms of COVID-19 should be promptly isolated, and where possible cared for in a single room with a separate bathroom. Contact the NHS 111 COVID-19 service for advice on assessment and testing. If further clinical assessment is advised, contact their GP. If symptoms worsen during isolation or are no better after 7 days, contact their GP for further advice around escalation and to ensure person-centred decision making is followed. For a medical emergency dial 999.

a. Capacity or Incapacity of Residents during the COVID-19 outbreak

The Scottish Government has made changes to the law for the period of the COVID 19 outbreak which can be brought into effect if required. These changes will only apply to those who do not have capacity or who may already have a certificate of incapacity, guardianship order in place.

The changes are summarised as follows:

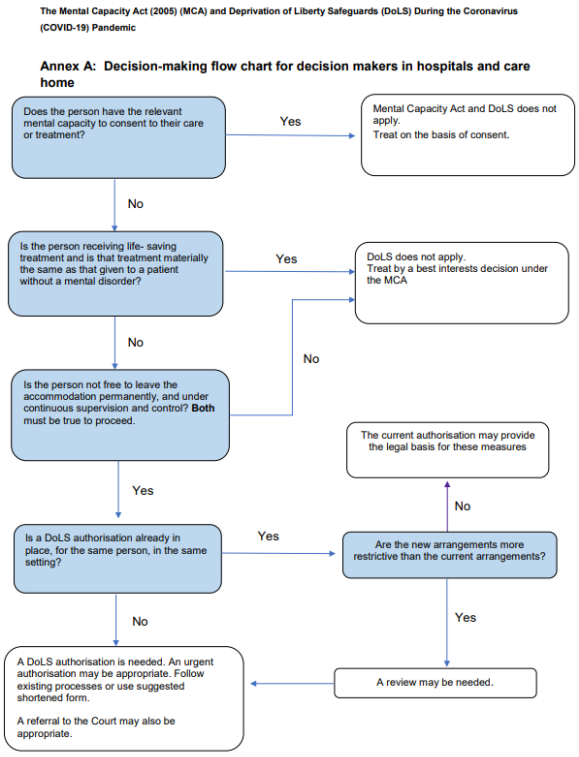
- The local authority will be able to take immediate steps to safeguard the health and welfare of vulnerable adults, which will include moving the adult from an acute hospital l ward to residential care, or other appropriate accommodation. These powers will be where there may be a deprivation of liberty in order to protect them from the risk of infection. It removes the requirement of the local authority to take into account the past and present wishes of the adult, and the views of any interested party when taking any steps to help an adult lacking capacity to benefit from a community care service which can includes residential accommodation.

- The 'clock will stop' on existing Certificates of Incapacity, Guardian Orders, and Welfare Guardianship Orders. This means they cannot expire during the COVID 19 pandemic outbreak. Once the COVID 19 Pandemic is over the 'clock' will recommence and they will be run the remaining timeframe to expiry.

  https://www.gov.scot/publications/coronavirus-covid-19-adults-with-incapacity-guidance/

The Department of Health & Social Care has issued guidance for Hospitals, Care Homes and supervisory bodies regarding deprivation of liberty during the COVID19 pandemic.

The key message from the guidance is that where lifesaving treatment is being provided, including for the treatment of COVID-19, then the resident will not be deprived of their liberty as long as the treatment is the same as would normally be given to any person without a mental disorder. The DoLS will therefore not apply.



https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878910/Emergency_MCA_DoLS_Guidance_COVID19.pdf

It may be necessary, for several reasons to change the usual care and treatment for somebody who lacks the relevant capacity to consent to such changes. In most cases the changes to a person's care or treatment in these scenarios will not constitute a new deprivation and a DoLS authorisation will not be required. Care and treatment should continue to be provided in the person's best interests.

CQC report they will continue to consider whether there are risks to deprivation of liberty when deciding whether to visit or inspect. Home Managers must continue to assess whether deprivations of liberty are occurring and make referrals as necessary. Where a DOLS authorisation is already in place, they would not normally expect an additional application to be made for management of the COVID 19 virus.

b. Monitoring of vital signs and for symptoms of the virus

All residents will have a minimum of a twice daily check to be able to identify any changes in temperature, oxygen saturation levels and their physical health or development of symptoms of the virus in a timely manner.

As minimum the daily check will include:

Twice Daily	Temperature check Pulse Signs of coughing or shortness of breath Oxygen saturation levels – to monitor for changes Assessment of level of alertness New loss of sense of smell or taste
Once Daily	Blood pressure – unless a healthcare professional has requested more frequent monitoring.

This means a full NEWS check will only be recorded once per day. This is because regular twice daily testing of blood pressure has at times caused sensitivity and some bruising, particularly for those who are most frail.

The observations taken once a day should still be recorded on the NEWS record chart to make it easier to monitor for any changes.

Home Managers must ensure scoring is completed correctly and appropriate action taken dependent on the score or instructions from the relevant health care professional.

Homes should have NEWS kits available on a ratio of 1 kit to every 10 registered beds (rounded up), unless the occupancy at the home is significantly under the expected occupancy, then the

number of kits should be based on actual occupancy of residents (rounded up).

Plans are underway so that additional kits will be able to be ordered from Monday 7th September. Orders should be placed through the usual ordering route.

NEWS is important to be able to identify deterioration or possible sepsis., so the frequency of completion will depend upon the previous readings and their general level of illness. Where a resident is clinically unwell with an infection and there is the risk of sepsis NEWS scores should be completed in line with the correct actions from the previous NEWS score, which could be hourly.

The same method / type of equipment should be used for each resident. The record of temperature must show the method/location used to take the temperature, as this may account for variations if they occur.

DO NOT take readings by placing thermometers in the resident's mouths or using glass mercury thermometers.

The symptom of the virus is either –

- Fever – 37.8°C+ NB this will not be the main symptom for people where a pre-existing condition such as a spinal injury prevent their body from developing a temperature to fight infection.
- New persistent / continuous cough, difficulty in breathing.

Resident should be encouraged to breathe deeply and cough where it is appropriate for them. Where appropriate windows should be opened to allow fresh air into the room, to allow for exchanges of air in the room.

DO NOT USE FANS in the room of a person with symptoms as this circulates any droplets that may be in the air.

The door to the room should be kept closed to prevent the virus in the air from drifting into the corridor. If this is likely to cause distress, the rooms must be arranged so that the chair or bed is appropriately distanced from the door and the door left open.

Where possible ensure there is a good view from the window which can be seen from where the resident is laying or seated.

The resident must be isolated in their room, and the number of staff entering limited to the minimum possible.

Barrier nursing must be implemented using PPE as described in the PPE section of this guidance. Aprons, gloves and fluid repellent surgical masks should be used in these situations. If there is a risk of splashing, then eye protection will minimise risk.

The stores of clean and used PPE should be kept separate and ideally be located at the doorway for the room. Where this is not possible due to the circumstances around layout or the residents the equipment should be placed as close to the room as practically possible.

Implement barrier nursing. Staff should use personal protective equipment (PPE) for activities that

bring them into close personal contact, such as washing and bathing, personal hygiene and contact with bodily fluids.

Contact the local Health Protection Team for advice on management or if short of any equipment.

Follow the guidance for care homes – https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-on-residential-care- provision

The Regulator will need to be notified. Scotland and England have issued the following guidance. Wales has not yet issued any guidance about notifications during the virus outbreak period.

Waste should continue to be collected and managed as usual. Where a person has symptoms of the virus, the tissues, continence pads and all waste products should be placed in an orange bag.

c. Mouth Care for a person with COVID - 19

Scotland have issued guidance for mouth care under their Caring for Smiles initiative. This information may be helpful to all homes.

It is important that day to day mouth care should continue to ensure good oral health.
There may be anxiety about splashes, but wearing PPE will help carers continue to maintain the everyday health and care of the people they look after.
Mouth care is part of everyday personal care and should be undertaken at the same time.
PPE for delivering mouth care to residents

- Single use disposable apron
- Single use disposable gloves
- Fluid resistant face mask
- Eye/face protection

Further information on PPE for care home settings can be found in Section 5 of this guidance and online through the links provided.

It is possible that some residents living with dementia might find PPE confusing or it may make them anxious. In that case, be patient and respectful, and try to find out what might help the resident to feel more comfortable.

Encourage continued independence for residents who are able to undertake their own mouth care. Prompt and support if required.
Mouth care should continue as detailed in the Caring for Smiles Guide for Care Homes and the resident's care plan.

- A small headed toothbrush and toothpaste can be used for natural teeth.
- Dentures should be removed and cleaned.
- Soft tissues should be cleaned using a piece of wet, non-fraying gauze over a gloved finger.
- Manual toothbrushes would be preferable at this time to minimise droplets.

End of life mouth care

- In the event that a resident reaches the end stages of life, keeping their mouth moist and comfortable is the main aim of mouth care.
- Continue to carry out mouth care if it is not causing distress
- If the resident has a dry mouth, hydrate with a toothbrush dipped in water or apply a dry mouth product to the tongue, inside of cheeks and roof of mouth.
- Keep the resident's lips moist with water-based gels.

If you have a concern about a resident's mouth and need advice from a dentist, please contact the dentist that they are registered with in the first instance.
If a resident does not have a dentist, please contact the dental helpline for your local area.

For out of hours dental emergencies please call NHS 24, NHS Direct or NHS 111.

15. Waste

Investigation of previous outbreaks of the virus have identified the transfer of waste as a potential source of cross infections.

Prior to collection of waste bags and when handling and transporting waste to the external waste bins, the following PPE must be worn:

- Vinyl gloves
- Apron.

The gloves and apron will be removed prior to re-entering the building and disposed of in an appropriate bin, and hand hygiene will be undertaken.

All waste belonging to an individual, or PPE from caring for an individual in isolation or affected by the virus, should be placed in an orange bag and disposed of immediately as clinical waste – for incineration. There is no need to hold waste in orange bags for 72 hours. There is no need to double bag orange bags as this will waste them.

Waste from Lateral Flow Device testing will be placed in clear bags and disposed in general waste. It does not need to be placed in clinical waste bags, but the waste handlers need to be able to see the contents of the bag to process the waste correctly. Clear waste bags can be ordered from Blue Leaf on Care Blox.

Orange bags or designated bins are available by contacting
ashley.groombridge@hcsolutions.co.uk

Management of healthcare waste from care home settings.

Please note that some of the normal waste management practices are adapted to support suitable management of COVID-19 waste. These adaptions are recognised by Defra, and the Environment Agency and have been developed in conjunction with Public Health and it is important that non-healthcare waste e.g., recycling, domestic type waste, packaging etc. must

continue to be handled and managed as normal.

Current guidance for disposal of waste from LFD testing is that it should be in a clear plastic bag which is quarantined for 72 hours and then disposed of in the usual wate for the home.
Bags will need to be labelled and records kept for bags to evidence the date they commenced and left quarantine.

Description of Waste	Requirement	Note
Personal contact waste (including PPE) from routine care (of all residents) e.g. performing meal rounds, medication rounds, prompting people to take their medicines, or cleaning close to residents, assisting with getting in/out of bed, feeding, dressing, bathing, grooming, toileting, applying dressings etc.	Place in the usual "tiger bag" – a yellow bag with a black stripe. Secure with swan neck and zip tie or tape and store safely or see note.  Dispose of as per usual arrangements.	Where you do not have an 'offensive waste' stream, 'black bags' for residual waste disposal can be used.
Offensive Waste – Waste contaminated with body fluids from all residents e.g., bodily fluids, incontinence waste, stoma bags etc.	Place in the usual "tiger bag" – a yellow bag with a black stripe. Secure with swan neck and zip tie or tape and store safely.  Dispose of as per usual arrangements.	Where possible urine and faeces collected in vessels/mobile toilets shall be flushed to sewer. Where macerators are routinely used, their use may be continued
Where a resident is suspected of or confirmed as having COVID-19 and you can securely store for at least 72hrs for the specified wastes below: **Respiratory Intervention waste**: Suction catheters and other waste contaminated with respiratory secretions generated from the care of residents with a tracheostomy or long-term ventilation. **Personal contact waste**: Used tissues, and other soiled items, discarded PPE and	Place in the usual "tiger bag" – a yellow bag with a black stripe. Secure with swan neck and zip tie or tape and store safely. This should be securely stored for at least 72 hours before being put in your usual collected waste bin and disposed of as per usual arrangements. If this is not possible please follow guidance below.	If using this option, you must have clear and clearly displayed procedures to ensure good segregation from other tiger bag waste detailed in this table. You should maintain written records to demonstrate the waste has been

disposable cleaning cloths.		held for 72hrs.
Where a resident is suspected of or confirmed as having COVID-19 and you **cannot** securely store for at least 72hrs for the specified wastes below: **Respiratory Intervention waste**: Suction catheters and other waste contaminated with respiratory secretions generated from the care of residents with a tracheostomy or long-term ventilation. **Personal contact waste**: Used tissues, and other soiled items, discarded PPE and disposable cleaning cloths.	Place in an orange bag. Secure with swan neck and zip tie or tape and store safely.  Dispose of as infectious clinical Waste, for incineration.	
Other Clinical Waste Associated with treatment of individuals – this may include other infectious waste from other treatments, sharps, pharmaceuticals.	This waste requires require specialist disposal and should be managed in line with the advice given in Health Technical Memorandum. 07-01: Safe management of healthcare waste. See link below 	Your clinical waste contractor should be able to give you advice and help you get this right.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/167976/HTM_07-01_Final.pdf

a. Basic Life Support for a person with COVID – 19

Government guidance (section 8.1) states that chest compressions and defibrillation are NOT considered Aerosol Generating Procedures.

Any first responders can commence chest compressions and defibrillation (if trained) without the need for AGP PPE while waiting for the arrival of other clinicians / paramedics to undertake airway manoeuvres. On arrival of the team, the person giving basic life support should leave the scene before any airway procedures are carried out and only return of needed and if wearing AGP PPE.

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/updates-to-the-infection-prevention-and-control-guidance-for-covid-19

On 7th August 2020, the Government body NERVTAG (New and Emerging Respiratory Virus Threats Advisory Group) issued a statement following a review of the evidence of cardiopulmonary resuscitation as an aerosol generating procedure (AGP).

In conclusion NERVTAG stated that it "does not consider that the evidence supports chest compressions or defibrillation being procedures that are associated with a significantly increased risk of transmission of acute respiratory infections." As such it should not be added to the list of aerosol generating procedures.

16. Regulators

a. CQC, CI & CIW

Regulators are gradually reintroducing inspections; these are generally with a focus on the arrangements and staff practice for infection control.

All homes should be ready for inspections and have their COVID file up to date.

Decisions made by Registered Managers to implement a process or to not omit something that would normally be expected should:

- document the decision,
- their rationale for the decision,
- alternatives they have considered,
- complete a risk assessment to support their decision, and
- store this in the COVID file.

Care Inspectorate in Scotland are focussing on a new Key Question 7 which focusses on the arrangements in place to manage the pandemic and keep people safe.

CQC have reported inspections are due to recommence in September with a strong focus in infection control processes. Services that were rated Inadequate or subject to enforcement proceeding prior to the commencement of the pandemic have been prioritised for inspection.

Care Inspectorate Wales have been contacting homes on a 2 weekly and are working jointly with Public Health Wales, Commissioners and Environmental Health to conduct visits to homes to monitor how well they are coping in the COVID crisis.

Each home must have a Covid-19 evidence folder, we have provided a contents index for guidance. We will also produce an ESF call reporting template so that you can easily make notes of the discussions and agreed actions from each call. A copy of this will need to be kept in your Covid-19 folder and copied to your RM and OD.

b. Notifications

It is important to maintain notification to regulators during the pandemic.

Key notifications to Regulators are:

- End of outbreak notification - The end of the COVID-19 outbreak in your service is when there has not been a new person who experiences care with symptoms for 14 days.
- Staffing Absences/Shortages – To report about staff who are not able to work due to the virus. This may be due to self-isolating, in hospital, shielding and those who are not working due to stress related to COVID-19.
- Death of a staff member - this notification to be completed as soon as the service is made aware.

c. HSE – RIDDOR

You must only make a report under RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) when:

- an unintended incident at work has led to someone's possible or actual exposure to coronavirus. This must be reported as a dangerous occurrence.
- a worker has been diagnosed as having COVID 19 and there is reasonable evidence that it was caused by exposure at work. This must be reported as a case of disease.
- a worker dies as a result of occupational exposure to coronavirus.

What to report

Dangerous occurrences

If something happens at work which results in (or could result in) the release or escape of coronavirus you must report this as a dangerous occurrence. An example of a dangerous occurrence would be a lab worker accidentally smashing a glass vial containing coronavirus, leading to people being exposed.

Cases of disease: exposure to a biological agent

If there is reasonable evidence that someone diagnosed with COVID-19 was likely exposed because of their work you must report this as an exposure to a biological agent using the case of disease report. An example of a work-related exposure to coronavirus would be a health care professional who is diagnosed with COVID-19 after treating patients with COVID-19.

Where a member of staff has tested positive for the virus and they have been working with residents who have tested positive for the virus – then a RIDDOR report for Exposure to a biological agent needs to be made.

Canterbury Homes MUST ensure the insurers are notified of any RIDDOR notifications.

https://notifications.hse.gov.uk/riddorforms/Disease

Work related fatalities

If a worker dies as a result of exposure to coronavirus from their work and this is confirmed as the likely cause of death by a registered medical practitioner, then you must report this as a death due to exposure to a biological agent using the 'case of disease' report form.

You must report workplace fatalities to HSE by the quickest practicable means without delay and send a report of that fatality within 10 days of the incident.

This will be employees that have tested positive and this will be referred to as a cause of death on the death certificate.

For further information and links to online reporting go to:

https://www.hse.gov.uk/news/riddor-reporting-coronavirus.htm

17. Press & Media

Several homes have been contacted by the media. Homes must not agree to hold interviews, invite cameras, or interviewers to discuss the business.

Tony Stein is the only person who will conduct interviews on behalf of the Homes / Companies. The instructions below MUST be followed where there are any enquiries from the press or media. Please make staff aware that at times the media are not always honest about their identity when they make contact.

Homes should advise the Regional Manager as soon as they receive any queries or contact from the Press. Members of the Press should be asked to leave the premises if they have entered the grounds or home. 'No comment' should be made in response to any question they make ask at that time.

Any contact or queries from the Press must be directed through Recognition PR whose contact telephone number is 01325 363436.

During office hours the homes need to ask for either Caroline or Rosie from the crisis team. Out of hours the number will divert to an on-call member of the team. They will take all of the details and pass onto Caroline or Rosie if immediate action is required.

18. When a person dies

a. Advance care planning and wishes

Documentation to capture wishes and expectations for end of life. This was issued as part of policy of the month for May 2020 – End of Life.

Home Managers must ensure DNACPRs, plans for end of life or admission to hospital are based on the individual needs/ wishes of residents and not blanket instructions for a group of residents.

Any pressure to implement blanket rules for these circumstances must be escalated to the COVID

Action Team.

b. Verification or confirmation of death

Nurses who were previously trained or who have undertaken recent training and completed competency assessment should continue to verify death. Nurses who have not yet been assessed as competent to verify deaths should ensure they update their skills and knowledge to be able to undertake this clinical procedure safely and competently.

On 5th May 2020 new guidance was issued on verification of death.

https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verifying-death-in-times-of-emergency

This new guidance states medical practitioners, registered nurses or paramedics may verify death, in line with policies and competency assessments.

Confirmation of death by others must be in conjunction with remote clinical support. Non- medical professional should not experience any pressure to verify deaths if they are not comfortable or equipped to take part in the verification they should defer to medical colleagues or refer to NHS 111, the GP or another provider of primary medical services.

Where a death occurs during core practice hours – the deceased persons registered general practice must be notified.

Outside core practice hours, call NHS 111 or the Integrated urgent Care Clinical Assessment Service (IUC CAS) where a clinician will provide remote clinical support to work through the verification/confirmation process.

In order to assist with verification/confirmation of death with remote clinical support the following equipment must be available.

- Pen torch or mobile phone torch
- Stethoscope (optional)
- Watch or digital time (can be on phone)
- Appropriate PPE – gloves, apron, fluid repellent surgical face mask.

The clinician must check

- Check that you have enough time to carry out this procedure in a compassionate manner
- Record the steps below in their organisation's host IT system
- Be aware of any cultural or religious requirements
- Identify the person verifying and their role
- Ensure the verifier has considered privacy and dignity prior to verifying – such as ensuring only essential persons are in attendance or checking with family whether they wish for only persons of the same sex to verify the body
- Establish the circumstances immediately prior to the death and any patient history. You, and the verifier, need to be satisfied that there is no reason to refer this death to the police or coroner

Key questions the clinician must ask:

- Is this an unexpected death? If yes, report to coroner
- Is there any sign of a suspicious death? If yes, report to police
- Have you established the identity of the deceased person, for example using photo ID?

The clinician will then as the verifier to complete the following checks:

Neurological system

- Check pupils are dilated and fixed (unresponsive to light directed into both eyes using a torch).
- Check there is no response to painful stimuli. If you squeeze the muscle between the neck and the shoulder (the trapezius), do they respond?

Respiratory system

- Check that there is no movement of the chest wall for 3 minutes by observing the chest (you may need to advise removal of clothing to expose the chest or abdomen).

Circulatory system

- Advise verifier to find the site of the carotid pulse and check for 1 minute that pulse is absent.
- This must be reassessed and confirmed. The verifier will be asked to wait 10 minutes and repeat the actions above.

Other information to record

- Full name, date of birth, address and NHS number (if available) of person whose death is being verified
- Name of person verifying
- Role of person verifying
- Who is present?
- Circumstances of death (location, who first noted it, anyone present at the time of death)
- Outcome of verification, including time of death
- Any discussions with staff or relatives
- Any concerns from staff or relatives

The Clinician must confirm the Identity of the deceased person.
For the purpose of confirming the identity of the deceased, it is recommended that an appropriate identity document is provided to the remote verifier, for example via the video call or separate secure email.

Following verification
Be clear about removal from the deceased or safe keeping of items such as jewellery. Inform the key person(s) of the next steps in the process and the range of options available to them.

We will provide a form for use in the homes so that a record of information collected at the time of verification can be recorded and kept with the care record.

c. Care of the body

Those handling bodies should be aware that there is likely to be a continuing risk of infection from the body fluids and tissues of cases where coronavirus (SARS-CoV2) infection is identified, through either a clinical diagnosis or laboratory confirmation.

The usual principles of Standard Infection Control Precautions (SICPs) and Transmission-Based Precautions (TBPs) apply for bodies that are suspected or confirmed to be infected with coronavirus (SARS-CoV2). This means that gloves, aprons, masks and eye protection (fi splashes are expected) should be worn, when handling the body of deceased person who had symptoms of the virus or was being isolated.

If a resident dies of suspected coronavirus (COVID-19) in a residential care setting:

- ensure that all residents maintain a distance of at least 2 metres (3 steps) or are in another room from the deceased person,
- avoid all non-essential staff contact with the deceased person to minimise risk of exposure.
- If a member of staff does need to provide care for the deceased person, this should be kept to a minimum and correct PPE used as set out in the guidance on residential care provision (gloves, apron and fluid resistant surgical mask), see How to Work Safely in Care Homes.
- you should follow the usual processes for dealing with a death in your setting, ensuring that infection prevention and control measures are implemented as set out in the guidance on residential care provision.

Personal waste (for example, used tissues, continence pads and other items soiled with bodily fluids) and disposable cleaning cloths can be stored securely within disposable rubbish bags, as set out in the guidance on cleaning in non-healthcare settings.

The bags containing waste from the rooms of people in isolation should now be treated as potentially infectious clinical waste (Category B) and be placed in an orange bag to go in the rigid yellow waste container for incineration.

Staff in residential care settings are requested to inform those who are handling the deceased when a death is suspected or confirmed to be COVID-19 related as required. This information will inform management of the infection risk.

Dirty laundry should not be shaken out to minimise the possibility of dispersing virus through the air.

https://www.gov.uk/government/publications/covid-19-guidance-for-care-of-the-deceased/guidance-for-care-of-the-deceased-with-suspected-or-confirmed-coronavirus-covid-19

d. Referral to the Coroner or Procurator Fiscal

COVID-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009.

Home Managers should be aware that it may be appropriate to make a referral to the Coroner where access to services have not been available – such as refusal to admit to admit or transfer to hospital, and this has contributed to the death of a resident. They should also be aware that others may refer a death to the Coroner where there is a belief that a service has not appropriately managed an outbreak or failure to prevent an outbreak leading to death(s).

The fact that COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 means the Health Protection Team must be notified and does not mean referral to a coroner is required by virtue of its notifiable status.

In Scotland, any death meeting the following conditions must be reported to the Procurator Fiscal under section 3(g) of the Reporting of Deaths to the Procurator Fiscal guidance:

1. Where the deceased was resident in a care home when the virus was contracted
2. Where to the best of the certifying doctor's knowledge, there are reasonable grounds to suspect that the deceased may have contracted the virus in the course of their employment or occupation.

e. Death certificates

Guidance has been issued to Doctors which extends the period during which an attending medical practitioner completing a Medical Certificate of Cause of Death (MCCD) must have seen the deceased before death (the 'last seen alive' requirement) from 14 days to 28 days before death. 'Seen' in this context includes consultation using video technology. However, it does not include consultation by telephone/audio only.

f. Relatives welfare

If someone dies of coronavirus or complications resulting from the virus, a number of things may be particularly hard for family and friends to deal with.

Infection controls may mean that family members do not have an opportunity to spend time with someone who is dying, or to say goodbye in person.

Depending on the person, the illness may have progressed and become serious very quickly, which can lead to feelings of shock. If they were not able to be present for the death and cannot view the body, it may be difficult to accept the reality of a bereavement.

At times of considerable trauma, people tend to look for certainty. However, at the moment, that certainty is not there. This can amplify any feelings of angst and distress.

Bereaved people may be exposed to stories in the media which highlight the traumatic nature of death in these circumstances. Where services become stretched, friends or family may also have concerns about the care the person received before they died. This in turn can lead to feelings of anger and guilt. This may lead them to behave or say things they would not normally do.

Try to listen and understand their circumstances and refer to your Manager if you do not feel able to handle a situation.

On 23 April 2020, the Government issued a new guidance booklet for families 'Support for the Bereaved'. The booklet explains changes for registering deaths and arranging funerals and provides links to information on financial support.

https://www.gov.uk/government/publications/support-for-the-bereaved

In Scotland the Scottish Social Services Council SSSC have produced a new resource to support care providers. See link for details.

https://learn.sssc.uk.com/coronavirus/dying/

g. Staff welfare

During a pandemic, members of staff are likely to see increased numbers of deaths of residents, but they may also experience bereavement of friends, family and even colleagues.

Staff can also contact organisations such as Cruse for advice on the next steps when they are bereaved.

Cruse National Freephone Helpline is available - call 0808 808 1677. Opening hours are Monday-Friday 9.30-5pm (excluding bank holidays), with extended hours on Tuesday, Wednesday and Thursday evenings, when we are open until 8pm. Or online https://www.cruse.org.uk/get-help/about-grief

19. Record Keeping in the Home

All homes will maintain a COVID File in which they keep a copy of:

- HCMS guidance - FAQs
- Daily Managers' report & resulting actions
- Risk assessments
- Evidence of ways in which social isolation has been reduced
- Evidence of ways in which physical activity has been promoted to retain muscle tone and physical health.
- Records of key decisions made during the pandemic, such as:
    - Decisions to move residents
    - Decisions to vary staffing levels
- Audits completed during the pandemic
- Records of training – infection control, use of PPE, donning and doffing PPE
- Records of increased cleaning and records of checks
- Records of increased laundry to launder staff uniforms
- Extra purchase of uniforms
- Isolation log staff and residents
- Copies of 'Hot Spot' investigation reports
- Flash daily meetings
- Staff communications

- Relatives or residents' communications
- Temperature checks for staff and visitors
- Staff posters
- Any communication from Regulators, Public Health, Commissioners or Government
- Record of testing staff and residents
- Feedback from visits
- Gifts or donations

Regional Managers will monitor the COVID File to ensure it provides a comprehensive record of practice and decisions during the pandemic. They may request scanned copies of evidence if they are not present in the home.

20. Staff

a. Compliance with rules

All employees are expected to keep themselves updated for the rules and restrictions to prevent the spread of the virus in their home and work areas.

HCMS as a responsible employer expects ALL employees and any person acting on their behalf to comply with the rules as directed by the Government, Directors of Public Health at all times.

Failure to do so will be considered Gross Misconduct and subject to summary dismissal.

b. Social Media

Social media groups such as WhatsApp have been popular with homes as an aid to communication with staff groups and visitors.

Home Managers must ensure they contain the consent of individuals **BEFORE** they add them to groups or share contact details to avoid breach of confidentiality or data protections.

c. Annual leave

We allowed accrued annual leave that could not be taken in 2020 leave year to be carried forward to this year up to a maximum of 5 days. Staff are expected to take leave where possible and staffing in the service allows. It has been a difficult and stressful 12 months; the main reason to encourage staff to take leave as the opportunity arises is in recognition of the importance of leave to maintain their physical and mental wellbeing.

Staff who are on furlough leave will be expected to take leave proportionate to how much of the leave year is left when they exit furlough. This is so that leave has not accumulated at the end of the year which may prevent staff who have worked through the pandemic from taking their leave.

Anyone who is self-isolating in accordance with guidance issued by the Government will continue to accrue their annual leave. Where a member of staff requests annual leave to be taken whilst they are self-isolating this should be approved if it appears appropriate and they will be paid

accordingly.

We are reviewing the guidance from the Government about carry over of leave and will provide an update to you in updates of this guidance.

All cases of self-isolation must still be reported to HR so that we can track the progress of the virus through homes and areas and make appropriate decisions.

d. Travel and annual leave

Home Managers and staff should check the list at the time of applying for, and prior to taking leave for the most up to date instructions. Home Managers approving leave must be aware that rules can change at short notice and new quarantine requirements may be imposed while a person is out of the country.

The Government website should always be consulted for the most up to date information.

https://www.gov.uk/guidance/coronavirus-covid-19-countries-and-territories-exempt-from-advice-against-all-but-essential-international-travel

It is expected members of staff will declare they intend to travel abroad when they apply for their leave. If staff intend to travel abroad, they should make this known to the Manager at the earliest opportunity.

It is Company policy that staff who choose travel whilst these restrictions are in place, will not be paid during the self-isolation period. By agreement with the Home Manager, they may take a combination of annual leave and unpaid leave to cover this period.

It is the responsibility of the Home Manager to consider whether they can approve the amount of absence requested and can safely cover the leave period and self-isolation period.

The maximum amount of annual leave that can be taken will be that as accrued in the year to date.

Any member of staff that travels abroad and does not comply with the requirements for self-isolation prescribed by the Government at that time, will be considered to have committed Gross Misconduct and relevant procedures will be implemented without delay.

Staff should be made aware that when members of their household travel abroad and are required to isolate on return, the rest of the household will also have to isolate for 10 days, or 10 days from start of symptoms/positive test, whichever is later. It is Company policy that this isolation period will not be paid, however they may take leave during this period if they have any due to them.

e. Sick Notes and Isolation Notes

Anyone can obtain an isolation note from the NHS website to provide to your employer.

https://111.nhs.uk/isolation-note/

if a member of staff has symptoms and is isolating, they are expected to obtain a PCR COVID-19 test without delay to continue to be paid during their isolation period.

The sick note or isolation note is provided by email and this should be forwarded to your Manager or Head of Department.

f. Workforce Risk Assessment

A workforce risk assessment has been developed for all HCMS staff and staff working in HCMS managed services. Each member of staff will complete the risk assessment and then discuss the results with their Line Manager or the Home Manager.

This has been completed for all staff in work and those returning to work after shielding or furlough. The risk assessment assists in determining the level of risk to all staff due to conditions that may increase the risk to their health if they were to have the virus. Line Managers will agree with staff any arrangements or alterations that may be necessary to minimise risk.

Home Managers will keep the workforce risk assessments for their staff teams under review.

g. Minimising staff movement

Information about staff with employment in addition to our homes has been gathered from all Home Managers.

Risk assessments will be completed for each staff member to assess the level of risk posed by their additional employment; decisions as a result of the risk assessment will be on a case-by-case basis.

Where possible staff will be offered equivalent hours and pay within the home to reduce the need for movement between other work environments where there is an increase the risk of introducing the COVID -19 virus into the home. This will be for a specified time period only and linked to the ability of the home to claim additional costs back from the Infection Control Fund.

Members of staff who continue with additional employment will ensure Infection Control Training is up to date and regular observations of competencies for use of PPE will be implemented.

h. Capacity Tracker (England)

Home Managers are responsible for ensuring the Capacity Tracker is updated daily. Any reimbursement of additional costs that are available from central government are dependent upon completion for the tracker.

It is vitally important that Home Managers have contingency arrangements in place for completion of the tracker as this is required to be eligible for money from the Infection Control Fund. In some

areas there may be and NHS and a Local Authority Capacity Tracker it is important that both of these are completed.

The Home Manager must ensure there are delegated persons in the home to complete the tracker when they are on days off, annual leave or if they are not available for any other reason e.g., emergency sick leave.

i. Government Payments for Health and Social Care Staff

The Scottish Government has announced a £500 payment for care home staff who worked a minimum of one month between 17 March and 30 November 2020.

The Welsh Government Has announced a £500 payment for care home staff who worked between 15 March and 31 May 2020.

Part time staff will be paid a proportion of £500 depending on their hours of employment. Payments will be made to employers to be included in staff pay.

j. Pay & Furlough

Guidance from central Government has been issued to help with the most appropriate way to financially support staff at this time and as the crisis develops. We will always comply with our legal obligations and wherever possible we will seek to find ways of going beyond this without compromising the overall term financial viability of the business.

The table below shows the Company's approved position for remuneration of staff in the various circumstances they find themselves.

Remuneration Guide COVID19

Updated 21.01.21 (England, Scotland & Wales)

All employees in all homes managed by HCMS and all HCMS employees will be covered by the following arrangements:

Category	Pay
Employees self-isolating for 10 days because they have COVID19 symptoms	Employees will receive full pay. This will be in place until March 2021.
Employees self-isolating for 10 days because someone in their household is displaying COVID19 symptoms or has a positive COVID test by PCR.	Employees will receive full pay. This will be in place until March 2021.
Employees self-isolating for 14 days from first positive PCR test result because they have received hospital treatment for COVID.	Employees will receive full pay. This will be in place until March 2021. If staff need to be off longer than 14 days each case will be assessed separately as to whether full pay will continue.
Employees who are off longer than 10 days following isolation for being symptomatic or positive for COVID	Statutory Sick Pay to be paid "Fit note" to be submitted by employee
Employees not at work who are displaying symptoms and awaiting a test	Employees will receive full pay. This will be in place until March 2021
Employees who have received the vaccine and are feeling unwell afterwards	To be paid full pay up to 48 hours
Employees with a child sent home from school because they are part of a bubble but are not displaying symptoms. The employee cannot attend work because they do not have any child care for their child during the isolation period.	Employees will receive full pay. This will be in place until March 2021. Evidence from the school will need to be provided to be eligible for full pay.
Employees who test positive and have to isolate for 10 days and their child has to self-isolate for 10 days.	Employees will receive full pay. This will be in place until March 2021. Positive test for staff member will be evidence.
Employees who are extremely clinically vulnerable and have been advised not to attend work for a period of time because of local tier/level system restrictions/national lockdown. Formal notification will be required to be provided from NHS or GP/Consultant	Employees will be entered onto the Furlough system and will receive 80% (up to £2,500 per month). This is will be reviewed in line with tier/national lockdown restriction reviews. This is likely to affect areas (but not in all cases) where the tier or level is 3 or above

Employees who have an extremely clinically vulnerable child and have been advised not to attend school for the period of time because of local restrictions/national lockdown and are unable to work due to looking after the child. Formal notification will be required to be provided from NHS or GP/Consultant	Employees will be entered onto the Furlough system and will receive 80% (up to £2,500 per month). This is will be reviewed in line with tier restriction reviews. This is likely to affect areas (but not in all cases) where the tier or level is 3 or above
Employees who do not have childcare because their child's school is closed	Employees may be entered onto the Furlough system and will receive 80% (up to £2,500 per month). This is will be reviewed in line with tier /national lockdown restriction reviews. Evidence that places are not available at school to be used as evidence
Employees who have an extremely clinically vulnerable family member living in the same household	Employees may be entered onto the Furlough system and will receive 80% (up to £2,500 per month). This is will be reviewed in line with tier restriction/national lockdown reviews. Evidence of letter for family member to be used as evidence
Employees who receive a "fit note" from their GP/Consultant	Statutory Sick Pay
Employees who have to self-isolate for 7 or 14 days due to having an operation or has to self-isolate for 7 or 14 days because a family member is having an operation	Employees will receive full pay. To be eligible, a letter from the hospital confirming the isolation period will need to be shown to the Home Manager
Employees less than 28 weeks pregnant A full risk assessment will be conducted to establish if reasonable adjustments are possible to allow them to remain in the workplace. Where this is not possible or the employee or their midwife/consultant has reason to believe that they and their unborn child are at risk	Employees will be entered onto the Furlough system and will receive 80% (up to £2,500 per month). The remaining 20% will be paid by the employer as a top up MATB1 form or letter from GP/Consultant would be used as evidence of pregnancy
Employees more than 28 weeks pregnant are at a higher risk of becoming seriously ill if they contract Covid-19 A full risk assessment will be conducted. To establish if reasonable adjustments are possible to allow them to remain in the work	Employees will be entered onto the Furlough system and will receive 80% (up to £2,500 per month). The remaining 20% will be paid by the employer as a top up MATB1 form or letter from GP/Consultant would be used as evidence of pregnancy

place. Where this is not possible or the employee or their midwife/consultant has reason to believe that they and their unborn child are at risk	This provision will be until maternity leave commences at 36 weeks or before
Employees returning from a country which requires them to self-isolate for 10 days and provide proof of a negative test.	All employees are encouraged not to travel during the national lockdown restrictions. If employees do have to travel, they are encouraged to inform their managers if they travelling abroad and where they are travelling to. Anyone who is required to self-isolate and provide a negative test on return to the UK will not be paid. There may be the opportunity to take annual leave that has been accrued but this must be authorised by the Home Manager.
Employees who have a household member returning from a country which requires them to self-isolate for 10 days	Employees will not be paid. There may be the opportunity to take annual leave that has been accrued but this must be authorised by the Home Manager.
Employees who have the COVID vaccination in their own time	1.5 hours will be paid. Normal pay will be paid if the COVID vaccine is done during work time
Employees who choose to self- isolate for any other reason than those listed above will not receive any payment for the duration of their absence.	Unpaid

Evidence

Employees will be asked to provide a self-isolation note or correspondence from the school for the period they are self-isolating for payroll purposes.

Track and trace

For employees that will be self-isolating after being contacted through track and trace will receive notification either via a text message or email from the contact tracers. The notification should be given to the home manager for payroll purposes.

Non-Contractual

The payments for the period of isolation are non-contractual and is a discretionary payment. Any changes to the fund or confirmation that funding will cease will be communicated to employees. Once funding has ceased usual SSP payments will apply.

Review

The Company will keep the available funding under review and will conduct a 2-weekly review.

Communication
The updated remuneration guide will be communicated to the GMB, Unison and RCN Unions.

The Company hopes that by paying full pay during these difficult times, it will help relieve any financial difficulties staff may have encountered.

21. Staff skills and training

a. Training

Wherever possible training updates should be online or by video link, especially when employees are overdue to complete training. Training can also be completed by virtual classes.

Where there is an urgent requirement, Fire Evacuation, Moving & Handling Practical & Basic Life Support Practical Training to be completed face to face. Other urgent face to face courses to be completed where needed.

Any face-to-face courses will be in groups of no more than 5 people (including the trainer). Courses will be held in a well-ventilated room and participants will be 2 metres apart:

- Manual handling – If the home is short staffed, trainers will do the training whilst the employee "is on the job"
- Basic Life Support
- Fire Evacuation (each person must have completed within the last 12 month)

All employees on furlough leave are expected to maintain training updates during their leave.

Employees who are in work are encouraged to continue with all other training through the eLFY online system. The following courses will be critical courses and anyone who is untrained will be expected to complete this online This will continue to be monitored and homes will be advised if training is unable to go ahead.

- Infection Control (Online)
- Medication Training (role specific) (Online)
- SOVA (Online)

NEWS training will shortly be available through ELfY. Home Managers must ensure all nurses and senior care staff who complete observations are able to score NEWS correctly and identify the appropriate action to be taken dependent on the score.

A training video for putting 'donning' and taking off 'doffing' PPE is available for all staff on the ELFY website. COVID training is also available on the ELfY website.

Training on BOTH of these subjects must be completed by all care home staff by the end of September if they have not already completed the training during this COVID pandemic.

Whilst the outbreak is ongoing and prevention of transmission of the virus and care of residents the following will apply. This can be amended at any time.

a) Yearly updates of training are suspended during this time.

b) Risk assessments will be completed prior to each training session

c) Training rooms, will be wiped down after each session to reduce the chances of infection. Room to be cleaned between each session.

d) All parties part-taking in the training sessions will follow the preventative measures before and after each session. Handwashing must be implemented before and after entering the training room.

In Scotland the Scottish Social Services Council SSSC have produced a new resource to support care providers who are providing support to people with palliative and end of life care needs. See link for details.

https://learn.sssc.uk.com/coronavirus/dying/

Skills for Care

Skills for Care provide a range of training and development for staff teams working in social care. Home Managers are encouraged to use these resources and to encourage staff to access them.

Staff should be asked to provide evidence of updates and training, so that this can be recorded on their peroneal file and the training PORTAL where appropriate.
https://www.skillsforcare.org.uk/Home.aspx