NYCC Public Health advice for care settings

Contents

This guidance was updated by North Yorkshire's Public Health Team on 20th December 2022 and reflects the latest national guidance published up to and including 15th December 2022.

Latest guidance

Please continue to refer to this link for a list of the latest national COVID-19 guidance. The most recent guidance updates for adult social care are as follows:

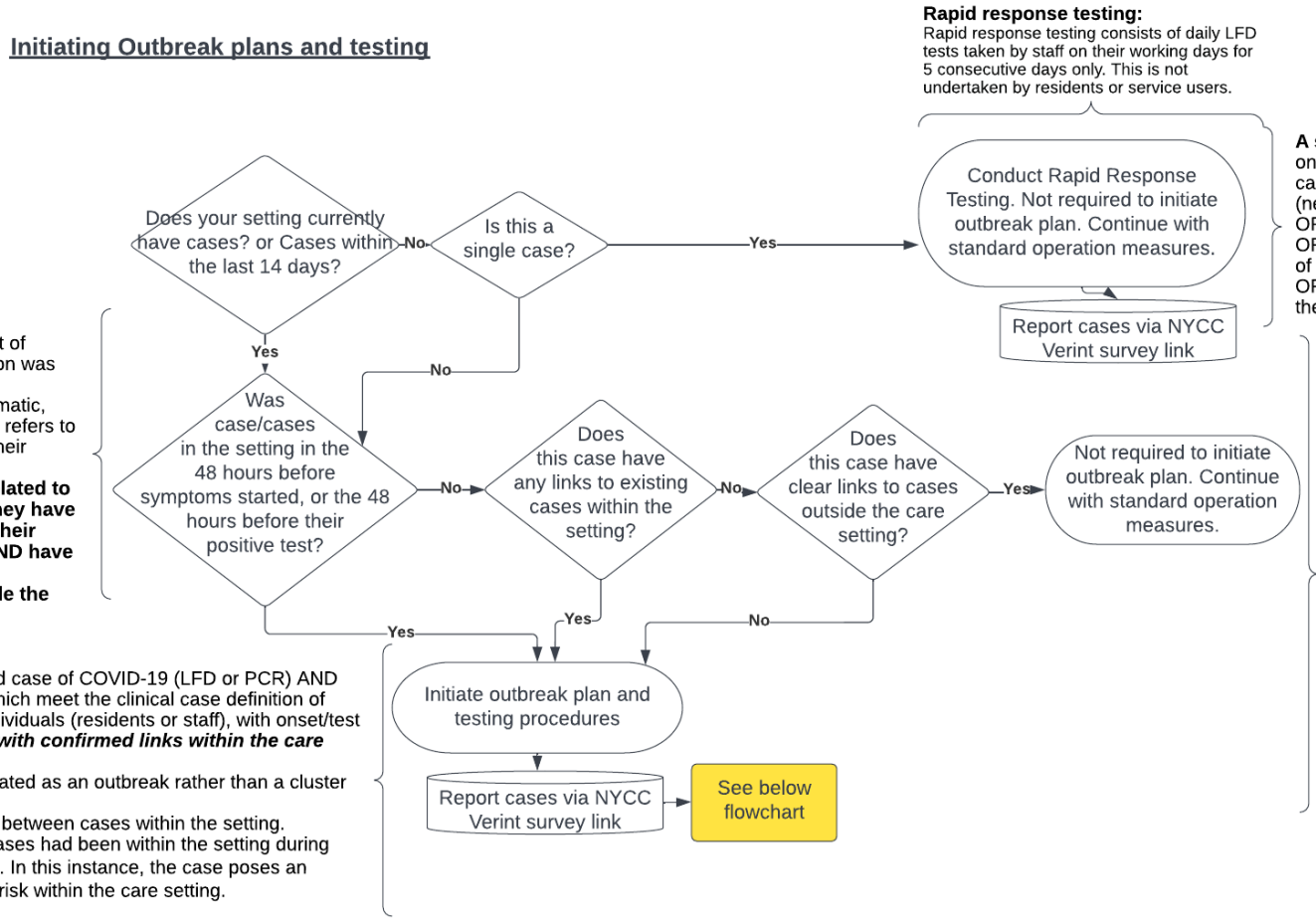
- COVID-19 supplement to the infection prevention and control resource for adult social care
    - Provides information on IPC considerations for staff and people receiving care such as vaccination, PPE and staff movement, environmental considerations such as ventilation and waste management, and considerations specific to care homes such as admissions, visiting and outbreak management.
- Infection prevention and control: resource for adult social care
    - General IPC principles to be used in combination with advice and guidance on managing specific infections.
- Infection prevention and control: quick guide for care workers
    - Provides information on hand hygiene, respiratory hygiene, PPE, cleaning, laundry and waste disposal for care workers.
- Hospital discharge and community support guidance
- COVID-19 testing in adult social care
    - This guidance is for adult social care providers and staff to set out the current testing regime across adult social care. This guidance replaces all previous guidance for testing in adult social care, and applies to care homes, homecare, extra care, supported living, adult day care centres, personal assistants, shared lives carers, and social workers.
    - Throat and nose test (Innova 25) for care home staff: COVID-19 rapid test kit instructions
- Guidance for people previously considered clinically extremely vulnerable from COVID-19
    - Outlines that there is no longer separate guidance for people previously identified as clinically extremely vulnerable, and to instead refer to the general public guidance and/or guidance for people whose immune system means they are at higher risk.
- Managing healthcare staff with symptoms of a respiratory infection or a positive COVID-19 test result
    - This guidance only applies to patient-facing healthcare staff in the NHS and NHS commissioned services. Advice on managing adult social care staff and residents can be found in IPC in adult social care: COVID-19 supplement and IPC in adult social care settings.
- PPE portal: How to order COVID-19 PPE
    - Access the new portal platform, where to can continue ordering free PPE.

Symptoms:

For symptoms of COVID-19, and other respiratory infections, which may initiate testing or other measures to be instigated as outlined in this guidance please refer to people with symptoms of a respiratory infection including COVID-19.

Outbreak management

Initiating outbreak plans and testing



Rapid response testing:
Rapid response testing consists of daily LFD tests taken by staff on their working days for 5 consecutive days only. This is not undertaken by residents or service users.

A single case:
one confirmed case of COVID-19 (LFD or PCR) or one case which meets the clinical case definition of COVID-19: (new/continuous cough OR a high temperature (≥37.8C) OR a loss of/change in normal sense of taste or smell OR a combination of other respiratory symptoms - see list of possible symptoms below.
OR an acute deterioration in physical or mental ability in the elderly with no known cause.

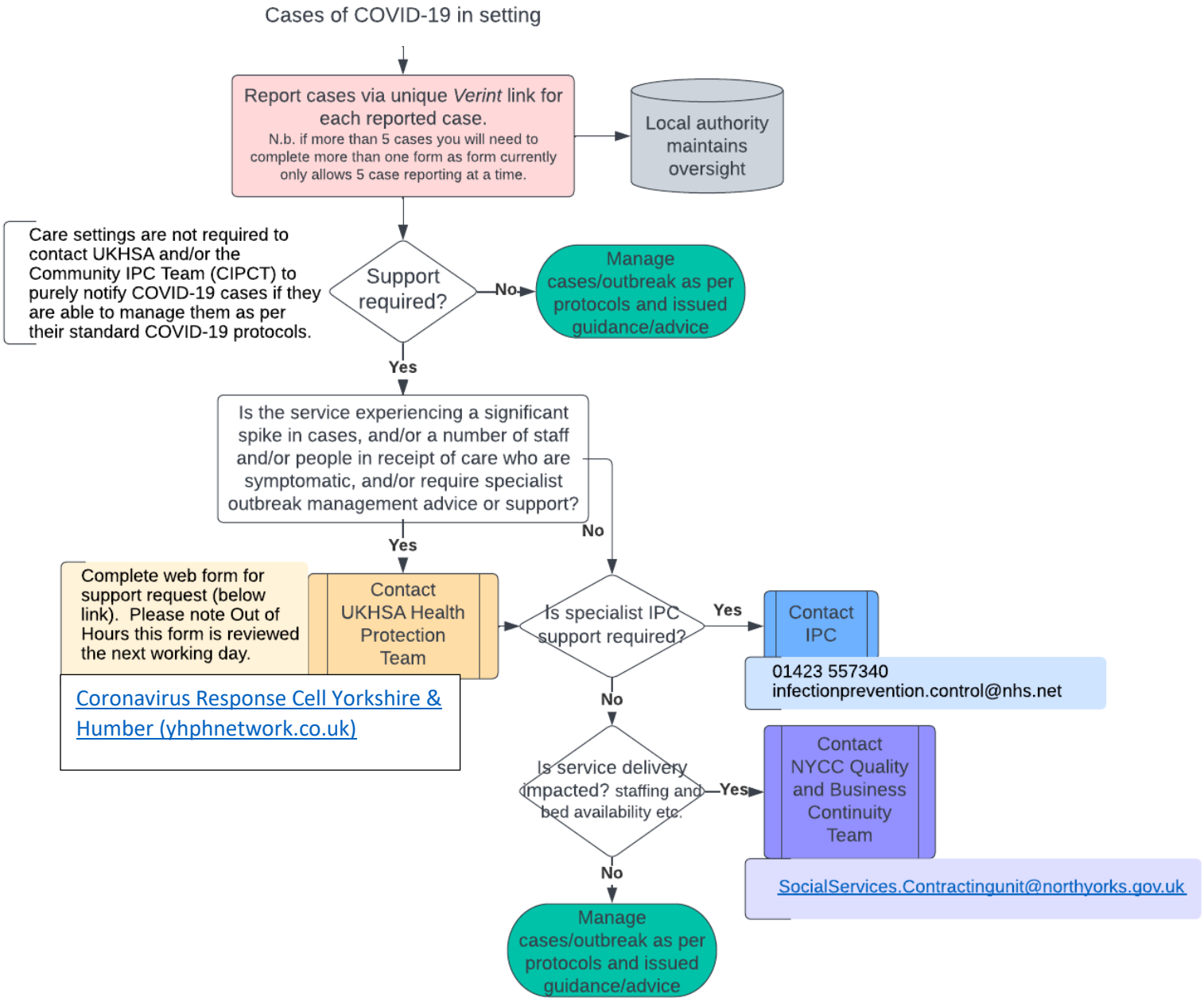
Infectious period:
48 hours before onset of symptoms if the person was symptomatic.
If they were asymptomatic, their infectious period refers to the 48 hours before their positive test.
A case may be unrelated to the care setting if they have not been in during their infectious period AND have a clear source of transmission outside the setting

A cluster:
two or more cases which meet the clinical case definition of COVID-19 among individuals (residents or staff) with onset/test dates within 14 days of each other, but ***with no confirmed contact within the care setting, and/or links to cases outside the care setting.***
Examples of when incidents may be treated as a cluster rather than an outbreak include:
·Cases may be across different units or areas within the same setting, but there may be no crossover. If there is no crossover between cases, there is unlikely to be transmission within the setting and as such, outbreak restrictions are not required.
·When case(s) have not been in the service during their infectious period. These cases are not counted as they pose negligible onward transmission risk within the care setting.

An outbreak:
at least one confirmed case of COVID-19 (LFD or PCR) AND one or more cases which meet the clinical case definition of COVID-19 among individuals (residents or staff), with onset/test dates within 14 days,***with confirmed links within the care home.***
An incident will be treated as an outbreak rather than a cluster if:
·There are clear links between cases within the setting.
·When two or more cases had been within the setting during their infectious period. In this instance, the case poses an onward transmission risk within the care setting.

What to do in the event of cases within your service

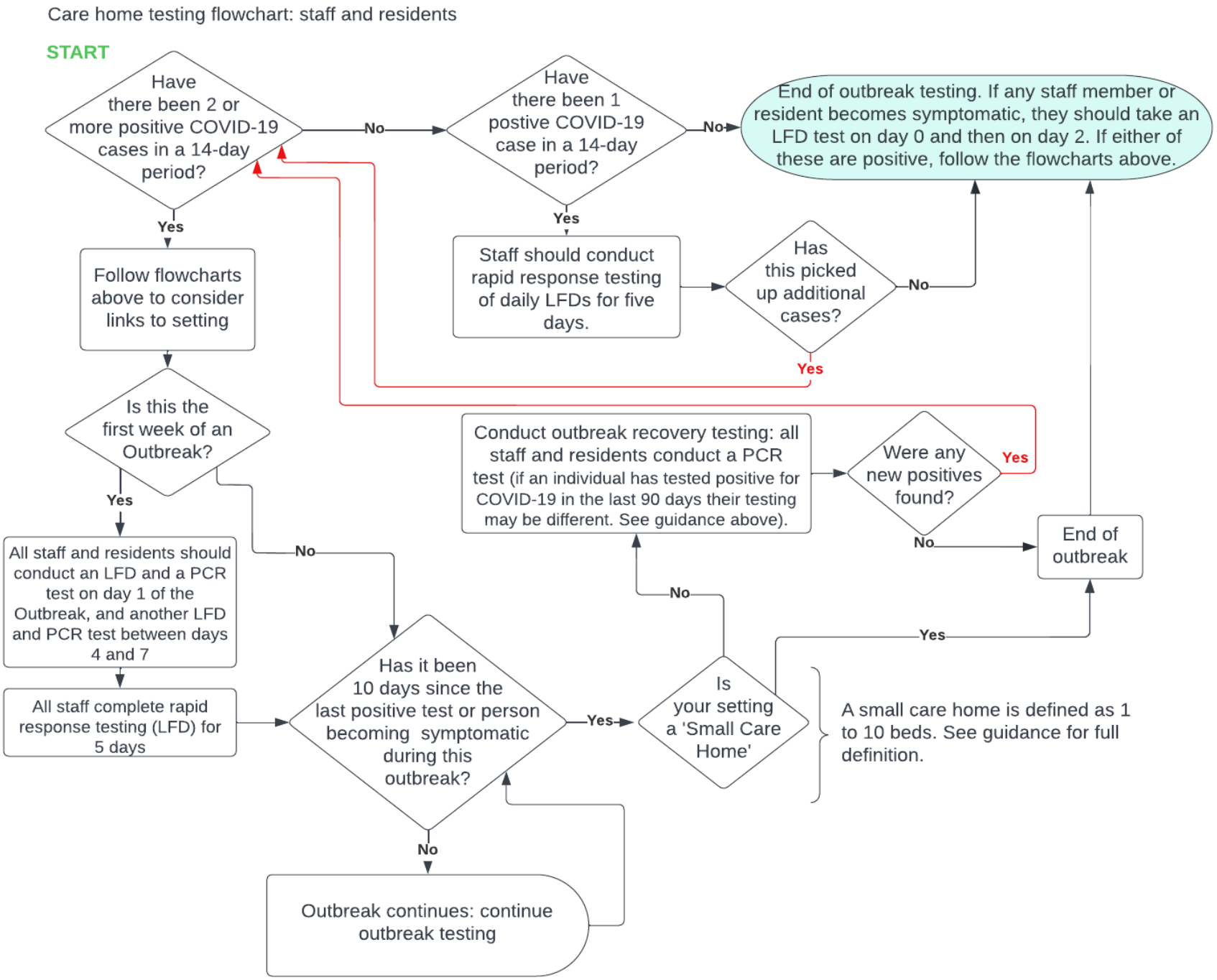
Any case of COVID-19 should be notified to NYCC by the service's Verint survey link. If you would like specialist support with managing cases of COVID-19 within your setting, please contact the UK Health Security Agency's Health Protection Team in the first instance. See below flowchart.



Coronavirus Response Cell Yorkshire & Humber (yhphnetwork.co.uk)

In the event of an outbreak within your setting, you should follow your outbreak plans. This may include reviewing IPC measures, enhanced cleaning, cohorting of staff and residents where possible, considering visit safety, and following outbreak testing procedures. Ensure you keep your outbreak plans up to date and ask for support if required to maintain these.

Testing Flowchart



Contact details

In the event of symptomatic people, cases, or outbreaks of COVID-19 within care settings, the local authority (NYCC), Community IPC Team (CIPCT) and UK Health Security Agency's Health Protection Team (UKHSA/HPT) have different roles with outbreak management and advice.

- **For outbreak management advice/support, please use the webform or call Yorkshire and Humber HPT (0113 386 0300 in or out of hours)**
- **Webform:** Coronavirus Response Cell Yorkshire & Humber (yhphnetwork.co.uk)
- In the instance of any events that may impact service delivery, please contact SocialServices.Contractingunit@northyorks.gov.uk
- For specialist Infection Prevention Control (IPC) support, please call 01423 557340 or email infectionprevention.control@nhs.net
- North Yorkshire NYCC Public Health team: dph@northyorks.gov.uk

COVID-19 Testing in Adult Social Care

The full guidance is available at: https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings/covid-19-testing-in-adult-social-care

Note - there has been an addition in the above guidance, section 2.3.2- small care homes (<10 beds). This differentiation between small homes has not been made in any previous guidance.

Eligibility for free testing in adult social care

Care homes are eligible for free testing if they are regulated by the Care Quality Commission (CQC).

Extra care and supported living settings are eligible if they meet at least one of the following criteria:

- the setting is a closed community with substantial facilities shared between multiple people
- it is a setting where the majority of residents (more than 50%) receive the kind of personal care that is CQC-regulated (rather than help with cooking, cleaning and shopping)

A setting is classified as a 'high-risk extra care and supported living' if it meets both criteria above. For eligibility on all other settings please refer to the national guidance above.

Asymptomatic staff testing

Staff are not required to conduct regular asymptomatic staff testing. Some staff without COVID-19 symptoms may be asked to undertake testing as part of rapid response testing for care homes and high-risk extra care and supported living services or as part of outbreak testing in care homes.

Rapid response testing

Rapid response testing is triggered if one or more positive staff or resident cases are found in:

- a care home
- a high-risk extra care and supported living setting

Rapid response testing consists of daily LFD tests taken by staff on their working days for 5 consecutive days only. This is not undertaken by residents or service users. The purpose of rapid response testing is to detect cases among staff to help determine whether an outbreak is occurring and to prevent further transmission.

This is distinct from outbreak testing which is only undertaken by care homes in the event that 2 or more positive or suspected linked cases of COVID-19 occur in the same setting within a 14-day period (this means where the cases are linked to each other and transmission in the care setting is likely).

Rapid response testing in small care homes

A small care home is defined as 1 to 10 beds in this guidance. It is up to a service to determine and be prepared to evidence that small care home guidance applies to them if the size of the care home is above 10 beds. For example, if there are individual units or floors with completely separate staff and residents who do not mix with other staff and residents outside of this unit or floor.

If there is only 1 positive case in a small care home:

- rapid response testing should be initiated

If there are 2 or more positive cases in a small care home:

- a small care home should start outbreak testing as soon as possible – this is because there is a higher likelihood that these cases are linked due to the close networks in small settings
- a small care home may decide to undertake rapid response and whole home outbreak testing at the same time or may only undertake outbreak testing in the event of 2 or more cases – rapid response testing should not delay outbreak testing in either case

Small care homes can therefore determine whether rapid response testing has value if there are 2 or more positive cases. For example:

- rapid response testing of new staff would not be initiated if a high proportion of the staff are symptomatic or have tested positive, and new staff enter the home
- rapid response testing has limited value in protecting residents if the majority of residents are symptomatic or have already tested positive; this may, however, still be beneficial to prevent further transmission among staff

This decision can be made by the provider, with further support available from the local health protection team (HPT), community infection prevention and control team or local authority. Settings should contact IPC or UKHSA HPT in the first instance.

When to isolate:

Any individual who tests positive for COVID-19 should isolate for 10 days and take part in daily lateral flow testing from day 5. They can end self-isolation after receiving 2 consecutive negative tests 24 hours apart, or after 10 days' isolation.

If an individual (staff or resident/tenant/person in receipt of care) receives a positive result (from any test) in a care home, adult day care centre, or high-risk extra care and supported living setting, then all staff should conduct rapid response LFD testing.

Rapid response LFD testing refers to a lateral flow test, taken at the start of each shift on every day that they are working, for 5 days. Only the staff working in the setting over the rapid response testing period need to be tested; those not working during this period do not need to be tested. You should not bring people into work to get tested on their non-working days. Once this 5-day period has ended, staff should continue their regular twice-weekly asymptomatic LFD testing.

If an outbreak is suspected

If an outbreak is suspected, the care home should undertake a risk assessment as soon as possible to determine if the situation can be considered an outbreak and if outbreak management measures are needed. The provider should inform the HPT as per the flowcharts within this document of a suspected outbreak, but they are not required to wait for advice from the HPT (or other relevant local partner) should they feel able to initiate the risk assessment independently.

The risk assessment can be undertaken directly by the care home provider with the expertise of relevant care home staff, with further support also available from the local HPT (or other local partner such as community IPC team or local authority) at the care home's request.

The risk assessment should determine if the cases are likely to have been the result of transmission within the care home. This is to assess whether the cases are linked. The risk assessment should consider whether:

- there is a known source of infection
- the initial individual with suspected or confirmed COVID-19 may have infected others while in the setting. For example, if the individual was in the setting while they were likely to be infectious (up to 2 days before symptoms onset or a positive test, and up to 10 days after)
- the initial individual had contact with the other individual or individuals with suspected or confirmed COVID-19 while they were likely to have been infectious
- the initial individual may have picked up the infection from the setting. This may be possible if the individual was in the setting during their incubation period (up to 14 days prior to symptom onset and/or a positive test)
- there are any factors which may increase the risk of transmission occurring in the setting

Cases would not be considered linked if:

- the cases were more than 14 days apart, from the earliest of symptom onset or a positive test
- the cases were in people who had not been in the care setting in the last 14 days
- the cases were among different staff members or residents in discrete units, floors or sections who are completely separate and do not mix
- a case or the cases were recently discharged from hospital and safely isolated under the care of cohorted staff

As noted above, the care home should inform the HPT (or other relevant local partner) of the outbreak with the option of contacting them for further advice if there are specific issues of concern. For example if:

- there is a higher number of deaths or hospitalisations than expected
- cases are increasing rapidly making it difficult to control the outbreak
- there are staffing shortages or concerns about safety within the care home
- there is a suspected outbreak of another infection in addition to COVID-19

Use the **flowcharts** at the start of this document to get the right support with each issue.

In the event of an outbreak of COVID-19 in the care setting

An outbreak consists of 2 or more positive or suspected linked cases of COVID-19 that occur in the same setting within a 14-day period (this means where the cases are linked to each other and transmission in the care setting is likely). This applies to both staff and residents and includes PCR and LFD test results.

If the care home suspects that 2 or more confirmed or suspected cases are linked, the provider should conduct a risk assessment. This is to determine if an outbreak should be declared and to then determine what outbreak measures should be implemented.

See section **below** for more support on risk assessment considerations.

The risk assessment can be undertaken directly by the care home provider with the expertise of relevant care home staff, and further support is also available from the local health protection team (HPT), community infection prevention and control team or local authority. Settings should contact IPC or UKHSA HPT in the first instance.

If an outbreak is identified, the care home should implement whole home outbreak testing and consider further measures. More details can be found in the COVID-19 supplement to the infection prevention and control (IPC) resource for adult social care.

In the event of an outbreak of COVID-19 in the care setting, all staff and residents should participate in outbreak testing, in addition to the rapid response LFD testing outlined above. Outbreak testing requires staff and residents/tenants/people in receipt of service to conduct both an LFD test and a PCR test on day 1 of the outbreak and another LFD test and PCR test between days 4 and 7. The LFD test will allow you to identify and isolate the most infectious cases immediately whilst awaiting PCR results, therefore reducing the risk of the virus spreading. If either test is positive, it is highly likely that the individual has COVID-19.

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

The local HPT may decide to differ from this approach based on the local circumstances, and where possible their instructions should be followed. For example, there may be circumstances in which the HPT or other local partner advises that the original cases were considered highly unlikely to be linked to transmission within the setting (a cluster) and they advise that outbreak measures may be stood down after 2 rounds of whole home PCR testing (at around the 7 day point).

Risk Assessments in outbreak

The risk assessment should determine if the cases are likely to have been the result of transmission within the care home. This is to assess whether the cases are linked. The risk assessment should consider whether:

- there is a known source of infection
- the initial individual with suspected or confirmed COVID-19 may have infected others while in the setting. For example, if the individual was in the setting while they were likely to be infectious (up to 2 days before symptoms onset or a positive test, and up to 10 days after)
- the initial individual had contact with the other individual or individuals with suspected or confirmed COVID-19 while they were likely to have been infectious
- the initial individual may have picked up the infection from the setting. This may be possible if the individual was in the setting during their incubation period (up to 14 days prior to symptom onset and/or a positive test)
- there are any factors which may increase the risk of transmission occurring in the setting

Cases would not be considered linked if:

- the cases were more than 14 days apart, from the earliest of symptom onset or a positive test
- the cases were in people who had not been in the care setting in the last 14 days
- the cases were among different staff members or residents in discrete units, floors or sections who are completely separate and do not mix
- a case or the cases were recently discharged from hospital and safely isolated under the care of cohorted staff

As noted above, the care home should inform the HPT (or other relevant local partner) of the outbreak with the option of contacting them for further advice if there are specific issues of concern. For example if:

- there is a higher number of deaths or hospitalisations than expected
- cases are increasing rapidly making it difficult to control the outbreak
- there are staffing shortages or concerns about safety within the care home
- there is a suspected outbreak of another infection in addition to COVID-19

Outbreak recovery testing

This section does not apply to small care homes (please refer to the definition above). Where the definition applies, please see the section below '**Small care homes outbreak testing'.**

For outbreak recovery testing, all staff and residents (who have not tested positive in the last 90 days) should be tested with a PCR test, no earlier than 10 days after the last resident or staff member had a positive test result or showed COVID-19 symptoms. If there are no positive results from outbreak recovery testing, outbreak restrictions can be lifted and the normal regular staff testing pattern should be followed.

If there are further positive results from outbreak recovery testing, care home managers can risk-assess this themselves but if required may seek advice from their local HPT (or community IPC

team, local authority, or ICB in accordance with local protocols), together with advice on when it might be reasonable to lift outbreak measures.

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

UKHSA HPT may notify NYCC of complex situations, e.g. high attack rate amongst residents and/or staff; large number of deaths; difficulties managing IPC, lack of PPE, staff absences, etc. where they feel that local authority input would be beneficial. NYCC can then provide ongoing support with regards to staffing, IPC, PPE, and other consequences that may affect safe and effective care provision.

Small care homes outbreak testing

This section outlines rapid response testing specific to small care homes (defined as 1 to 10 beds). For full details please visit COVID-19 testing in adult social care - GOV.UK (www.gov.uk)

A small care home should start outbreak testing as soon as possible if 2 or more cases are identified. This is because there is a higher likelihood that these cases are linked due to the close networks in small settings.

Recovery testing does not need to be undertaken in small care homes. This is because transmission is likely to occur early in the outbreak with less potential for hidden chains of transmission in small populations. Instead, outbreaks can be considered to have ended once all resident self-isolation periods have been completed.

This does not alter when staff with COVID-19 should return to work, which is outlined in the COVID-19 supplement to the infection prevention and control (IPC) resource for adult social care.

After this point, if there are 2 or more positive or suspected linked cases of COVID-19 within the same setting within a 14-day period this would be considered a new COVID-19 outbreak.

Routine (Asymptomatic) Testing for COVID-19

Routine asymptomatic testing was paused across care settings. Testing for individuals with symptoms including health and social care staff will continue. Immunocompromised patients in hospitals and people being admitted into care homes and hospices will also continue to be tested.

Some staff without COVID-19 symptoms may be asked to undertake testing as part of rapid response testing for care homes and high-risk extra care and supported living services or as part of outbreak testing in care homes.

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

In the event of someone developing symptoms (across all services)

If an individual experiences any of the main symptoms of coronavirus (COVID-19), they should immediately take a lateral flow device (LFD) test as soon as they develop symptoms and take another LFD test 48 hours after the first test.

Symptomatic staff should stay away from work and conduct the LFD test at home. Staff can come into work if both LFD test results are negative and medically fit to do so.

If any resident (care homes, extra care, supported living) displays symptoms, they should take a lateral flow device (LFD) test as soon as they develop symptoms, and another LFD test 48 hours after the first. Symptomatic residents (care homes, extra care, supported living) should be isolated immediately and tested with LFDs. They should follow the guidance regarding staying at home and avoiding others – this can end if both tests are negative. If the individual lives in a residential setting that is similar to a care home, such as in an extra care and supported living service, providers may wish to follow all or some of the guidance for care home residents set out in the adult social care testing guidance

In the event of someone testing positive

If any staff or resident receives a positive result in a care home, adult day care centre, or high-risk extra care and supported living setting, then all staff should conduct LFDs every day that they are working, for 5 days. Only the staff working in the setting over the rapid response testing period need to be tested; those not working during this period do not need to be tested. You should not bring people into work to get tested on their non-working days.

Social care staff with COVID-19 should not attend work until they have had two consecutive negative lateral flow test results (taken at least 24 hours apart), they feel well and they do not have a high temperature. The first lateral flow test should only be taken from 5 days after day 0 (the day their symptoms started, or the day their test was taken if they did not have symptoms). If both lateral flow tests results are negative, they may return to work immediately after the second negative lateral flow test result on day 6, if their symptoms have resolved, or their only symptoms are cough or anosmia which can last for several weeks.

Residents who test positive for COVID-19 should isolate for 10 days and take part in daily lateral flow testing from day 5. They can end self-isolation after receiving 2 consecutive negative tests 24 hours apart, or after 10 days' isolation.

Testing to release from isolation

Individuals who test positive for COVID-19 should take part in daily lateral flow testing from day 5 (counting the day of the original positive test as day 0). They can end isolation after receiving 2 consecutive negative tests 24 hours apart, or after 10 days' isolation. Any individual who is unable to test should be isolated for the full 10 days following a positive test. Isolation should only be stopped when there is an absence of fever (less than 37.8°C) for 48 hours without the use of medication.

What to do if a staff member continues to test positive after day 10

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

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

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

In the event of inconclusive test results

Staff who receive an inconclusive test result should take another lateral flow test, and symptomatic staff who do not have immediate access to another lateral flow test should not attend work while waiting to receive another lateral flow test to take.

If the test was being taken by an asymptomatic member of staff as part of outbreak testing for example, they can continue working but should still take the repeat test.
If the repeat test result is positive, they should follow the advice on receiving a positive test. If their test result is negative, they can return to work.

Recovery testing/ end of outbreak

For outbreak recovery testing, all staff and residents (who have not tested positive in the last 90 days) should be tested with a PCR test, no earlier than 10 days after the last resident or staff member had a positive test result or showed COVID-19 symptoms.

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

If there are further positive results from outbreak recovery testing, then the HPT may advise that outbreak restrictions should continue until no further positives are found before advising that the outbreak has ended. In this instance contacting UKHSA HPT is advised.

If there are 2 or more positive cases after outbreak recovery testing, this should be classed as a new potential outbreak and the care home should follow the flowcharts on *page 4 and 5*.

Accessing COVID-19 treatments for people in the highest risk group

Individuals who are in the highest risk group from COVID-19 can access new COVID-19 treatments directly.

Service and care managers are requested to support residents who are eligible for treatment with where to store these priority tests so that they are available when needed. Each priority treatment test kit will have an information leaflet enclosed which details how these kits should be stored and provide full testing instructions.

If positive for COVID-19, the resident will be contacted by a COVID-19 Medicines Delivery Unit clinician who will assess the resident's eligibility and decide on the appropriate treatment. In most cases the treatment prescribed will be monoclonal antibodies, which are given intravenously, however, if monoclonal antibodies are unsuitable for the individual, they will be given oral antivirals.

If the resident is not contacted within 24 hours of receiving the positive result, contact their GP or call 111.

Further information on treatments for COVID-19 is available on the NHS website. Any queries regarding priority treatment tests can be raised via 119.

Guidance on care home visiting

Contact with relatives and friends is fundamental to care home residents' health and wellbeing and visiting should be supported. There should not normally be any restrictions to visits into or out of the care home.

The right to private and family life is a human right protected in law (Article 8 of the European Convention on Human Rights).

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

Additionally, end-of-life visiting should always be supported in all circumstances.

Precautions for visitors

Care homes should ask visitors to follow the same PPE recommendations as care workers, to ensure visits can happen safely, noting that additional requirements for face masks may be in place if the care setting is in an outbreak. This should be based on individual assessments, taking into account any distress caused to residents by use of PPE or detrimental impact on communication. Additional recommendations may be in place regarding mask wearing from the local authority, infection prevention team, or health protection team.

Please see **Interpreting COVID PPE Guidance** at the end of this document for full information on mask wearing recommendations locally.

In the event that visitors are being asked to wear face masks, children under the age of 11 who are visiting may choose whether to wear face masks. However, they should be encouraged to follow other IPC measures such as practicing hand hygiene. Face coverings for children under the age of 3 are not recommended for safety reasons.

Visiting professionals

Health, social care and other professionals may need to visit residents within care homes to provide services. Visiting professionals should follow the same advice as **in the section above** and within the **Interpreting COVID PPE Guidance** at the end of this document. NHS staff and Care Quality Commission (CQC) inspectors also have access to symptomatic testing and should follow the same guidance as staff about staying away from work if they test positive.

For the latest full guidance on visiting arrangements in care homes, please visit COVID-19 supplement to the infection prevention and control resource for adult social care - GOV.UK (www.gov.uk)

A visitor to my care home has respiratory symptoms. What should I do?

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

Do visitors need to wear face masks?

Care homes should ask visitors to follow the same PPE recommendations as care workers, to ensure visits can happen safely, noting that additional requirements for face masks may be in place if the care setting is in an outbreak. This should be based on individual assessments, taking into account any distress caused to residents by use of PPE or detrimental impact on communication. Additional recommendations may be in place regarding mask wearing from the local authority, infection prevention team, or health protection team.

A resident in my care home has tested positive, can they have visitors if they are still in self-isolation?

Isolation does not preclude:

- receiving one visitor
- going into outdoor spaces within the care home grounds through a route where they are not in contact with other care home residents – this should be supported where safe and possible given its importance in rehabilitation and to minimise the deconditioning impact of isolation

There is a COVID-19 outbreak within my service. Do I need to stop visiting?

When visiting is modified during an outbreak of COVID-19 or where a care home resident has confirmed COVID-19, evert resident should be enabled to continue to have visits. However, proportionate changes to visiting may be implemented. One visitor at a time per resident should always be able to visit inside the care home. This number can be flexible in the case that the visitor requires accompaniment (for example if they require support, or for a parent accompanying a child). End-of-life visiting should always be supported

Any measures that the care home chooses to implement must be proportionate, consider resident wellbeing, the care home's legal obligations, and be risk-based. The care home manager should ensure staff, residents and their loved ones are informed of the outbreak and any relevant measures that have been implemented.

If an outbreak is declared as a result of the risk assessment then measures will be taken. These will include testing and may also include temporarily stopping or reducing communal activities and changes to visiting: some forms of visiting should continue if individual risk assessments are carried out. One visitor per resident should always be able to visit inside the care home.

Personal protective equipment

Appropriate PPE should be worn by care workers in all settings, as well as visitors to residential care settings, subject to a risk assessment of likely hazards such as the risk of exposure to blood and body fluids. Please visit COVID-19 supplement to the infection prevention and control resource for adult social care - GOV.UK (www.gov.uk) for full guidance on the type of PPE that is recommended, to help protect care workers and care recipients and prevent the transmission of infectious diseases, with particular advice regarding care of people suspected or confirmed to be COVID-19 positive.

Interpreting COVID-19 PPE guidance

The national Infection Prevention and Control in Adult Care Settings guidance (IPC guidance) sets out recommendations on the use of PPE as part of safe systems of working for health and social care workers relative to their day-to-day work. The COVID-19 supplement sets out additional guidance on PPE relating to the COVID-19 pandemic specifically and should continue to be followed on top of the general IPC guidance.

Within North Yorkshire and York we continue to ensure we do all we can to protect our teams who are working within the community. We therefore continue to recommend a risk assessment takes place in line with the PPE guidance to decide what level of PPE is required for each situation.

Appropriate personal protective equipment (PPE) should be worn by care workers and visitors to residential care settings, subject to a risk assessment of likely hazards such as the risk of exposure to blood and body fluids. PPE should be worn for all interactions with suspected and confirmed COVID positive persons.

PPE should be used in conjunction with other measures intended to decrease the risk of disease transmission, including vaccination, ventilation, and good hand and respiratory hygiene.

Appropriate donning and doffing of PPE is important to ensure it works effectively. For guidance on donning and doffing please see here: https://www.gov.uk/government/publications/ppe-guide-for-non-aerosol-generating-procedures

In December 2022 the requirement for universal mask wearing in care settings was removed. However, the national COVID-19 guidance for care settings continues to include several scenarios for when face masks should be worn, such as during outbreaks or when caring for individuals with suspected/confirmed COVID-19. In addition to this, local recommendations on mask wearing have been set out below to support managers and individual staff members decide whether wearing a mask is appropriate in certain situations. You should refer to this table **before** determining that masks do not need to be worn in a situation.

Recommendations for risk-assessing mask wearing in social care settings from December 2022

National COVID-19 Guidance
There remains a number of circumstances where it is recommended that care workers and visitors to care settings wear masks to minimise the risk of transmission of COVID-19. These are: • if the person being cared for is known or suspected to have COVID-19 (recommended Type IIR fluid-repellent surgical mask) • if the member of staff is a household or overnight contact of someone who has had a positive test result for COVID-19 • if the care setting is in an outbreak – see section on outbreak management for further information

- If a care recipient is particularly vulnerable to severe outcomes from COVID-19 (for example, potentially eligible for COVID-19 therapeutics) mask wearing may be considered on an individual basis in accordance with their preferences
- Mask wearing may also be considered when an event or gathering is assessed as having a particularly high risk of transmission
- If the care recipient would prefer care workers or visitors to wear a mask while providing them with care then this should be supported
- Providers should also support the personal preferences of care workers and visitors to wear a mask in scenarios over and above those recommended in this guidance
- As per the recommendations for standard precautions, type IIR masks should always be worn if there is a risk of splashing of blood or body fluids.
- If masks are being worn due to an outbreak or risk assessment, consideration should be given as to how best to put this into practice while taking account of the needs of individuals and minimising any negative impacts

Additional Local Recommendations

In addition to the above we recommend that settings consider wearing masks when:

- Interacting with someone suspected/confirmed to have **ANY** infectious respiratory disease (e.g. flu)
- Circulating levels of respiratory infections are high in the community or in the setting
- If already experiencing high sickness absence rates, wearing masks as preventative measures to protect as part of business continuity
- When unable to keep indoor air clean (i.e. if no/poor ventilation, no HEPA filters/air filtration systems in place)
- If you are coughing/sneezing (N.B if staff member unwell they should be at home) **OR** just returned to work following absence for respiratory infection
- If you have been in close contact with someone with an infectious respiratory disease in the last few days

The following tables are taken from the COVID-19 PPE supplement for adult social care

- **Table 1** covers PPE requirements when NOT caring for a person with suspected or confirmed COVID-19
- **Table 2** covers PPE requirements when caring for a person with suspected or confirmed COVID-19

Table 1: PPE requirements when NOT caring for a person with suspected or confirmed COVID-19

Activity	Face mask	Eye protection	Gloves	Apron
Social contact with clients, staff, visitors	Check if anything listed in Recommendations above applies	No	No	No
Care or domestic task involving likely contact with blood or body fluids (giving personal care, handling soiled laundry, emptying a catheter or commode)	Risk assess; - Type IIR if splashing likely - Check if anything listed in Recommendations above applies	Risk assess if splashing likely	Yes	Yes
Tasks not involving contact with blood or body fluids (moving clean linen, tidying, giving medication, writing in care notes)	Risk assess and Check if anything listed in Recommendations above applies	No	No	No

General cleaning with hazardous products (disinfectants or detergents)	Risk assess; - type IIR if splashing likely or if recommended by manufacturer of cleaning product - Check if anything listed in Recommendations above applies	Risk assess or if recommended by manufacturer of cleaning product	Risk assess or if recommended by manufacturer of cleaning product	Risk assess or if recommended by manufacturer of cleaning product
Undertaking an AGP on a person who is not suspected or confirmed to have COVID-19 or another infection spread by the airborne or droplet route	Yes – type IIR to be used for single task only	Yes	Yes	Yes (consider a gown if risk of extensive splashing)

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

Note: Where sessional use of masks is required or recommended this applies to communal care settings only. Homecare workers should remove their masks when leaving the home of the person they are caring for and wear a new mask when entering different people's homes.

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

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

How to access Personal Protective Equipment (PPE)

From April 2022 the PPE Portal has moved to a new platform – the login page is here: Customer Login (ppe-portal.nhs.uk). PPE ordered from the portal is free of charge. Orders will be delivered within 5 days.
More information on accessing the PPE portal is available here: PPE portal: how to order COVID-19 personal protective equipment (PPE) - GOV.UK (www.gov.uk)

If you have any queries or issues regarding the PPE Portal, please contact the Department of Health and Social Care customer services team on 0800 876 680, Monday to Friday between 8am to 5pm.

NYCC guidance for admissions to care settings

Background

A risk-based approach to considering admissions whilst in outbreak should be undertaken. This risk assessment should take into account:

- the size of outbreaks and whether they only affect staff
- the care home environment, including size/layout
- rates of booster vaccination
- current Care Quality Commission (CQC) rating.

This local guidance is subsequently updated to reflect guidance changes and to reflect changes in guidance for admitting COVID positive residents.

Care home providers must be able to refuse admissions where they feel they cannot provide safe care and they must not be put under undue pressure.

If the setting is in outbreak (2 or more linked cases with 14-days) then a proportionate reduction in admissions, which may include temporary closure of the home to further admissions may be considered. This may be determined in conjunction with the Health Protection Team (UKHSA), the Infection Prevention Control Team, or by your own assessment of your settings business continuity or resilience plans.

Risk assessment

Care homes have existing procedures for assessing the safety and suitability of admissions and transfers. This guidance is intended to provide extra support on COVID-19 specific assessment, and covers:

- (Re)admission of individuals into settings where there is currently an outbreak (whose COVID-19 status could be positive or negative)
- (Re)admission of COVID-19 positive individuals into a setting where there is no current COVID-19 outbreak

First it should be established whether the registered manager would be prepared to accept the admission, providing the risk assessment indicates it is safe to do so. As per the above, care home providers must be able to refuse admissions where they feel they cannot provide safe care and they must not be put under undue pressure.

Should the registered manager by happy to progress, a risk assessment can then be undertaken.

- Testing for admission should include a PCR test within the 72 hours before admission (or a lateral flow test if they have tested positive for COVID-19 in the past 90 days) **and** a lateral flow test on the day of admission (day 0).
- These tests should be provided by the care home if the individual is being admitted from the community. These tests will be provided by the hospital if the individual is being discharged into the care home.
- Discharge from hospital into a care home will normally include a PCR test undertaken within 48 hours prior to discharge, or a lateral flow test if the individual has tested positive for COVID-19 in the last 90 days.

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

Admission decisions must be made on an individual basis, with decisions documented as per Annex A below**.**

Risk assessments and the subsequent decision on whether to admit an individual can be undertaken by the Registered Manager, it is essential that all items in Annexe A are completed in the following circumstances:

- The setting is in an escalating outbreak (i.e. sustained increase in cases since original notification)
- There have been more than 10 cases in the last 10 days, or more than 10% of staff/residents affected in the last 10 days (whichever number is smaller)

Non-urgent admissions during significant or escalating outbreaks should be avoided.

All admissions require the informed consent of the individual involved and/or their nominated representative. In order for informed consent to be given they must be made aware of the situation in the care setting and so must be involved in the risk assessment process.

Other opinions may also be sought to supplement the risk assessment, for example from IPC or the relevant clinician. Should a Registered Manager wish for support or advice for any admission please contact socialservices.contractingunit@northyorks.gov.uk.

Risk assessments undertaken by the Registered Manager should be based on the following criteria:

- the exceptionality of the admission
- the size of outbreak and whether it only affects staff
- the care home environment, including size/layout
- rates of booster vaccination among residents and staff
- whether had at least one clear round of whole home testing since the last positive case
- any outstanding concerns e.g. IPC issues, CQC rating
- risk assessment in place for individual (including testing, isolation etc.)
- any concerns for staffing levels
- the ultimate risk of admitting versus not admitting

Annex A provides further details on what information is required to support each of these points to facilitate the risk assessment.

Annex A: Checklist/guidance for COVID-19 risk assessments for admissions to care homes

Assessing the individual:	Response
Is the individual coming from a place where there is an active outbreak of COVID-19?	**Y/N**
• *If so, can they be isolated for 10 days from the date of admission in order to prevent possible introduction of infection into the care home?*	Y/N – only proceed if Y or mitigation measures in place
Have they taken a PCR test prior to discharge or a lateral flow test if they have tested positive for COVID-19 in the past 90 days?	**Y/N** – only proceed if Y (or N but setting will ensure testing before admission takes place)
If the person is moving to the care home from the community: • For urgent admissions to a care home from the community, the care home manager should find out whether the resident being admitted has had a lateral flow or PCR test and, if so, when and what the result was. If the individual has taken a lateral flow or PCR test within 72 hours of the urgent admission into the care home, the care home manager should share the result with the relevant and responsible person. This may be a delegated responsibility. If a PCR or lateral flow test has not been taken or was taken more than 72 hours before urgent admission, the individual should be tested again with a lateral flow test by the care home. If the test result is positive, the individual should isolate in the care home and follow the guidance for care home residents who are symptomatic or test positive for COVID-19. **If the person is being admitted to the care home from hospital:** • The NHS will do a PCR test within 48 hours prior to an individual's discharge into a care home, or a lateral flow test if the individual has tested positive for COVID-19 in the last 90 days. The test result should be shared with the individual themselves, their key relatives or advocate and the relevant care provider before the discharge takes place. *If an individual tests positive prior to discharge*, they can be admitted to the care home, if the home is satisfied they can be cared for safely. They should be isolated on arrival for 10 days and follow the guidance on care home residents who are symptomatic or test positive for COVID-19. • If an individual returning or being admitted to a care home has tested positive for COVID-19, they should be isolated for a total period of 10 days from the day symptoms started or the day of the positive test if asymptomatic (counting the day of symptom onset or the original positive test as day 0). **This isolation period should include days in the hospital, so when entering a care home, they only need to isolate for the remainder of the 10 days since symptoms or positive test.** • However, if an individual who is isolating can participate in testing, they may undertake daily lateral flow testing from day 5 (counting the day of symptom onset or the original positive test as day 0). They can end isolation after receiving 2 consecutive negative tests 24 hours apart. • Any individual who is unable to test should be isolated for the full 10 days following symptom onset or a positive test if asymptomatic. Isolation should only be stopped when there is an absence of fever (less than 37.8°C) for 48 hours without the use of medication.	Test conducted: Result:
Is the person currently positive for COVID-19? See section below **"For COVID-19 positive people"**	**Y/N**
Is the person displaying potential symptoms of COVID-19?	**Y/N**
Are they fully vaccinated against COVID-19? • *Have they completed their primary course of COVID/19 vaccination?* • *Have they had the appropriate booster dose(s)?*	**Y/N**
Is the care home the person's preferred place of care at this time?	**Y/N** – only proceed if Y
• *Consider their personal preferences (importantly, residents and their families should be made aware of the situation and given the opportunity to highlight any concerns and make alternative arrangements where necessary)*	

Is the admission exceptional enough to be warranted during an outbreak (and/or whilst infectious)?	**Y/N**
• *Is it the individual's usual place of residence?*	
• *Are there urgent pressures driving the request?*	*Details:*
• *Are they currently in a place of safety? (If there are safety risks in current setting will need to be balanced against the COVID-19 risks of admission)*	**Y/N** *Details if unsafe:*
Is the resident/family aware of the COVID-19 situation in the care home and happy to proceed with the admission?	**Y/N** – only proceed if Y
Is there a risk assessment in place for individual?	**Y/N** – only proceed if Y
• *Can they be isolated appropriately (if required)?*	
• *Can their needs be met?*	
• *Can they access appropriate testing?*	

For COVID-19 Positive people:	
Can the person be isolated effectively for the remainder of their isolation period on admission to the care home, and barrier nursed?	**Y/N** – only proceed if Y
Is it possible to enable them to receive one visitor and have access to outside space to assist rehabilitation during isolation?	**Y/N**
Is the care home confident they can care for the person safely?	**Y/N** – only proceed if Y
• *Consider the ability for IPC advice to be followed within the home including zoning of resident and cohorting of staff type of care home and the residents that live there (which may in turn impact on ability to follow outbreak prevention and control actions).*	
• *Does the person require specialist support e.g. do they live with Dementia or other condition which requires additional support and resources from the care home.*	
• *Can the home consider providing a smaller number of staff dedicated to supporting the person during their infectious period?*	
• *Is there a risk assessment in place for the individual, considering the following:*	
○ *care plans, including any preferred routines, and advance care plans*	
○ *communication and accessibility needs*	
○ *current medicines*	
○ *triggers to behavioural issues*	
○ *family, including carers and next of kin*	
○ *housing issues*	
○ *preferred places of care.*	

Outbreak assessment This section should be completed to support your own assessment of the situation, you may wish to seek support from other organisations including IPC to facilitate this. Unless there is an explicit pause on admissions within your setting as part of an outbreak management measure, the RMs assessment is proportionate.	
Is the care home considering the admission currently in outbreak? If yes:	**Y/N**
• *When did the outbreak start?*	
• *Has there been at least one clear round of whole home testing since the outbreak started?*	*Y/N*
○ *Date and results of most recent WHT*	*Date:* *Results:*
• *Does the outbreak appear to be escalating (i.e. sustained increase in cases since original notification), stable (intermittent, low numbers of cases), or recovering (no recent cases, approaching/undertaking recovery testing)*	*Escalating/ Stable/Recovering*
The size of outbreak and whether it only affects staff	
• *Number of residents who have tested positive during this outbreak (out of total residents)*	_____ out of _____

• *Number of staff who have tested positive during this outbreak (out of total staff)*	_____ out of _____
• *Have the staff cases been in work during their infectious period (i.e. in the 2 days prior to their positive test result)*	
• *Do the staff cases have a clear route of transmission outside of the setting e.g. positive household members? [If no – assume in-setting transmission by default]*	
• *Number of residents still in isolation (i.e. number of COVID-19 positive people remaining on site)*	
○ *Are cases all in the same part of the care setting i.e. contained within a particular building/floor? Is this the same/different part of the building that the admission is meant to be in to?*	
○ *Are all COVID-19 positive residents able to effectively isolate?*	
• *Number of staff currently in isolation*	
○ *Are staffing levels sufficient to allow for the admission to take place safely?*	
The care home environment, including size/layout	
• *Does the layout of the setting allow for cohorting between different groups of residents AND staff?*	*Y/N*
• *Are there any outstanding concerns identified around IPC e.g. as identified by QIT, CQC or IPC teams?*	*Y/N*
• *Is there any ongoing intervention from the NYCC QIT team?*	*Y/N*
• *What is the current Care Quality Commission (CQC) rating, and date of last inspection?*	*Rating:*
What are the rates of booster vaccination among residents and staff?	

Care home providers must be able to refuse admissions where they feel they cannot provide safe care and they must not be put under undue pressure.	
Considering all the above, is the registered manager, in consultation with the person/s supporting the admission willing to go ahead?	
Outcome of Decision: **Name of persons consulted:**	