UK Health Security Agency

Acute Respiratory Infection Resource Pack for Care Homes (Interim)

Version 3.0

(Adapted for use by Westmorland and Furness Council Health Protection Team)

15 November 2023

About the UK Health Security Agency

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

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

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List of Abbreviations

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

National guidance on COVID IPC measures in adult social care and the national guidance on the management of outbreaks of influenza-like illness (ILI) in care homes provide the majority of the content of this pack.

Both are due to be updated and once published, updated guidance will **immediately supersede** this resource pack**.**

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

Section 1: Local Contacts

Community Infection Prevention and Control Team (CIPCT)	
Westmorland and Furness Council Health Protection Team - email contact preferred IPC@westmorlandandfurness.gov.uk Public Health Manager- Health Protection Nicola Holland	**Mon-Fri 9am-5pm** Email contact 0788 126 4861
UKHSA North West Health Protection Team (HPT)	
Monday – Friday 9am – 5pm	0344 225 0562
Out of Hours	0151 434 4819

Reporting Outbreaks of suspected / confirmed Acute respiratory infection (ARI)	
Monday to Friday 9am – 5pm	Community Infection Prevention and Control Team (CIPCT) IPC@westmorlandandfurness.gov.uk
Weekends/Bank Holidays 9am – 5pm (or after 5pm for urgent queries)	Local UKHSA Health Protection Team (HPT): 0151 434 4819
After 5PM	Refer to this resource pack and report the next day with either Community Infection Control Team (weekdays) or UKHSA Health Protection Team (weekends)

Section 2: Acute Respiratory Infection Key Messages

The most commonly identified causes of acute respiratory infection (ARI) in care homes are **influenza (flu) viruses**, as well as non-influenza viruses such as respiratory syncytial virus (RSV), rhinovirus, adenovirus, parainfluenza and human metapneumovirus (hMPV), and SARS-CoV-2 virus (COVID-19).

Symptoms are difficult to distinguish between COVID-19, influenza, and other, influenza-like illness (ILI) viruses. COVID-19, influenza, and other ILI will need to be investigated and managed simultaneously. Therefore, acute respiratory infection in care homes should initially be managed with stringent infection control measures as per guidance, and prompt testing is recommended to confirm the diagnosis.

2.1 Disease Characteristics & Exclusion Periods

	COVID-19	Influenza-like illness (ILI)
Symptoms	• New, persistent cough (coughing for >1 hour, or ≥3 coughing episodes in 24 hours) AND/OR • Fever (temperature of 37.8°C or higher) AND/OR • Anosmia (loss of the sense of smell and/or taste) Other symptoms that may indicate COVID-19 in care home residents include: • Worsening shortness of breath • Delirium, particularly in those with dementia A laboratory detection of COVID-19 would fulfil the definition of a case of COVID-19.	• Fever (Oral (mouth) or tympanic (ear) temperature of 37.8°C or higher) AND • New onset of one or more respiratory symptoms: - Cough (with or without sputum) - Hoarseness - Nasal discharge or congestion - Shortness of breath - Sore throat - Wheezing - Sneezing OR • An acute deterioration in physical or mental ability without other known cause Whilst it is recognised that older people may not always develop a fever with influenza, fever is necessary to define ILI[1]. A laboratory detection of influenza virus would fulfil the definition of a case of influenza.

[1] The World Health Organisation (WHO) defines ILI as an acute respiratory infection with fever (38.0 °C or higher) and cough, while the US Centers for Disease Control and Prevention (CDC) defines ILI as fever (37.8°C or higher) with a cough and/or sore throat. The UKHSA case definition is consistent with these approaches.

	COVID-19	Influenza-like illness (ILI)
Infectious Period	2 days before onset of symptoms (or 2 days before test date if asymptomatic) up to 10 days after onset of symptoms (or 10 days after test date if asymptomatic) Please see current guidance	From 24 hours before onset of symptoms until symptoms have resolved. For influenza specifically, it is generally assumed that people are infectious from the onset of symptoms and whilst they have symptoms.
Exclusion/ isolation Periods	Minimum of 5 days after the test was taken until feeling well (if tested positive for COVID) COVID-19 supplement to the infection prevention and control resource for adult social care - GOV.UK (www.gov.uk) Symptomatic residents should be cared for in single rooms and any symptomatic staff should isolate at home https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance	Minimum of 5 days after the onset of symptoms and until feeling well Symptomatic residents should be cared for in single rooms and any symptomatic staff should isolate at home

* E.g. cancer, chronic lung disease, renal disease, heart disease, liver disease, stroke, systemic corticosteroid use, chemotherapy, organ or bone marrow transplant, advanced HIV/AIDS infection, and pneumonia diagnosis
** Refer to Guidance

2.2 Basic Infection Prevention Messages

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

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

- **Hand Hygiene** - reinforce education about hand and respiratory hygiene to staff and residents and display the hand hygiene poster throughout the setting. Ensure infection control policies are up to date, read and followed by all staff. Staff, residents and any visitors should wash their hands regularly and use tissues for coughs and sneezes.

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

- **Facilities** - ensure liquid soap and disposable paper towels are available at each hand wash basin and sink; alcohol-based hand rub (at least 70%) and tissues are available throughout the home; and stocks are adequately maintained in all areas including bathrooms, communal and work areas.

- **Personal Protective Equipment (PPE)** – ensure PPE is available where required. This may include disposable gloves, aprons, and surgical masks, plus eye protection for procedures that may generate splashback. Where staff are being asked to use PPE, they should be trained in donning, doffing and correct disposal. See PPE guide for non-aerosol generating procedures. Ensure the care home follows national guidance for when PPE should be used, see Infection prevention and control: resource for adult social care and COVID-19 PPE guide for adult social care services and settings. Additional PPE is required for aerosol generating procedures (AGP).

- **Cleaning** - clean surfaces and high touch areas frequently. Clean commonly used equipment regularly. If there are suspected or confirmed ARI cases, all areas should be cleaned at least twice daily. Appropriate PPE should be worn when cleaning locations where symptomatic people have been (see section 6).

- **Ventilation** is an important IPC measure. Letting fresh air from outdoors into indoor spaces can help remove air that contains virus particles and prevent the spread of COVID-19 and other respiratory conditions

The comfort and wishes of the person receiving care should be considered in all circumstances, for example balancing with the need to keep people warm. Rooms may be able to be repurposed to maximise the use of well-ventilated spaces, which are particularly important for communal activities.

Section 3: Acute Respiratory Infection Preparedness in Care Home Settings

3.1 General Advice

The COVID-19 and influenza vaccinations offer the best protection against the viruses for staff and residents. To minimise risk to people who receive care and support, health and social care providers should encourage and support all their staff to obtain a COVID-19 vaccine and a booster dose as and when they are eligible, as well as a vaccine for seasonal influenza. Providers can do this by putting in place arrangements to facilitate staff access to vaccinations, and regularly reviewing the immunisation status of their workforce in line with immunisation against infectious disease ('the Green Book').

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

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

3.2 Advice for Management

- Managers should review sick leave policies and occupational health support for staff and support unwell or self-isolating staff to stay at home as per national guidance.
- Managers have a duty of care to protect their staff and residents from influenza and COVID-19 and should actively encourage ALL staff and residents to receive their free seasonal influenza vaccine in partnership with the GP Practice/Community Pharmacy and a full course of COVID-19 vaccinations. COVID-19 booster vaccinations will also be offered as per national guidance.
- Managers should review their list of resident details, and ensure it is kept up to date, and includes the level of support and any clinical procedures that residents require.
- Managers should have up to date business continuity plans.
- Managers should ensure care home infection control policies are up to date, read and followed by all staff.
- Managers should nominate staff members to act as their ARI coordinators and manage working practices and care home environment on every shift.
- Managers should ensure that sufficient PPE is available for staff, and that they are trained in its safe use and disposal.
- Managers should reinforce education of staff, residents and visitors about hand and respiratory hygiene, quick guide here.

- Managers should make sure there is sufficient time/staff numbers on shifts to enable good infection prevention and control (IPC).

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

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

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

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

3.3 Advice for Staff

- All staff involved in resident care are encouraged to have a COVID-19 and seasonal influenza vaccine to protect themselves and their residents.

- Adult social care staff should book their vaccinations as early as possible via local booking services or the national booking service. Staff vaccinated elsewhere should highlight they work in the care sector to the vaccinator.

- Appointments can also be booked through the NHS App, or by phoning 119

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

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

- There are no longer any additional precautions for staff contacts of a confirmed case of COVID-19.

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

3.4 Advice Regarding Residents

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

- Tissues and handwashing facilities should be available throughout your facility to enable residents to wash their hands regularly and to use tissues for any coughs or sneezes.

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

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

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

- During an outbreak of ARI, management should monitor residents and record symptoms (see Appendix 2).

Section 4: Management of Suspected ARI Cases and Outbreaks in Care Home

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

Checklists for the management of single cases and outbreaks of ARI are provided in Appendices 3 and 4. Suspected or confirmed outbreaks of ARI should be immediately notified to your local Community Infection Prevention Control Team (CIPCT) in hours and the UKHSA HPT out of hours (see section 1).

Within the 'influenza season' (*as declared by the Chief Medical Officer*) or outside the 'influenza season' where influenza is known to be circulating locally, antivirals should be considered for any outbreaks where influenza is either suspected or confirmed and following a risk assessment undertaken in partnership with the care home, CIPCT, relevant GP and UKHSA HPT.

COVID-19 Case Definition	**Influenza Like Illness Case Definition**
See 2.1	See 2.1
Definition for an Acute Respiratory Outbreak	
Two or more cases that meet the clinical case definition of ILI or COVID-19 (above) arising within the same 14-day period in people who live or work in the care home, without laboratory confirmation.	
Definition for a Confirmed COVID-19 Outbreak	**Definition for a Confirmed Influenza Outbreak**
At least one confirmed COVID-19 case and one or more cases that meet the clinical case definition of COVID-19, arising within the same 14-day period in people who live or work in the care home.	At least one laboratory confirmed influenza case and one or more cases that meet the clinical case definition of ILI arising within the same 48-hour period in people who live or work in the care home.
PUBLIC HEALTH ACTIONS SHOULD NOT BE DELAYED WHILE AWAITING CONFIRMATORY TEST RESULTS	

Managers should increase the frequency and intensity of cleaning for all areas, focusing on shared spaces and ensure appropriate linen and waste management systems are in place.

- If possible, managers should consider limiting staff movement within setting, e.g. individual care staff to only work on one floor/unit.

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

4.1 Public Health Actions for Symptomatic or Confirmed Cases

4.1.1 Residents

- Individuals who are eligible for COVID-19 treatments and who have symptoms of a respiratory infection should take an LFD test immediately and follow the guidance for people who are eligible for COVID-19 treatments.

- Individuals who are not eligible for COVID-19 treatments no longer need to test if they develop symptoms of a respiratory infection.

- Residents with respiratory infections, including influenza, must isolate in a single room or appropriately cohorted (see section 4.3) in line with summary in section 2.1.

- Ensure that anyone displaying ARI symptoms or with a positive test, receives appropriate clinical assessment via GP/111/A&E (depending on the severity of symptoms). The GP can assess suitability of antiviral treatment irrespective of outbreak status of home, if clinically indicated.

4.1.2 Staff

- If a member of staff develops ARI symptoms during a shift, they should go home as soon as possible; and stay away from work as outlined in section 2.1 & national guidance

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

- A risk assessment should be undertaken with staff members at risk of complications if they become infected with COVID-19 or influenza e.g. pregnant or immunocompromised individuals, to determine if they should avoid caring for symptomatic patients. Managers should undertake a risk assessment before staff return to work in line with normal return to work processes.

- Agency and temporary staff who are exposed during the influenza outbreak should not work in any other health or care settings until 2 days after their last shift in the affected home. They can continue to work in the affected home once exposed and when the outbreak is over they can work elsewhere as normal.

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

4.2 Actions for COVID-19 or ILI close Contacts

Close contacts of any individual with any a respiratory virus including COVID-19 no longer need to self-isolate.

4.3 Cohorting Residents

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

- If there is co-circulation of COVID-19, influenza, or other respiratory viruses, consider **separate cohorts of residents with different viruses** if possible. If this is not possible, prior to testing and laboratory confirmation, symptomatic residents with compatible symptoms should be cared for in separate areas (e.g. units or floors) from residents without symptoms.

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

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

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

- Please see guidance for people whose immune system means they are at higher risk for details.

- Separate staff should be allocated to cohort areas to prevent wider infection spread across the home. Consider using staff vaccinated against influenza at least 14 days

beforehand to care for symptomatic patients with suspected influenza. IPC and PPE guidance should be followed, regardless of vaccination status.

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

4.4 What Local Support Can Care Homes Expect?

- Suspected or confirmed ARI infection should be reported to the CIPCT by emailing IPC@westmorlandandfurness.gov.uk. This inbox will be checked at regular intervals Monday-Friday 9am-5pm. Please include as much information as possible (number of residents/staff affected, date of onset, name and contact number of staff member in charge).

- An IPC Practitioner/ Advisor will call the home and gather additional information required to support the risk assessment. It is important that the Home Manager or ARI Lead has completed appendices 1 and 2 in preparation for these discussions. The CIPCT will provide case or outbreak management and infection prevention and control advice to the care home.
- An email will be sent to confirm any agreed actions and provide links to current national guidance as appropriate.
- Your local Community Infection Control teams will liaise directly with UKHSA Health Protection Team (HPT) to provide information about what is happening in your home. In some instances, UKHSA HPT may contact you directly, for example out of hours.

4.5 Key Actions for Care Home Management During an ARI Outbreak

1. Ensure there is a named ARI co-ordinator on every shift.

2. Maintain adequate PPE supplies.

3. Maintain accurate records of residents with ARI symptoms and share these with CIPCTs/HPT as requested. See Appendix 2. **Accurate information is essential for outbreak investigation.**

4. Ensure regular symptom checks for all residents and staff in line with routine care practices.

5. Display appropriate signage across the home. As a minimum, this should include:

    a. Notice of outbreak at all entrances including exclusion information for anyone (staff or visitors) displaying symptoms.

    b. Infection control notices outside rooms of symptomatic residents.

6. Adhere to all infection prevention and control measures, including stringent hand and respiratory hygiene for staff, residents and visitors, enhanced cleaning across all affected units of the home, particularly focusing on frequently touched sites or points.

7. Increase the frequency of infection control audits to weekly.

8. Limit close contact with other people especially during an outbreak, or when spending prolonged periods of time with a vulnerable individual. This can help reduce your risk of catching or spreading any ARI.

9. Visiting:

- Inform visitors that there is an outbreak of respiratory illness in the care home
- Visitors should not enter the care home if they are feeling unwell, especially if they have any symptoms that suggest other possible infections such as cough, high temperature, diarrhoea or vomiting
- Keep visitors, who are visiting an affected resident, to the minimum number that is required for the resident's welfare
- Visiting health staff such as GPs or District Nurses can continue to visit the care home but must be informed of the outbreak and advised about personal protective equipment and other control measures e.g., hand washing as necessary
- Other visiting professionals (social workers, physiotherapists etc.) should also be informed so they can make their own risk assessment of whether they should visit

10. Consider closure of the home to new admissions, supported by a risk assessment and discussion with IPC/HPT and social care commissioners and hospital discharge team (see section 9).

Section 5: Testing

5.1 COVID-19 testing regimes in care homes

Routine asymptomatic testing in care home settings is no longer recommended. Care homes should keep enough test kits to prepare for symptomatic testing of individuals eligible for treatment and for outbreak testing where applicable. See guidance on when to test. See guidance for how to order COVID-19 tests for your organisation.

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.

5.1.1 Outbreak testing in care homes

To inform the risk assessment, the first 5 linked symptomatic residents should be tested using LFD tests irrespective of their eligibility for treatments. This is to determine if there are 2 or more linked cases of COVID-19 or another respiratory infection. After this, new cases do not require testing unless they are eligible for COVID-19 treatments, as set out above on when to test.

Wider outbreak testing should only be done if it is advised by the HPT or other local partner. The HPT may also provide advice if a variant of concern is suspected.

5.1.2 Outbreak recovery testing in care homes

Outbreak recovery testing is no longer undertaken. Outbreak measures can be lifted 5 days after the last suspected or confirmed case. This is from the day of the last positive test, or the day the last resident became unwell, whichever is latest.

Residents should be monitored for up to a further 5 days after this to ensure they can access appropriate treatments where necessary.

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

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

The current North West arrangements are outlined below:

- The CIPCT (weekdays, in-hours) or UKHSA HPT (weekends) remain the first point of contact for the care home to report a symptomatic resident or residents with ARI and

lead the risk assessment, provide case or outbreak management and infection prevention and control advice to the care home.

- In an outbreak situation, the first 5 symptomatic residents should undertake lateral flow testing.
- If all 5 are negative, the IPC team or HPT may advise testing of up to 5 of the most recently symptomatic residents for wider respiratory viruses including influenza A and B, through the UKHSA Public Health Laboratory Manchester if influenza is suspected.

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

- **The UKHSA laboratory will arrange for a courier to deliver the necessary swab kits to the care home at the earliest available opportunity. The laboratory will inform CIPCT/UKHSA HPT if a same day courier has been arranged, who will then communicate this to the care home. If a same day courier cannot be arranged, it will be arranged for the next day. The courier will take the test kits to the home, wait for 30 minutes while swabs are taken, packaged and returned to the courier.**

  Swabbing instructions will be included with these test kits. **PLEASE ENSURE NAME, DOB & ILOG NUMBER ARE WRITTEN CLEARLY ON ALL FORMS AND SPECIMEN TUBES.** Failure to follow this instruction will result in specimen rejection by the laboratory.

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

If Point of Care testing (POCT) for influenza is carried out in the care home, please follow your local protocols, ensuring that an additional swab is taken for each individual so that laboratory confirmation and other respiratory virus testing can still be undertaken where indicated. All test providers have a legal duty to notify the results of a positive POCT for influenza virus to UKHSA within 7 days. Further information about the POCT notification process can be found here.

5.3 Declaring an Outbreak Over

Any respiratory outbreak should not be declared over until no new symptomatic cases or positive results have occurred in residents or staff for a minimum of 5 days after onset of symptoms in the last case.

If there are risk factors for the prolonged infectiousness of cases remaining symptomatic e.g. residents with long-term conditions or impaired immune systems (see section 2.1), infection control measures, including isolation, should be maintained for longer than 5 days until residents have fully recovered, with no on-going fever or respiratory symptoms.

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

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

Repeat testing is no longer recommended for residents or staff. Isolation is only required for 5 days from the initial positive test.

Section 6: Personal Protective Equipment (PPE)

6.1 PPE Requirements

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

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

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

The personal protective equipment section on the COVID-19 supplement guidance provides information on the type of PPE that is recommended, to help protect care workers and care recipients and prevent the transmission of infectious diseases, with particular advice regarding care of people suspected or confirmed to be COVID-19 positive.

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

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

Care workers and visitors to care homes do not routinely need to wear a face mask in care settings or when providing care in people's own homes.

However, there are certain circumstances where it is recommended for staff and visitors to wear a face mask to minimise the risk of transmission of COVID-19. These are:

- if a person being cared for is known or suspected to have COVID-19 (staff and visitors are recommended to wear a Type IIR fluid-repellent surgical mask)
- if a COVID-19 outbreak has been identified within a care home
- if a care recipient would prefer care workers or visitors to wear a mask while providing them with care

Providers should also support the personal preferences of care workers and visitors who wish to wear a mask.

6.2 Ordering PPE in Social Care

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

The National Supply Disruption line (If you have immediate concerns over your supply of PPE)	Tel: 0800 876 6802 Email: supplydisruptionservice@nhsbsa.nhs.uk
Local Arrangements:	

Section 7: Environmental Considerations

The Infection prevention and control quick guide for care workers details general IPC principles including cleaning, ventilation, uniforms and workwear and is to be used in combination with guidance on managing specific infections such as the COVID-19 supplement.

The national specifications for cleanliness guidance can be found here.
Guidance on decontamination of linen must also be followed.

7.1 Ventilation

Ventilation is an important IPC measure. Letting fresh air from outdoors into indoor spaces can help remove air that contains virus particles and prevent the spread of COVID-19.

Rooms should be ventilated whenever possible with fresh air from outdoors after any visit from someone outside the setting, or if anyone in the care setting has suspected or confirmed COVID-19.

The comfort and wishes of the person receiving care should be considered in all circumstances, for example balancing with the need to keep people warm. Rooms may be able to be repurposed to maximise the use of well-ventilated spaces, which are particularly important for communal activities.

Further information regarding ventilation can be found in Infection prevention and control: resource for adult social care and guidance on the ventilation of indoor spaces.

7.2 Waste management

In addition to standard precautions the following should be observed:

- in a nursing care home, waste generated when supporting a person with confirmed COVID-19 or influenza should enter the hazardous waste stream (usually an orange bag). Other care homes may have a hazardous waste stream and should use it if available
- waste visibly contaminated with respiratory secretions (sputum, mucus) from a person suspected or confirmed to have COVID-19 or influenza should be disposed of into foot-operated lidded bins lined with a disposable waste bag
- if there is not access to a hazardous waste stream, such as waste generated in people's own homes, this should be sealed in a bin liner before disposal in the usual way

Section 8: Visitors

8.1 Visiting arrangements and precautions

It is important that any visitor follows the IPC processes put in place by the care home, such as practising hand hygiene and wearing appropriate personal protective equipment (PPE), as outlined in the section on PPE recommendations. Visitors should consider taking up any COVID-19 and flu vaccines they are eligible for.

Visitors should not enter the care home if they are feeling unwell, even if they have tested negative for COVID-19 or flu, 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 symptoms that suggest COVID-19, they should follow the guidance for people with symptoms of a respiratory infection.

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 be supported in all circumstances.

Visitors should be encouraged to only access residents own rooms and avoid areas of communal living such as lounges and dining rooms (where this doesn't impact on the health and wellbeing of the resident)

Visits out should be facilitated wherever possible and there should not be any restrictions on visits out for individuals who are not symptomatic or who have not tested positive in any circumstance.

Care home residents should not usually be asked to avoid contact with others or to take a test following visits out of the care home.

Precautions for visitors

Care homes should ask visitors to follow the same PPE recommendations as care workers to ensure visits can happen safely. Additional requirements for face masks may be in place during a confirmed outbreak of COVID-19. This should be based on individual assessments, taking into account any distress caused to residents or barriers to communication from the use of PPE.

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

Health, social care and other professionals may need to visit residents within care homes to provide services. Visiting professionals should follow the PPE recommendations as per other visitors.

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

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

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

- Care homes should carry out a risk assessment prior to all admissions to the home and contact local CIPCT if they require further advice.

- Care homes should follow discharge and testing guidance.

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

Hospital discharge

Individuals being discharged from hospital into a care home should be tested with a COVID-19 LFD test within 48 hours before planned discharge. This test should be provided and done by the hospital.

The result of the test should be shared with the individual and their key relatives or advocate. The relevant care should be provided within the hospital before the discharge takes place. Evidence of the LFD test result should be communicated by hospitals to care homes in writing within the usual communications provided at the time of discharging a patient to a care home.

Individuals who test positive for COVID-19 can be admitted to the care home if the home is satisfied they can be cared for safely. Individuals who are admitted with a positive test result should be kept away from other residents on arrival and should follow the guidance on care home residents who test positive for COVID-19.

The period individuals should stay away from others is from the day after the positive test and does not restart when the individual is admitted into the care home. If the individual has already tested positive before the planned discharge, they do not need to test again if they continue to have symptoms of a respiratory infection and feel unwell or have a high temperature.

Community admission

Individuals admitted from the community or other care settings do not need to be tested before they are admitted into the care home.

Section 10: National Guidance Documents

This local guidance document has been based on national UKHSA, NHS and government guidance. Hyperlinks to key national guidance are displayed here for reference (click on the link to be taken to the relevant guidance/information online).

Influenza-like Illness

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

National COVID-19 Guidance

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

Infection Prevention and Control

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

- COVID-19 PPE guide for unpaid carers
- PPE guide for non-aerosol generating procedures
- Standard Infection Control Precautions - Literature Reviews

Cleaning and Waste Management

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

Other

- CQC: Adult social care: information for providers

Appendix 1: Care Home and Resident Information Template

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

Room	Name	DOB	NHS No.	Medical Conditions	GP Practice	Date of 1st COVID-19 Vaccine	Date of 2nd COVID-19 Vaccine	COVID-19 Booster Date	Date of Flu Vaccine	Kidney Function: Date & result of most recent eGFR	Weight (Kg)
In the event of an outbreak, this table will ensure that important information is recorded in one place and is easily accessible											

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

Room	Name	Age	NHS No.	Date of symptom onset	Symptoms*	COVID-19 Vaccines 1st? 2nd? Booster?	Flu Vaccine Yes/No (date)	Date GP informed	Date swabbed**	Date Antivirals commenced	Date CIPCT informed

***Symptoms:** **T** = Temp (≥37.8 C), **C** = Cough, **NC** = Nasal Congestion, **ST** = Sore Throat, **W** = Wheezing, **S** = Sneezing, **H** = Hoarseness, **SOB** = Shortness of Breath, **CP** = Chest Pain, **AD** = Acute deterioration in physical or mental ability (without other known source) ***If Swabbed*

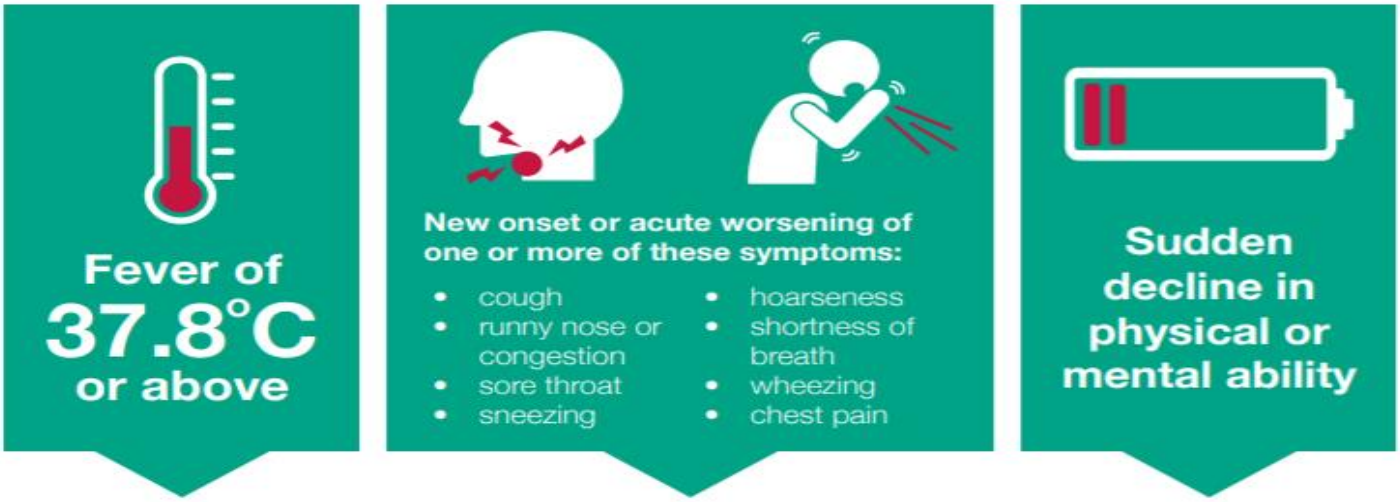
Appendix 3: Checklist for **Single Case** of ARI - **Actions**	**Date, time & sign when action completed**
1) **Clinical assessment** and management by clinician - GP/111/A&E *If* **flu is** clinically suspected/detected, antivirals may need to be arranged within 48 hours of symptom onset for the case, but this is a clinical decision. Should a case of flu be reported and it's within 48 hours of exposure antivirals may be considered for resident contacts and any staff in at risk groups who are unvaccinated against flu, but this is . Discuss with CIPCT /UKHSA HPT	
2) **Testing** • *Test for COVID-19 as per guidance for clinically vulnerable only*	
3) **Management of resident cases** • *If COVID-19, isolate resident cases for 5 days from date of test and until feeling well* • *If ARI (non COVID-19), isolate resident cases for a minimum 5 days after the onset of symptoms and until feeling well.*	
4) **Management of staff cases** **Exclude symptomatic staff from work**. *If COVID-19 positive isolate and follow staying at home guidance. Staff should not attend work until 5 days afgter date of test and until feeling well.* *If negative for COVID-19 and have symptoms of or are confirmed as having influenza, they should remain off work for a minimum of 5 days after the onset of symptoms and until feeling well.*	
5**) Management of contacts** No specific management of any contacts of COVID or ARI	
6) **Hand and respiratory hygiene** for staff; residents and visitors. *Ensure access to tissues, handwashing facilities with liquid soap, disposable paper towels and alcohol-based hand rub.* *Reinforce education:* ***"Catch it! Bin it! Kill it!"***	
7) **Personal Protective Equipment (PPE)** for staff *and* visitors. *Adequate PPE worn as per national guidance..*	
8) **Enhanced Cleaning** *Clean surfaces and high touch areas frequently. Clean shared equipment between residents, e.g. hoists, aids, showers. If suspected or confirmed cases, all areas should be cleaned at least twice daily.*	
9) Segregate **Linen and Waste** appropriately *Ensure linen management and clinical waste disposal systems are in place. No specific COVID laundry requirements any more, see general guidance for managing waste and laundry*	

Appendix 4 (Part 1**):** Checklist for **2 or more Cases** of ARI **- Actions**	**Date, time & sign when action completed**
1) **Clinical assessment** and management by clinician - GP/111/A&E *If* **flu is** clinically suspected/detected, antivirals may need to be arranged within 48 hours of symptom onset for the case, but this is a clinical decision. Should cases of flu be reported and it's within 48 hours of exposure antivirals may be considered for resident contacts and any staff in at risk groups who are unvaccinated against flu, but this is . Discuss with CIPCT /UKHSA HPT	
2) **Communicate** – Immediately inform the Community Infection Prevention & Control Team (CIPCT) weekdays, and UKHSA Health Protection Team (HPT) weekends/Bank Holidays (9-5pm). Outside of these hours, refer to Resource Pack and inform the CIPCT or UKHSA HPT the next day.	
3) **Commence Outbreak Testing** ***For COVID-19***: Undertake LFT testing on first 5 symptomatic residents **Wider respiratory testing:** Where influenza is clinically suspected and/or COVID-19 testing is negative, wider respiratory testing may be advised.	
4) **Management of cases and contacts** a) **Isolation of cases** • *If COVID-19 positive, isolate resident cases for Minimum of 5 days after the test was taken and until feeling well* • *Symptomatic residents should be cared for in single rooms and any symptomatic staff should isolate at home* • *If ARI (non COVID-19), isolate resident cases for a minimum 5 days after the onset of symptoms and until feeling well.* • If **cohorting** is required, only cohort residents together who have the same virus. *ALWAYS consider whether residents have any other potentially transmissible conditions before cohorting e.g. diarrhoea, MRSA* - Separate staff should be allocated to work in a cohort area on each shift. Movement of staff between different cohorts / resident groups should be restricted as far as possible. - Access to communal areas should be restricted. b) **Exclusion of symptomatic staff** from work. • *If COVID-19 positive, isolate and follow staying at home guidance. Staff should not attend work until 5 days after test was taken and until feeling well guidance.* • *If negative for COVID-19 and have symptoms of or are confirmed as having influenza, they should remain off work for a minimum of 5 days after the onset of symptoms and until feeling well.* *c)* **Contacts** • Exclusion or isolation of contacts no longer required	
5) Named **ARI Co-ordinator** to be allocated on every shift. This staff member would ensure they have up to date information re: the care home situation & outbreak in anticipation of liaison with CIPCT, UKHSA HPT, GP	
6) **Hand and Respiratory Hygiene** for staff; residents and visitors. Ensure access to tissues, handwashing facilities with liquid soap, disposable paper towels and alcohol-based hand rub. Reinforce education: "Catch it! Bin it! Kill it!"	

Appendix 4 (Part 2**):** Checklist for **2 or more Cases** of ARI **- Actions**	**Date, time & sign when action completed**
8) **Personal Protective Equipment (PPE)** for staff and visitors. Adequate PPE worn as per national guidance. All staff should be trained in donning and doffing. Ensure PPE is changed between residents (gloves and aprons) or worn sessionally (masks and eye protection). Additional PPE is required for aerosol generating procedures.	
9) **Enhanced Cleaning** Clean surfaces and high touch areas frequently. Clean shared equipment between residents, e.g. hoists, aids, showers. If suspected or confirmed cases, all areas should be cleaned at least twice daily. Locations where symptomatic residents have been should be cleaned wearing PPE.	
10) Segregate **Linen and Waste** appropriately. Ensure linen management and clinical waste disposal systems are in place in line with routine IPC guidance	
11) **Outbreak & IPC Signage** to be displayed. Display appropriate signage as a prompt to ensure correct IPC & isolation precautions followed to prevent onwards transmission of infection.	
12) **Visitors** Visiting is no longer suspended during an outbreak, each care home must complete a dynamic risk assessment to consider proportionate changes to visiting in line with guidance. Visitors including professionals should follow the visiting precautions in guidance.	
13) Consider cohorting residents or restriction of movement of staff providing direct care to avoid 'seeding' of outbreaks between different settings supported by risk assessment.	
15) **Vaccination** Consideration of seasonal flu (and COVID-19 vaccination if unvaccinated/booster dose outstanding) of all unvaccinated residents and staff, supported by risk assessment.	
16) Consider closure of the home to new admissions, supported by a risk assessment and discussion with IPC/HPT and social care commissioners and hospital discharge team (see section 9).	
17) An outbreak of ARI can be declared over after a minimum of 5 days since the onset of symptoms in the latest case and when agreed with the CIPCT	

UK Health Security Agency

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



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

Individuals who are eligible for COVID-19 treatments and who have symptoms of a respiratory infection should take an LFD test immediately and follow the guidance for people eligible for COVID-19 treatments.

Irrespective of LFD results, call and notify the Westmorland and Furness Council Health Protection Team at IPC@westmorlandandfurness.gov.uk

W&F HPT can arrange testing for other respiratory viruses if appropriate e.g. flu A, flu B, RSV

Antivirals for flu may also be arranged after risk assessment by IPC/UKHSA, but are most effective if given with 48 hrs of symptom onset.