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Admission and Care of Residents in a Care Home during COVID-19

Version 2

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Summary Change Note

This note outlines the changes made to the 'Admission and care of residents during COVID-19 incident in a care home', originally published on 2 April 2020.

No.	Guidance Section	Overview of changes
1	Introduction	<ul style="list-style-type: none"> Updated in line with recent policy announcements
2	1. Admission, isolation and testing of residents	<ul style="list-style-type: none"> Updated advice on isolation of residents on admission Updated testing guidance. Includes additional information on testing for residents and staff and managing outbreaks, where to go for further information, and Test and Trace service
3	2. Caring for residents, depending on their COVID-19 status and particular needs	<ul style="list-style-type: none"> Updated advice on monitoring residents for COVID-19 symptoms, and supporting residents who have been exposed to a COVID-19 case Updated advice on supporting symptomatic residents. Includes additional information on isolation procedures, engagement with the Health Protection Team, and supporting residents who require hospital care Additional information on primary care and community health services for residents, and supporting residents without relevant mental capacity
4	3. Reporting of COVID-19 cases and outbreak management	<ul style="list-style-type: none"> Additional information on Health Protection Team engagement and advice on admission during an outbreak
5	4. Care for people at the end of life and after death	<ul style="list-style-type: none"> Additional information on end of life care and end of life plans
6	5. Advice for staff	<ul style="list-style-type: none"> Updated advice for staff. Includes additional information on PPE, workforce restrictions, Test and Trace for staff, staff with symptomatic family members, and what staff should do if they test positive or negative for COVID-19 Updated advice for care home managers. Includes further information on sick leave policies and training
7	6. National support available to implement this guidance	<ul style="list-style-type: none"> Additional information on the Adult Social Care Infection Control Fund and care homes support package
	ANNEXES	
8	Annex A: COVID-19 symptoms and higher risk groups	<ul style="list-style-type: none"> Additional information on additional COVID-19 symptoms, NHS mutual aid, and presentation of symptoms in different groups of people
9	Annex B: Definitions of COVID-19 cases and contacts	<ul style="list-style-type: none"> Additional information on additional COVID-19 symptoms, definition of 'contacts', 'outbreaks' and care homes seeking advice from Health Protection Teams
10	Annex C: Isolation of residents during	<ul style="list-style-type: none"> Updated advice on isolation procedures

No.	Guidance Section	Overview of changes
	periods of sustained transmission	
11	Annex D: Infection Prevention and Control (IPC) Measures	<ul style="list-style-type: none"> • <i>Additional information on using single-resident use devices, PHE support and cleaning and waste disposal</i>
12	Annex E: Restricting workforce movement and minimising workforce transmission	<ul style="list-style-type: none"> • <i>New section</i> • <i>Updated advice on workforce restrictions to minimise the risk of workforce transmission. Includes additional information and recommendations for staff to reduce the risk of asymptomatic transmission</i>
13	Annex F: Provision and use of Personal Protective Equipment (PPE)	<ul style="list-style-type: none"> • <i>Updated advice on PPE distribution and utilisation</i> • <i>Additional information on support available to the care sector, hand hygiene, and respiratory and cough hygiene</i>
14	Annex G: Decontamination and cleaning processes for care homes with possible or confirmed cases of COVID-19	<ul style="list-style-type: none"> • <i>Additional information on cleaning equipment and disinfectant</i>
15	Annex I: Use of the Capacity Tracker	<ul style="list-style-type: none"> • <i>Updated advice on using the Capacity Tracker</i>
16	Annex J: Interim COVID-19 Waste Management Measures	<ul style="list-style-type: none"> • <i>New section</i> • <i>Additional information on the management of healthcare waste from care home settings</i>

Introduction

On **15 May 2020**, the government published a [support package for care homes](#) backed by a £600 million Adult Social Care Infection Control Fund. This is the next phase of our response for care homes, using the latest domestic and international evidence brought together by Public Health England (PHE), and drawing on the insights of care providers.

This document updates the previous 'Admission and care of residents during COVID-19 incident in a care home' guidance published on 2 April 2020, in line with the support package for care homes and latest updated advice on testing and Infection Prevention and Control (IPC).

This guidance is for periods of sustained community transmission. It will be updated as the situation relating to the spread of and risk posed by coronavirus changes. Proprietors, managers, social workers, family members and relevant health professionals should check this guidance at regular intervals to ensure they are viewing the most current version and should continue to keep the implementation of any locally adopted measures under review to ensure that they are appropriate.

Care homes are a vital part of our health and social care system and we want to make sure you and your staff can continue to care for some of the most vulnerable to COVID-19 in our society.

We want to support care home providers to protect their staff and residents, ensuring that each person is getting the right care in the most appropriate setting for their needs. We know that to do this care homes need to have access to the right knowledge, staff and resources, so they are equipped to deliver care in this challenging time.

The Department of Health and Social Care (DHSC) has led on this guidance, with input and advice from NHS England and NHS Improvement (NHSE&I), PHE and the Care Quality Commission (CQC)¹.

This guidance is intended for care homes, local health protection teams, local authorities, Clinical Commissioning Groups (CCGs) and registered providers of accommodation for people who need personal or nursing care. This includes registered residential care and nursing homes for people with learning disabilities, mental health and/or other disabilities. This guidance has also been shared with NHSE&I providers and GPs for information.

Please note that this guidance is of a general nature and that an employer should consider the specific conditions of each individual place of work and comply with all applicable legislation, including the Health and Safety at Work etc. Act 1974.

¹Note that references to 'we' in this guidance refer to the Department of Health and Social Care

Everyone with responsibility for the admission and care of care home residents must always be mindful of the needs and rights of those residents. This guidance should therefore be considered alongside the wellbeing principles outlined in the Care Act 2014, the [Ethical Framework for Adult Social Care](#), and relevant equalities-related legal and policy frameworks. Any assessment of a resident's needs and subsequent decisions made must consider individual circumstances and ethical implications, ensuring that the resident is treated with respect so that their human rights, personal choices, safety and dignity are upheld.²

DHSC acknowledges that care home settings differ significantly. That is why care home managers and proprietors need to undertake a balanced risk assessment when considering the implementation of this guidance. This must consider the needs of all residents and staff in the care home to ensure that they are taking timely and proportionate measures for each setting.

² Specific legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic has also been provided by NHS England and can be accessed [here](#).

1. Admission, isolation and testing of residents

The care sector looks after many of the people who are most vulnerable to COVID-19 in our society. In this pandemic, we appreciate that care home providers are first and foremost looking after the people in their care and doing so while some of their staff are absent due to sickness or isolation or have taken the decision to shield. As part of the national effort, the care sector also plays a vital role in accepting patients as they are discharged from hospital, because recuperation is better in non-acute settings. Residents may also be admitted to a care home from a home setting. Some of these patients may have COVID-19, and as we learn more about the condition it can be difficult to distinguish symptoms of COVID-19 from other conditions of morbidity, whether they are symptomatic or asymptomatic.

Isolation of residents discharged from hospital or another social care facility

To minimise the risk to residents in care homes during periods of sustained community transmission, all residents being discharged from hospital or interim care facilities to the care home, and new residents admitted from the community, should be isolated for 14 days within their own room. This should be the case unless they have already undergone isolation for a 14-day period in another setting, and even then, the care home may wish to isolate new residents for a further 14 days. If new residents are admitted part way through an isolation period, they should as a minimum complete the remaining isolation period within their own room in the care home.³

A 14-day period of isolation is recommended for residents in care homes as older care home residents are a particularly vulnerable group and their immune response may differ from younger, normally healthier individuals.

People with dementia or a learning disability, autistic people, and people experiencing serious mental ill health are likely to experience particular difficulties during the pandemic. This could include difficulty in understanding and following advice on social distancing, and increased anxiety. They may need additional support to recognise and respond to symptoms quickly, and in some cases may be at greater risk of developing serious illness from COVID-19. The government has worked with the Social Care Institute for Excellence (SCIE) to provide additional guidance for [care staff supporting adults with learning disabilities and autistic adults](#).

For further guidance on discharge, please refer to the [discharge service requirements](#) and guidance for [stepdown of infection control precautions and discharging COVID-19 patients](#).⁴

³ The issue of a negative result should be interpreted with caution, particularly in the presence of relevant clinical symptoms. These residents should have a clinical assessment in line with the local IPC policy which should account for where the patient was prior to admission to the home. The care home may still be advised to isolate these residents from other vulnerable and shielded residents for 14 days from admission.

⁴ Please note that the discharge service requirements are currently under review and will be updated in due course.

This covers both patients who have recovered or are recovering from COVID-19. For advice on safe practices in a care home please see the guidance document [How to Work Safely in a Care Home](#).

A small number of people may be discharged from hospital within the 14-day period from the onset of COVID-19 symptoms needing ongoing social care, but no longer needing in-patient care. They will have been COVID-19 tested and have confirmed COVID-positive status. Test results should be included in discharge documentation. They will also need to be isolated until they complete their 14-day recommended isolation period. No care home will be forced to admit an existing or new resident to the care home if they are unable to cope with the impact of the person's COVID-19 illness for the duration of the isolation period. Some care providers will be able to accommodate these individuals through effective isolation strategies or cohorting policies. If appropriate isolation/cohorted care is not available with a local care provider, the individual's local authority will be asked to secure alternative appropriate accommodation and care for the remainder of the required isolation period.

The government has made £1.3 billion available via the NHS to support enhanced discharge, and this funding can be drawn on for this alternative provision. Local authorities are responsible for ensuring that there is sufficient alternative accommodation to quarantine and isolate residents as required. We expect local authorities to work together with the NHS to put this approach into practice, in accordance with the NHS Discharge Requirements. Please see the [Adult Social Care Action Plan](#) for more details.

Where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as every admission or transfer to a care home.

Testing staff and residents in care homes

Care homes are on the frontline in tackling COVID-19 and we are determined that staff will have everything they need to keep themselves and their residents safe. The safety of residents and staff is a priority, and testing is a crucial part of this. It helps to both prevent and control outbreaks and allows the right steps to be taken at the right time to reduce the spread of the virus and protect the most vulnerable.

As we have ramped up our testing capacity, we have continued to prioritise testing for care home staff and residents. All symptomatic social care workers, including care home staff, have been able to access a test since 8 April and PHE have been providing testing to support outbreak control in care homes since the start of the outbreak. We published the [Adult Social Care Action Plan](#) on 15 April, which set out our commitment to test all residents prior to their admission to care homes, including on discharge from hospital and to expand outbreak testing to include all symptomatic residents.

We have since gone even further, with the government announcing on 28 April that testing would be expanded in the care sector to include both symptomatic and asymptomatic care home staff and residents. We have now made 50,000 tests per day available and launched the [care home portal](#) on 11 May to allow care home managers to request tests for all staff and residents – known as ‘whole home testing’. We initially prioritised whole home testing for care homes that specialise in caring for older people and those living with dementia in line with advice from PHE and Scientific Advisory Group for Emergencies (SAGE). We met our target to offer whole home testing to all care homes caring for older people and those with dementia by 6 June. On 7 June, we expanded eligibility for whole home testing to all remaining adult care homes. We expect these to be largely specialist adult care homes catering for adults with learning disabilities or mental health issues, physical disabilities, acquired brain injuries and other categories for younger adults under 65 years. Expansion of testing to other care settings and retesting of care homes will be guided by clinical advice on relative priority and available testing capacity. The care home portal (see details below) should be checked for the latest advice on eligibility.

Where to go for further information?

Further information, including additional guidance documents, instructional videos to support administration of tests and links to access testing are [available here](#).

Specifically:

- Symptomatic care home workers (and anyone with symptoms that lives in the same household as a care home worker) can arrange a test at either a Regional Testing or Mobile Testing Site, or choose to receive a home testing kit delivered direct to their door by visiting the online [self-referral portal](#).
- Alternatively, employers can refer their symptomatic staff for a test via the employer-referral portal – further information is available via the link above and employers will need to email portalservicedesk@dhsc.gov.uk to obtain a login.
- Care home managers should contact their local Health Protection Team (HPT) if they suspect their care home has a new coronavirus outbreak and/or it has been 28 days or longer since the last case and there are new cases.⁵ HPTs will provide advice and arrange the first tests and can be contacted using the form available on [GOV.UK](#).
- Care home managers can apply for coronavirus testing kits to test residents and staff of their care home via the online [care home portal](#). They can apply whether or not

⁵ Recovery from an outbreak of COVID-19 in a care home is defined by a period of 28 days or more since the last laboratory confirmed or clinically suspected cases was identified in a resident or member of staff in the home.

any of their residents or staff have coronavirus symptoms. Visit the care home portal for details of eligibility.

- Care home residents will be tested as a matter of course prior to their discharge from hospital, and results should be included in discharge documentation.
- If you cannot access resources online, please call 119 (in England and Wales).

Test and Trace service

The NHS Test and Trace service forms a central part of the government's COVID-19 recovery strategy, which seeks to return life to as close to normal as possible, for as many people as possible, in a way that is safe and protects our NHS and social care.

The NHS Test and Trace service:

- provides testing for anyone who has symptoms of coronavirus to find out if they have the virus
- gets in touch with anyone who has had a positive test result to help them share information about any close recent contacts they have had
- alerts those contacts, where necessary, and notifies them they need to self-isolate to help stop the spread of the virus

For further information on how the Test and Trace service works please [click here](#).

For further information on what the Test and Trace system means for staff working in care homes, please see section 5 (Test and Trace information for staff) and Annex B for potential scenarios of staff contacts.

2. Caring for residents, depending on their COVID-19 status and particular needs

When caring for residents, providers should pay regard to the [Ethical Framework for Adult Social Care](#), and the well-being duty in [Section 1 of the Care Act 2014](#).

For advice on caring for particular needs, please see the sections below.

- a) Keeping asymptomatic residents safe and monitoring symptom development**
- b) Symptomatic residents**
- c) Supporting existing residents who may require hospital care**
- d) Management and isolation of residents exposed to a possible or confirmed COVID-19 case**
- e) Primary care and community health services for residents**
- f) Residents without relevant mental capacity**

a) Keeping asymptomatic residents safe and monitoring symptom development

Care home providers should follow relevant government guidance for everyone in the care home. For example, wherever possible care homes should be implementing [social distancing measures](#), and supporting individuals to follow the [shielding guidance](#) for the clinically extremely vulnerable group. Care home residents (both older residents and younger residents with a learning disability or autistic people) may not present with the typical symptoms of cough or fever and may not be able to report a loss of taste or smell. It is important to assess residents twice daily for the development of a high temperature (37.8°C or above), a cough, as well as for softer signs i.e. being short of breath, being not as alert, having a new onset of confusion, being off food, having reduced fluid intake, diarrhoea or vomiting.

Through NHS 'mutual aid' the NHS will be supporting care home professionals to use well evaluated tools such as [RESTORE2](#) and [NEWS2](#) (supported in current British Geriatric Society (BGS) [guidance](#)). This will be accompanied by support and access to specific equipment such as pulse oximeters, which can also help determine whether a resident is unwell. Equipment which is used to support the monitoring of residents will need to meet infection control and decontamination standards and guidance.

Any such changes could alert staff to the possibility of new COVID-19 infection. Staff should immediately report residents with these symptoms or signs to the Health Protection Team (HPT), as outlined in the section below.

b) Symptomatic residents

Any resident presenting with symptoms of COVID-19 should be promptly isolated (if not already) and tested (see Annex D for further detail on infection control measures and section 1 for information on testing). This should be in a single room with a separate bathroom, where possible.

If the design and capacity of the care home and the number of residents involved is manageable, it is preferable to isolate residents into separate floors or wings of the home. Residents in isolation should not attend communal areas, including shared lavatories and bathrooms. Symptom management measures should be taken to keep the resident as comfortable as possible. This may include medicines which will need to be prescribed and monitored by the resident's GP.

If symptoms worsen during isolation or are no better after 7 days, contact NHS 111 or the named clinician for the care home to receive further advice around escalation and to ensure appropriate clinical care and person-centred decision making is followed. For a medical emergency dial 999.

Care homes will be supported to recognise residents with symptoms using daily monitoring as above. During the weekly check-in, the clinical lead can support the home to understand the RESTORE2 and NEWS2 scoring system as a way of monitoring residents with symptoms. Should a patient's symptoms worsen, it is important to contact 111 or the registered GP to receive a clinical assessment either remotely or face to face. Further advice should be given on escalation and how to ensure that decisions are made in the context of a resident's advance care plan, supporting an escalation to secondary care where appropriate. In a medical emergency the care home should dial 999.

Staff should immediately instigate full infection control measures to care for the resident with symptoms (if not already in place), which will avoid the virus spreading to other residents in the care home and stop staff members or other residents becoming infected. Guidance on use of Personal Protective Equipment (PPE) in care homes is provided [here](#).

Care home staff should note that people with dementia and cognitive impairment may be less able to report symptoms because of communication difficulties, and therefore staff should be alert to the presence of signs as well as symptoms of the virus. This could include delirium, which people with dementia are more prone to suffer from if they develop an infection.

For people with a learning disability and/or autistic people further [guidance](#) is available. This provides information about the additional things to do if you are caring for this group of people. Around two-thirds of people living in care homes for the over 65s are over 85 years old and it is estimated that around 70% will be living with dementia. Advice on [dementia](#) has also been provided by the Social Care Institute for Excellence.

Annex C provides further information on the appropriate isolation required for care home residents who have been discharged from hospital following treatment for COVID-19.

c) Supporting existing residents who may require hospital care

If you think a resident may need to be transferred to hospital for urgent and essential treatment, consider the following checklist.

If a resident shows symptoms of COVID-19:

- Assess the appropriateness of hospitalisation: to do this the care home may need to contact their local registered GP or the appropriate out of hours service for advice. Consult the resident's advance care plan/treatment escalation plan and discuss with the resident and/or their family member(s) or Health and Welfare attorney and their GP as appropriate, following usual practice to determine if hospitalisation is the best course of action for the resident.

If hospitalisation is required:

- Follow [infection prevention and control guidelines](#) for patient transport.
- Inform the receiving healthcare facility as early as possible that the incoming patient has COVID-19 symptoms.

If hospitalisation is not required:

- Follow infection prevention and control and isolation procedures and consult the resident's GP for advice on clinical management, using remote monitoring as needed (see Annex C and D).

If a resident requires support with general health needs:

- Flag each resident who requires review by the weekly 'check in' with the aligned Primary Care Network (PCN) or GP practice (see section on NHS support).
- Consult the resident's GP and community healthcare staff to seek advice.
- Alternatively, contact NHS 111 for clinical advice.

Postpone routine non-essential medical and other appointments:

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

d) Management and isolation of residents exposed to a possible or confirmed COVID-19 case

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

If a resident displays symptoms or signs consistent with COVID-19 in the 14 days after exposure then relevant diagnostic tests, including for SARS-CoV-2 (the virus which causes COVID-19), should be performed (see testing section above for more information). These residents should be isolated or cohorted with other suspected cases whilst results are pending if these measures are not already in place.⁶

Please see section 5 for advice for **staff** exposed to a possible or confirmed COVID-19 case.

e) Primary care and community health services for residents

NHS England and NHS Improvement wrote to all Clinical Commissioning Groups (CCGs), general practices and community health service providers on [1 May](#), requesting that primary care and community health services help to support care homes, building on the services already in place in much of England. This should include:

- delivery of a consistent, weekly ‘check-in’, to review patients identified as a clinical priority for assessment and care;
- supporting the development and delivery of personalised care and support plans for care home residents; and
- provision of clinical pharmacy and medication support to care homes, including facilitating medication supply and delivering structured medication reviews.

⁶ A personalised care and support plan based on the principles set out in the [Dementia: Good Care Planning](#) guide, to manage behavioural disturbances is important for people with dementia. Often, a person-centred approach can help diffuse any behavioural and psychological symptoms of dementia, such as walking with purpose. Alternatives to drugs should be tried before prescribing medication. Specialist advice should be sought, including if medication is being considered. [NICE guideline NG97](#) provides guidance on medication for behavioural disturbances in people with dementia.

This support should be provided by a multidisciplinary team, working across general practices and community services providers, and will be delivered remotely where appropriate in order to reduce infection control risks. Care homes should have access to an identified clinical lead for this primary care and community health service support.

f) Residents without relevant mental capacity

Some residents of care homes, including those being admitted from hospitals and the community, may lack the relevant mental capacity needed to make decisions about arrangements for their own care and treatment. For example, some people with dementia and learning disabilities may lack the relevant capacity to make these decisions, and will fall under the empowering framework of the Mental Capacity Act 2005 (MCA) and are protected by its safeguards, including the Deprivation of Liberty Safeguards (DoLS).

Duties and powers under the MCA still apply during this period. If care home staff think the person may lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before a decision about their discharge from hospital and admission to a care home, is made. During the emergency period, professionals may want to consider a proportionate approach to such assessments to enable timely discharge.

If a resident does not have relevant mental capacity, for example, to make necessary decisions (including care, treatment and residence decisions), staff will need to consider the legal, decision-making framework offered by the MCA. DHSC has issued [guidance](#) on the use of the MCA and DoLS during this emergency period. The Social Care Institute of Excellence (SCIE) provides [guidance on implementing the Mental Capacity Act](#)⁷ specifically to support care homes in undertaking this. It covers involving residents in the process, best interests decisions, reviews, DoLS and includes a useful checklist for monitoring MCA implementation.

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

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

⁷ <https://www.scie.org.uk/mca/practice/care-planning/monitoring-implementation>

3. Reporting of COVID-19 cases and outbreak management

Please inform the local Health Protection Team (HPT) at PHE of a single possible or confirmed case within the care home (See Annex B for definitions of cases and contacts). The HPT will also provide initial testing for symptomatic residents (see information on testing in section 1). The HPT will provide advice and support along with local authority partners to help the care home to manage the outbreak.

- Follow the outbreak control measures advised by the HPT.
- The outbreak can be declared over once no new cases have occurred in the 28 days since the onset of symptoms in the most recent case, which is twice the incubation period. To support local areas in controlling the infection, questions are being added to the Capacity Tracker to monitor where care homes have had an outbreak which is now over. Further detail is being sent with the Capacity Tracker itself.
- If a new case is identified in a care home (not a discharged COVID-19 positive case diagnosed in hospital), a risk assessment should be undertaken to see if all communal activities in the care home can be stopped and follow HPT advice. The HPT may advise that restrictions may need to be implemented for 28 days. For example, they may advise closure of home to further admissions, recognising this is usually the care home manager's decision in discussion with their commissioners (and alerting the Clinical Commissioning Group (CCG) and local authority).
- During an outbreak, visitors should be supported to wear Personal Protective Equipment (PPE). We are reviewing our policy on visitors and are looking to update our guidance shortly.

4. Care for people at the end of life and after death

Care at the end of life for residents, regardless of the cause of their deterioration, should be provided for in line with the [five priorities for care](#). Each resident should have a plan of care tailored to their individual needs and preferences that includes explicit consideration of food and fluids, symptom management and psychological, social and spiritual support. They should be asked, where possible, if they would like to receive a visit from a loved one or a faith leader. Their family and those important to them should be informed about what is happening and offered the opportunity to visit.

After death, the infection control precautions described in this document continue to apply whilst a person who has died remains in the care home. This is due to the ongoing risk of infectious transmission via contact, although the risk is usually lower than from those living.

Further information can be found [here](#).

5. Advice for staff

Responsibility for the safety of staff remains with their employer.

During a period of sustained transmission of COVID-19 across the UK, **an additional level of Personal Protective Equipment (PPE)** is required for normal care. Guidance on specific PPE for use in the care home sector can be accessed [here](#).

Given the evidence of the prevalence of asymptomatic transmission, PHE strongly recommends that care homes do all they can to restrict staff movement wherever feasible. The check list in Annex E sets out the actions that providers from care homes should take – as far as it is feasible for them to do so without compromising other aspects of safe care – if they have not already done so.

When there are visits from health care and social care workers, these staff should be advised to wear appropriate [PPE](#).

If a health or social care worker, has come into close contact with a resident with confirmed COVID-19, or a symptomatic resident suspected of having COVID-19, while not wearing PPE, or had a breach in their PPE while providing personal care to a resident with confirmed or suspected COVID-19, then the staff member should inform their line manager. Please refer to the [How to work safely in care homes](#) PPE resource.

In assessing whether a health or social care worker has had a breach of PPE, a risk assessment should be undertaken in conjunction with local Infection Prevention and Control (IPC) policy. The following factors should be taken into consideration – the severity of symptoms the resident has, the length of exposure, the proximity of the resident, the activities that took place when the worker was in proximity (e.g. Aerosol Generating Procedures (AGPs), monitoring, personal care) and whether the health or social care worker had their eyes, nose or mouth exposed. If the risk assessment concludes there has been a significant breach, or close contact without PPE, the worker should remain off work for 14 days.

Examples that are unlikely to be considered breaches include if a health or social care worker was not wearing gloves for a short period of time or their gloves tore, and they washed their hands immediately, or if their apron tore while caring for a resident, and this was replaced promptly.

This would also apply to other individuals present in a care environment e.g. allied health professional, visitor or family member, if they are following instructions from that institution.

For more information on interpreting test results and the actions required for both symptomatic and asymptomatic individuals, see the [flowcharts illustrating the return to work process](#).

Test and Trace System: information for staff

Under the new COVID-19 Test and Trace system, anyone who has had a specific “close contact” with someone who tests positive for COVID-19 will be expected to isolate themselves for 14 days, or for seven days from developing symptoms of COVID-19. Broadly, a “close contact” is spending 15 minutes or more within 2 metres of an infected person, very close specified personal interaction for a shorter period of time or someone who has lived within the same household during a period of potential risk transmission. More detailed definitions of close contact for staff and residents are provided at Annex B.

If someone who tests positive for COVID-19 works in, or has recently visited, a care home, the case will be referred to local public health teams who will liaise with the care home.

If anyone who has tested positive for COVID-19 identifies a member of staff as a close recent contact (i.e. as the result of a contact outside the workplace), and if the NHS Test and Trace service notifies that member of staff, they must self-isolate for 14 days in line with the standard guidance.

For care home staff, it is helpful to distinguish between three potential scenarios where “close contact” occurs:

- A staff member who has been caring for a person who has tested positive for COVID-19 or who has symptoms of COVID-19 while the staff member was wearing appropriate PPE. **Staff will not need to isolate in these cases, but these contacts will be escalated to the local public health team for further advice if needed.**
- A staff member who has been caring for a person who has tested positive for COVID-19 or who has symptoms of COVID-19 while the staff member was wearing appropriate PPE but the PPE has been breached; **The member of staff will need to isolate for 14 days in line with the advice to the general population** (see advice above for examples of PPE breaches).
- A staff member who has been in contact with anyone else who has tested positive for COVID-19 whether at work (most likely a colleague in communal areas) or in the community. **The member of staff will need to isolate for 14 days in line with the advice to the general population.**

Staff with suspected symptoms

For staff who have COVID-19 symptoms, they should:

- Not attend work.
- Notify their line manager immediately.

- Self-isolate for 7 days, following the [guidance for household isolation](#) and [guidance on management of exposed health care workers here](#).
- If care home staff or a member of their household have symptoms and are self-isolating, they should be tested (using the testing routes described above).
- Staff who have a symptomatic household member should stay at home and not leave the house for 14 days. The 14-day period starts from the day when the first person in the house became ill. If the staff member develops symptoms during this period, they can return to work on day 8 after their symptoms started but should have been well without fever for at least 48 hours in addition. Further guidance is available [here](#).
- If all symptomatic household members test negative, the member of staff can return to work if they feel well enough to do so. If any members of the household test positive, they should continue to isolate and follow government guidelines.
- Staff who test negative for COVID-19 can return to work if they are medically fit to do so, as long as they have not been identified as a close contact of a confirmed case. Staff should have a discussion with their line manager and appropriate local risk assessment before returning to work. Staff should consult their GP and Occupational Health if symptoms persist.
- Interpret negative results with caution together with clinical assessment. If needed, local support for staff return to work risk assessments during an outbreak can be accessed from your local HPT or from your IPC lead via your local CCG.
- Symptomatic staff who test positive for COVID-19 and symptomatic staff who have not had a test can return to work only if they meet the criteria below:
 - no earlier than 7 days from symptom onset, provided clinical improvement has occurred and they have been afebrile (not feverish) without medication for 48 hours and they are medically fit to return;
 - if a cough or a loss of or a change in normal sense of smell or taste (anosmia) is the only persistent symptom after 7 days (and they have been afebrile for 48 hours without medication), they can return to work on day 8 (post-viral cough known to persist for several weeks in some cases) if they are medically fit to return.

If staff are asymptomatic when tested:

Staff may be tested when they are asymptomatic as part of the whole care home testing approach.

Staff who test negative for SARS-CoV-2 (the virus which causes COVID-19) and who were asymptomatic at the time of the test can remain at work or return to work immediately as long as they remain asymptomatic and as long as they have not been identified as a close contact of a confirmed case (see above).

Staff who test positive for SARS-CoV-2 (the virus which causes COVID-19) and who were asymptomatic at the time of the test must self-isolate for 7 days from the date of the test. If they remain well, they can return to work on day 8.

If applicable, all members of a household shared with the individual who has tested positive should self-isolate for 14 days from the day the individual's test was taken. However, if any household member of a care worker develops symptoms of COVID-19, they should isolate for 7 days from the onset of their symptoms, in line with the [stay at home guidance](#).

A care worker can return to work:

- no earlier than 7 days from symptom onset, provided clinical improvement has occurred and they have been afebrile (not feverish) without medication for 48 hours and they are medically fit to return.
- if a cough or a loss of or a change in normal sense of smell or taste (anosmia) is the only persistent symptom after 7 days (and they have been afebrile for 48 hours without medication), they can return to work on day 8 (post-viral cough known to persist for several weeks in some cases) if they are medically fit to return.

Staff may require evidence of viral clearance prior to working with extremely vulnerable people. This is subject to local policy.

Currently it is not known how long any immunity to COVID-19 might last. If staff become unwell again, they should self-isolate and may need to be tested again.

Further advice on return to work of staff with complex health needs, including immunosuppression, can be received from designated infection control leads in Clinical Commissioning Groups (CCGs), from [local health protection teams in PHE](#) and/or from directors of public health, according to local arrangements.

Advice for care home managers

- Care home capacity should be monitored via the Capacity Tracker and this data will be shared with Local Resilience Forums (LRFs) via the daily national Situation Reports to support capacity planning and response. Local authorities will also use this information to inform their care home support plans. Where providers consider there to be imminent risks to the continuity of care, such as the potential closure of a service, they should raise this with the local authority without delay.

- Care home managers should review sick leave policies and occupational health support for care home staff and support unwell staff to stay at home as per guidance for household isolation. Support for employers is available [here](#). Staff may be ill due to other reasons and may need to adhere to specific return to work procedures – for example, staff may be off due to diarrhoea and vomiting and should wait 48 hours before returning to work.
- Ensure staff are provided with appropriate training and support to continue providing care to all residents. Employers can access rapid [online induction training](#) for new staff. This includes key elements of the Care Certificate and is available free of charge.
- All care homes should have a business continuity policy in place including a plan for surge capacity for staffing, including using mutual aid.

The government's £600 million Adult Social Care Infection Prevention Fund is helping providers pay for additional staff and/or maintain the normal wages of staff who are self-isolating, or have reduced the number of hours they work to stop the spread of infection.

Social care staff in England can refer anyone who needs to self-isolate to NHS Volunteer Responders. You can make direct referrals through the [NHS Volunteer Responders referrers' portal](#).

6. National support available to implement this guidance

On 15 May 2020, the government published a [care home support package](#), backed by an additional £600 million to support care home providers through a new Adult Social Care Infection Control Fund.

Providers should look at this support package to view details of the support for care homes which provides additional resources for care homes, using the latest domestic and international evidence brought together by PHE, and drawing on the insights of care providers.

Annex A: COVID-19 symptoms and higher risk groups

Provided by HMG

Symptoms of COVID-19 (Coronavirus) are⁸ recent onset of:

- a. A new continuous cough and/or
- b. high temperature
- c. a loss of, or change to, the individual's sense of smell or taste.

Care home residents (both older residents and younger ones living with a learning disability or autism) may not present with the typical symptoms of cough or fever and may not be able to report loss of taste or smell. It is important to assess residents twice daily for the development of a high temperature (37.8°C or above), a cough, as well as for softer signs i.e. being short of breath, being not as alert, having a new onset of confusion, being off food, having reduced fluid intake, diarrhoea or vomiting.

Through NHS 'mutual aid' the NHS will be supporting care home professionals to use well evaluated tools such as RESTORE2 and NEWS2 (supported in current British Geriatric Society (BGS) [guidance](#)). This will be accompanied by support and access to specific equipment such as pulse oximeters, which can also help to determine whether a resident is unwell. Equipment which is used to support the monitoring of residents will need to meet infection control and decontamination standards and guidance.

Persons at higher risk of COVID-19 in a care home setting

The following individuals may be at an increased risk of severe illness from coronavirus (COVID-19). Care home providers should be stringent in following [social distancing measures](#) for everyone in the care home and in supporting those in clinically extremely vulnerable groups to follow shielding guidance.

- a. Anyone who falls under the category of clinically extremely vulnerable should consider following the [shielding guidance](#) to protect themselves.
- b. Anyone aged 70 years or older (regardless of medical conditions) is advised to follow social distancing guidance for the clinically vulnerable.

⁸ Symptoms may be more nuanced in older people with co-morbidities in care homes who may present with Influenza Like Illness (ILI), respiratory illness, new onset confusion, reduced alertness, reduced mobility, or diarrhoea and sometimes do not develop fever. This may be true for COVID-19, so such changes should alert staff to the possibility of new COVID-19 infection.

- c. Anyone aged under 70 years with an underlying health condition – for most this will align with eligibility for the flu jab on medical grounds – is advised to follow social distancing guidance for the clinically vulnerable.

Residents should also be up to date with their routine vaccinations such as annual influenza and pneumococcal vaccination.

Annex B: Definitions of COVID-19 cases and contacts

Provided by HMG

A 'contact' is a person who has been close to someone who has tested positive for coronavirus (COVID-19) anytime from 2 days before the person was symptomatic up to 7 days from onset of symptoms (this is when they are infectious to others). Please also see section 5 of the main guidance for further advice for staff. Further guidance for staff is available on [GOV.UK](https://www.gov.uk).

- **Possible case of COVID-19 in the care home:** Any resident (or staff member) with symptoms of COVID-19 (high temperature, new continuous cough, or loss of or change to the individual's sense of smell or taste), or new onset of influenza like illness or worsening shortness of breath.
- **Confirmed case of COVID-19:** Any resident (or staff member) with a laboratory confirmed diagnosis of COVID-19.
- **Resident contacts:** Any resident that meets one of the following criteria:
 - lives in the same unit or floor as a confirmed case (e.g. shares the same communal areas)
 - or**
 - has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact
 - or**
 - has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact
 - or**
 - has spent more than 15 minutes within 2 metres of a confirmed case.
- **Staff contacts:** Any staff member that has had the following contact while not wearing appropriate PPE or who has had a breach in their PPE:
 - has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact
 - or**
 - has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact

or

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

or

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

or

- has been notified that they are a contact of a co-worker who has been confirmed as a COVID-19 case.
- **Outbreak:** An outbreak is defined as two or more confirmed cases of COVID-19 OR clinically suspected cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days.⁹

NB. If there is a single laboratory confirmed case, this would initiate further investigation and risk assessment.

Care homes should seek advice from their local Health Protection Team (HPT) if they have a single possible case of COVID-19.

⁹ Please note that some datasets have counted all care homes with 1 or more cases as outbreaks. In line with the new definition, one confirmed case will be reported as an 'incident', and two or more laboratory-confirmed or clinically suspected cases will now be recorded as an 'outbreak'. Data on the onset and recovery from outbreaks will be recorded and reported via the Capacity Tracker using the definitions provided above.

Annex C: Isolation of residents during periods of sustained transmission

Provided by HMG

Due to evidence of asymptomatic spread, during periods of sustained transmission we recommend that all residents being discharged from hospital or interim care facilities to the care home and new residents admitted from the community should be isolated for 14 days within their own room.

Isolation of COVID-19 positive residents

- a. **Single case - isolation of a symptomatic resident:** All symptomatic residents should be immediately isolated for 14 days from onset of symptoms or positive test result when available and until their fever has resolved for 48 hours consecutively without medication to reduce their fever.¹⁰

- b. **More than one case - cohorting of all symptomatic residents:**
 - Symptomatic residents should ideally be isolated in single occupancy rooms.
 - Where this is not practical, cohort symptomatic residents together in multi-occupancy rooms. Residents with suspected COVID-19 should be cohorted only with other residents with suspected COVID-19. Residents with suspected COVID-19 should not be cohorted with residents with confirmed COVID-19.
 - Do not cohort suspected or confirmed patients next to immunocompromised residents.
 - When transferring symptomatic residents between rooms, the resident should wear a surgical face mask.
 - Clearly sign the rooms by placing Infection Prevention and Control (IPC) signs, indicating droplet and contact precautions, at the entrance of the room.

Isolation and cohorting of contacts:

Careful risk assessment of the duration and nature of contact should be carried out, to put in place measures such as isolation and cohorting of exposed and unexposed residents. Please refer to the definition of contacts in Annex B. There are broadly three types of isolation measures:

¹⁰ The 7 days isolation period usually applies but care home residents are a particularly vulnerable group and their immune response may differ from younger normally healthier individuals. Therefore, a 14-day period of isolation is recommended for residents in care homes.

- **Isolation of contacts individually in single rooms for 14 days after last exposure to a possible or confirmed case:** This should be the preferred option where possible. These contacts should be carefully monitored for any symptoms of COVID-19 during the 14-day period as described earlier.
- **Cohorting of contacts within one unit rather than individually:** Consider this option if isolation in single rooms is not possible due to shortage of single rooms when large numbers of exposed contacts are involved.
- **Protective cohorting of unexposed residents:** Residents who have not had any exposure to the symptomatic case can be cohorted separately in another unit within the home away from the cases and exposed contacts.
- Clinically extremely vulnerable residents should be in a single room and **not share bathrooms with other residents or staff.**

Annex D: Infection Prevention and Control (IPC) Measures

Provided by HMG

Care homes are not expected to have dedicated isolation facilities for people living in the home but should implement isolation precautions when someone in the home displays symptoms of COVID-19 in the same way that they would operate if an individual had influenza or diarrhoea and vomiting, taking the following precautions:

- If isolation is needed, a resident's own room can be used. Ideally the room should be a single bedroom with en-suite facilities. Where this is not available, a dedicated bathroom near to the person's bedroom should be identified for their use only.
- Protective Personal Equipment (PPE) should be used when within 2 metres of a resident with possible or confirmed COVID-19. Guidance on PPE can be accessed [here](#) and guidance on working safely in care homes [here](#). Display signage to prevent unnecessary entry into the isolation room. Confidentiality must be maintained.
- Room door(s) should be kept closed where possible and safe to do so. Where this is not possible ensure the bed is moved to the furthest safe point in the room to try and achieve a 2-metre distance to the open door as part of a risk assessment.
- All necessary procedures and care should be carried out within the resident's room. Only essential staff rostered to the individual resident (wearing PPE) should enter the resident's room (see Annex E and F).
- Entry and exit from the room should be minimised during care, specifically when these care procedures produce aerosols or respiratory droplets (this is further explained in Annex F).
- Ensure adequate appropriate supplies of PPE, cleaning materials, hand hygiene and respiratory hygiene materials, and waste disposal are available for all staff in the care home.
- All staff, including domestic cleaners, must be trained to understand how to use the PPE appropriate to their role to limit the spread of COVID-19.
- To support this PHE has worked with the care sector representative bodies to produce specialised training videos for using standard PPE, offering tailored insights into how the PPE guidance applies in care settings (available [here](#)).
- Dedicate specific medical equipment (e.g. thermometers, blood pressure cuffs, pulse oximeters, etc.) for residents. Clean and disinfect equipment (including mobility aids) before re-use with another resident in accordance with manufacturer's instructions, and where relevant return to the company for cleaning e.g. pressure-relieving

mattresses. Particular attention should be paid to cleaning of any reusable equipment taken between the residents' bedrooms

- Where possible during outbreaks of COVID-19, use single-resident use devices such as blood pressure cuffs. Single-resident use equipment will be marked with this symbol:



- Ensure only equipment needed for the resident's care is kept in their bedroom to make cleaning easier.
- Restrict sharing of personal devices (mobility devices, books, electronic gadgets) with other residents.

Annex E: Restricting workforce movement and minimising workforce transmission

Provided by HMG

Since the beginning of the pandemic we know that most care home providers have been taking steps that minimise the movement of workforce in order to reduce the risk of asymptomatic transmission of the virus between members of staff and between staff and residents. These steps have been taken on top of, not instead of, appropriate use of Personal Protective Equipment (PPE).

Given the evidence of the prevalence of asymptomatic transmission, PHE strongly recommends that care homes do all they can to restrict staff movement wherever feasible. The checklist below sets out the actions that providers from care homes should consider taking if they have not already done so. Not all of these actions will be possible or appropriate for every provider, but when taken in combination will help reduce the risk of outbreaks in homes and slow the spread of the virus.

- Ensure that members of staff work in only one care home wherever possible. This includes staff who work for one employer across several homes, or members of staff that work on a part-time basis for multiple employers.
- Extend these restrictions to agency staff, under the general principle that the fewer settings members of staff work in, the better.
- Providers should consider limiting or “cohorting” staff to individual groups of patients or floors/wings. This needs careful management and explicit agreement with staff, adherence to the latest guidance and relevant PPE.
- Where additional staff are needed to restrict movement between or within care homes, look to actively increase recruitment of staff. Advertise vacancies on [Find a Job](#), and use materials from the [national recruitment campaign](#) in order to support recruitment activities.
- Take steps to limit use of public transport by members of staff. Where they do not have their own private vehicle, this could include encouraging walking or cycling to and from work and supporting this with changing facilities or rooms, ideally used separately rather than at the same time on shift change. In some instances, local taxi firms may be willing to provide fares to and from a care home at discounted rates.
- Consider how you could provide accommodation for staff who proactively choose to stay separately from their families in order to limit social interaction outside work. This may be provision on site, or in partnership with local hotels.

Annex F: Provision and use of Personal Protective Equipment (PPE)

Provided by HMG

On Friday 10 April 2020, the Government set out its [PPE plan](#), including for the social care sector. The Government's [PPE guidance](#) includes guidance for usage in the social care sector. When there is sustained transmission of COVID-19 across the UK, **an additional level of PPE** is required in line with guidance on specific PPE for use in the care home sector, which can be accessed [here](#). Providers should ensure PPE meets the required specifications recommended in PHE guidance. Advice on what to do in the case of a PPE shortage can be found [here](#).

The rationale underlying all PPE distribution and utilisation should be based on clinical risk. Managers of care homes, and all staff should be familiar with and should use the PPE recommended by PHE to keep staff and patients safe and to assure essential flows of equipment.

To support this, PHE has worked with the care sector representative bodies to produce a specialised [training video](#) for donning (putting on) and doffing (taking off) standard PPE that offers tailored insights into how the PPE guidance applies in care settings. We will keep under review what other forms of training and support may be required locally to ensure safety and respond to the needs of staff working in the sector.

Distribution

We recognise the challenges providers have experienced in obtaining PPE supplies over recent weeks. An increase in global demand for both PPE and non-PPE products has put the supply chain under significant pressure.

As an initial step, in mid-March, social care providers across England received an emergency drop of **7 million** PPE items, so that every Care Quality Commission (CQC) registered care provider received at least 300 face masks to meet immediate needs.

To support the existing supplier network, we have made arrangements with eleven wholesalers to provide supplies to care providers registered with CQC.

In advance of the new PPE on-line portal becoming fully operational, we have worked with the Ministry of Housing, Communities and Local Government (MHCLG) to provide Local Resilience Forums (LRFs) with supplies of PPE to help them respond to urgent local spikes in need across the adult social care system and other front-line services. This route should only be used where providers have an urgent need for PPE and are unable to access PPE through their existing business as usual and designated wholesaler routes.

We have also mobilised a National Supply Disruption Response (NSDR) system to respond to emergency PPE requests, including for the social care sector. Providers who have an

urgent need for PPE and have not been able to access this through their business as usual routes, designated wholesalers and LRFs should raise a request by contacting the 24/7 NSDR helpline: 0800 915 9964. The NSDR does not have access to the full lines of stock held at other large wholesalers or distributors, but can mobilise small priority orders of critical PPE to fulfil an emergency need.

To enable those working in the system to register their PPE requirements more easily, we are piloting a new website for ordering PPE. eBay has worked at pace on development and the portal is beginning to be used by social care providers and GPs in some initial test areas. Once the new system is fully up and running, we will look to expand further to meet the demands of the health and care sectors.

In addition, we are working urgently to ensure we are buying and making more PPE to see us through this pandemic. We have set up a new unit to identify and buy PPE supplies from across the globe as well as encouraging UK manufacturers to produce PPE in a national call to action.

Hand hygiene

- Washing hands with soap and water for at least 20 seconds is essential before and after all contact with the person being cared for, removal of protective clothing and cleaning of equipment and the environment.
- Ensure that liquid soap and disposable paper towels are available at all sinks.
- Alcohol-based hand rub (ABHR) can be used if hands are not visibly dirty or soiled and should have adequate provision and be accessible.
- Promote hand hygiene ensuring that everyone, including residents, staff, service users and visitors, have access to hand washing facilities.
- Provide alcohol-based hand rub in prominent places, where possible.
- Any visitors should be instructed in respiratory and hand hygiene, and should wash their hands on arrival into the home, often during their stay, and upon leaving.
- Homes should regularly audit hand hygiene practice and provide feedback to employees.

Respiratory and cough hygiene – ‘catch it, bin it, kill it’

- Disposable single use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose. Used tissue should be disposed of promptly in the nearest foot operated waste bin. Hands should be cleaned with soap and

water if possible, after coughing or sneezing, using tissues or after contact with respiratory secretions and/or contaminated objects.

- Encourage individuals to keep hands away from eyes, mouth and nose. Some people may need assistance with containment of respiratory secretions. Those who are immobile will need a container at hand for immediate disposal of the tissue such as a bag.

Visible reminders, such as posters, should be placed around the facility, targeting employees, residents, and visitors both for hand hygiene and respiratory etiquette.

More information on the use of PPE and infection control can be found on [GOV.uk](https://www.gov.uk), including guidance on '[How to work safely in care homes](#)'.

Annex G: Decontamination and cleaning processes for care homes with possible or confirmed cases of COVID-19

Provided by HMG

Domestic staff should be advised to clean the isolation room(s) after all other unaffected areas of the facility have been cleaned. Ideally, isolation room cleaning should be undertaken by staff who are also providing care in the isolation room.

The person responsible for undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures:

a. In preparation

- Collect any cleaning equipment and waste bags required before entering the room.
- Any single-use cloths and mop heads must be disposed of and reusable ones must be laundered.
- Before entering the room, perform hand hygiene then put on a fluid resistant surgical mask (FRSM), disposable plastic apron and gloves.

b. On entering the room

- Keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products.
- Bag any disposable items that have been used for the care of the patient as per Annex J Interim COVID-19 Waste Management Measures.

c. Cleaning process

- Use disposable cloths/paper roll/disposable mop heads to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, following one of the 2 options below:
 - Use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)
 - or**
 - A neutral purpose detergent followed by disinfection (1000 ppm av.cl.).
 - If an alternative disinfectant is used within the organisation, the care home should seek advice from a local infection prevention and control specialist to ensure that this is effective against enveloped viruses.

- Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants.
- Any single-use cloths and mop heads must be disposed of and reusable ones must be laundered.

Cleaning and disinfection of reusable equipment

- Clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers, glucometers, that are in the room prior to their removal.
- Clean all reusable equipment systematically from the top or furthest away point.

Carpeted flooring and soft furnishings

- For carpeted floors/items, consult the manufacturer's instructions for cleaning.

d. **On leaving the room**

- Discard detergent/disinfectant solutions safely at disposal point.
- Dispose of all waste as per Annex J Interim COVID-19 Waste Management Measures.
- Clean, dry and store re-usable parts of cleaning equipment, such as mop handles.
- Remove and discard PPE as per local policy.
- Perform hand hygiene.

e. **Staff Uniforms**

Uniforms should be transported home in a disposable plastic bag.

Uniforms should be laundered:

- wash heavily soiled uniforms separately;
- in a load not more than half the machine capacity;
- at the maximum temperature the fabric can tolerate, then ironed or tumble dried.

f. **Safe Management of Linen**

Please refer to [guidance](#) here.

Any towels or other laundry used by the individual should be treated as infectious and placed in an alginate bag then a secondary clear bag. This should then be removed from the isolation room and placed directly into the laundry hamper/bag. Take the laundry hamper as close to the point of use as possible, but do not take it inside the isolation room.

When handling linen do not:

- Rinse, shake or sort linen on removal from beds.
- Place used/infectious linen on the floor or any other surface e.g. table top.
- Re-handle used/infectious linen when bagged.
- Overfill laundry receptacles; or
- Place inappropriate items in the laundry receptacle.

Laundry must be tagged with the care area and date, and stored in a designated, safe lockable area whilst awaiting uplift or laundering.

This should be laundered in line with local policy for infectious linen.

g. Waste

Care homes that provide nursing or medical care are considered to produce healthcare waste and should comply with [Health Technical Memorandum 07-01: Safe management of healthcare waste](#).

See Annex J for COVID-19 specific guidance on waste disposal.

All consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, double bagged and tied. This should be put in a secure location awaiting uplift in line with local policies for contaminated waste.

Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system. If able, the individual can use their en-suite WC.

Communal waste facilities should not be used. Care homes should have well-established processes for waste management.

Annex H: Communications

Provided by HMG

- Display signs to inform of the outbreak and infection control measures, examples can be found [here](#).
- Provide 'warn and inform' letters to residents, visitors and staff if there is a possible case of COVID-19 in the home.
- Although the Health Protection Team (HPT) will provide public health advice in response to an outbreak (including potential closure to new admissions), the care home management has the final responsibility to communicate information, including to staff and visitors and to implement infection control recommendations and any advice on closure to admissions from the HPT. The care home has the primary responsibility for the safety of its staff and residents.

Annex I: Use of the Capacity Tracker

Provided by NHS England and NHS Improvement

Summary

- The Capacity Tracker provides an England-wide single portal for publishing vacancies in care homes and additional information to support care homes managers linked with the COVID-19 pandemic.
- Accurate and timely data is essential for effective management of the response to the COVID-19 pandemic both locally and nationally. A key priority is to ensure daily update of data and DHSC has made access to the [Adult Social Care Infection Control Fund](#) conditional on provision of regular information.
- Any information gathered will not be used to drive any regulatory enforcement activity. Our intention is for this information to be used to support collective planning across the health and social care sector and swiftly resolve issues wherever possible, whether through local or national actions.

What is the Capacity Tracker?

The Capacity Tracker is managed by the NHS North of England Commissioning Support unit (NECS). It is an established and robust system that has been successfully supporting the tracking of care home vacancies across a large proportion of England for some time.

During the COVID-19 pandemic there has been a need to quickly extend its use to collect other information such as: PPE status, workforce status and numbers of residents with COVID-19. This provides local knowledge to support care homes and national visibility of the needs of care homes during the pandemic.

What information should be inputted?

To support current discharge planning and understanding of the needs of care homes, providers are asked to input data on current bed capacity and vacancies, and also data on business continuity issues such as workforce, PPE, number of residents with COVID-19 and overall status of the care home.

Further information can be found in the [joint letter](#) from the Care Provider Alliance, CQC, DHSC and NHS England and Improvement which was sent to providers on 17 April outlining the approach to data collection during the COVID-19 period.

How are the NHS and social care system using this information?

This essential information is being used to support capacity planning and response for care homes by local organisations such as Local Resilience Forums (LRFs), local authorities and Clinical Commissioning Groups (CCGs) to understand capacity and pressures across the care home sector.

How often do providers need to update the Capacity Tracker?

To support reliable real time information, it must be updated at least once per day, even if there has been no change in the vacancies within the care home.

What do care home providers need to do?

Please register via the [Capacity Tracker website](#). NECS will provide support to help you with this, through a contact centre, online guides and short videos to help you understand what you need to do.

The Resource Centre in the Capacity Tracker also contains up to date guidance and information to support you. You will also receive emails containing essential guidance and resources to help you safely care for your residents/patients. Information received will improve the understanding of the support you and colleagues in the care sector may need.

Further advice can be provided by the [Digital Social Care Helpline](#).

What is the role of local authorities in supporting the Capacity Tracker?

- Local authorities, and in particular their Brokerage Teams, have a key role to play. They should request the required level of access from NECS directly via necsu.capacitytracker@nhs.net and local authorities should also identify System Champions and send their name and email address to NHS NECS via necsu.capacitytracker@nhs.net as soon as practicable. Local authorities are also asked to provide any support they can to care homes and all parties should be aware of the support available via the [Capacity Tracker website](#).
- Local authorities have access to full data reports via the Capacity Tracker website.

Annex J: Interim COVID-19 Waste Management Measures

Provided by HMG

Management of healthcare waste from care home settings

Please note that some of the normal waste management practices are adapted to support suitable management of COVID-19 waste. These adaptations are recognised by Defra, and the Environment Agency and have been developed in conjunction with Public Health England

It is important that non-healthcare waste e.g. recycling, domestic type waste, packaging etc. must continue to be handled and managed as normal.

Description of Waste	Requirement	Note
<p>Personal contact waste (including PPE) from routine care (of all residents) e.g. performing meal rounds, medication rounds, prompting people to take their medicines, or cleaning close to residents, assisting with getting in/out of bed, feeding, dressing, bathing, grooming, toileting, applying dressings etc.</p>	<p>Place in the usual “tiger bag” – a yellow bag with a black stripe. Secure with swan neck and zip tie or tape and store safely or see note.</p>  <p>Dispose of as per usual arrangements.</p>	<p>Where you do not have an ‘offensive waste’ stream, ‘black bags’ for residual waste disposal can be used.</p>
<p>Offensive Waste – waste contaminated with body fluids from all residents e.g. bodily fluids, incontinence waste, stoma bags etc.</p>	<p>Place in the usual “tiger bag” – a yellow bag with a black stripe. Secure with swan neck and zip tie or tape and store safely.</p>  <p>Dispose of as per usual arrangements.</p>	<p>Where possible urine and faeces collected in vessels/mobile toilets shall be flushed to sewer.</p> <p>Where macerators are routinely used, their use may be continued.</p>

<p>Where a resident is suspected of or confirmed as having COVID-19 and you can securely store for at least 72hrs for the specified wastes below:</p> <p>Respiratory Intervention waste: Suction catheters and other waste contaminated with respiratory secretions generated from the care of residents with a tracheostomy or long-term ventilation.</p> <p>Personal contact waste: Used tissues, and other soiled items, discarded PPE and disposable cleaning cloths.</p>	<p>Place in the usual “tiger bag” – a yellow bag with a black stripe. Secure with swan neck and zip tie or tape and store safely.</p> <p>This should be securely stored for at least 72 hours before being put in your usual collected waste bin and disposed of as per usual arrangements. If this is not possible please follow guidance below.</p> 	<p>If using this option, you must have clear and clearly displayed procedures to ensure good segregation from other tiger bag waste detailed in this table.</p> <p>You should maintain written records to demonstrate the waste has been held for 72hrs.</p>
<p>Where a resident is suspected of or confirmed as having COVID-19 and you cannot securely store for at least 72hrs for the specified wastes below:</p> <p>Respiratory Intervention waste: Suction catheters and other waste contaminated with respiratory secretions generated from the care of residents with a tracheostomy or long-term ventilation.</p> <p>Personal contact waste: Used tissues, and other soiled items, discarded PPE and disposable cleaning cloths.</p>	<p>Place in an orange bag. Secure with swan neck and zip tie or tape and store safely.</p>  <p>Dispose of as infectious clinical waste.</p>	

<p>Other Clinical Waste</p> <p>Associated with treatment of individuals – this may include other infectious waste from other treatments, sharps, pharmaceuticals.</p>	<p>This waste requires specialist disposal and should be managed in line with the advice given in Health Technical Memorandum. 07-01: Safe management of healthcare waste.</p> <p>This guidance can be found here.</p> 	<p>Your clinical waste contractor should be able to give you advice and help you get this right.</p>
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Adult Social Care Directorate

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