Managing the COVID-19 pandemic in care homes

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Good Practice Guide Introduction

The evidence from the UK in the COVID-19 pandemic shows that care home residents are particularly vulnerable to the infection as a consequence of their complex medical problems and advanced frailty.

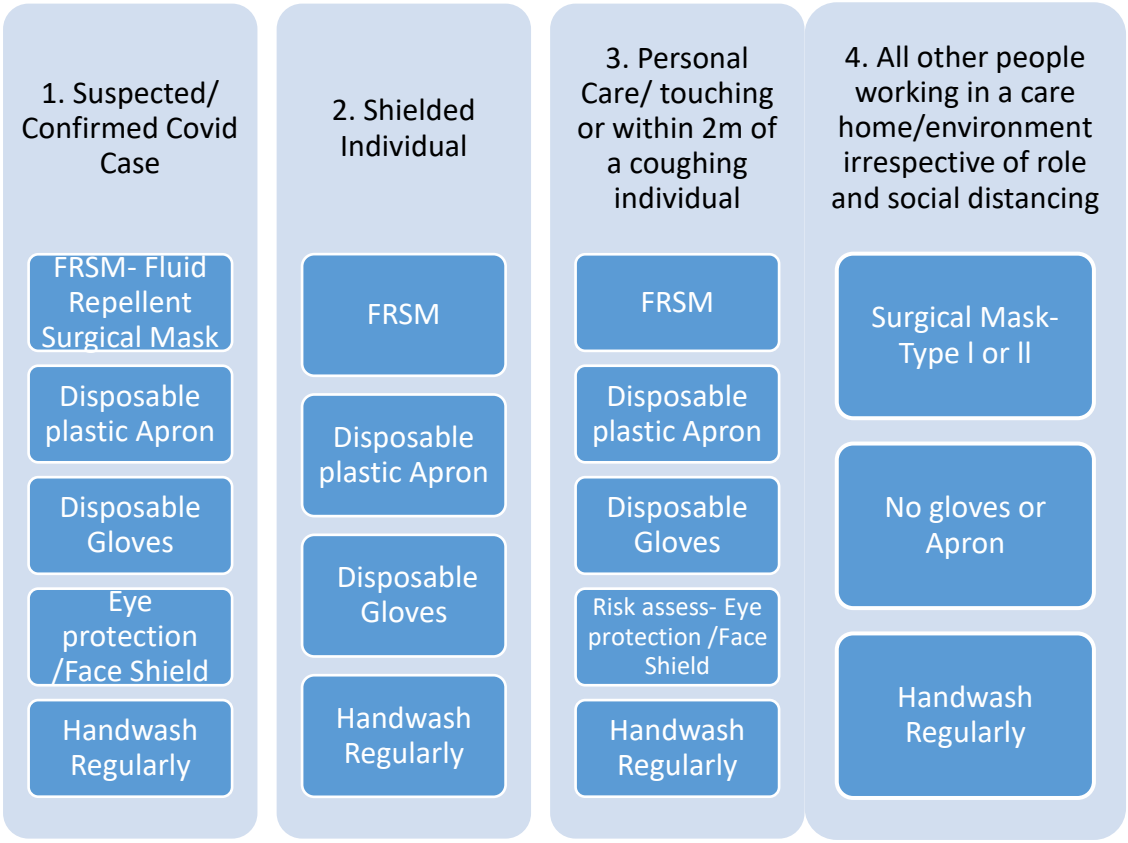
Whilst many care home staff are trained in recognising and managing acutely unwell residents, this is not universally the case, particularly in care homes without nursing. Care home staff are usually not trained in managing outbreaks of infectious diseases and most are not trained nurses. They are,

though, expert in supporting people with cognitive impairment and behavioural symptoms. They are often very experienced and skilled in providing end-of-life care.

Services should follow CareTech's current advice about admissions from Hospital or other homes.

PPE

There is guidance on Rezume for PPE. The table below reflects the most up to date guidance for social care settings.



COVID-19 symptoms and higher risk groups

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

a. new continuous cough and/or

b. high temperature

c. anosmia.

Anosmia is the loss of or a change in your normal sense of smell. It can also affect your sense of taste as the two are closely linked.

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

a. Anyone who falls under the category of extremely vulnerable should follow the Shielding guidance to protect these individuals**. (Currently suspended but reintroduced in areas under local lockdowns)**

The Extremely vulnerable shielding group are:

Solid organ transplant recipients.
People with specific cancers:

- people with cancer who are undergoing active chemotherapy
- people with lung cancer who are undergoing radical radiotherapy
- people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
- people having immunotherapy or other continuing antibody treatments for cancer
- people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
- people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs

People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD.
People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell).
People on immunosuppression therapies sufficient to significantly increase risk of infection.
People with significant heart disease, congenital or acquired.

b. Anyone aged 70 years or older (regardless of medical conditions) should follow social distancing guidance for the clinically vulnerable.

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 – should follow social distancing guidance for the clinically vulnerable.

Shielding residents

1st August 2020- As shielding guidance is reduced across England, services should remain vigilant about protecting those individuals who have been shielding and are vulnerable.

Care homes should take advantage of videoconferencing software on smartphones, tablets and portable computers as much as possible to maintain human contact for residents. They, and healthcare professionals supporting them, must recognise and respond to the strain that social isolation puts on residents and their families.

CareTech retains the stance that visits should only be held in garden areas- guidance available on Rezume. Services should be mindful of any localised lockdown in place where visits to services will need to be suspended.

Please note, that at the time of writing, there is no relaxation of Deprivation of Liberty Safeguards (DoLS) associated with the pandemic and care homes should ensure that they adhere to DoLS guidelines.

- Maintain normality in how you provide services as far as you can, unless isolation related to COVID-19 is advisable, while bearing in mind the current requirement to avoid all non-essential contact with other people.
- Continue to make decisions in accordance with the Mental Capacity Act (MCA). This means work within the five statutory principles, and actively look for the least restrictive options to

meet a need, while being aware that the realistically available options are drastically reduced from normal.

See here for the MCA code of practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Reducing workforce movement between care homes

Based on the latest evidence of significant asymptomatic transmission in care homes, providers should take all possible steps to minimise staff movement between care homes, to stop infection spreading between locations. Subject to maintaining safe staffing levels, providers should employ staff to work at a single location.

Testing

August 1st 2020- Although homes for learning disabilities are not the governments focus for cyclical testing, we expect this to change and weekly testing to be available and expected for staff with monthly testing available and expected for service users. Separate guidance is available on Rezume.

Identifying residents who may have COVID-19 and how to respond

Public Health England have suggested that COVID-19 should be suspected in residents with influenza-like illness. They define this as a fever of at least 37.8°C and a new persistent cough. However, COVID-19 in care home residents may commonly present with non-respiratory tract symptoms, such as new onset/worsening confusion or diarrhoea. Care home staff, with detailed knowledge of residents, are well-placed to intuitively recognise these subtle signs ('soft signs') of deterioration.

In the event of large numbers of residents with suspected or confirmed COVID-19, care homes are advised to work with local infection teams to separate symptomatic and non-symptomatic residents within the care home, if possible.

Staff caring for symptomatic patients should also be cohorted away from other care home residents and other staff, where possible/practical. If possible, staff should only work with either symptomatic or asymptomatic residents. Where possible, staff who have had confirmed COVID-19 and recovered should care for COVID-19 patients. Such staff must continue to follow the infection control precautions, including PPE as outlines in "PPE Guidance" document available on the company Policy Portal.

Practical guidance:

If a person supported complains of, or appears to show, symptoms staff must make sure:

- The person is safe.
- Don appropriate FRSM/ PPE and immediately advise and support the person to self-isolate, explaining why, and providing reassurance in what is a very frightening situation for them.
- Consider immediately any need for analgesics. Paracetamol is recommended, unless their doctor has told them that paracetamol is not suitable.
- They contact 111 for advice or 999 if an emergency (if the person is seriously ill)
- The staff member contacts their internal senior management or internal support line to inform and seek further advice.

Practical guidance whilst awaiting test results and following positive diagnosis

- Staff should use appropriate personal protective equipment (PPE) for activities that bring them into close personal contact, such as washing and bathing, personal hygiene and contact with bodily fluids. Aprons, gloves and fluid resistant surgical masks should be used in these situations.
- If your service does not have dedicated isolation facilities, the person's own room can be used. Ideally the room should be a single bedroom with en-suite facilities or designated bathroom arrangements.
- The resident's General Practitioner, or alternative primary care support team where available, should be notified. They will advise on the medical treatment plan and isolation requirements, to prevent transmission of COVID-19 to other residents. These requirements will change over time and we have not specified them here. The GP has a requirement to inform the local Health Protection Team.
- There may be doubt about whether to admit a person who uses adult social care services to hospital, whether with COVID-19 or other health problems. Include the person or, if the person lacks capacity to be part of decision-making, close relatives or friends who know them well and can advise on what they would probably want. It might be in someone's best interests to remain with their familiar carers, for example, if they live with significant underlying health problems and are not well enough to withstand IC treatment. Managers and other staff should always do everything possible to ensure that decision-makers (doctors or paramedics) do not unintentionally discriminate against people on the basis of their age, diagnosis, or appearance.

Reporting of COVID-19 cases

- Report to GP
- We recommend that the home contacts the Health Protection Teams (HPTs) when the care home suspects for the first time, that a resident has symptoms.
- The HPT can arrange for the testing of all symptomatic residents only at this point, and will provide locally tailored infection control advice.

http://www.careengland.org.uk/sites/careengland/files/130520%20Factsheet%20-%20Care%20Home%20Testing.pdf

- 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 14 days since the appearance of symptoms in the most recent case.

Symptomatic residents

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

Staff should immediately instigate full infection control measures to care for the resident with symptoms, which will avoid the virus spreading to other residents in the care home and stop staff members becoming infected.

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. There are broadly three types of isolation measures:

1. **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. The 10 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. These contacts should be carefully monitored for any symptoms of COVID-19 during the 14-day period as described earlier.
2. **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.
3. **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.

• Extremely clinically vulnerable residents should be in a single room and **not share bathrooms with other residents**.

Test and Trace- Implications for Care staff

The NHS Test and Trace service has been established to minimise community transmission of COVID-19. It is designed to:

- ensure that anyone who develops symptoms of COVID-19 can quickly be tested to find out if they have the virus
- help trace close recent contacts of anyone who tests positive for COVID-19 and, if necessary, notify them that they should self-isolate at home to help stop the spread of the virus

If health and social care staff are providing direct care to a patient or a resident with COVID-19 and are wearing the correct PPE in accordance with the current IPC guidance, they will not be considered as a contact for the purposes of contact tracing and isolation, and will not be required to self-isolate for 14 days.

It is important to note that the effectiveness of the use of face masks, face coverings, or other PPE for prevention of transmission or acquisition of coronavirus infection cannot be guaranteed in settings other than the provision of direct care with patients or residents. Therefore, the use of PPE in other settings (such as a staff room or canteen) will not exclude an individual from being considered a close contact. In addition, if health and social care staff have been in contact with a COVID-19 case and are not following appropriate IPC, including wearing correct PPE, they will be considered as a contact for the purposes of contact tracing and isolation.

If a health or social care worker is considered to be a contact, and the recommendation for them to self-isolate would have implications for the provision of the service, their employer will need to

escalate this for a risk- assessment to a Tier 1 contact tracer at the local Health Protection Team (HPT). Advice about whether a risk-assessment is needed may also be sought from the HPT. The risk-assessment should take account of any PPE use (including its type and situational appropriateness) and other mitigating factors that may reduce the risk of infection transmission to such an extent that the individual identified as a contact does not need to self-isolate.

All staff who come into contact with COVID-19 cases, whether or not they are protected by the use of PPE or by other factors, should remain vigilant to the possibility of contracting infection and should self-isolate immediately if they develop relevant symptoms.

Keeping asymptomatic residents safe and monitoring symptoms

Care home providers should follow Social distancing measures for everyone in the care home, wherever possible, and the Shielding guidance for the extremely vulnerable group.

Care homes should implement daily monitoring of COVID-19 symptoms amongst residents and care home staff, as residents with COVID-19 may present with a new continuous cough and/or high temperature. Assess each resident twice daily for the development of a fever (≥37.8°C), cough or shortness of breath.

There are Temperature monitoring sheets available on Rezume.

Major Incidents

If your Service declares a “Major Incident” due to high rates of infection among people we support and staff, seek additional support from the health community which includes CCGs (essential where the person receives Continuing Healthcare Funding as they are the responsible commissioners) and Public Health England or Public Health Wales (as appropriate). If NHS-funded people we support are involved, direction and support may also come from NHS England. Primary Care support will also be required if high numbers of staff are affected.

In the event of a “Major Incident”, providers should follow their Business Continuity Plan which provides options to support safe minimum staffing levels at which each Service can operate, before the care we provide to people we support is compromised.

There is no need to “lock down” services. Staff do not need to stay around the clock with residents. Staff should adhere to strict infection control including full PPE to prevent the spread of the infection. Services may introduce additional measures such as changing clothes on entry and exit to a service where there is a COVID case.

Services should allocate limited staff to COVID positive people, and allocate specific staff to individual service users elsewhere in the home as much as possible, to prevent any cross infection. If you identify that self-isolation of one person within the care setting is essential, risk assess the people they live with and their staff team, with the likelihood that the whole household would need to self-isolate. Consider, in light of ongoing Government guidance, if this isolation should be apply to ‘whole house’ or ‘section’ or must be solitary. If individual isolation is necessary, consider how to meet the person’s needs for human contact, especially contact with those they love and trust, and how to ensure sufficient staff to care for people in a dignified and humane way. Isolation in this context entails isolation to a room, or house; not that staff need to stay in the service for the duration of an outbreak.

It may be difficult for people being supported to understand why they need to self-isolate. It is essential to continue to explain what is happening by all means possible, while seeking to avoid alarming and even terrifying people. Appropriate communication tools should be used which could include pictures and social stories.

The Business Continuity Plan is in place to provide emergency direction around staff deployment in the event of an emergency. If the minimum safe staffing levels are breached, notify CQC and commissioners, and raise a safeguarding concern, in line with local procedures.

In periods of heightened pressure in the wider health system, providers should be mindful of impacts on partner organisations: all organisations must be prepared to do what they can to support and help each other.

Decisions about escalation of care to hospital

Care homes should be aware that escalation decisions to hospital will be taken in discussion with paramedics, general practitioners and other healthcare support staff. They should be aware that transfer to hospital may not be offered if it is not likely to benefit the resident and if palliative or conservative care within the home is deemed more appropriate. Care Homes should work with healthcare providers to support families and residents through this.

Supporting care home residents and staff

Care home staff are encouraged to work with residents to address their fears and vulnerability about COVID-19, especially while they are unable to have visitors. The COVID-19 pandemic is also expected to add to the strain on care home staff who were already working under challenging circumstances. Advice on the pandemic shifts on a daily basis and care home managers may struggle to support staff who feel isolated from the rest of the health and social care system and hence vulnerable.

Advice for staff

During this period of “sustained transmission” all staff should be wearing masks when in the vicinity of **service users or other staff** irrespective of a 2 metre distance. Where there is a confirmed or suspected case, all masks should be fluid resistant whether or not a staff member is likely to have contact with the person.

These are guiding principles and there should be an individual risk assessment based on staff circumstances, for example staff who are vulnerable should be carefully assessed when assigning duties, and where a possible or confirmed COVID-19 case is present in a care home, efforts should be made to cohort staff caring for that person.

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

• Not attend work if they develop symptoms.

• Notify their line manager immediately.

• Access testing facility- either through self referral or supported by the service.

Providing care after death

The infection control precautions described in this document continue to apply whilst an individual 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 for those living. Refer to the specific policy for further details: Care of a deceased Individual.

Advance care planning and escalation

The COVID-19 pandemic has received much coverage in the news and residents and their families will have almost certainly considered what this means for them. This represents an important opportunity for care home staff to revisit, or visit for the first time, advance care planning, including plans about escalation to hospital, for all their residents. This should include discussions about how the COVID-19 pandemic may affect residents with multiple comorbidities. It should also consider whether people want to be admitted for other long term conditions, such as COPD or heart failure.

Where care home staff feel unable to explore such issues, they should be supported by GPs and primary care teams. This could include redeploying relevant staff from other tasks specifically to do this. The recent advice to stay at home, and to shield care home residents, means that these discussions may need to be held by telephone, or using videoconferencing software on tablets or phones. This is not ideal and will require conversations to be planned in advanced to avoid confusion or distress as much as possible.

Advance Care Plans must be recorded in a way that is useful for healthcare professionals called in an emergency situation. A paper copy should be filed in the care home records and, where the facility already exists, an electronic version used which can be shared with relevant services.

Legal Framework

In an emergency, front-line care takes precedence over bureaucracy and recording, but don't neglect to keep simple records of your actions, such as discussions with the local authority DoLS or legal teams about how to proceed. It will be very helpful, before we are approaching the predicted peak of infection, to find out if these bodies have provided protocols for business as usual about DoLS authorisations or Court applications, or about how to make urgent contact if worried about a possibly unlawful deprivation of liberty or a Safeguarding issue. Set up links to the local authority so that information on this and other issues will be shared with you promptly.

Summary points

- The new Covid-19 law and regulations do not remove our existing rights and duties to work within the empowering ethos of human rights law; the Mental Capacity Act (MCA) is an essential part of this.
- It is important to remember that best interests decisions can only be made by choosing among the available options. At this time, clearly the freedom of action and choice is limited for all citizens; there is no way to exempt vulnerable people who may lack capacity from these great but necessary restrictions, though of course empathy, kindness and a proactive effort to quell fear and anxiety remain the bedrock of good care.
- All restrictions must be considered to see if they are both necessary at this time to prevent harm to the individual and others, and a proportionate response to the likelihood and seriousness of the harm they are designed to prevent. A proportionate and humane response will always prioritise ways to keep vulnerable people and those who love them in contact with each other.
- Record how decisions were reached: explain why less restrictive options were discounted (this will usually be because they would spread illness, they are forbidden by Government, or they are impossible in practice due to staff illness.)

- It may quickly seem ‘normal’ to restrict people’s rights very intensely to keep them safe. Every care must be taken to avoid the risk of continuing with such restrictions after the end of the current crisis, when they are no longer proportionate and necessary.

Record how you have reached decisions on restricting people’s freedom. It is essential you leave a ‘trail of breadcrumbs’ that will show any concerned person (CQC inspector, relative, advocate) that you have both recognised that the unprecedented nature of the pandemic is leading to more restriction of an individual’s rights and freedoms than normal, and done all you can to lessen the impact of these restrictions on the person and their relatives, who are undoubtedly worried sick. Restrictions on someone’s freedom, or contact with those who love them, must be necessary and proportionate: test your decision-making against these criteria and record that you’ve considered less restrictive options and discounted them

Definitions of COVID-19 cases and contacts

• **Possible case of COVID-19 in the care home:** Any resident (or staff) with symptoms of COVID-19 (high temperature or new continuous cough), or new onset of influenza like illness or worsening shortness of breath.

• **Confirmed case of COVID-19:** Any resident (or staff) with laboratory confirmed diagnosis of COVID-19.

• **Infectious case:** Anyone with the above symptoms is an infectious case for a period of 7 days from the onset of symptoms.

• **Resident contacts:** Resident contacts are defined as residents that:

• Live in the same unit / floor as the infectious case (e.g. share the same communal areas).

or

• Have spent more than 15 minutes within 2 metres of an infectious case.

• **Staff contacts:** Staff contacts will need to be assessed on an individual basis and consider the correct usage of PPE.

• **Outbreak:** Two or more cases which meet the case definition of possible or confirmed case as above, within a 14-day period among either residents or staff in the care home.