Managing the COVID-19 pandemic in care homes

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Good Practice Guide Introduction

The emerging evidence from countries ahead of the UK in the COVID-19 pandemic suggests 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.

Care homes should remain open to new admissions as much as possible throughout the pandemic. They should be prepared to receive back care home residents who are COVID positive and to isolate them on return, as part of efforts to ensure capacity for new COVID cases in acute hospitals. They

should follow the advice from Public Health England when accepting residents without COVID back when there are confirmed COVID cases within a home.

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

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

The following individuals are 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 the shielding guidance for those in extremely vulnerable groups.

a. Anyone who falls under the category of extremely vulnerable should follow the Shielding guidance to protect these individuals**.**

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.

For delivery of care to any individual meeting criteria for shielding (vulnerable groups) in any setting, as a minimum, single use disposable plastic aprons, gloves and surgical mask must be worn for the protection of the patient.

Shielding residents

In light of the latest government advice about staying at home, and the need to shield care home populations, it is recommended that care homes do not allow visiting. This will pose particular challenges for residents who 'walk with purpose' (often called 'wandering') or those with limited mental capacity but require isolation.

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.

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

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 at least one of: new persistent cough, hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing or sneezing. 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.

Once care home staff have a suspected case they should isolate that resident to their room and commence use of the personal protective equipment (PPE) provided by NHS England. This comprises gloves, aprons and face masks.

It is important to note that the PPE requirements for care home staff are the same as those for hospital staff on general wards.

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 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.
- The staff member immediately washes their own hands and avoids touching their face, nose, mouth or eyes.
- 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.
- The staff member does not attend any other people supported, visit their GP or travel in the community until advice is sought.
- While the staff member waits for advice from NHS 111, or an ambulance to arrive, both the staff member and the isolated individual should remain at least 2 metres from other people. They should avoid touching people, surfaces and objects and be advised to cover their mouth and nose with a disposable tissue when they cough or sneeze and put the tissue in a

bag, then throw the tissue in the bin (ideally double-bagging their tissues). If they do not have any tissues available, they should cough and sneeze into the crook of their elbow.

- If they need to go to the bathroom while waiting for medical assistance, they should use a separate bathroom if available. This will apply only to the period of time while waiting either for transport to hospital or to gain further advice.

Practical guidance whilst awaiting test results and following positive diagnosis

- Staff should use personal protective equipment (PPE) for activities that bring them into close personal contact, such as washing and bathing, personal hygiene and contact with bodily fluids. Aprons, gloves and fluid resistant surgical masks should be used in these situations.
- Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), with disposal and hand hygiene after each patient contact.
- New PPE (Aprons and gloves) must be used for each episode of care. It is essential that used PPE is disposed of as clinical waste. Where clinical waste bins are not available, personal waste (such as used tissues, continence pads and other items soiled with bodily fluids) and disposable cleaning cloths can be stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste within the room. This should be put aside for at least 72 hours before being disposed of as normal.
- Surgical masks can be subject to single sessional use.
- A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. A session ends when the health and social care worker leaves the clinical care setting or exposure environment. Once the PPE has been removed it should be disposed of safely. The duration of a single session will vary depending on the clinical activity being undertaken.
- 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.
- 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.

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:

• 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 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.

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.

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

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. Immediately report residents with fever or respiratory symptoms to NHS 111, as outlined in the section below.

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.

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.

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.

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.

Advice for staff

Care home staff who come into contact with a COVID-19 patient while not wearing PPE can remain at work. This is because in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing.

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.

• Self-isolate for 7 days, following the guidance for household isolation.

Reporting of COVID-19 cases

Please inform the local Health Protection Team (HPT) of two or more possible or confirmed cases within the care home. The Health Protection Team will advise on further communication to local infection control teams and local authority colleagues and CCGs.

• 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.

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.

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.

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 are care home staff that have provided care within 2 metres to a possible or confirmed case of COVID-19 for more than 15 minutes.

• **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.

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.

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