Guidance

COVID-19 supplement to the infection prevention and control resource for adult social care

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Contents

This publication is available at https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement/covid-19-supplement-to-the-infection-prevention-and-control-resource-for-adult-social-care

This guidance applies from 4 April 2022.

Introduction

As we learn to live safely with COVID-19, this guidance should be used to help reduce the spread of COVID-19 in adult social care settings.

This guidance applies to adult social care settings and services in England and should be read in conjunction with the infection prevention and control (IPC) resource for adult social care (https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings), which should be used as a basis for any infection prevention and control response. The devolved administrations will each set out their own guidance.

This supplement provides additional information regarding safe working when caring for people with COVID-19 in the provision of adult social care services.

The supplement includes guidance on:

- staff IPC considerations
  - vaccination
  - personal protective equipment (PPE)
  - staff movement
  - testing
- IPC considerations for people receiving care:
  - vaccination
  - testing
- environmental considerations
  - ventilation
  - waste management
- considerations specific to care homes
  - admissions
  - testing
  - visiting
  - outbreak management

This supplement should also be read in conjunction with the adult social care testing guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings), which details the testing regimes for all staff, as well as any resident and outbreak testing where applicable.

Adult social care staff IPC considerations

Vaccination

Vaccination remains a primary protection measure against COVID-19, reducing the risk of serious illness, hospitalisation and death. The Secretary of State for Health and Social Care, along with the Chief Medical Officer, the Chief Nurse for Adult Social Care and others, have been clear that all

people working in health and social care settings, including volunteers and unpaid carers, have a responsibility to be vaccinated against COVID-19. This is to ensure that safe care is provided to people who receive care and support.

To minimise risk to people who receive care and support, health and social care providers should encourage and support all their staff to get a COVID-19 vaccine and a booster dose as and when they are eligible, as well a vaccine for seasonal influenza. Providers can do this by putting in place arrangements to facilitate staff access to vaccinations, and regularly reviewing the immunisation status of their workforce in line with immunisation against infectious disease ('the Green Book' (https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book)).

Everyone eligible can either book their first dose, second dose and booster dose of a COVID-19 vaccination online via the national booking service (https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/book-coronavirus-vaccination/), or can attend a walk-in centre.

To ensure the safety of people who receive care, providers should undertake risk assessments wherever possible. These should take into account the COVID-19 vaccination status of both staff members and the people they care for. Relevant clinical advice should be considered, including whether any individuals are at higher risk of severe COVID-19 infection. As a result of these risk assessments, providers may consider taking additional steps such as prioritising the deployment of vaccinated staff to care for those who are at higher risk of severe COVID-19 infection, where proportionate.

Testing

For more information on regular testing in adult social care settings, see the COVID-19 testing in adult social care guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings).

Personal protective equipment

Appropriate personal protective equipment (PPE) should be worn by care workers and visitors to residential care settings, subject to a risk assessment of likely hazards such as the risk of exposure to blood and body fluids. The advice below provides guidance on the type of PPE that is recommended, to help protect care workers and care recipients and prevent the transmission of infectious diseases, with particular advice regarding care of people suspected or confirmed to be COVID-19 positive.

For PPE to be effective, it is important to use it properly and follow instructions for putting it on (donning) and taking it off (doffing) (https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures).

All used PPE should be disposed of appropriately according to the waste management section below.

Gloves, aprons and eye protection

In addition to recommendations for standard precautions (https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings) (for example, when there is a risk of contact with blood or body fluids), gloves and aprons should be worn when the care worker or visitor is providing close care for a person who has suspected or confirmed COVID-19. These should be removed and disposed of upon leaving the room.

If the person being cared for has suspected or confirmed COVID-19, it is recommended that eye protection is worn when providing close care for them, or when cleaning their room. Eye protection should be worn if there is a risk that splashes, droplets or secretions from the person's mouth, nose, lungs or body fluids may reach the care worker or visitor's eyes, and when undertaking aerosol-generating procedures (AGPs) (see section below on AGPs). If eye protection is used, this should be removed after leaving the room. If providing care in the person's own home, eye protection should be removed when leaving their house. Reusable eye protection should be cleaned and disinfected as per the manufacturer's instructions between use.

Face masks

Face masks should be worn by all care workers and visitors in care settings and when providing care in people's own homes, irrespective of whether the person being cared for is known or suspected to have COVID-19 or not. This is sometimes referred to as 'universal masking' or 'source control' and is a means of preventing any spread of infection from the mask wearer.

There are a variety of different face masks which are useful for both protecting the wearer (PPE) and protecting others (source control). However, the type of mask recommended depends on the type of activity being undertaken and whether the person is known or suspected to have COVID-19 or not.

All face masks should:

- be well fitted to cover nose, mouth and chin
- be worn according to the manufacturer's recommendations (check which side should be close to the wearer)
- not be allowed to dangle around the neck at any time
- not be touched once put on
- be worn according to the risk-assessed activity
- be removed and disposed of appropriately, with the wearer cleaning their hands before removal and after disposal

Face masks should be changed:

- if they become moist
- if they become damaged
- if they become uncomfortable to wear
- if they become contaminated or soiled
- at break times
- after 4 hours of continuous wear
- between different people's homes

The use of face masks can be distressing or inhibit communication for some people. There may be circumstances where the use of masks is challenging for the client, for example, where lip-reading or facial recognition is important, or the use of PPE is causing distress. This should be taken into account as part of a risk assessment. Consideration should be given to how best to put into practice PPE guidance to minimise any negative impact on people receiving care, while maintaining infection prevention and control. The needs of the person receiving care should be recognised and they should be as involved as they wish to be, and are able to be, in determining their needs in these circumstances.

It may be appropriate in certain circumstances to consider transparent face masks, some of which could be considered for use as an alternative to type IIR surgical masks (see below for more detail).

Transparent face mask technical specification (https://www.gov.uk/government/publications/technical-specifications-for-personal-protective-equipment-ppe/transparent-face-mask-technical-specification) offers further guidance.

Visitors should wear a face mask when visiting a care home, particularly when moving through the home. Individual approaches may be needed as the wearing of face masks may cause distress to some residents. In circumstances where wearing a face mask causes distress to a resident, face masks may be removed when the visit is not in a communal area of the care home. However, other mitigations should be considered, including limiting close contact and increased ventilation (while maintaining a comfortable temperature).

Type I and type II face masks

Type I and type II masks are not considered PPE and are worn to provide source control – that is, to protect others from the wearer's respiratory droplets should they have asymptomatic COVID-19 infection. A type I or type II mask should be worn in care settings when undertaking any social, care or domestic activity that does not involve close care with, or cleaning the room of, an individual with suspected or confirmed COVID-19 or contact with blood or body fluids. This is because type I and II masks are not fluid repellent. A type IIR mask (see below) may also be worn for these purposes.

Face masks are not routinely required when supporting someone outdoors as exhaled air is quickly dispersed. Care staff should consider wearing face masks if supporting people in indoor public spaces outside of a care setting.

Type IIR face masks

Type IIR fluid-repellent surgical masks protect the wearer by providing a fluid repellent barrier between the wearer and the environment. This protects the wearer against blood or body fluid splashes and against the respiratory droplets of others reaching their mouth and nose. These masks also protect others from the wearer's respiratory droplets should they have asymptomatic COVID-19 infection. Workers should wear a type IIR fluid-repellent surgical face mask when providing close care for people who are symptomatic, suspected or confirmed as having COVID-19 or when cleaning their rooms. A type IIR mask should also be worn when undertaking any task where there is a risk of splashing with blood or body fluids.

Use of face masks for care 'sessions'

Face masks of all types can be used for source control and can be worn sessionally, that is for a maximum of 4 hours, unless the worker is providing personal care or cleaning the room of someone with suspected or confirmed COVID-19 or is carrying out an AGP (see section below). After 4 hours, or after leaving the room (or cohorted area) of someone with suspected or confirmed COVID-19 (whichever is sooner) masks should be disposed of and replaced with a new mask. Masks should also be replaced if they become contaminated, dirty, damp or after being removed for breaks or to allow the care worker to eat or drink.

Staff who are providing personal care to someone with known or suspected COVID-19 in a residential care setting should dispose of their face mask after leaving the individual's room, and put a new mask on. The only exception to this is if a care worker is caring for a cohort of people who have been grouped together for their care because they are in a group suspected to have COVID-19 or are in a group confirmed to have COVID-19. If all people the care worker is caring for have COVID-19, the worker may continue to wear a type IIR mask sessionally after providing personal

care to someone with COVID-19. If they are then called to provide care for someone who does not have COVID-19, this mask should be removed and disposed of once outside of the room and a new mask put on.

Homecare workers should remove their masks when leaving the home of the person they are caring for and wear a new mask when entering different people's homes.

Aerosol-generating procedures

An AGP is a medical procedure that can cause the release of virus particles from the respiratory tract and can increase the risk of airborne transmission to those in the immediate area. AGPs in the community setting include suctioning procedures on a person with a tracheostomy, continuous positive airway pressure (CPAP) and ventilatory support.

Filtering face piece class 3 (FFP3) respirators are required when you are undertaking AGPs on a person with suspected or confirmed COVID-19 infection, or another infection spread by the airborne or droplet route. FFP3 respirators should be removed outside of the room where the AGP was carried out and disposed of. They should then be replaced with a type I, II or IIR mask depending on what is most appropriate for the next task. If undertaking an AGP in someone's own home, FFP3 respirators and face masks should be removed and disposed of when leaving the house.

The use of FFP3s is governed by health and safety regulations and they should be fit tested to the user to ensure the required protection is provided. The Health and Safety Executive (HSE) provides information and tools to help select and manage the use of respiratory protective equipment (RPE) (https://www.hse.gov.uk/respiratory-protective-equipment/).

Workers should wear a type IIR mask when carrying out an AGP on someone who is not suspected or confirmed to have COVID-19 or another infection spread via airborne or droplet routes.

Workers should wear gloves, aprons and eye protection when carrying out AGPs. Where there is an extensive risk of splashing, workers should wear gowns instead of aprons.

The list of procedures which are currently classed as AGPs in relation to COVID-19 which may be relevant to adult social care:

- tracheal intubation and extubation
- manual ventilation
- tracheotomy or tracheostomy procedures (insertion or removal)
- non-invasive ventilation (NIV), bi-level positive airway pressure ventilation (BiPAP) and continuous positive airway pressure ventilation (CPAP)
- high flow nasal oxygen (HFNO)
- induction of sputum using nebulised saline
- respiratory tract suctioning
- upper ear nose and throat (ENT) airway procedures that involve respiratory suctioning
- upper gastrointestinal endoscopy where open suction of the upper respiratory tract occurs

The available evidence relating to respiratory tract suctioning is associated with ventilation.

The defined list of AGPs is currently under review and will be updated in national IPC guidance (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations#transmission-based-precautions).

Certain other procedures or equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk for COVID-19. In care settings, procedures commonly undertaken which are not classified as AGPs include oral or pharyngeal suctioning (suctioning to clear mucus or saliva from the mouth), administration of humidified oxygen, administration of Entonox or medication via nebulisation.

PPE recommendations summary

The tables below detail some common scenarios in care and the appropriate PPE to be worn.

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

Activity	Face mask	Eye protection	Gloves	Apron
Social contact with clients, staff, visitors	Yes – universal masking for source control Sessional use of type I, II or IIR	No	No	No
Care or domestic task involving likely contact with blood or body fluids (giving personal care, handling soiled laundry, emptying a catheter or commode)	Yes – universal masking for source control Sessional use of type I, II or IIR Type IIR if splashing likely	Risk assess if splashing likely	Yes	Yes
Tasks not involving contact with blood or body fluids (moving clean linen, tidying, giving medication, writing in care notes)	Yes – universal masking for source control Sessional use of type I, II or IIR	No	No	No

Activity	Face mask	Eye protection	Gloves	Apron
General cleaning with hazardous products (disinfectants or detergents)	Yes – universal masking for source control Sessional use of type I, II or IIR Type IIR if splashing likely	Risk assess if splashing likely	Risk assess	Risk assess
Undertaking an AGP on a person who is not suspected or confirmed to have COVID-19 or another infection spread by the airborne or droplet route	Yes – type IIR to be used for single task only	Yes	Yes	Yes (consider a gown if risk of extensive splashing)

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

Table 2: PPE requirements when caring for a person with suspected or confirmed COVID-19 (symptoms may include coughing, sneezing, diarrhoea, vomiting, shortness of breath, temperature)

Activity	Face mask	Eye protection	Gloves	Apron
Giving personal care to a person with suspected or confirmed COVID-19	Yes – type IIR Remove on leaving the area	Yes	Yes	Yes
General cleaning duties in the room where a person with suspected or confirmed COVID-19 is being isolated or cohorted (even if more than 2 metres away)	Yes – type IIR Remove on leaving the area	Yes	Yes	Yes

Activity	Face mask	Eye protection	Gloves	Apron
Undertaking an AGP on a person who is suspected or confirmed to have COVID-19 or another infection spread by the airborne or droplet route	Yes – FFP3 RPE to be used for single task only	Yes	Yes	Yes (consider a gown if risk of extensive splashing)
For tasks other than those listed above, when within 2 metres of a person with confirmed or suspected COVID-19	Yes – type IIR Remove on leaving the area	Yes	Risk assess (if contact with blood or body fluids likely)	Risk assess (if contact with blood or body fluids likely)

Staff movement

Care homes are not normally required to limit staff movement between sites or services. However, they may be asked to limit staff movement by the local Director of Public Health or health protection team (HPT) if, for example, there is high prevalence of COVID-19 locally or in an outbreak. For further information see below on outbreak handling.

If a staff member develops COVID-19 symptoms

The main symptoms of COVID-19 are recent onset of any of the following:

- a new continuous cough
- a high temperature
- a loss of, or change in, your normal sense of taste or smell (anosmia)

For most people, COVID-19 will be a mild illness. However, if any member of staff has any of the symptoms listed above, even if those symptoms are mild:

- they are advised to stay at home, and they should take a rapid lateral flow test as soon as they develop symptoms and take another lateral flow test 48 hours after the first test. Free lateral flow tests have been provided for symptomatic testing and staff should ensure they have some at home for this purpose. For more information on accessing COVID-19 tests, see the adult social care testing guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings)
- if symptoms begin at home (off-duty), they should not attend work while awaiting both lateral flow test results and should notify their employer or line manager immediately
- if symptoms begin at work, they should inform their employer or line manager and return home as soon as possible

There are several other symptoms linked with COVID-19. Any of these symptoms may also have another cause. If staff members are concerned about their symptoms, they should seek medical advice.

If a staff member receives a positive lateral flow or PCR test result

To avoid passing on the virus, anyone who receives a positive lateral flow or PCR test result should follow the advice regarding staying at home and avoiding contact with other people (https://www.gov.uk/government/publications/covid-19-people-with-covid-19-and-their-contacts) from the day they test positive or develop symptoms. This is called day 0. There is no need to take a PCR test after a positive lateral flow test result.

In addition, social care staff with COVID-19 should not attend work until they have had 2 consecutive negative lateral flow test results (taken at least 24 hours apart), they feel well and they do not have a high temperature. The first lateral flow test should only be taken from 5 days after day 0 (the day their symptoms started, or the day their test was taken if they did not have symptoms). If both lateral flow tests results are negative, they may return to work immediately after the second negative lateral flow test result on day 6, if their symptoms have resolved, or their only symptoms are cough or anosmia which can last for several weeks.

If the staff member cares for people who are at higher risk of becoming seriously unwell with COVID-19 (seek clinical advice as necessary), careful assessment should be undertaken, and consideration given to redeployment until 10 days after their symptoms started (or the day their test was taken if they did not have symptoms). The staff member should continue to comply with all relevant infection control precautions and PPE should be worn properly throughout the day.

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

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

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

If a staff member receives a negative or inconclusive test result

Staff who had symptoms of COVID-19 and who received negative results (2 lateral flow tests 48 hours apart as per the symptomatic section above) can return to work providing they are medically fit to do so, subject to discussion with their line manager or employer and a local risk assessment.

Staff who receive an inconclusive test result should take another lateral flow test, and symptomatic staff who do not have immediate access to another lateral flow test should not attend work while waiting to receive another lateral flow test to take. If the test was being taken by an asymptomatic member of staff as part of outbreak testing for example, they can continue working but should still take the repeat test. If the repeat test result is positive, they should follow the advice on receiving a positive test (see above). If their test result is negative, they can return to work.

Staff contacts of confirmed cases

Staff who are contacts of confirmed cases can continue working. They should comply with all relevant infection control precautions and PPE should be worn properly throughout the day. They no longer need to undertake any additional testing, and instead should continue their usual testing regime.

If the staff member develops symptoms, they should follow the guidance for staff with symptoms (see above).

If the staff member works with people who are especially vulnerable to COVID-19 (seek clinical advice as necessary), a risk assessment should be undertaken, and consideration given to redeployment during the 10 days following their last contact with the case.

Consideration should be given to how to ensure staff can deliver safe care during the 10 days after being identified as a close contact of someone who has tested positive for COVID-19. This includes applying the measures known to reduce risk such as distancing, maximising ventilation, PPE and cohorting. This should be built into provider's general risk assessments for responding to infectious diseases and ensuring safe staffing levels are maintained.

IPC considerations for people receiving care

Vaccination

Vaccines are the best way to protect people from COVID-19 and people receiving care are encouraged to get their COVID-19 vaccinations, including boosters, as soon as they are eligible. Furthermore, wherever possible they are encouraged to get their COVID-19 vaccines ahead of entering adult social care settings. See the COVID-19 vaccination: guide for adults (https://www.gov.uk/government/publications/covid-19-vaccination-guide-for-older-adults) for advice on who is eligible for, and where to book vaccines.

If a person receiving care is symptomatic or tests positive

If someone receiving care who does not live in a care home is symptomatic (https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/) or tests positive for COVID-19, they should be encouraged to follow the advice for the general population (https://www.gov.uk/government/publications/covid-19-people-with-covid-19-and-their-contacts) which is to stay at home and avoid contact with others.

In addition, symptomatic residents in extra care and supported living have access to free lateral flow testing to check if they have COVID-19. Residents should immediately take a lateral flow test as soon as they develop symptoms and take another lateral flow test 48 hours after the first test. For more information see the adult social care testing guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings).

If the individual lives in a residential setting that is similar to a care home, such as in an extra care and supported living service, providers may wish to follow all or some of the guidance for care home residents set out in the adult social care testing guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings).

Environmental considerations

Ventilation

In addition to standard precautions (https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings), particular attention should be given to how ventilation can be improved. Ventilation is an important control to manage the threat of COVID-19. Letting fresh air into indoor spaces can help remove air that contains virus particles and prevent the spread of COVID-19.

Where possible, rooms should be ventilated after any visit from someone outside the setting, or if anyone in the care setting has suspected or confirmed COVID-19. This is because ventilation is particularly important in spaces which are shared with other people for longer periods of time.

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

Further information regarding ventilation can be found in Infection prevention and control: resource for adult social care (https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings) and Ventilation of indoor spaces (https://www.gov.uk/government/publications/covid-19-ventilation-of-indoor-spaces-to-stop-the-spread-of-coronavirus/ventilation-of-indoor-spaces-to-stop-the-spread-of-coronavirus-covid-19).

Waste management

In addition to standard precautions (https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings) the following should be observed:

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

Considerations specific to care homes

Resident IPC considerations

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

Residents should take both of the following:

- a PCR test within the 72 hours before they're admitted (or a lateral flow test if they have tested positive for COVID-19 in the past 90 days)
- a lateral flow test on the day of admission (day 0)

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

Urgent care home admissions from the community

For urgent admissions to a care home from the community, the care home manager should find out whether the resident being admitted has had a lateral flow or PCR test and, if so, when and what the result was.

If the individual has taken a lateral flow or PCR test within 72 hours of the urgent admission into the care home, the care home manager should share the result with the relevant and responsible person. This may be a delegated responsibility.

If a PCR or lateral flow test has not been taken or was taken more than 72 hours before urgent admission, the individual should be tested again with a lateral flow test by the care home. If the test result is positive, the individual should isolate in the care home and follow the guidance below on care home residents who are symptomatic or test positive for COVID-19.

Discharge from hospital into a care home

The NHS will do a PCR test within 48 hours prior to an individual's discharge into a care home, or a lateral flow test if the individual has tested positive for COVID-19 in the last 90 days.

The test result should be shared with the individual themselves, their key relatives or advocate and the relevant care provider before the discharge takes place.

If an individual tests positive prior to discharge, they can be admitted to the care home, if the home is satisfied they can be cared for safely. They should be isolated on arrival for 10 days and follow the guidance below on care home residents who are symptomatic or test positive for COVID-19.

If an individual is being discharged to a care home from a location in the hospital where there was an active outbreak, they should be isolated for 10 days from the date of admission, regardless of whether their overnight hospital stay was planned (elective) or unplanned. This is to prevent possible introduction of infection into the care home. Information about hospital outbreak status should be provided as part of the discharge process. Residents should be enabled to receive one visitor and have access to outside space to assist rehabilitation if possible during isolation. Individuals who are isolating should take 2 LFD tests on days 5 and 6, 24 hours apart, and if both are negative, they can end isolation early. Any individual who is unable to test should be isolated for the full 10 days following a positive test.

Care home residents who are contacts of confirmed cases

Care home residents who are close contacts of a COVID-19 case are no longer advised to isolate nor undertake additional testing. Instead, it is advised that they:

- minimise contact with the person who has COVID-19
- avoid contact with anyone who is at higher risk of becoming severely unwell (https://www.gov.uk/government/publications/covid-19-people-with-covid-19-and-their-contacts/covid-19-people-with-covid-19-and-their-contacts#higherrisk) if they are infected with COVID-19, especially those whose immune system means that they are at higher risk of serious illness, despite vaccination (https://www.gov.uk/government/publications/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk)
- follow the advice regarding testing and isolation if they develop symptoms of COVID-19

Care home residents who are symptomatic or test positive for COVID-19

Residents who have symptoms of COVID-19 (https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/main-symptoms/) should test for COVID-19. They should take:

- a lateral flow test as soon as they develop symptoms (day 0)
- another lateral flow test 48 hours after the first test (day 2)

All residents who test positive for COVID-19 with either lateral flow or PCR tests, regardless of whether they are symptomatic or asymptomatic, should isolate in the care home for 10 days from when the symptoms started, or from the date of the test if they did not have symptoms. The care home manager should inform the resident's GP and should:

- inform the HPT or local partner
- isolate the resident for 10 days within their own room – it may be possible to reduce the period of isolation (see below for further information)
- closely monitor the resident's symptoms
- consider if the resident is eligible for COVID-19 treatments including antivirals or monoclonal antibodies

Isolation does not preclude:

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

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

Support caring for care home residents who test positive for COVID-19

Consideration should be given to having a smaller number of workers dedicated to supporting the person during their infectious period.

Pulse oximeters will be available to care homes via their named clinical lead, or local clinical commissioning group (CCG), as part of COVID oximetry at home. One oximeter per 10 beds with a minimum of 2 oximeters per home is recommended. Equipment which is used to support the monitoring of residents will need to meet infection control and decontamination standards and guidance.

The Care Provider Alliance has produced guidance on COVID oximetry at home (https://careprovideralliance.org.uk/coronavirus-oximetry-at-home-guidance-for-care-homes). Health Education England and West of England AHSN have also produced training and support for care home staff using pulse oximetry (https://portal.e-lfh.org.uk/Component/Details/679015).

Care homes should have a weekly check-in with the home's PCN or multidisciplinary team, who can support staff to understand the RESTORE2 (https://www.hampshiresouthamptonandisleofwightccg.nhs.uk/your-health/restore-official) and NEWS2

(https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/) scoring system as a way of monitoring residents with symptoms. If a patient's symptoms worsen, it is important to contact NHS 111 or the registered GP for a clinical assessment either by phone or face to face.

The resident's GP should give further advice on escalation and ensuring decisions are made in the context of the resident's advance care plan. In a medical emergency, the care home should dial 999.

Visiting arrangements in care homes

Access inside the care home

Contact with relatives and friends is fundamental to care home residents' health and wellbeing and visiting should be encouraged. There should not normally be any restrictions to visits into or out of the care home. The right to private and family life is a human right protected in law (Article 8 of the European Convention on Human Rights). Where visiting is modified during an outbreak of COVID-19 or where a care home resident has confirmed COVID-19, every resident should be enabled to continue to receive one visitor inside the care home. End-of-life visiting should always be supported, and testing is not required in any circumstances for an end-of-life visit.

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

Precautions for visitors

Some residents may need support with personal care from a visitor with whom they have a close relationship. Visitors who are providing personal care should wear appropriate PPE and have a negative COVID-19 lateral flow test result from a lateral flow device before entering a care home, unless medically exempt. Care homes are being provided with tests to support this. If these visitors attend once or twice a week, they should only test on that day (testing can be completed at home or on site). If they visit more than twice a week, they should test a maximum of twice weekly, 3 to 4 days apart.

Visitors providing personal care should show proof of their negative test result prior to entry. This may be an email or text from reporting the result, a date stamped photo of the test cartridge, or any other proof. If they are not able to produce a negative test, they may be asked to reschedule. Care homes do not need to retain records of proof.

In addition to negative test results, care homes should ask all visitors to wear face masks, in addition to other PPE, if they are providing personal care to ensure visits can happen safely. This should be based on individual assessments, taking into account any distress caused to residents by use of PPE or detrimental impact on communication.

Care home residents will no longer be asked to isolate following high-risk visits out of the care home (including following emergency hospital stays) and will not be asked to take a test following a visit out.

Visiting professionals

Health, social care and other professionals may need to visit residents within care homes to provide services. Visiting professionals should follow the same advice as in the section above on visiting precautions. PPE usage is recommended in line with guidance above. NHS staff and Care Quality Commission (CQC) inspectors should be testing regularly as set out below. Any other visiting professionals should be tested with tests provided by the care home if they are providing personal care, as per the guidance for visitors providing personal care.

NHS staff

Care homes can ask the NHS professional when they were last tested. The professional should provide evidence of a negative rapid lateral flow test within 72 hours to show they are following the NHS staff testing regime. This may be an email or text from reporting the result, a date stamped photo of the test cartridge, or any other proof. If the individual has not been tested within 72 hours (or is unable to provide proof) and it is not possible to test prior to entry, the care home will need to make a risk-based decision regarding whether to permit entry, taking into account the reason for and urgency of the visit.

In emergency visits such as a 999 response, it's not appropriate to ask for proof before entry to a care home, given the potential delay this could cause and the implications for prompt management of the emergency situation. Further guidance is given below.

Where the manager makes a risk-based decision to allow entry of someone without evidence of a negative test, all IPC measures must continue to be followed to mitigate the risk, including correct use of PPE, cleaning, ventilation and distancing.

It should be noted however, that all NHS professionals visiting care homes must follow the NHS testing regime and be testing twice a week.

The majority of NHS professionals will be using rapid lateral flow testing for their regular testing regime. However, if a professional falls under a different NHS testing regime which uses PCR or loop-mediated isothermal amplification (LAMP) testing, the individual will also need to demonstrate that they are testing in line with NHS policy for that testing technology. Given the importance of NHS staff testing regularly to ensure the safety of their patients, and the role of care home managers to keep their care homes safe, if care homes have any problems with NHS staff not following this policy, they should contact their CCG chief nurse.

CQC inspectors

CQC inspectors should test every day before they visit a care home or care setting (including extra care or supported living settings) up to a maximum of twice a week. If the CQC inspector is conducting more than 2 inspection visits a week, the 2 tests should be spread throughout the week. These should be conducted at home by the CQC inspector.

As above, the CQC inspector should be able to provide evidence to the care home or care setting of the negative rapid lateral flow test result within the timeframe when they arrive. This evidence could be the text or email from NHS Test and Trace or a photo of the rapid lateral flow test cartridge with the time and date stamp or another method of proof.

As CQC inspectors by law have a right to enter a care setting as part of an inspection, they should not be denied access if they do not provide this evidence.

CQC policy is that inspectors are only allowed to visit care homes or other settings if they have been tested as per this policy and adhering to the testing policy is a requirement of the risk assessment carried out prior to a visit to a care home or care setting.

Outbreak management

Outbreak handling

An outbreak consists of 2 or more positive (or clinically suspected) linked cases of COVID-19 associated with the same setting within a 14-day period. This applies to both staff and residents and includes PCR and lateral flow test results.

If an outbreak is suspected, the HPT (or community IPC team, local authority or CCG, according to local protocols) should be informed. A risk assessment should be undertaken with the HPT or other local partner to see if the clinical situation can be considered an outbreak and if outbreak management measures are needed.

If an outbreak is declared as a result of the risk assessment then measures will be taken. These will include testing and may also include:

- temporarily stopping or reducing communal activities
- closure of the home to further admissions
- restriction of movement of staff providing direct care to avoid ‘seeding’ of outbreaks between different settings
- changes to visiting: some forms of visiting should continue if individual risk assessments are carried out. One visitor per resident should always be able to visit inside the care home

In specific situations, where the local or national risk assessment indicates that cases may be caused by a variant with vaccine escape potential or other concerns, additional measures may be advised.

In the event of an outbreak in a residential setting where care is provided (including care homes), outbreak restrictions will be in place for different lengths of time, depending on the characteristics of the home, the outbreak and the results of outbreak testing.

Outbreak testing

For information on testing in an outbreak and outbreak recovery testing, please see the adult social care testing guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings).