Acute Respiratory Infections [ARIs]

(including COVID-19 and Influenza)

Checklists for Care Settings

Aims & Objectives

Aim: To assist residential community care settings in managing single cases and outbreaks of acute respiratory infections (ARIs) efficiently and effectively to:

1. reduce the number of cases, the severity of illness, the number of potential deaths
2. to reduce disruption to the provision of health and social care services

Objectives: To ensure:

1. appropriate measures are taken to prevent and control outbreaks
2. suspected outbreaks are detected early and control measures are initiated promptly
3. relevant information is documented to allow review by the care home and the Health Protection Team

Key Messages: The 3 Ps

Prevention is the most effective method of stopping transmission and outbreaks **before** they happen. Infection prevention and control measures should be in place in care and supported living settings at all times

Preparedness is about thinking ahead. Are you resilient enough? How ready are you are to act in the event of an outbreak or incident? What will make you vulnerable? What risks do you have? Do you have clear instructions on what to do? Do you have business continuity plans e.g. other staff to draw on if required?

Protection is about quick detection. Recognising illness early and acting quickly protects resident and staff health; and helps to stop infections from spreading.

Some Similarities and Differences between COVID-19 and Flu

	COVID-19	INFLUENZA (Flu)
Similarities	Both are infectious respiratory illnesses but caused by different viruses • Some similar signs and symptoms (for differences see below) hence **testing** is required to confirm diagnosis • Can be asymptomatic, mild to severe disease and death possible • Transmitted by direct contact (person to person), droplets, aerosols and fomites • Possible to spread the virus for at least 1 day before symptoms develop	
Differences	• **Incubation period = Time from exposure to symptoms:** Longer than flu. 1-14 days after exposure; usually 5 - 7 days. • **Infectious period**: Longer. From 2 days before to 10 days after onset of symptoms. • **Antivirals** not approved yet	• **Incubation period = Time from exposure to symptoms:** Shorter than COVID-19. Usually 1-3 days, but possibly up to 5 days. • **Infectious period**: Shorter. From 12 hrs before to 3-5 days after onset of symptoms. • **Antivirals** approved
Key Symptoms	New continuous cough AND/OR Fever > 37.8 AND/OR Loss of or change in smell/ taste	Fever > 37.8 AND new onset or acute worsening of one or more respiratory symptoms: cough, hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing
Other symptoms	Shortness of breath Fatigue (tiredness) Loss of appetite Muscle aches Sore throat Headache Nasal congestion Diarrhoea, nausea and vomiting	Headache Aching muscles Aching joints

Note
COVID-19 is the name given to the disease caused by the virus SARS-CoV-2 (often just called the COVID-19 virus)

Definitions

1. Case definition for COVID-19

Possible/Suspected case of COVID-19: Any resident or staff member with symptoms of COVID-19 (fever, new continuous cough, change or loss of normal sense of smell or taste)
Note: elderly people can often present with non-typical symptoms such as sudden decline in physical or mental ability, lethargy or change from usual demeanour without explanation.

Confirmed case of COVID-19: Any resident or staff with an LFD or PCR positive test for COVID-19.

Contact: anyone who has been close to a confirmed case of COVID-19 during the case's infectious period

Resident/Tenant/Client contacts are those who:

- live in the same house/unit/floor as the infectious case or share the same kitchen or bathroom areas or
- has had face-to-face contact including being coughed on or having a face-to-face conversation within one metre or
- been within one metre for one minute or longer without face-to-face contact
- are sexual contacts or
- been within 2 metres of someone for more than 15 minutes (either as a one-off contact, or added up together over one day) or
- travelled in the same vehicle

Staff contacts - as for resident contacts, or

- has cleaned a personal or communal area where a confirmed case has been located (note - only applies to the first time cleaning the personal or communal area) or
- has been notified that they are a contact of a co-worker who has been confirmed as a COVID-19 case

However, if social distancing was maintained and/or PPE was worn appropriately WITHIN THE CARE SETTING, the staff contact does not need to be isolated, providing staff have been supplied with the correct PPE, are trained and are adhering to, the correct us of PPE (donning and doffing).

Outside of the immediate care setting e.g. in a vehicle, or in a staffroom, or smoking outside during breaks, the likelihood of a breach in infection control or social distancing is much higher. Therefore, you should take a cautious approach to considering whether staff contacts require exclusion from work in these scenarios

Double vaccinated staff and residents may be exempt from self-isolation as a contact if certain conditions and mitigations are in place – see PHE guidance COVID-19: management of staff and exposed patients and residents in health and social care settings - GOV.UK (www.gov.uk) and DHSC/PHE/NHS guidance Coronavirus (COVID-19): admission and care of people in care homes - GOV.UK (www.gov.uk)

2. Case definition for Influenza Like illness (ILI)

- Temperature ≥37.8C

  AND one of the following
- acute onset of at least one of the following respiratory symptoms: cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing

  OR
- an acute deterioration in physical or mental ability without other known cause

Influenza like illness (ILI) can be caused by various different respiratory viruses, including COVID-19, Influenza, parainfluenza, human metapneumovirus, rhinovirus, adenovirus, respiratory syncytial virus.

3. Case definition for Confirmed Influenza (Flu)

Any resident or staff member with laboratory or Point of Care Test positive for Influenza.

4. Acute Respiratory Outbreak

TWO or more residents and/or staff members that meet the case definition of ILI or COVID-19 with onset dates within 14 days, but without laboratory confirmation.
[Consider an influenza outbreak as an alternative diagnosis if there are several residents with suspected chest infections]

5. Outbreak of Confirmed Influenza

At least one confirmed case of influenza AND one or more cases which meet the clinical case definition of ILI among (residents and/or staff members at the setting within a 48-hour period.

6. Outbreak of Confirmed COVID-19

At least one confirmed case of COVID-19 AND one or more cases which meet the clinical case definition of COVID-19 among (residents and/or staff members at the setting with onset dates within 14 days.

7. Infectious periods and Isolation periods

COVID-19: 2 days before onset of symptoms (or date of test if asymptomatic) to 10 full days after (for staff) and 14 full days after (for residents)

Flu and other respiratory viruses: It is generally assumed that the period of infectiousness starts with onset of symptoms and lasts for the duration of symptoms. However, viral shedding may be prolonged particularly in elderly with long term medical conditions, and the risk of complications greater for those with Flu. Therefore, isolation periods for confirmed flu in care homes should be 5 days from onset of symptoms (for residents and staff). In other care settings and in care homes with respiratory viruses other than COVID-19 or Flu, staff can return to work once acute symptoms have resolved and they have been free of fever for 24 hours. See Algorithm for the management of outbreaks of acute respiratory infection in care homes (due for update in Sept21)

When to call the Health Protection Team (HPT)

1) **Two or more staff members or residents with confirmed COVID-19; or suspected or confirmed flu within 14 days (an outbreak)** we can arrange testing for flu; and will give outbreak and IPC advice
2) **Hospitalisations** or **deaths** due to COVID-19, Flu or unidentified respiratory viral infection
3) **A significant increase in the number or cases in an outbreak**
4) If you have **any concerns** about the management of cases/outbreak of COVID-19 or flu

Key Information to give to HPT

- Type of setting e.g. Residential/Nursing/Children's Home, Hospice, Learning Disability, Supported Living setting etc
- Specific risk factors e.g. Dementia, challenging behaviour, immuno-compromised etc
- Total number of residents with symptoms
- Total number of staff members with symptoms
- Confirmation of diagnosis (positive test)?
- Onset date of symptoms or positive test result for first case
- Onset date of symptoms or positive test result for most recent case
- Latest round of routine test results for COVID-19
- Symptoms
- Total number of residents in the care setting
- Total number of staff employed by the setting and/or who visit on a regular basis if not directly employed e.g. staff delivering care within Supported Living settings etc
- Location of symptomatic cases with respect to layout e.g. particular floor/wing affected or throughout the setting?
- Any Aerosol Generating Procedures carried out?
- IPC measures in place
- Number of Staff in clinical risk groups for Flu (if flu suspected or confirmed)
- Any recent testing? results?
- Any deaths or hospitalisations – If so, which hospital/when? Vaccination history of anyone hospitalised or died because of COVID-19 or flu
- Which GPs are the residents (symptomatic and non-symptomatic) registered with?

Checklist for care settings during COVID-19 pandemic and throughout winter season

Key Guidance	
• DHSC/PHE/CQC/NHSE Admission and Care of Residents during COVID-19 Incident in a care home • PHE COVID-19: how to work safely in care homes • NHS National Infection Prevention and Control Manual	Tick / Comments
Infection Prevention and Control	
Reinforce Infection Control Precautions to all staff **Hygiene – hand & respiratory** • Reinforce education of staff and visitors and display posters widely • Provide waste bins for every resident • Ensure safe disposal of tissues **Hand Hygiene Facilities** • Ensure liquid soap and disposable paper towels are available at each wash basin. If handwashing facilities are not readily available ensure alternatives such as alcohol gel hand is in every room/communal area and stocks are adequately maintained. If it is not possible to have alcohol hand rub in rooms/communal areas, consider providing staff with individual containers	
Personal protective equipment (PPE) • Ensure that PPE is readily available, i.e. disposable gloves, aprons and fluid resistant surgical masks (FRSM), plus eye protection for procedures that may generate splashback. Ensure gloves & aprons are changed between residents, masks are changed at regular intervals and eye protection is worn according to risk assessment (see guidance). • *NB: PPE should be stored outside residents' rooms* • Ensure staff training regarding PPE/IPC is in place and is regularly reviewed and reiterated including for agency and bank staff • *See key guidance above* *We are currently in a period of sustained COVID-19 community transmission. Older people might not have typical symptoms of COVID-19 and some asymptomatic staff and/or residents could be carrying the virus. PPE should be worn whenever staff members are within 2m of a resident.*	
Linen, waste and environmental cleaning • Equipment should be for single-use wherever possible • Ensure linen management and clinical waste disposal systems are in place, including foot operated bins • Clean surfaces and high touch areas frequently – at least twice daily • Equipment/facilities that has to be shared by residents, e.g. hoists, baths and showers etc needs to be thoroughly cleaned and then disinfected with a chlorine-based solution (1000 ppm) between each use	

• Increase external ventilation/open windows • Guidance on waste management can be found in Annex J of DHSC/PHE/CQC/NHSE Admission and Care of Residents during COVID-19 Incident in a care home. Waste should be stored for 72 hours before disposal if COVID-19 is suspected or confirmed and there are no clinical waste facilities available. • Staff should wear clean uniform daily & change out of their uniforms prior to leaving the setting. If uniforms are laundered at home, they should be washed at the highest temperature that the material will tolerate. • Guidance on linen & environmental cleaning can found in Annex G of DHSC/PHE/CQC/NHSE Admission and Care of Residents during COVID-19 Incident in a care home	
• **Social Distancing and Clinically Extremely Vulnerable** - Due to the Covid-19 pandemic, all care settings should be reducing contact between residents in communal areas. Some particularly vulnerable residents and staff may require extra precautions throughout the pandemic - see Annex A of DHSC/PHE/CQC/NHSE Admission and Care of Residents during COVID-19 Incident in a care home **.** • **Clinically Extremely Vulnerable** - PHE COVID-19: guidance on protecting people defined on medical grounds as extremely vulnerable and - PHE COVID-19: guidance for employees, employers and businesses - NHS HR guidance on protecting vulnerable staff	
• **Care plans** should be put in place in liaison with the GP, care setting, residents and relatives. This should include advance care planning, mental capacity assessments, plans to deal with "wandering", end of life considerations & hospitalisation etc • See British Geriatric Society: Managing the COVID-19 pandemic in care homes	
• **Transfer of residents** to hospital or other institutions during a suspected or confirmed outbreak should be avoided unless clinically necessary/in a medical emergency and, if possible, with the approval of the GP – see Annex D DHSC/PHE/CQC/NHSE Admission and Care of Residents during COVID-19 Incident in a care home • If transfer is required, transport services (including emergency ambulances) and the receiving hospital/setting should be made aware of the suspected or confirmed outbreak in the setting, and/or if the resident is a suspected or confirmed case BEFORE transfer • During transfer, the resident should wear a surgical mask (if tolerated). • If appointments or transfers are essential, inform the clinic/hospital so appropriate infection control plans can be made for the resident.	
• Visiting arrangements in care homes see DHSC guidance • Arrangements for visiting out of the care home see DHSC guidance • COVID-19: guidance for supported living DHSC/PHE	

Checklist for Single Case of Acute Respiratory Infection / Influenza Like Illness

These items are additional to those in the previous checklists for:

- **Care settings during the COVID-19 pandemic and throughout the winter season**

STAFF

- **Send symptomatic staff home to get tested via the online portal or by dialling 119** They should avoid using public transport for their journey

RESIDENT

- **Isolate symptomatic resident** in their room/accommodation
- **Ensure all IPC measures** as above are in place
- **IF SINGLE CASE OF confirmed FLU or TWO SUSPECTED CASES of FLU within 14 days**
- **Call the HPT: Tel 0300 303 8162**
- If appropriate, HPT will arrange swabbing/testing of symptomatic resident. **This includes Flu A/Flu B/RSV and other viral respiratory pathogens – these tests are NOT available with Pillar 2 routine COVID-19 testing pathways**
- HPT will advise and give information on IPC, Outbreak Recognition and Management

Checklist for outbreak of Acute Respiratory Infection / Influenza Like Illness

These items are additional to those in the previous checklists for:

- **Care-settings during the COVID-19 pandemic and throughout the winter season**

- **Send symptomatic staff home to get tested via the online portal or by dialling 119.** They should avoid using public transport for their journey
- **Isolate symptomatic residents in their rooms/accommodation and cohort symptomatic residents**, where possible, e.g. into one wing
- **Ensure all IPC measures** as above are in place
- **Twice daily monitoring of symptoms among residents** (including temperature check)
- **Daily symptom check for staff**
- **Call the HPT on 0300 303 8162**
- If appropriate, HPT will arrange **swabbing/testing of all symptomatic residents**
  This includes Flu A/Flu B/RSV and other viral respiratory pathogens – these tests are NOT available with Pillar 2 routine COVID-19 testing pathways
- HPT will advise and give information on IPC, Outbreak Recognition and Management
- **Visiting by friends and family should cease**
  In exceptional situations such as end of life, immediate next of kin may be allowed in for short visits. They should be supervised by staff to put on and take off PPE (as would staff). There should be very limited physical contact between the case and their relatives and the visitors should limit any contact with surfaces etc. as much as possible.
  Wash hands and dry thoroughly before and after visits.
  All visitors should remain vigilant for symptoms.
  Visiting arrangements in care homes see DHSC guidance
  Arrangements for visiting out of the care home see DHSC guidance
- **Staff cohorting** Where possible, divide staff into teams, with one team caring for residents who are symptomatic and one team caring for the other residents. Avoid, where possible allocating agency staff to caring for symptomatic residents.
- **Enhanced cleaning** care settings should already be using chlorine-based solutions for regular cleaning during the COVID-19 pandemic, but in the event of an outbreak of respiratory illness, the frequency of cleaning should be increased, particularly for high touch areas. Deep cleaning should also be undertaken. See Annex G in DHSC/PHE/CQC/NHSE Admission and Care of Residents during COVID-19 Incident in a care home and NHS National Infection Prevention and Control Manual

Notices and Documentation	
• Put up **notices** regarding the outbreak at all entrances including exclusion information for staff or visitors with symptoms. Also, ensure notices are outside the rooms of symptomatic residents. • Enter the details of symptomatic cases on **Resident and Staff Log sheet** for COVID-19 or influenza (at the end of this document).	
Restriction of admission/closure	
• **Capacity Tracker** please complete it daily • Because we are likely to be in a period of prolonged community circulation of COVID-19, a **respiratory outbreak does not necessarily mean automatic closure to admissions**. **However, movements of residents should be restricted** between settings with **social distancing** maintained between residents within the setting. • Each **new admission should be risk assessed** with the relevant stakeholders. e.g. resident, family, LA, CCG, other care setting, etc. • For any respiratory outbreak, discuss any potential **closure to new admissions** with the hospital discharge team and commissioning authority. Be aware that, with heightened bed pressures across the health and care sector, decisions around closure are not straight-forward. The decision to close will depend on the number of residents and/or staff affected, their location within the setting, whether symptomatic residents can be effectively isolated, cohorting possibilities for staff, staffing levels, availability of PPE etc.	
Isolation of residents and exclusion of staff	
• Until laboratory tests indicate otherwise, isolation and exclusion periods should be as per COVID-19 guidance	
Communications	
• **HPT can provide template letters for** Relatives**,** Staff**,** Residents **and** GPs • **Visiting health professionals** e.g. district nurses, physiotherapists etc should also be informed of outbreaks. Visits should be deferred unless essential and if visits occur, appropriate PPE should be worn (as for staff) • The HPT will inform the LA and CCG • Carers should inform all relevant GPs of the presence of a respiratory outbreak. Individual GPs should be updated for those residents/clients with laboratory confirmed infection. The HPT may be able to help with outbreak communications for non-residential care settings.	
Escalation	
• **Call the HPT again if:** - there is a large increase in the number of cases - any of your residents or staff are hospitalised due to suspected or confirmed Flu or COVID-19 - there is a death in the setting due to suspected or confirmed Flu or COVID-19 - there is difficulty in applying the relevant outbreak control measures on which the care home has been advised	

Checklist for outbreak of Confirmed COVID-19

These items are additional to those in the previous checklists for:

- **Care settings during the COVID-19 pandemic and through the winter season**
- **Outbreaks of any Acute Respiratory Infection/Influenza Like Illness**

Residents	
• **Symptomatic residents or residents who have tested positive** but are asymptomatic should be isolated in their rooms for 14 days after their onset of symptoms/test date (see Annex C of DHSC/PHE/CQC/NHSE Admission and Care of Residents during COVID-19 Incident in a care home). -For those with major underlying illnesses, immunosuppression or pneumonia, the infectious period may be prolonged. • The **Resident and Staff Log sheet** (at the end of this document) can be used for recording those with symptoms and/or who have tested positive • **Contacts** should be isolated for **14** days after last exposure to a confirmed case (see contact tracing document from HPT for details of how to do this) • Double vaccinated staff and residents may be exempt from self-isolation as a contact if certain conditions and mitigations are in place – see PHE guidance COVID-19: management of staff and exposed patients and residents in health and social care settings - GOV.UK (www.gov.uk) and DHSC/PHE/NHS guidance Coronavirus (COVID-19): admission and care of people in care homes - GOV.UK (www.gov.uk) • **Discourage use of communal areas** • See The British Geriatric Society: Managing the COVID-19 pandemic in care homes for suggestions on how to manage **wandering residents** • If not possible to isolate contacts in their rooms, consider **cohorting** the contacts	
Staff	
• **Symptomatic staff or those who have tested positive but are asymptomatic** should stay at home until day 11 after the onset of symptoms/their test date. This applies as long as they have been fever free for 2 days (without the use of medication) and if a cough or a change in normal sense of smell or taste is the only persistent symptom. • **Symptomatic staff members who test negative** for COVID-19 may return to work after the negative test result, providing they are well • **Staff with a household member who has symptoms** of COVID-19 will need to self-isolate for 10 days after onset of symptoms. • **Staff contacts** of a resident with confirmed COVID-19 who were not wearing appropriate PPE/had a breach in their PPE at the time of exposure will need to go home and self isolate for **10** days after the last exposure. They may not return to work before this even if they test negative. • See COVID-19: management of exposed healthcare workers and patients	

in hospital settings • **Agency staff** should try to stay working in the same setting during the outbreak. If this is not possible, they should be advised to watch out for symptoms of coronavirus and stop working immediately if symptomatic. In this instance, they should get tested via the online portal or by dialling 119. They should avoid using public transport for their journey home.	
Testing for COVID-19	
• Symptomatic staff should arrange testing through the online portal or 119 • Symptomatic residents can be testing using the test kits used for regular resident testing. However, if another respiratory virus is suspected other than COVID-19 e.g. Flu, it is important to call the HPT – they can arrange swabs specific for Flu (and other respiratory viruses) testing • See DHSC Coronavirus (COVID-19) testing for adult social care settings	
Lifting of Outbreak Restrictions	
• See DHSC Coronavirus (COVID-19) testing for adult social care settings • Testing regimes and guidance on when outbreak restrictions may be lifted may change over the course of the autumn/winter, therefore always check the latest guidance As at the date of publication of this reference document: • If 14 days have passed since the onset of symptoms in the most recent case a round of PCR and LFD recovery testing of all residents and staff should be undertaken. If there are no LFD ***and*** PCR positive results, outbreak restrictions can be lifted (await PCR results before restrictions are lifted). At this point regular asymptomatic and symptomatic testing should be restarted. • NB: If Whole Genome Sequencing (WGS) results are not available by day 14 testing then assume that no Variant of Concern (VOC) has been detected and declare the outbreak over if there are no positive results. If WGS results confirm a VOC in the outbreak (other than Alpha or Delta variant) then the outbreak restrictions should remain in place until whole home recovery testing has been completed after a period 28 days with no new cases. • If cases occur in the period between recovery testing (negative) and 28 days since the last case, a risk assessment should be done as to whether this is a new outbreak or reflects ongoing transmission from the old outbreak. Advice can be sought from LA, CCG or HPT.	

Checklist for outbreak of Confirmed Influenza

These items are additional to those in the previous checklists for:

- **Care settings during the COVID-19 pandemic and through the winter season**
- **Outbreaks of any Acute Respiratory Infection/Influenza Like Illness**

Residents	
• **Symptomatic residents or residents who have tested positive for flu** should be isolated in their rooms until at least 5 days after the date of onset of their symptoms/positive test date and until they are feeling well. If there is any doubt as to infection with COVID-19 or co-infection with COVID-19 then isolation should be maintained for at least 14 days after onset of symptoms. For those with major underlying illnesses, immunosuppression or pneumonia, infectiousness with influenza may be prolonged. • **Close Contacts** of confirmed cases of influenza (or respiratory viruses other than COVID-19) do not need to self-isolate entirely within their room/accommodation but use of communal areas during an outbreak should be discouraged.	
Staff	
• **Symptomatic staff members should get tested for COVID-19 as a minimum** through the online portal or by dialling 119 • **Symptomatic staff members who test negative** for COVID-19 may return to work after a minimum of 5 days after the date of onset of acute respiratory symptoms and when they feel well enough to do so. • **Those who have tested positive for flu** should remain off work for a minimum of five days after the onset of symptoms and until they feel well enough to return. • If there is any doubt as to infection with COVID-19 or co-infection with COVID-19 then isolation should be maintained for at least 10 days after onset of symptoms. • Throughout the pandemic, **Agency staff** should restrict working in more than one setting as much as possible. When they are working in a setting with an acute respiratory outbreak, this becomes vital.	
Antivirals	
• If Flu is confirmed or considered to be highly likely, the HPT will recommend antivirals for all symptomatic residents if the treatment can be given within 48 hours of onset of symptoms and for exposed residents, if antivirals can be given within 36-48* hours of exposure. Antivirals will be prescribed by the GP and will be recommended regardless of the flu vaccination status of the resident. • If flu is confirmed or considered to be highly likely, the HPT will only recommend antivirals for staff if they - are in a high risk group for flu	

AND - have not had their seasonal flu vaccination for the current season at least 14 days previously • The HPT will provide template letters for staff, residents, visitors and GPs *within 48 hours for oseltamivir; within 36 hours if zanamivir is required	
End of Outbreak	
• For **influenza or any respiratory virus other than COVID-19,** the outbreak can be declared over if there are no new cases after 5 days since the onset of symptoms in the most recent case. This should be based on a risk assessment of the setting as evidence shows prolonged viral shedding in older persons, so isolation may need to be longer.	

What does good Respiratory Hygiene mean?

Rigorous respiratory hygiene measures help prevent the spread of infection.

In practice this means:

- Single use, disposable tissues should be readily available and once used should be disposed of promptly in the nearest bin
- Hand hygiene facilities should be readily available with foot-operated waste bins
- Hands should be cleaned (using soap and water if possible or alcohol-based hand rub if not) after sneezing, coughing, using tissues or after any contact with respiratory secretions and contaminated objects
- Encourage residents and staff members to keep hands away from eyes, mouth, nose and from the front of masks
- Assist residents with the disposal of items, e.g. tissues contaminated with respiratory secretions and then wash hands. Where possible place waste bins or other receptacles near residents so they can dispose of items themselves

What does good Hand Hygiene mean?

Soap and water

- Use liquid soap, warm water and paper towels
- Ensure hand washing facilities are available in each resident's room
- Ensure hand washing facilities are available in key areas e.g. kitchen, sluice, laundry, utility rooms, toilets, bathrooms and near cleaning cupboards
- Washing hands and forearms with soap and water for at least 20 seconds is essential at the following times:
    - before touching each resident
    - before clean/aseptic procedures
    - after exposure to body fluids
    - after touching each resident
    - after touching resident surroundings
    - after removing gloves
    - on arrival and when leaving work
    - before preparing food and eating/drinking
    - after using the toilet
    - before and after smoking/vaping

Alcohol based hand rub

- Undertake a risk assessment to ensure it is safe to use, store or carry these in your care setting
- Only use on hands that are visibly clean. If hands are visibly dirty, wash with soap and water as above.
- Do not use when caring for residents with diarrhoea and/or vomiting (alcohol gel is not effective against norovirus)
- Use 60-80% or above alcohol-based hand rubs
- At this strength, alcohol based hand rubs are effective against enveloped viruses e.g COVID-19

Residents and visitors

- Residents need to clean their hands regularly too. Assist residents where required and/or provide suitable wipes/rubs as per risk assessment.
- Any visitors should wash their hands on arrival to the home, ~~often~~ during their visit and immediately prior to departure.

National Guidance Documents: COVID-19

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

Social distancing for different groups

- PHE COVID-19: guidance for households with possible coronavirus infection
- Gov.uk Local COVID alert levels: what you need to know
- Gov.uk Coronavirus (COVID-19): Social distancing
- PHE COVID-19: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable

Infection prevention and control

- NHS National Infection Prevention Control Manual
- PHE COVID-19: how to work safely in care homes
- NHS National Infection Prevention and Control Manual
- WHO 5 moments for hand hygiene: with how to hand rub and how to handwash posters
- PHE Catch it. Bin it. Kill it. poster
- PHE COVID-19: putting on and removing PPE – a guide for care homes (video)
- PHE COVID-19: management of staff and exposed patients or residents in health and social care settings
- PHE COVID-19: personal protective equipment use for aerosol generating procedures

Care home specific guidance and policy

- PHE Influenza-like illness (ILI): managing outbreaks in care homes (due update Sept 21)
- PHE Algorithm for outbreaks of acute respiratory infection in care homes (due update Sept 21)
- DHSC Overview of adult social care guidance on coronavirus (COVID-19)
- DHSC/CQC/PHE/NHSE Admission and care of residents during COVID-19 incident in a care home
- DHSC COVID-19: our action plan for adult social care
- PHE How to work safely in care homes
- DHSC Coronavirus (COVID-19) testing for adult social care settings
- The British Geriatric Society: Managing the COVID-19 pandemic in care homes.
- DHSC NHSE Reuse of medicines in a care home or hospice
- Social Care Institute for Excellence Dementia in care homes and COVID-19 - Supporting residents, supporting carers, supporting homes
- PHE Guidance for stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings
- Social Care Institute for Excellence SCIE COVID-19 hub for resources, funded by DHSC Coronavirus (COVID-19) advice for social care
- DHSC Dedicated app for social care workers launched
- DHSC Visiting arrangements in care homes
- DHSC Arrangements for visiting out of the care home

- Video guidance on how to take nose and throat swabs https://www.gov.uk/government/publications/covid-19-guidance-for-taking-swab-samples

Cleaning and waste management

- DHSC Management and disposal of healthcare waste (HTM07-01)
- DHSC Decontamination of linen for health and social care (HTM01-04)
- PHE COVID-19: cleaning in non-healthcare settings

Provision of care in supported living and home care

Most of the principles in national Public Health England guidance for care homes apply to supported living and home care. There are some differences in approaches, particularly in relation to isolation of residents.

- PHE Coronavirus (COVID-19): providing home care
- PHE How to work safely in domiciliary care
- DHSC/PHE COVID-19: guidance for supported living

Other

- Campaign Resource Centre leaflets and posters
- PHE Guidance for care of the deceased with suspected or confirmed COVID-19 .
- Dept for Transport Coronavirus (COVID-19): safer travel guidance for passengers
- https://www.nhs.uk/oneyou/every-mind-matters

National Guidance Documents: Influenza

- PHE Guidance for HPTs Influenza-like illness (ILI): managing outbreaks in care homes (due update Sept 21)
- PHE Influenza: treatment and prophylaxis using anti-viral agents (due update Sept 21)
- PHE Algorithm for outbreaks of acute respiratory infection in care homes (due update Sept 21)

Local Guidance Documents: Winter Infections

Information, advice, posters, checklists on all aspects of Infectious disease prevention and control, particularly related to **winter infections in care homes** e.g. flu, norovirus is available at https://www.england.nhs.uk/south/info-professional/public-health/infection-winter/ (due update Sept 21)

Note about this document – for any weblinks that become broken, the document can be found by typing the authoring organisation and the title into a search engine.

Glossary

AGP: Aerosol Generating Procedure

ARI: Acute Respiratory Infection

Asymptomatic = someone with no symptoms

CCG: Clinical Commissioning Group

CPAP: Continuous Positive Airways Pressure

CQC: Care Quality Commission

DHSC: Department for Health & Social Care

Fomite: inanimate object e.g. table, door handle on which body fluids may sit and from which they can then be transferred (e.g. by touching and then rubbing face) to another person

FRSM: Fluid resistant surgical mask

HPT: Health Protection Team

ILI: Influenza Like Illness

LA: Local Authority

NHSE: National Health Service England

PHE: Public Health England

PPM: Parts per million

Symptomatic Resident and Staff Log sheet - Complete Daily for symptomatic cases:

Acute Respiratory Illness

In the event of an outbreak, this table will ensure important information is readily accessible

RESIDENT LOG SHEET								
Room	Name & Date of Birth	Date of last flu vaccine	Date of onset of symptoms	Symptoms *	Date seen by GP	Date swabbed (if swabbed)	Result	GP informed of test result
STAFF LOG SHEET								
Job Title	Name & Date of Birth	Date of last flu vaccine	Date of onset of symptoms	Symptoms *	GP Surgery	Date swabbed (if swabbed)	Result	Last day worked /comments

Symptoms * T = High Temp (>=37.8 C), C = Cough, LT/S = Loss of sense of taste or smell, ST = Sore Throat, RN = runny nose, FB = fast breathing/shortness of breath, CS = audible chest sounds, H= headache, LA = loss of appetite, AP = general aches /pains; O = Other symptoms [provide details] AD = Acute Deterioration in physical or mental ability (without another known source).

Updates

Date	Page	SECTION	UPDATES
15/10/20	4	When to call the HPT	• **Single case of suspected or confirmed COVID-19 or flu in a resident** (we can arrange testing and will give IPC advice) • **Two or more staff members with suspected or laboratory confirmed COVID-19 or flu**
15/10/20	6	Key guidance and throughout the document	• Deleted any reference to PHE COVID-19: infection prevention and control (no longer applicable to care homes) • added NHS National Infection Prevention and Control Manual
15/10/20	10	Checklist for Outbreak of Acute respiratory infection	**Isolation of residents and exclusion of staff** • Until laboratory tests indicate otherwise, isolation and exclusion periods should be as per COVID-19 guidance
15/10/20	11	Checklist for Outbreak of COVID-19	• **Symptomatic staff members who test negative** for COVID-19 may return to work after the negative test result if they are well [DELETED THE FOLLOWING WORDS and have been not been feverish for 24 hours]
15/10/20	12	Checklist for Outbreak of Flu - residents	• **Symptomatic residents or residents who have tested positive for flu** should be isolated in their rooms until they have been symptom free for 24 hours. Assume cases will be infectious for up to 5-7 days following the onset of symptoms or until full recovered Changed to • **Symptomatic residents or residents who have tested positive for flu** should be isolated in their rooms until at least 5 days after the date of onset of symptoms and until they are feeling well.
15/10/20	12	Checklist for Outbreak of Flu - staff	• **Symptomatic staff or those who have tested positive for flu** should stay at home until they have been symptom free for 24 hours. If there is any doubt as to infection with COVID-19 or co-infection wit6h COVID-19 then isolation should be maintained for at least 14 days after onset of symptoms. • **Symptomatic staff members who test negative** for COVID-19 may return to work after the negative test result if they are well and have been not been feverish for 24 hours • **Agency staff** working in a home where there is an outbreak of influenza should not work in other settings for at least 4 days after last contact with the home or, if exposure is continuous, when the outbreak is declared over Changed to • **Symptomatic staff should get tested for COVID-19 as a minimum** (through the online portal or dialling 119) • **Symptomatic staff members who test negative** for COVID-19 may return to work after a minimum of 5 days after the date of onset of symptoms and when feeling well • **Those who have tested positive for flu** should remain off work for a minimum of five days after the onset of symptoms and until feeling well. • If there is any doubt as to infection with COVID-19 or co-infection with COVID-19 then isolation should be maintained for at least 14 days after onset of symptoms. • Throughout the pandemic, **Agency staff** should restrict working more than one setting as much as possible. When they are working in a setting with an acute respiratory outbreak, this becomes vital
15/10/20	14-15	Guidance documents	Updated with new guidance and links refreshed
13/12/20		Contacts of COVID-19	Updated throughout the document: reduction of period of isolation required for close contacts of confirmed COVID-19 cases from 14 to 10 days, as per new national instruction for staff
22/10/20		Contacts of COVID-19	Rectified guidance for isolation of resident contacts back to 14 days

			after national clarification.
22/12/20		Throughout	Multiple simplifications/clarifications in wording throughout the document Changes in wording to allow use in other care settings, not just care homes
9.5.21	13	End of Outbreak	End of outbreak changed from 28 days since last case to 14 days (once 14 day whole home testing results are available and negative for COVID-19) – see page 13 for details
9.5.21		Visiting – all sections	Visiting guidance updated Visiting arrangements in care homes see DHSC guidance Arrangements for visiting out of the care home see DHSC guidance
30.6.21		COVID-19 – End of Outbreak	Changed the wording in red text If WGS results confirm a VOC in the outbreak (other than Alpha or Delta variant) then the outbreak restrictions should remain in place until whole home recovery testing has been completed after a period 28 days with no new cases.
1.7.21	19	Algorithm for outbreaks of flu like illness in care homes	Added
1.7.21	4	Infectious periods and Isolation periods	Added for COVID-19, Flu and other respiratory viruses
1.7.21	5	When to call the HPT	Updated to reflect care setting access to PCR tests and to PHE Helpline
1.7.21	5	Info to collate for HPT	Added information on vaccine history for hospitalised or deaths
20.8.21	1	Definitions COVID-19-Case	Changed **Confirmed case of COVID-19**: Any resident or staff with laboratory confirmed COVID-19. **Contact:** anyone who has been close to someone who has tested positive for COVID-19 with a laboratory PCR test during their infectious period To **Confirmed case of COVID-19**: Any resident or staff with an LFD or PCR positive test for COVID-19. **Contact:** anyone who has been close to a confirmed case of COVID-19 during the case's infectious period
20.8.21	1	Definitions –COVID-19 Contacts	Added Double vaccinated staff and residents may be exempt from self-isolation as a contact if certain conditions and mitigations are in place – see PHE guidance COVID-19: management of staff and exposed patients and residents in health and social care settings - GOV.UK (www.gov.uk) and DHSC/PHE/NHS guidance Coronavirus (COVID-19): admission and care of people in care homes - GOV.UK (www.gov.uk)
20.8.21	2	Definitions – Influenza Case	Added the words Point of Care Test to the following sentence **Confirmed case of Influenza** Any resident or staff member with laboratory or Point of Care Test positive for Influenza.
	5	When to call the HPT	deleted **Single case of confirmed COVID-19 or flu in a resident -** we can arrange testing and will give Infection Prevention & Control (IPC) advice Clarified wording/phrasing in the following sentence, including adding reference to timescale **Two or more staff members or residents with confirmed COVID-19; or suspected or confirmed flu within 14 days (an outbreak)** we can arrange testing for flu; and will give outbreak and IPC advice

20.8.21		Key information for the HPT	deleted • CQC number for the setting, where applicable added • Confirmation of diagnosis (positive test)? • Latest round of routine test results for COVID-19 • Any Aerosol Generating Procedures carried out? IPC measures in place
20.8.21	7	Removed reference to Shielding and replaced with Clinically Extremely Vulnerable	• **Social Distancing and Clinically Extremely Vulnerable** - Due to the Covid-19 pandemic, all care settings should be reducing contact between residents in communal areas. Some particularly vulnerable residents and staff may require extra precautions throughout the pandemic - see Annex A of DHSC/PHE/CQC/NHSE Admission and Care of Residents during COVID-19 Incident in a care home . • **Clinically Extremely Vulnerable** - PHE COVID-19: guidance on protecting people defined on medical grounds as extremely vulnerable and - PHE COVID-19: guidance for employees, employers and businesses NHS HR guidance on protecting vulnerable staff
20.8.21	8	Checklist for single Case of ARI/Influenza like Illness	Highlighted and elaborated on extra testing available from HPT • **IF SINGLE CASE OF confirmed FLU or TWO SUSPECTED CASES of FLU within 14 days** • **Call the HPT: Tel 0300 303 8162** • If appropriate, HPT will arrange swabbing/testing of symptomatic resident. **This includes Flu A/Flu B/RSV and other viral respiratory pathogens – these tests are NOT available with Pillar 2 routine COVID-19 testing pathways**
20.8.21	11	Checklist for Outbreak of Confirmed COVID-19	Added para Double vaccinated staff and residents may be exempt from self-isolation as a contact if certain conditions and mitigations are in place – see PHE guidance COVID-19: management of staff and exposed patients and residents in health and social care settings - GOV.UK (www.gov.uk) and DHSC/PHE/NHS guidance Coronavirus (COVID-19): admission and care of people in care homes - GOV.UK (www.gov.uk)
20.8.21	12	Checklist for Outbreak of Confirmed COVID-19	Added new section on testing Testing for COVID-19 • Symptomatic staff should arrange testing through the online portal or 119 • Symptomatic residents can be testing using the test kits used for regular resident testing. However, if another respiratory virus is suspected other than COVID-19 e.g. Flu, it is important to call the HPT – they can arrange swabs specific for Flu (and other respiratory viruses) testing • See DHSC Coronavirus (COVID-19) testing for adult social care settings .
20.8.21	12	Checklist for Outbreak of Confirmed COVID-19	Changed wording from End of Outbreak – to Lifting of Outbreak restrictions and added new para on cases arising between negative recovery testing at 14 days and 28 days since the latest case

			Lifting of Outbreak Restrictions • See DHSC Coronavirus (COVID-19) testing for adult social care settings • Testing regimes and guidance on when outbreak restrictions may be lifted may change over the course of the autumn/winter, therefore always check the latest guidance As at the date of publication of this reference document: • If 14 days have passed since the onset of symptoms in the most recent case a round of PCR and LFD recovery testing of all residents and staff should be undertaken. If there are no LFD and PCR positive results, outbreak restrictions can be lifted (await PCR results before restrictions are lifted). At this point regular asymptomatic and symptomatic testing should be restarted. • NB: If Whole Genome Sequencing (WGS) results are not available by day 14 testing then assume that no Variant of Concern (VOC) has been detected and declare the outbreak over if there are no positive results. If WGS results confirm a VOC in the outbreak (other than Alpha or Delta variant) then the outbreak restrictions should remain in place until whole home recovery testing has been completed after a period 28 days with no new cases. • If cases occur in the period between recovery testing (negative) and 28 days since the last case, a risk assessment should be done as to whether this is a new outbreak or reflects ongoing transmission from the old outbreak. Advice can be sought from LA, CCG or HPT
20.8.21	Appendix	Algorithm for Management of Acute Respiratory Infections in care homes	Deleted as currently undergoing update – see weblink for latest version