Public Health England

Protecting and improving the nation's health

Risk assessment guide for care homes admitting residents with infections

Risk assessment guide for care homes assessing residents with infections

Introduction

Sometimes care homes will be asked by a hospital to admit a resident who has an infection. This leaflet has been produced by Public Health England, to enable care home managers to risk assess each situation to help them determine whether it is safe for the resident to be transferred into their care home.

This risk assessment encourages a co-ordinated approach between the care home, Hospital Discharge Team and the local Health Protection Team for the admission of a resident who may be infectious.

Background

Hospital patients are not usually transferred to care homes whilst they are still infectious, for example, if there is a Norovirus outbreak on a ward and the resident is symptomatic, it is unlikely that they will be transferred back to the care home when still symptomatic. However, on some occasions, it may be appropriate to transfer a patient who may be infectious to a care home. Here are some examples where this may happen:

- A patient with diarrhoea due to Clostridium difficile and who is on an end of life care pathway; the patient no longer needs to be in hospital and they want to die in a care home. It is not appropriate to give the patient any antibiotic treatment;
- A hospital patient has MRSA infection or colonisation;
- A patient was admitted to the hospital from a care home during an outbreak and they have the same infection that caused the care home outbreak;
- A catheterised hospital patient has a Multi-Resistant Gram Negative Organism (ESBL) urinary infection or colonisation;
- A patient has CPE infection or colonisation.

Next steps

In order to determine whether you are able to safely admit the patient to your care home, you need to perform an infection control risk assessment. This involves answering the question: Can this person's care needs be safely met, without putting others in the care home at risk?

All care homes will have residents who are infectious at some time. The code of practice on the prevention and control of infections (GOV.UK, 2015) lists the infection control requirements that care homes should already have in place in order to manage residents with infections.

When can I admit a resident who is infectious?

If you have sufficient capacity and facilities in order to safely meet the patient's needs, then you may accept the patient. There is no guideline that states that you must refuse all patients who are infectious.

What about when there is an outbreak within the home itself?

A suspected outbreak can be defined as two or more cases with similar symptoms of infection, occurring around the same time, in residents and/or their carers, or an increase in the number of cases normally observed.

The commonest outbreaks are due to viral respiratory infections (e.g. influenza like illness, COVID-19), diarrhoea and vomiting (e.g. norovirus) and scabies.

Sometimes a resident may need to be admitted to a hospital with the outbreak symptoms; this may even be before an outbreak has been declared in the home. In these instances, residents can return to the home during the outbreak once they are fit for discharge and their care needs can be safely met, because they have already been affected by the infection.

Suspected outbreaks must be notified to the Health Protection Team who will give further advice on management of the outbreak.

There should be close liaison between the care home and hospital discharge teams to ensure timely and appropriate resident movement once the homes' outbreak has resolved

Need any help?

As every scenario is different, you may wish to discuss the patient with the Public Health England South West Health Protection Team. We can discuss with you how infectious the patient is likely to be and what extra precautions will be needed, if any.

Our Contact Details:

Public Health England South West

Email: swhpt@phe.gov.uk

Main Tel No: 0300 303 8162.

Please see the appendix for some examples of how you could manage a resident with an infection.

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Date: Aug 2021

Appendix 1. *Clostridium difficile*

In order to accept a symptomatic resident with lab-confirmed toxin-positive *Clostridium difficile* can you:

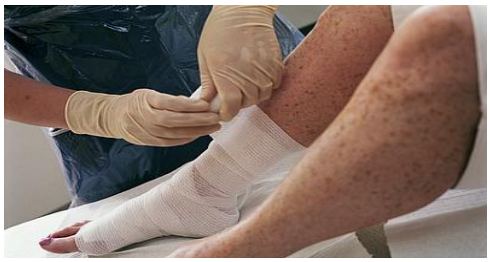
Provide a single room/cohort bed with an en-suite/dedicated commode?

If so the requirements are:

- The door must be closed and an isolation sign placed on the door;
- All staff must wear disposable apron and gloves for direct contact with body fluids and/or excretions;
- Staff must wash their hands with liquid soap and water, and dry thoroughly before leaving the resident's room;
- Change all bed linen daily and treat as infected. Place into a water soluble alginate bag and then into a laundry bag for linen to be washed;
- Use yellow clinical waste bags for all waste;
- Advise visitors to wash their hands with liquid soap and water, and dry thoroughly before they leave the resident's room;
- Clean the room with detergent and hot water followed by a clean using a chlorine or sodium hypochlorite disinfectant, e.g. Milton, and daily thereafter (to include bed, toilet, commode and all horizontal surfaces);
- Clean commode after every use with detergent and hot water followed by a clean using the above disinfectant. Keep dedicated commode for duration of resident's stay.

  Once Clostridium difficile has been identified, no further stool specimens should be sent. Isolation can be discontinued when bowel habit returns to normal (i.e. type 1 – 4 stool) for 72 hours**. There is no need to send a stool sample for clearance of the infection.**

Appendix 2. *MRSA – Methicillin-resistant Staphylococcus aureus*



Does the resident have MRSA in:

- Sputum with a productive cough?
- Infected wound with pus that cannot be contained within a dressing?
- Severe skin condition shedding skin cells/pus?

If so can you:

Provide a single room/cohort bed?

If not defer the admission until the risk factors have been reduced, e.g. by having MRSA treatment.

If the resident has MRSA in:

Skin creases (e.g. groin/under breasts): Standard infection control procedures. Meticulous hand hygiene following contact with skin creases.

Sputum/tracheostomy site: Ensure respiratory secretions can be contained e.g. in tissues. Promote service user hand hygiene.

Superficial pressure sores or wounds: Standard infection control procedures. Ensure wound is covered. Contact GP if signs of infection (redness, warmth, swelling and pain at the site.

Urine and is catheterised: Standard infection control procedures, the same as for any other service user.

PEG site: Standard infection control procedures.

Nose only/ No catheters/PEG/other tubes and devices: Standard infection control procedures.

Residents can circulate within the home in the same way as other residents if staff adhere to standard infection control procedures as is usual practice for all residents.

Appendix 3. MRSA Risk Assessment for Care Homes

Undertake a risk assessment on or prior to a resident coming into / returning to the home or if the risk factors change. Use the risk assessment tool.

MRSA Risk Assessment Tool

Name:	Date of Birth:
Key worker:	

Exclusion of potential residents from care homes due to them having MRSA may have disadvantages for individuals, such as adverse psychological consequences and delays in the therapeutic process, which outweigh the control of infection risk. Use the risk assessment tool to decide whether accepting an MRSA colonised or infected service user is safe practice.

How to use the risk assessment:

- On or prior to a resident coming to live at / returning to the home, tick the boxes which apply to that service user (but do not add the risk factors scores).
- Identify as many of the criteria as appropriate for that person.
- Manage the resident according to the highest risk factor. For example, if risk factor 1 & 3 identified manage according to risk factor 3.
- If the risk factors change – reassess the risk and take appropriate precautions.

Criteria	Risk factor	Precautions	Tick box
No catheters/PEG/other tubes and devices.	0	Standard infection control procedures, the same as for any other service user.	
MRSA in urine and service user has a catheter. If it is a suprapubic catheter, the site should be healing and not draining pus)	1		
PEG (Site healing not draining pus)	1		
MRSA in the nose only.	1		
The service user has superficial skin lesions but these are not infected.	1	Standard infection control procedures. Cover wounds	
MRSA in skin creases, e.g. the groin, under the breast	2	Standard infection control procedures. Meticulous hand hygiene following contact with skin creases.	
MRSA in sputum / tracheostomy site	2	Ensure respiratory secretions can be contained e.g. in tissues. Promote service user hand hygiene.	
MRSA in superficial pressure sores or wounds (Pus not draining from wounds)	2	Standard infection control procedures. Ensure wound is covered. Contact GP if signs of infection (redness, warmth, swelling and pain at the site).	

Criteria	Risk factor	Precautions	Tick box
Respiratory tract infection (MRSA in sputum with productive cough)	3	Isolate in single room. If this cannot be achieved, defer admission until treated.	
MRSA in infected wounds with pus draining from them – the pus cannot be contained under wound dressings and padding.	3	Isolate in single room. If this cannot be achieved, defer admission until the pus can be contained under a dressing.	
The service user has a severe skin condition with huge amounts of skins cells or pus being shed into the environment.	3	Isolate in single room. If this cannot be achieved, defer admission until treated.	

Risk factor:

1. **Low risk of spread of MRSA** – No limitations on admission to the care home.

2. **Moderate risk of spread of MRSA** – The service user may be admitted to the home but extra precautions are needed as per the chart.

3. **High risk of spread of MRSA** Isolate the resident in their room. If this cannot be achieved, defer the individual's admission until the risk factors have been reduced, e.g. by having MRSA treatment.

Risk assessment undertaken by: *delete as appropriate

Signature: _____ Date: _____

Appendix 4. MRSA Risk Assessment for the Day Centres

Undertake a risk assessment on or prior to a new service-user attending the day centre or if the risk factors change. Use the risk assessment tool.

MRSA Risk Assessment Tool

Name:	Date of Birth:
Key worker:	

Exclusion of service users due to them having MRSA may have disadvantages for individuals, such as adverse psychological consequences and delays in the therapeutic process, which outweigh the control of infection risk. Use the risk assessment tool to decide whether accepting an MRSA colonised or infected service user is safe practice.

How to use the risk assessment:

- On or prior to a new service user attending the centre, tick the boxes which apply to that service user (but do not add the risk factors scores).
- Identify as many of the criteria as appropriate for that service user.
- Manage the patient according to the highest risk factor. For example, if risk factor 1 & 3 identified manage according to risk factor 3.
- If the risk factors change – reassess the risk and take appropriate precautions.

Criteria	Risk factor	Precautions	Tick box
No catheters/PEG/other tubes and devices.	0	Standard infection control procedures, the same as for any other service user.	
MRSA in urine and service user has a catheter. If it is a suprapubic catheter, the site should be healing and not draining pus)	1		
PEG (Site healing not draining pus)	1		
MRSA in the nose only.	1		
The service user has superficial skin lesions but these are not infected.	1	Standard infection control procedures. Cover wounds	
MRSA in skin creases, e.g. the groin, under the breast	2	Standard infection control procedures. Meticulous hand hygiene following contact with skin creases.	
MRSA in sputum / tracheostomy site	2	Ensure respiratory secretions can be contained e.g. in tissues. Promote service user hand hygiene.	
MRSA in superficial pressure sores or wounds (Pus not draining from wounds)	2	Standard infection control procedures. Ensure wound is covered. Contact GP if signs of infection (redness, warmth, swelling and pain at the site).	

Criteria	Risk factor	Precautions	Tick box
Respiratory tract infection (MRSA in sputum with productive cough)	3	Defer attendance until treated and service user feels well.	
MRSA in wounds with pus draining from them – the pus cannot be contained under wound dressings and padding.	3	Defer attendance until the pus can be contained under a dressing for the duration of attendance at the day centre.	
The service user has a severe skin condition with huge amounts of skins cells or pus being shed into the environment.	3	Defer attendance until the skin condition has improved.	

Risk factor:

4. **Low risk of spread of MRSA** – No limitations on attendance at the day centre.

5. **Moderate risk of spread of MRSA** – The service user may attend the day centre but extra precautions are needed as per the chart. Contact the Health Protection Nurses for advice. Tel: 01380 814000.

6. **High risk of spread of MRSA** Defer the individual's attendance until the risk factors have been reduced, e.g. by having MRSA treatment. Contact the Health Protection Team for advice. Tel: 0300 303 8162

Risk assessment undertaken by: *delete as appropriate

Signature: _____ Date: _____

Appendix 5: Admission Decisions during Outbreaks of Viral Respiratory Infections

When can hospitalised care home residents diagnosed with influenza, COVID-19 or other respiratory viruses be discharged?

Care home residents admitted to hospital with a diagnosis of influenza, or other respiratory viral infections such as respiratory syncytial virus (RSV), may remain infectious to others even after discharge from hospital, and infection control measures as outlined in PHE guidance are indicated to prevent transmission to others.

Residents may be discharged from hospital at any point when the following criteria are satisfied:

- in the view of the treating clinical staff, the resident has clinically recovered sufficiently to be discharged to a care home. Note that there is no requirement for the resolution of all symptoms or a minimum period of treatment
- all appropriate treatment will be completed after discharge
- appropriate infection control measures to prevent transmission of infection, including single room dwelling or cohorting, will be continued outside hospital until a minimum of five days after the onset of symptoms for non-COVID-19 respiratory infections, 14 days for COVID-19. Note that in some circumstances (see below) it may be considered necessary to continue infection control measures beyond these periods
- the discharge is planned in accordance with local hospital policy

Care homes may close wholly or in part to new admissions during outbreaks of influenza or other respiratory viruses. Where all the above criteria are satisfied, and appropriate outbreak control measures have been taken at the care home, residents hospitalized with a respiratory viral infection may return home during a period of closure occasioned by an outbreak of the same type of respiratory virus.

Can hospitalised care home residents hospitalised for reasons unrelated to influenza, COVID-19 or other respiratory viral infections be discharged to a care home with an outbreak of a respiratory virus?

Care home residents hospitalised for reasons unrelated to influenza or respiratory viral infections should only be discharged back to a care home with an on-going respiratory virus outbreak after a careful assessment of the risk of exposure to cases of infection, as respiratory viral infections may have severe consequences in care home residents; prevention is key to minimising impact. The assessment of the likelihood of exposure to infection should take account of the affected sections of the care home, the location of the resident within the care home, the overall geography of the care home, contacts between residents or cross-over of staff or visitors between affected and unaffected sections of the care home and satisfactory compliance with infection control precautions by care home staff (including seasonal influenza vaccination uptake).

Where care homes have closed wholly or in part to new admissions because of an outbreak of a respiratory virus, when can they reopen?

Provided infection control measures are implemented according to guidance for residents with respiratory viral infections and care home staff are aware of the importance of an immediate response to new cases, care homes may re-open to new admissions

- five days after the onset date of the most recent case - for influenza or any respiratory virus other than COVID-19 or
- For COVID-19, see COVID-19 guidance and discuss with the commissioner (CCG or LA)

The following risk factors have been associated with prolonged shedding of influenza virus (the first three may also apply to COVID-19):

1. Case has other major medical conditions (including malignancy, chronic lung disease, renal disease, heart disease, liver disease, stroke)
2. Case has an impaired immune system from conditions including systemic corticosteroid use; chemotherapy, organ or bone marrow transplantation, or advanced HIV/AIDS infection
3. Case was diagnosed with pneumonia
4. Antiviral therapy of case was started > 48 hours after symptom onset
5. Case did not receive antiviral therapy
6. Case has persistent respiratory symptoms after five days of antiviral treatment

Please also see PHE guidance

- **Guidance for stepdown of infection control precautions and discharging COVID-19 patients** and
- **Coronavirus (COVID-19): admission and care of residents in a care home during COVID-19**
- **Designated settings for people discharged to a care home**

Appendix 6. Admission Decision Aid for care homes during Outbreaks of Viral Gastroenteritis

Admission decision aid for Nursing and Residential Care homes during a viral gastroenteritis e.g. Norovirus outbreak within the Care Home

This flow chart can be used to help you risk assess whether or not it is safe to accept the admission/transfer of a patient from hospital when your care home has been 'closed' due to a confirmed or suspected outbreak of viral gastroenteritis/norovirus **WHEN:**

1. The patient is medically fit for discharge from the hospital, **AND**
2. The SW PHE Health Protection Team has been notified of the suspected outbreak (call 0300 303 8162 option 1 option 1)

For more information on when to suspect an outbreak see: Care Home and Residential Care Guidance at: https://www.england.nhs.uk/south/info-professional/public-health/infection-winter/care-guidance/

Is the patient returning to the home in which they lived at the time of admission?

Yes

Was a viral gastroenteritis outbreak suspected or confirmed in the home at the time of the patient's admission (or the outbreak recognised shortly after their admission because others had symptoms) **AND/OR** the admitted resident was diagnosed with viral gastroenteritis in hospital?

Yes

Has the patient been clear of diarrhoea and/or vomiting symptoms for at least 48 hours and had a return to usual bowel habits?

Yes

This resident had acquired viral gastroenteritis in the care home but is no longer infectious and can return to the care home without requiring isolation

No

This resident had acquired viral gastroenteritis in the current care home outbreak but may still be infectious. **They can return to the care home but should be isolated** /'barrier nursed' until at least 48 hours clear of any diarrhoea or vomiting symptoms
If unable to isolate, restrict movement within the home and supply own toilet facilities. Contact the HPT if risk assessment required

No the patient was admitted prior to any residents or staff showing symptoms of viral gastroenteritis
and/or their admission was not related to this

No– they would be coming to a new home

There is a risk of becoming infected: Defer admission until care home outbreak has resolved and home 're-opened'.

You may come across scenarios which do not fit this flow chart for example when the discharging hospital ward also has an outbreak. Please contact the Health Protection Team for further advice (or the Hospital Infection Prevention & Control Team regarding hospital outbreaks)
Please send any feedback/questions you have about this tool to: penelope.edwards@phe.gov.uk