Department of Health & Social Care

Public Health England

CareQuality Commission

NHS

# Admission and Care of Residents during COVID-19 Incident in a Care Home

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## Introduction

Care homes have a vital role to play in the UK, especially during the response to the COVID-19 pandemic. We want to make sure you and your staff can continue to care for some of the most vulnerable in our society. With your help, we can help keep them safe and cared for.

We want to support Care Home Providers to protect their staff and residents, ensuring that each person is getting the right care in the most appropriate setting for their needs. We know that to do this care homes need to have access to the right knowledge, staff and resources, so they are equipped to deliver care in this challenging time.

We also need care homes to continue to make their full capacity available to support the national effort, both in terms of beds and their skilled care staff**.** Helping to move patients who no longer require acute care into the most appropriate setting will help to save thousands of lives. We thank you for your continued actions to support the implementation of the hospital discharge guidance COVID-19 Hospital Discharge Service Requirements.

In return we will support you and your staff and residents in the following ways:

- We will ensure you have the information and support you need to safely admit and care for patients during the pandemic (see section 2).

- We will ensure a longer-term supply of all aspects of personal protective equipment (PPE) for care homes - and home care providers - so that staff can provide care, as well as providing a national supply disruption line for immediate concerns (see Annex F).

- We have established Capacity Tracker as the single mechanism across the country to report bed vacancies and help manage demand during this incident (see Annex I for further details). This must be kept up to date on a daily basis. This information will not be used to drive any regulatory enforcement activity.

- We will work with commissioners to ensure fair and prompt payment for the existing care commitments and additional care provided during the response to the pandemic, recognising that both PPE and staffing costs are higher than usual.

- We have made NHSMail available for secure communication and transfer of information and this must be used for communication with the NHS.

This guidance is intended for care homes, local health protection teams, local authorities, clinical commissioning groups (CCGs) and registered providers of accommodation for people who need personal or nursing care. This includes registered residential care and nursing homes for people with learning disabilities, mental health and/or other disabilities.

We will also continue to provide domiciliary care providers with the information they need to continue providing care during the COVID-19 pandemic.

## 1. Admission of residents

The care sector looks after many of the most vulnerable people in our society. In this pandemic, we appreciate that care home providers are first and foremost looking after the people in their care, and doing so while some of their staff are absent due to sickness or isolation requirements. As part of the national effort, the care sector also plays a vital role in accepting patients as they are discharged from hospital – both because recuperation is better in non-acute settings, and because hospitals need to have enough beds to treat acutely sick patients. Residents may also be admitted to a care home from a home setting. Some of these patients may have COVID-19, whether symptomatic or asymptomatic. **All of these patients can be safely cared for in a care home if this guidance is followed.**

If an individual has no COVID-19 symptoms or has tested positive for COVID-19 but is no longer showing symptoms and has completed their isolation period, then care should be provided as normal.

The Hospital Discharge Service and staff will clarify with care homes the COVID-19 status of an individual and any COVID-19 symptoms, during the process of transfer from a hospital to the care home. Tests will primarily be given to:

- all patients in critical care for pneumonia, acute respiratory distress syndrome (ARDS) or flu like illness
- all other patients requiring admission to hospital for pneumonia, ARDS or flu like illness
- where an outbreak has occurred in a residential or care setting, for example long-term care facility or prisons.[1]

Negative tests are not required prior to transfers / admissions into the care home.

Duties and powers under the Mental Capacity Act 2005 still apply during this period. If a person thinks it is more likely than not that the person lacks the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before a decision about their discharge is made. During the emergency period professionals may want to consider a proportionate approach to such assessments to enable timely discharge. The Department of Health and Social Care will shortly be issuing guidance on the use of the MCA and Deprivation of Liberty Safeguards during this

[1] Further guidance on testing can be found online: https://www.gov.uk/government/news/coronavirus-testing.

emergency period. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made then please follow this guidance.

## 2. Caring for residents, depending on their COVID-19 status

COVID-19 positive cases

If you are caring for a resident who has been discharged from hospital and has tested positive for COVID-19, the discharging hospital will provide you with the following information upon discharge:

- The date and results of any COVID-19 test.
- The date of the onset of symptoms.
- A care plan for discharge from isolation.

Annex D provides further information on the appropriate isolation required for care home residents who have been discharged from hospital following treatment for COVID-19.

Keeping asymptomatic residents safe and monitoring symptoms

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

Care homes should implement daily monitoring of COVID-19 symptoms amongst residents and care home staff, as residents with COVID-19 may present with a new continuous cough and/or high temperature. Assess each resident twice daily for the development of a fever (≥37.8°C), cough or shortness of breath. Immediately report residents with fever or respiratory symptoms to NHS 111, as outlined in the section below.

Symptomatic residents

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

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

Care home staff should note that people with dementia and cognitive impairment may be less able to report symptoms because of communication difficulties, and therefore staff should be alert to the presence of signs as well as symptoms of the virus. This could include delirium, which people with dementia are more prone to suffer from if they develop an infection.

For people with a learning disability, autism or both we suggest that you read this guidance which has good information about the additional things to do if you are caring for this group of people.

Testing residents

Details of the current testing process are below.[2] As testing capacity increases, the government will aim to offer more comprehensive testing to the sector:

- **Single symptomatic resident:** Testing may be offered following contact with NHS 111 or according to local protocol for swabbing and testing.

- **More than one symptomatic resident:** Inform the Health Protection Team (HPT). They may arrange swabbing for up to 5 initial possible cases to confirm the existence of an outbreak. Testing all cases is not required as this would not change subsequent management of the outbreak.

Continue all strict control measures including isolation, cohorting and infection control measures until results for all residents who were tested are obtained or until the period of isolation has been completed.

## 3. Reporting of COVID-19 cases

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

- The HPT will provide advice and support along with local authority partners to help the care home to manage the outbreak.

- Follow the outbreak control measures advised by the HPT.

- The outbreak can be declared over once no new cases have occurred in the 14 days since the appearance of symptoms in the most recent case.

[2] Further guidance on testing can be found online: https://www.gov.uk/government/news/coronavirus-testing.

## 4. Providing care after death

The infection control precautions described in this document continue to apply whilst an individual who has died remains in the care home. This is due to the ongoing risk of infectious transmission via contact, although the risk is usually lower than for those living.

Further information can be found here.

## 5. Advice for staff

The personal protective equipment (PPE) that must be worn when caring for possible or confirmed COVID-19 patients, is described in Annex F.

Care home staff who come into contact with a COVID-19 patient while not wearing PPE can remain at work. This is because in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing. These are guiding principles and there should be an individual risk assessment based on staff circumstances, for example staff who are vulnerable should be carefully assessed when assigning duties, and where a possible or confirmed COVID-19 case is present in a care home, efforts should be made to cohort staff caring for that person. Further guidance can be found here.

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

- Not attend work if they develop symptoms.
- Notify their line manager immediately.
- Self-isolate for 7 days, following the guidance for household isolation.
- Care home capacity will be monitored via the capacity tracker and this data will be shared with Local Resilience Forums via the daily national Situation Reports to support capacity planning and response. However, where providers consider there to be imminent risks to the continuity of care, such as the potential closure of a service, they should raise this with the local authority without delay.

## 6. Supporting existing residents that may require hospital care

If you think one of your residents may need to be transferred to hospital for urgent and essential treatment, consider the following checklist:

If a resident shows symptoms of COVID-19:

- Assess the appropriateness of hospitalisation: consult the resident's Advance Care Plan/Treatment Escalation Plan and discuss with the resident and/or their family

member(s) or Lasting Power of Attorney as appropriate following usual practice to determine if hospitalisation is the best course of action for the resident.

- If hospitalisation is required:
  - Follow Infection Prevention and Control guidelines for patient transport (section 6.3).
  - Inform the receiving healthcare facility that the incoming patient has COVID-19 symptoms.
- If hospitalisation is not required, follow infection prevention and control, and isolation procedures and consult the resident's GP for advice on clinical management / end of life care as appropriate – see Annex C.

If a resident requires support with general health needs:

- Consult the resident's Advance Care Plan.
- Consult the resident's GP and community healthcare staff to seek advice.
- Alternatively, contact NHS 111 for clinical advice.

Postpone routine non-essential medical and other appointments.

- Review and postpone all non-essential appointments (medical and non-medical) that would involve residents visiting the hospital or other health care facilities.
- If medical advice is needed to manage routine care, consider arranging this remotely via a phone call with the GP or named clinician.

## 7. National support available to implement this guidance

To support implementation, NHS England and Improvement, in collaboration with other national organisations, will be running webinars to build on this guidance and provide Care Homes and their partner organisations with the opportunity to ask questions. This will be supported by a Frequently Asked Questions, which will be regularly updated. If you have any immediate questions on this guidance, please email ENGLAND.bettercaresupport@nhs.net.

For support to use the Capacity Tracker, NECS has set up a Contact Centre to support those providers who are being required to register and update their information daily. The number is 0191 691 3729 and operates between 8am and 8pm, 7 days a week. Outside of these hours, or for more general guidance, providers can email necsu.capacitytracker@nhs.net.

# ANNEXES

## Annex A: COVID-19 symptoms and higher risk groups

### Symptoms of COVID-19 (Coronavirus) are[3] recent onset of:

a. new continuous cough and/or

b. high temperature

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

The following individuals are at an increased risk of severe illness from coronavirus (COVID-19). Care home providers should be stringent in following Social distancing measures for everyone in the care home and the shielding guidance for those in extremely vulnerable groups.

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

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

c. Anyone aged under 70 years with an underlying health condition – for most this will align with eligibility for the flu jab on medical grounds – should follow social distancing guidance for the clinically vulnerable.

[3] Symptoms may be more nuanced in older people with co-morbidities in care homes who may present with Influenza Like Illness (ILI), respiratory illness, new onset confusion, reduced alertness, reduced mobility, or diarrhoea and sometimes do not develop fever. This may be true for COVID-19, so such changes should alert staff to the possibility of new COVID infection.

## Annex B: Definitions of COVID-19 cases and contacts

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

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

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

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

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

      **or**

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

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

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

## Annex C: Isolation of COVID-19 symptomatic patients

### Isolation of residents

a. **Single case - Isolation of a symptomatic resident:** All symptomatic residents should be immediately isolated for 14 days from onset of symptoms.[4]

b. **More than one case - Cohorting of all symptomatic residents:**

- Symptomatic residents should ideally be isolated in single occupancy rooms.
- Where this is not practical, cohort symptomatic residents together in multi-occupancy rooms. Residents with suspected COVID-19 should be cohorted only with other residents with suspected COVID-19. Residents with suspected COVID-19 should not be cohorted with residents with confirmed COVID-19.
- Do not cohort suspected or confirmed patients next to immunocompromised residents.
- When transferring symptomatic residents between rooms, the resident should wear a surgical face mask.
- Clearly sign the rooms by placing IPC signs, indicating droplet and contact precautions, at the entrance of the room.
- Staff caring for symptomatic patients should also be cohorted away from other care home residents and other staff, where possible/practical. If possible, staff should only work with either symptomatic or asymptomatic residents. Where possible, staff who have had confirmed COVID-19 and recovered should care for COVID-19 patients. Such staff must continue to follow the infection control precautions, including PPE as outlined in this document.

### Isolation and cohorting of contacts:

Careful risk assessment of the duration and nature of contact should be carried out, to put in place measures such as isolation and cohorting of exposed and unexposed residents. Please refer to the definition of contacts in Annex B. There are broadly three types of isolation measures:

- **Isolation of contacts individually in single rooms for 14 days after last exposure to a possible or confirmed case:** This should be the preferred option where possible.

[4] The 7 days isolation period usually applies but care home residents are a particularly vulnerable group and their immune response may differ from younger normally healthier individuals. Therefore, a 14 day period of isolation is recommended for residents in care homes.

These contacts should be carefully monitored for any symptoms of COVID-19 during the 14-day period as described earlier.

- **Cohorting of contacts within one unit rather than individually:** Consider this option if isolation in single rooms is not possible due to shortage of single rooms when large numbers of exposed contacts are involved.

- **Protective cohorting of unexposed residents:** Residents who have not had any exposure to the symptomatic case can be cohorted separately in another unit within the home away from the cases and exposed contacts.

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

## Annex D: Receiving residents being discharged from hospital

Hospitals around the country need as many beds as possible to support and treat an increasing number of COVID-19 cases. This means the NHS will seek to discharge more patients into care homes for the recovery period (see Table 1).

During the COVID-19 response it will not be possible for care homes to visit a potential resident in hospital to assess their care needs. A Discharge to Assess (D2A) model is in place to streamline the discharge process and the assessment of care needs will be undertaken by hospital discharge teams, in collaboration with Trusted Assessors.

**Table 1: Care needs of residents being discharged from hospital** (see plain text below)

| **Upon discharge, patient/resident has...** | **What care is required upon discharge?** | **What care is required upon first sign of symptoms?** |
|---|---|---|
| No symptoms of COVID-19 | Provide care as normal | Provide care in isolation if symptoms occur within 14 days of discharge from hospital<br>• Resident does not leave room (including for meals) **for 14 days** after onset of symptoms or positive test<br>• Staff wear protective equipment & place in clinical waste after use<br><br>Consult resident's GP to consider if re-hospitalisation is required |
| Tested positive for COVID-19<br><br>✓ No longer showing symptoms<br><br>✓ Completed isolation period | Provide care as normal | N/A |
| Tested positive for COVID-19<br><br>✓ No longer showing symptoms<br><br>⚠ Not yet completed isolation | Provide care in isolation<br>• Resident does not leave room (including for meals) **for 14 days** after onset of symptoms or positive test<br>• Staff wear protective equipment & place in clinical waste after use | N/A |

**Table 1 plain text.**

Upon discharge, care homes should follow the guidance below.

**If a resident has no symptoms of COVID-19**

- **What care is required upon discharge?** The care home should provide care as normal.
- **What care is required upon first sign of symptoms?** Provide care in isolation if symptoms occur within 14 days of discharge from hospital.[5]
    - Resident does not leave room (including for meals) for 14 days after onset of symptoms or positive test.
    - Staff wear protective equipment & place in clinical waste after use.
    - Consult resident's GP to consider if re-hospitalisation is required.

**If the resident has tested positive for COVID-19, is no longer showing symptoms and has completed an isolation period:**

- **What care is required upon discharge?** The care home should provide care as normal.
- **What care is required upon first sign of symptoms?** N/A.

**If the resident has tested positive for COVID-19, is no longer showing symptoms but has not yet completed isolation.**

- **What care is required upon discharge?** Provide care in isolation.
    - Resident does not leave room (including for meals) for 14 days after onset of symptoms or positive test.
    - Staff wear protective equipment & place in clinical waste after use.
- **What care is required upon first sign of symptoms?** N/A.

[5] The 7 days isolation period usually applies but care home residents are a particularly vulnerable group and their immune response may differ from younger normally healthier individuals. Therefore, a 14 day period of isolation is recommended for residents in care homes.

## Annex E: Infection Prevention and Control (IPC) Measures

Care homes are not expected to have dedicated isolation facilities for people living in the home but should implement isolation precautions when someone in the home displays symptoms of COVID-19 in the same way that they would operate if an individual had influenza or diarrhoea and vomiting, following the following precautions:

- If isolation is needed, a resident's own room can be used. Ideally the room should be a single bedroom with en-suite facilities. Where this is not available, a dedicated bathroom near to the person's bedroom should be identified for their use only.

- Protective Personal Equipment (PPE) should be used when within 2 metres of a resident with possible or confirmed COVID-19. Guidance on PPE can be accessed on gov.uk. Display signage to prevent unnecessary entry into the isolation room. Confidentiality must be maintained.

- Room door(s) should be kept closed where possible and safe to do so. Where this is not possible ensure the bed is moved to the furthest safe point in the room to try and achieve a 2 metres distance to the open door as part of a risk assessment.

- All necessary procedures and care should be carried out within the resident's room. Only essential staff (wearing PPE) should enter the resident's room (see Annex F).

- Entry and exit from the room should be minimised during care, specifically when these care procedures produce aerosols or respiratory droplets (this is further explained in Annex F).

- Ensure adequate appropriate supplies of PPE and cleaning materials are available for all staff in the care home.

- All staff, including domestic cleaners, must be trained and understand how to use PPE appropriate to their role to limit the spread of COVID-19.

- Dedicate specific medical equipment (e.g. thermometers, blood pressure cuff, pulse oximeter, etc.) for the use of care home staff for residents with possible or confirmed COVID-19. Clean and disinfect equipment before re-use with another patient.

- Restrict sharing of personal devices (mobility devices, books, electronic gadgets) with other residents.

## Annex F: Personal Protective Equipment (PPE)

### PPE supplies and availability

Supplies of personal protective equipment to the care sector is fundamental for the good care of individuals with suspected symptoms of COVID-19. No wholesaler has been asked to prioritise NHS provision over the care sector nor should they be doing so. The rationale underlying all PPE distribution and utilisation should be based on clinical risk. Managers of care homes should ensure all staff are familiar with and use the PPE recommended by PHE to keep staff and patients safe and to assure essential flows of equipment.

As part of the free distribution of fluid repellent facemasks from the pandemic flu stock, every care home and home care provider has received at least 300 facemasks.

We are working rapidly with wholesalers to ensure a longer-term supply of all aspects of personal protective equipment, including gloves, aprons, facemasks and hand sanitiser. For future PPE requirements, care providers should order PPE from their usual suppliers.

**Social care distributor details:**

- Careshop
  Email: coronavirus@careshop.co.uk

- Blueleaf Care
  Tel: 03300 552288
  Email: emergencystock@blueleafcare.com

- Delivernet
  Tel: 01756 70 60 50
  Email: kevin.newhouse@delivernet.co.uk

- Countrywide Healthcare
  Tel: 01226 719090
  Email: enquiries@countrywidehealthcare.co.uk

If care providers have immediate concerns overs their supply of PPE, please contact:

**The National Supply Disruption line**
Tel: 0800 915 9964
Email: supplydisruptionservice@nhsbsa.nhs.uk

In the future, if a care provider is unable to get PPE from their normal supplier, the supplier will be asked to report this to the National Supply Disruption Response (NSDR) team (as above), who can advise on alternative suppliers.

## Hand Hygiene

- Washing hands with soap and water for at least 20 seconds is essential before and after all contact with the person being cared for, removal of protective clothing and cleaning of equipment and the environment.
- Wash hands with soap and water. Alcohol-based hand rub (ABHR) can be used if hands are not visibly dirty or soiled.
- Promote hand hygiene ensuring that everyone, including staff, service users and visitors, have access to hand washing facilities.
- Provide alcohol-based hand rub in prominent places, where possible.
- Any visitors should wash their hands on arrival into the home, often during their stay, and upon leaving.

## Respiratory and Cough Hygiene – 'Catch it, bin it, kill it'

- Disposable single use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose. Used tissue should be disposed of promptly in the nearest foot operated waste bin. Hands should be cleaned with soap and water if possible, after coughing or sneezing, using tissues or after contact with respiratory secretions and/or contaminated objects.
- Encourage individuals to keep hands away from eyes, mouth and nose. Some people may need assistance with containment of respiratory secretions, those who are immobile will need a container at hand for immediate disposal of the tissue such as a bag.

More information on the use of PPE can be found on gov.uk, including a reference table of when PPE should be used in community settings.

## Annex G: Decontamination and cleaning processes for care homes with possible or confirmed cases of COVID-19

Domestic staff should be advised to clean the isolation room(s) after all other unaffected areas of the facility have been cleaned. Ideally, isolation room cleaning should be undertaken by staff who are also providing care in the isolation room.

The person responsible for undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures:

a. **In preparation**

- Collect any cleaning equipment and waste bags required before entering the room.
- Any cloths and mop heads used must be disposed of as single use items.
- Before entering the room, perform hand hygiene then put on a FRSM, disposable plastic apron and gloves.

b. **On entering the room**

- Keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products.
- Bag any disposable items that have been used for the care of the patient as clinical waste.

c. **Cleaning process**

- Use disposable cloths/paper roll/disposable mop heads, to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, <u>following one of the 2 options below</u>:
  - Use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)

    **or**
  - A neutral purpose detergent followed by disinfection (1000 ppm av.cl.).
- Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants.
- Any cloths and mop heads used must be disposed of as single use items.

Cleaning and disinfection of reusable equipment

- Clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers, glucometers, that are in the room prior to their removal.
- Clean all reusable equipment systematically from the top or furthest away point.

Carpeted flooring and soft furnishings

- For carpeted floors/items that cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use following, or combined with, detergent cleaning.

d. **On leaving the room**

- Discard detergent/disinfectant solutions safely at disposal point.
- Dispose of all waste as clinical waste.
- Clean, dry and store re-usable parts of cleaning equipment, such as mop handles.
- Remove and discard PPE as clinical waste as per local policy.
- Perform hand hygiene.

e. **Staff Uniforms**

Uniforms should be transported home in a disposable plastic bag.

Uniforms should be laundered:

- separately from other household linen,
- in a load not more than half the machine capacity,
- at the maximum temperature the fabric can tolerate, then ironed or tumble dried.

f. **Safe Management of Linen**

Please refer to guidance here.

Any towels or other laundry used by the individual should be treated as infectious and placed in an alginate bag then a secondary clear bag. This should then be removed from the isolation room and placed directly into the laundry hamper/bag. Take the laundry hamper as close to the point of use as possible, but do not take it inside the isolation room.

When handling linen do not:

- Rinse, shake or sort linen on removal from beds.
- Place used/infectious linen on the floor or any other surface e.g. table top.
- Re-handle used/infectious linen when bagged.
- Overfill laundry receptacles; or
- Place inappropriate items in the laundry receptacle.

Laundry must be tagged with the care area and date, and stored in a designated, safe lockable area whilst awaiting uplift or laundering.

This should be laundered in line with local policy for infectious linen.

g. **Waste**

Care homes that provide nursing or medical care are considered to produce healthcare waste and should comply with Health Technical Memorandum.

07-01: Safe management of healthcare waste.

All consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, double bagged and tied. This should be put in a secure location awaiting uplift in line with local policies for contaminated waste.

Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system. If able, the individual can use their en-suite WC.

Communal facilities should not be used. Care homes should have well-established processes for waste management.

## Annex H: Communications

- Display signs to inform of the outbreak and infection control measures, examples can be found here.
- Provide 'warn and inform' letters to residents, visitors and staff if there is a suspected case of COVID-19 in the home.
- Although the HPT will provide public health advice in response to an outbreak (including potential closure to new admissions), the care home management has the final responsibility to communicate information, including to staff and visitors and to implement infection control recommendations and any advice on closure to admissions from the HPT. The care home has the primary responsibility for the safety of its staff and residents.

### Considerations for visitors and non-essential staff

- Family and friends should be advised not to visit care homes, except next of kin in exceptional situations such as end of life. Follow the social distancing guidance.
- Visitors should be limited to one at a time to preserve physical distancing.
- Visitors should be reminded to wash their hands for 20 seconds on entering and leaving the home and catch coughs and sneezes in tissues.
- Visitors to minimise contact with other residents and staff (less than 15 minutes / 2 metres etc.)
- Alternatives to in-person visiting should be explored, including the use of telephones or video, or the use of plastic or glass barriers between residents and visitors.
- Visitors should visit the resident in their own room directly upon arrival and leave immediately after the visit.
- Cancel all gatherings and plan alternative arrangements for communal activities which incorporate social distancing.

### Support for care home staff

- Review sick leave policies and occupational health support for care home staff and support unwell staff to stay at home as per Public Health England (PHE) guidance. Support for employers is available here.

- Staff who have a symptomatic household member must stay at home and not leave the house for 14 days. The 14-day period starts from the day when the first person in the house became ill. If the staff member develops symptoms during this period, they can return to work 7 days after their symptoms started and they are no longer symptomatic. Further guidance is available here.

- Staff who fall into the clinically vulnerable group should not provide direct care to symptomatic residents.

- Ensure staff are provided with adequate training and support to continue providing care to all residents.

- All care homes should have a business continuity policy in place including a plan for surge capacity for staffing, including volunteers.

## Annex I: Use of Capacity Tracker to support effective discharge planning and continue care outside of hospitals

### Summary

- On 19 March, HM Government issued COVID-19 Hospital Discharge Service Requirements.
- As part of current discharge planning it is vital to understand the vacancies in community settings.
- Accurate and timely data is essential for effective management of the response to the COVID-19 pandemic both locally and nationally.
- Rapid system-wide adoption of Capacity Tracker from the 1st April 2020 is required. Comprehensive support for registration and operation is available.
- Any information gathered will not be used to drive any regulatory enforcement activity. Our intention is for this information to be used to support collective planning across the health and social care sector and swiftly resolve issues wherever possible, whether through local or national actions.

### What is the role of providers?

- The priority for the duration of the COVID-19 incident is that all providers input data into Capacity Tracker to inform one national and local picture.
- All care homes, all hospices (including children's hospices) and all providers of inpatient community rehabilitation and end of life care MUST input the information specified into Capacity Tracker by 1st April 2020.
- Providers who currently submit information through other systems similar to Capacity Tracker need only to use Capacity Tracker for the duration of the level 4 emergency COVID-19 response.

### What is Capacity Tracker?

Capacity Tracker is managed by the NHS North of England Commissioning Support (NECS) and provides the opportunity to easily track occupancy and vacancies to support system-wide bed and discharge planning. It is an established and robust system that has been successfully supporting the tracking of care home vacancies across a large proportion of England for some time.

More than 7,800 care homes are already registered and setup on Capacity Tracker. However, the COVID-19 situation has resulted in the need to quickly extend its use to the remaining care homes as well as all hospices plus all providers of inpatient rehabilitation and end of life care.

### What information should be inputted?

To support current discharge planning in response to COVID-19, Capacity Tracker will track care home vacancies and bed capacity in all hospices (including children's hospices) and providers of inpatient community rehabilitation and end of life care. Critically, Capacity Tracker will now also start to collect basic information from care homes on workforce and business continuity issues.

### How will the NHS and wider health & social care system use the information?

This essential information will be included in daily national Situation Reports to support capacity planning and response. It will also be used by localities to understand their capacity and pressures across the care sector, again to support care providers, system-wide discharge planning and system resilience. It is vital to maintain resilience across the care sector. To do this local councils and the NHS need to understand the pressures as they change so that support can be provided quickly and where it is most needed. A key element in extending the data capture for care homes is to be able to support any care home that is showing signs of difficulties before it is too late.

### How often do providers need to update Capacity Tracker?

To support reliable real time discharge planning when using Capacity Tracker it must be updated **as close to real time as practicable** – e.g. as and when any occupancy, or care home status changes and at least once per day if there has been no change.

### What do providers need to do now?

If you don't use Capacity Tracker already you need to register as soon as possible and be fully submitting the required information by 1st April. NECS will provide support to help you with this, through a contact centre, online guides and short videos to help you understand what you need to do.

The Resource Centre in Capacity Tracker also contains up to date guidance and information to support you. You will also receive emails containing essential guidance and resources to help you safely care for your residents/patients. Information received will improve the understanding of the support you and colleagues in the care sector may need.

Please register via Capacity Tracker website at: https://carehomes.necsu.nhs.uk/. Short videos to help you register are available on this website under the 'Help Videos' menu and further videos will be available once you've registered and logged in.

**What is the role of Local Authorities (LAs)?**

- Local authorities play the central role in ensuring that the local social care market overall works, and a key role in arranging discharge for many people.

- NHS staff are expected to work with and through local authorities in operationalising the Capacity Tracker tool.

- We are asking all partners to populate and use Capacity Tracker because we know that, when this is combined with local knowledge and expertise, key partners across the health and social care system are able to manage the system more effectively, ensure timely and appropriate hospital discharges and make best use of vital care home provision. Where possible if care homes register with an NHSmail email addresses no verification is required – making the process more straightforward. Registration with another type of email will require verification.

- LAs, and in particular their Brokerage Teams, have a key role to play. They should request the required level of access from NECS directly via necsu.capacitytracker@nhs.net and LAs should also identify System Champions and send their name and email address to NHS NECS via necsu.capacitytracker@nhs.net as soon as practicable. LAs are also asked to provide any support they can to care homes and all parties should be aware of the support available via the Capacity Tracker website (https://carehomes.necsu.nhs.uk/).

**What is the role of CCGs?**

- CCGs will also play a crucial role similar to LAs supporting the rapid implementation of Capacity Tracker across their locality and helping LA counterparts as required.

- It is vital that CCGs ensure all providers in their local area are submitting data to Capacity Tracker, and that they also support/facilitate use of Capacity Tracker.

- **CCGs must take the responsibility to each nominate a group of Capacity Tracker System Champions** (more than one person is required to cover in the case of absence) who will oversee the rapid implementation of Capacity Tracker in their locality.

- These System Champions are crucial because, before providers can submit data, they need to approve their access to Capacity Tracker. System Champions also have more reporting functionality for oversight across the locality. A key role is to ask care

homes, community rehabilitation bed providers and hospices to have a person register as an approver – so they can approve other colleagues as users quickly. The call centre can support any approver / registering issues. Also, registration with NHSmail email addresses will mean no verification is required and is more straightforward, and should be encouraged where possible.

- Name(s) and email address of System Champions which must be notified to NHS NECS via necsu.capacitytracker@nhs.net as soon as practicable.

Adult Social Care Directorate

www.gov.uk/dhsc