Public Health England

Protecting and improving the nation's health

PHE NW Acute Respiratory Illness (ARI) Resource Pack for Care Homes Version 2.1

For Care Homes Located in Bolton

February 2021

Guidance

Acute Respiratory Illness, particularly COVID-19, is a rapidly evolving situation, and guidance may change with little notice.

To ensure you are using the latest national guidance, refer to: Coronavirus (COVID-19): adult social care guidance as well as the links highlighted throughout this document.

Sign up to receive general guidance updates here and specific social care updates here

Contents

Local Contacts

Community Infection Prevention and Control Teams	
Monday – Friday 9am – 5 pm	01204 390 982
Community Infection Prevention and Control Team	

Public Health England North West Health Protection Team	
Monday – Friday 9 am – 5pm	0344 225 0562
Out of Hours PHE Contact: Public Health England first on call via the Contact People	0151 434 4819

Report a suspected case of acute respiratory illness by telephone to:

Monday to Friday 9am – 5pm: Community Infection Prevention and Control Team

After 5pm/weekends/bank holidays: Public Health England, NW Health Protection Team on 0151 434 4819

Causes of Acute Respiratory Illness in Care Homes

Refer to Guidance: Influenza-like illness (ILI): managing outbreaks in care homes

- COVID-19
- Influenza ('flu')

Also:

- Respiratory syncytial virus (RSV)
- Rhinovirus
- Adenovirus
- Parainfluenza
- Human metapneumovirus (hMPV)

Impact of Acute Respiratory Illness in Care Homes

Residents

- **Are more at risk** because they:
  - Are older
  - Have underlying medical conditions
  - Live closely, and spend a lot of time with other residents and staff
- Elderly residents are more likely to suffer **severe symptoms**, require **hospitalisation** or **die**.

Care Home

- Greater **resources** required for infection control measures.
- Potential **closure** of care home to new admissions.
- Potential impact on **reputation** of care home from severe cases or deaths.

Infection Prevention and Control (IPC)

Refer to Guidance: Coronavirus (COVID-19): admission and care of people in care homes

The basic IPC measures to prevent an outbreak are exactly the same for both COVID-19 and ILI:

- **Hand and respiratory hygiene** and facilities to support this
- **Personal Protective Equipment (PPE)** use: How to work safely in care homes and Aerosol generating procedures and Putting on and removing PPE video
- **Cleaning:** COVID-19: cleaning in non-healthcare settings and Safe management of healthcare waste and Decontamination of linen for health and social care
- **Social distancing and shielding:** COVID-19 social distancing and COVID-19 guidance on shielding and protecting people defined on medical grounds as extremely vulnerable

For COVID-19 – undertake regular DHSC whole home testing. COVID-19 vaccination is also recommended for residents and staff: COVID-19 vaccinations and care homes: programme launch and What to expect after your COVID-19 vaccination

For Seasonal Flu – Annual flu vaccination is recommended for residents and staff: Seasonal flu vaccination

Maintain a record of all residents' flu vaccination status and latest kidney function test to support antiviral prescribing in the event of a flu outbreak (see Appendix 1).

Even if care home does not have any ARI cases, maintain IPC measures to protect residents, staff and visitors. In addition, follow relevant local and/or national restrictions.

Disease Symptoms Suggesting COVID-19 or ILI

Refer to Guidance: Influenza-like illness (ILI): managing outbreaks in care homes

COVID-19	Influenza-like Illness (ILI)
New, persistent **cough** (coughing for >1 hour, or ≥3 coughing episodes in 24 hours) AND/OR **Fever** (temperature of 37.8°C or higher) AND/OR **Anosmia** (loss of the sense of smell and/or taste) Other symptoms that may indicate COVID-19 in care home residents include: • New onset of ILI • Worsening shortness of breath • Delirium, particularly in those with dementia A **laboratory detection** of COVID-19 fulfils definition of a confirmed COVID-19 case.	**Fever** (Oral (mouth) or tympanic (ear) temperature of 37.8°C or higher) AND New onset of one or more **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 Whilst it is recognised that older people may not always develop a fever with influenza, fever is necessary to define ILI. A **laboratory detection** of influenza A or B fulfils definition of a confirmed flu case.

When to Suspect an ARI Case and Outbreak

Refer to Guidance: Influenza-like illness (ILI): managing outbreaks in care homes

ILI Case Definition	COVID-19 Case Definition
An individual in the home has an oral or tympanic temperature of > 37.8°C AND One or more new 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 Whilst it is recognised that older people may not always develop a fever with influenza, fever is necessary to define ILI	An individual in the home has a new persistent cough AND/OR An oral or tympanic temperature of > 37.8°C AND/OR Anosmia (loss of taste and/or smell) OR Other symptoms that may indicate COVID-19 in care home residents include new onset of ILI, worsening shortness of breath and delirium, particularly in those with dementia
Definition for an Acute Respiratory Outbreak	
Two or more cases that meet the clinical case definition of ILI or COVID-19 (above) arising within the same 14-day period in people who live or work in the care home, without laboratory confirmation.	
Definition for a Confirmed Flu Outbreak	**Definition for a Confirmed COVID-19 Outbreak**
At least one laboratory confirmed flu case and one or more cases that meet the clinical case definition of ILI arising within the same 48-hour period in people who live or work in the care home.	At least one laboratory confirmed COVID-19 case and one or more cases that meet the clinical case definition of COVID-19, arising within the same 14-day period in people who live or work in the care home.
PUBLIC HEALTH ACTIONS SHOULD NOT BE DELAYED WHILE AWAITING CONFIRMATORY TEST RESULTS	

Differences in Infectious Periods

Refer to Guidance: Influenza-like illness (ILI): managing outbreaks in care homes and Stay at home: guidance for households with possible or confirmed coronavirus (COVID-19) infection

COVID-19	Influenza-Like Illness (ILI)
From 48 hours before onset of symptoms (or test date if asymptomatic) until 14 days after symptom onset (or test date) **for care home residents** OR until 10 days after symptom onset (or test date) **for staff**	From 24 hours before onset of symptoms until symptoms have resolved. For flu specifically, it is generally assumed that people are infectious from the onset of symptoms and whilst they have symptoms.

COVID-19 Contact Definitions

Refer to Guidance:
COVID-19 management of staff and exposed patients or residents in health and social care settings

<table>
<tr><th>RESIDENT CONTACT</th><th>STAFF CONTACT</th></tr>
<tr><td>Contact with a confirmed COVID-19 case at any time from 48 hours before onset of symptoms (or positive test date if asymptomatic) to 14 days after:</td><td>Contact with a confirmed COVID-19 case at any time from 48 hours before onset of symptoms (or positive test date if asymptomatic) to 10 days after:

(Contact while not wearing appropriate PPE or with a breach in PPE or outside the healthcare setting)</td></tr>
<tr><td colspan="2">• Face-to-face contact (within 1-metre) with a case, including being coughed on, having a face-to-face conversation or skin-to-skin physical contact.
• Any contact within 1-metre for 1-minute or longer with a case, without face-to-face contact.
• Has spent more than 15 minutes within 2 metres of a case (as one-off contact or added up over 1 day).</td></tr>
<tr><td>• Lives in the same unit or floor as a case and shares the same communal areas.
• Travelled in a small vehicle with a case or a large vehicle close to a case.</td><td>• Cleaned a personal or communal area where a confirmed case has been located (please note this only applies to the first-time cleaning of the area).
• Spent significant time in the same household as a case. This includes living and sleeping in the same house, sharing a kitchen or bathroom, or sexual partners.
• Travelled in a small vehicle with a case or a large vehicle close to a case.
• Notified by Test and Trace that they are a contact of a case.</td></tr>
<tr><td colspan="2">Any person who maintained >2m social distancing or used appropriate PPE or only had contact through a Perspex screen (or equivalent) would not be classed as a contact.</td></tr>
</table>

How Should ARI Be Managed?

Refer to Guidance

COVID-19 management of staff and exposed patients or residents in health and social care settings
Admission and care of residents in a care home during COVID-19
COVID-19 vaccination: a guide for social care staff
COVID-19 vaccination: guide for older adults
COVID-19 vaccination in care homes that have cases and outbreaks
Influenza-like illness (ILI): managing outbreaks in care homes
Influenza: treatment and prophylaxis using anti-viral agents
National Institute for Health and Clinical Excellence (NICE) technology appraisal 168:Amantadine, oseltamivir and zanamivir for the treatment of influenza
NICE technology appraisal 158:Oseltamivir, amantadine (review) and zanamivir for the prophylaxis of influenza

For COVID-19 includes:

- Identification and isolation of staff and resident contacts (see pg.13 for isolation/exclusion periods).
- Further testing – as advised by Community Infection Prevention and Control Team or PHE NW.
- Ensure COVID-19 vaccination of all unvaccinated residents/staff, supported by risk assessment.

For Flu includes:

- If clinically suspected or detected, a risk assessment should be undertaken to inform prompt treatment with antivirals, ideally within 48 hours of symptom onset.
- Antiviral therapy can be prescribed as treatment for cases and post-exposure prophylaxis (PEP) for residents in at-risk groups, regardless of their influenza vaccination status.
- Prescribe antivirals for staff in at-risk groups and those not vaccinated for influenza (at least 14 days previously)
- Ensure seasonal flu vaccination of all unvaccinated residents/staff to provide protection from future infection.

Key Actions: Isolation/Exclusion Periods

Refer to Guidance: Influenza-like illness (ILI): managing outbreaks in care homes and COVID-19 management of staff and exposed patients or residents in health and social care settings and Stay at home guidance for households with possible or confirmed COVID-19 infection*
COVID-19: guidance for households with possible coronavirus infection

	COVID-19	Flu	Flu and COVID-19	Other respiratory virus (flu and COVID-19 negative)
Cases	**Residents**: 14 full days from date of symptom onset/positive test, which counts as day 0 **Staff:** 10 full days from date of symptom onset/ positive test (day 0) and fever free (temp <37.8c) for 2 days before returning to work	**Residents:** Minimum 5 days after the onset of symptoms until feeling well. Longer period of isolation may be recommended for residents with long-term conditions, impaired immune system, those given antiviral therapy >48 hours after symptom onset or not at all, or remaining symptomatic after 5 days of antivirals. **Staff:** 5 days from onset of symptoms and should not return to work until fully recovered	**Residents:** isolate for appropriate period depending on whether confirmed Flu and/or confirmed COVID-19. **Staff:** exclude for appropriate period depending on whether confirmed Flu and/or confirmed COVID-19.	**Residents:** Isolate for at least 5 days until onset of symptoms and feeling well **Staff:** exclude from work until feeling well
Contacts	**Residents**:14 full days from the last date of contact with the case, which counts as Day 0. **Staff**:10 full days from the last date of contact with the case, which counts as Day 0. For further information to interpret isolation period see guidance above*	Do not need to self-isolate but should remain vigilant for symptoms.	**Residents**:14 full days from the last date of exposure to the case **Staff:** 10 full days from last date of exposure to the case	**Residents:** Isolation not required but should remain vigilant for symptoms. **Staff:** Isolation not required but should remain vigilant for symptoms.

If there is any doubt as to infection or co-infection with COVID-19, isolation should be maintained for 10 full days for staff and 14 full days for residents after onset of symptoms.

Other Key Actions

Refer to Guidance:

Influenza-like illness (ILI): managing outbreaks in care homes

Algorithm for outbreaks of ARI in care homes

COVID-19 management of staff and exposed patients or residents in health and social care settings

Laboratory Results	COVID-19	Flu	COVID-19 and Flu	Other Respiratory Virus (COVID-19 and Flu negative)
Antivirals	Consider stopping if already started	Consider use of antiviral treatment for symptomatic cases and prophylaxis for vulnerable contacts	Consider use of antiviral treatment for symptomatic cases and prophylaxis for vulnerable contacts	Consider stopping if already started
DHSC COVID-19 Testing	Continue with regular staff COVID-19 testing. Resident testing at Day 28 after most recent case	Continue with regular COVID-19 testing	Continue with regular COVID-19 staff testing. Resident testing at Day 28 after most recent case	Continue with regular COVID-19 testing
Declare End of Outbreak	28 days after onset of symptoms in most recent case	5 days after onset of symptoms in most recent case	28 days after onset of symptoms in most recent case	5 days after onset of symptoms in most recent case

Actions for a Single ARI Case

Refer to Guidance:
Influenza-like illness (ILI): managing outbreaks in care homes
COVID-19 management of staff and exposed patients or residents in health and social care settings

1. Clinical assessment and management by GP/111/A&E.
2. All IPC measures in place. Key measures to put in place include: • Isolation of symptomatic resident in a single room (see pg. 13). **If any doubt as to COVID-19 infection, isolate for 14 full days after symptom onset.** • Exclusion of symptomatic staff from work (see pg. 13) and advice re: ARI testing and self-isolation of household contacts. • Identification of close contacts of confirmed COVID-19 resident/staff member and isolation/exclusion (see pg. 10 &12). • Hand and respiratory hygiene for staff, residents and visitors. • Adequate Personal Protective Equipment (PPE) for staff and visitors. • Enhanced cleaning. • 2-metres social distancing and shielding guidance. • IPC signage on resident's door. • If COVID-19 case, agency staff not to work in other health/care settings until 10 days after last shift in home.
3. Testing of resident and signposting symptomatic staff to COVID testing via the NHS online portal NB: for all care homes - if positive test (lateral flow device or PCR): at least 7 days staff daily LFD testing.
4. If flu is clinically suspected/detected, antivirals within 48 hours of symptom onset to case.

Actions for Suspected or Confirmed ARI Outbreak (2 or more cases linked by time and place)

Refer to Guidance:

Influenza-like illness (ILI): managing outbreaks in care homes

COVID-19 management of staff and exposed patients or residents in health and social care settings

1. Clinical assessment and management by GP/111/A&E.
2. Inform Community Infection Prevention Control Team (CIPCT **in hours**) and PHE Health Protection Team (HPT **out of hours**) immediately.
3. All IPC measures are in place. Key actions include: • Isolation of symptomatic resident in a single room (see pg. 13). **If any doubt as to COVID-19 infection, isolate for 14 full days after symptom onset.** • Residents with different viruses cohorted separately. Symptomatic and asymptomatic residents cohorted in separate areas. Separate staff allocated to cohort areas and movement limited. • Exclusion of symptomatic staff from work (see pg. 13) and advice re: COVID-19 testing and self-isolation of household contacts • Identification of close contacts of confirmed COVID-19 resident/staff member and isolation/exclusion (see pg. 11 &13). • Named ARI coordinator on every shift. • Hand and respiratory hygiene for staff, residents and visitors. • Adequate Personal Protective Equipment (PPE) for staff and visitors. • Enhanced cleaning. • 2-metres social distancing and shielding guidance. • Health/care staff visits limited to essential care only and visitors excluded (except for in exceptional circumstances). • Outbreak and IPC signage displayed. • If flu outbreak, agency staff not to work in other health/care settings until 2 days after last shift in home. • If COVID-19 outbreak, agency staff not to work in other health/care settings until 10 days after last shift in home.

Actions for Suspected or Confirmed ARI Outbreak (2 or more cases linked by time and place)

Refer to Guidance:
Influenza-like illness (ILI): managing outbreaks in care homes
COVID-19 management of staff and exposed patients or residents in health and social care settings

4. Testing of residents and staff.
5. Twice-daily symptom checks of all residents/ staff and daily log of cases to be shared with CIPCT (see Appendix 2).
6. If flu outbreak clinically suspected/detected, antivirals within 48 hours of symptom onset to case and exposed residents/staff in at-risk flu groups/unvaccinated for flu.
7. Consideration of Seasonal flu and COVID-19 vaccination of all unvaccinated residents and staff and timing, supported by risk assessment.
8. Consideration of partial or whole home closure to new admissions and suspension of transfers, supported by a risk assessment.
9. See pg. 14 for when outbreak can be declared over. Discuss with CIPCT.

Cohorting Residents

Refer to Guidance

Influenza-like illness (ILI): managing outbreaks in care homes
COVID-19 guidance on shielding and protecting people defined on medical grounds as extremely vulnerable

- If co-circulation of COVID-19, flu or other respiratory viruses, consider **separate cohorting of residents with different viruses**. If not possible, symptomatic residents with compatible symptoms should be cared for in separate areas away from residents without symptoms.
- Residents with **suspected flu** should **not** be cohorted with residents with **confirmed flu or confirmed COVID-19.**
- Residents with **suspected COVID-19** should **not** be cohorted with residents with **confirmed COVID-19 or confirmed flu.**
- Suspected or confirmed ARI residents should not be cohorted next to **immunocompromised residents.**
- Cohort resident **COVID-19 contacts** together, if isolation in single rooms is not possible.
- Cohort unexposed residents in another unit within the home away from cases and exposed contacts.
- Extremely clinically vulnerable residents stay in a single room and do not share bathrooms with other residents.
- Separate staff should be allocated to cohort areas. Restrict movement of staff between areas with and without symptomatic residents.

- **Residents who walk with purpose:** Assign a designated 'symptomatic unit/area'– where symptomatic walking with purpose residents can walk around and be separated from confirmed cases and a closed off/separate 'asymptomatic unit/area' for those unaffected. Seek advice and support from local community mental health and dementia teams on behavioural modifying approaches for walking with purpose residents (refer to: Patients living with dementia who 'walk with purpose or intent' in the COVID-19 crisis)

Local Support for Care Home ARI Outbreaks

All care homes should be following guidance for COVID-19 testing as per updated Public Health England North West guidance:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/963633/Care_Home_Testing_Guidance_England_v22-02_2.pdf

Cases of acute respiratory infection or suspected COVID-19 should be reported to Community Infection Prevention and Control Team (CIPCT) in hours for advice.

If no positive COVID cases detected from Lateral Flow Device (LFD) rapid antigen testing (see guidance), and respiratory virus other than coronavirus suspected (e.g. influenza), an ILOG number will be obtained by CIPCT and swabbing of symptomatic cases arranged through Public Health England laboratory.

GP or admissions avoidance team must be informed to ensure the unwell resident(s) is/are assessed and monitored appropriately.

Care homes should contact CIPCT by phone daily with situation update.

DHSC COVID-19 Testing in Care Homes Without Outbreaks

Refer to Guidance:
Coronavirus (COVID-19) tests available for adult social care in England
Coronavirus (COVID-19): getting tested
COVID-19 management of staff and exposed patients or residents in health and social care settings
Your step-by-step guide for COVID-19 self-testing. Lateral Flow Test Kits
Evidence summary for LFD in relation to care homes

- Weekly Pillar 2 PCR testing of staff and testing of residents every 28 days.
- Immunocompetent staff/ residents with a positive test within the previous 90 days should not be PCR/LFD tested again within this time, unless they become symptomatic.
- Homes must register and order test kits via online digital portal: https://www.gov.uk/apply-coronavirus-test-care-home
- Twice-weekly lateral flow device (LFD) staff testing at home before shift:
  - One LFD test on same day as PCR test.
  - One LFD test mid-week between PCR tests (3-4 days after PCR test).
- Staff who have worked elsewhere since last shift in care home or are returning from annual/sick leave and have missed their weekly PCR test need to undertake an LFD test at home before starting their shift.

Testing	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Staff	P+L1 L2	P+L1 L2	P+L1 L2	P+L1 L2	P+L1 L2	P+L1 L2	P+L1 L2	P+L1 L2
Resident	P				P			

P=PCR test, L1=LFD test 1, L2=LFD test 2

DHSC COVID-19 Testing in Care Homes Without Outbreaks

- **Refer to Guidance:** Coronavirus (COVID-19): getting tested (particularly the document: 'care home testing guidance for residents and staff: PCR and LFD (England)'.
- If a single, positive COVID-19 case is identified, a risk assessment should be undertaken to determine actions.
- **For all care homes - if a resident or staff member has a positive LFD or PCR test, all staff should undertake daily LFD testing for 7 days, at beginning of shift.**
- **If further positive LFD/PCR tests are detected, daily LFD staff testing should continue until no further reported positive tests in residents/staff for 5 days.**
- If 2 or more COVID-19 cases are identified via LFD testing or PCR, testing moves to that in an outbreak setting. Regular DHSC testing of staff can continue during an outbreak.
- **Any queries regarding DHSC testing should be directed to the national helpline on 119**

Single Positive COVID-19 Result from DHSC Testing

Refer to Guidance

COVID-19 management of staff and exposed patients or residents in health and social care settings

Staff Member

- Asymptomatic positive staff member should self-isolate (see pg. 12).
- If they subsequently develop symptoms, they must self-isolate for the full time period from symptom onset as indicated for cases on pg.12.
- Household contacts should also self-isolate as per national guidance.

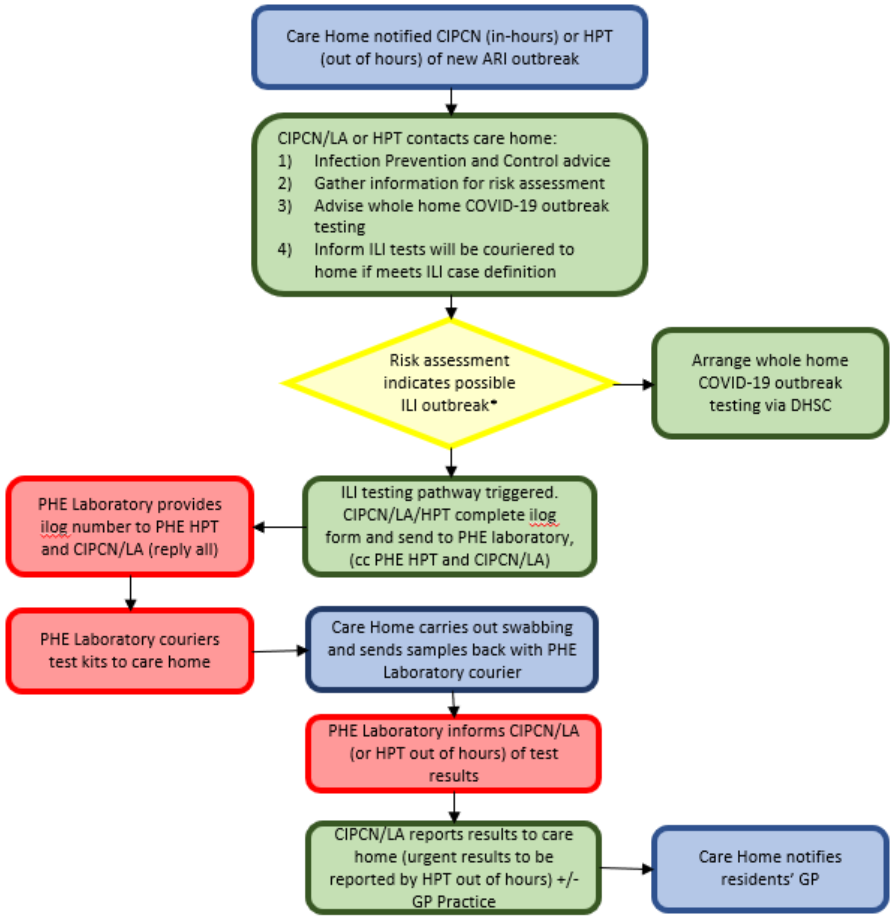
Resident

- Isolate asymptomatic positive resident in single room (see pg.13).
- Resident contacts of the case should also be isolated (see pg.13).
- If a single symptomatic COVID-19 positive resident is detected, CIPCT will undertake a local risk assessment to determine likelihood of further cases and if additional testing is required.

Testing in Care Homes with Suspected ARI Outbreak

Refer to Guidance
COVID-19: Getting Tested (particularly the document: 'care home testing guidance for residents and staff: PCR and LFD (England)' and 'care home testing schedule for a suspected or confirmed outbreak (England)'

- **Symptomatic** staff should be COVID-19 tested via the NHS online portal
- DHSC/Pillar 2 COVID-19 testing should be requested for care homes with a suspected ARI outbreak (2 or more cases in 14 days)
  - Round 1 (Day 1): Whole care home COVID-19 PCR testing (staff who do not have symptoms + all residents) should be arranged via DHSC. Staff and residents should also undertake an LFD test at the same time as the PCR test.
  - Daily staff LFD testing should continue (or commence) (see Slide 21)
  - If Influenza-like Illness is clinically suspected, testing up to **5 most recently symptomatic residents** (within 5 days of onset of illness) for Influenza A and B. This can be organised through the PHE NW Laboratory (see flow chart).



* 2 or more cases that meet the clinical case definition of influenza-like illness arising within the same 48 hour period in people who live or work in the care home

Testing in Care Homes with Suspected ARI Outbreak

- **Round 2** (4-7 days later) – residents and staff who did not test PCR positive for COVID-19, had a void result or missed testing in Round 1 should be tested via DHSC. Staff and residents should also undertake an LFD test at the same time as the PCR test.
- **Regular DHSC COVID-19 PCR/LFD staff testing** (days 8-27) continues during an outbreak.
- **Regular DHSC COVID-19 PCR resident testing** every 28 days continues.
- **DHSC COVID-19 Recovery point PCR testing** – can be undertaken 28 days from the onset of symptoms in the last suspected/confirmed COVID19 case in residents/ staff to confirm the outbreak has ended.

Testing	Day 1	4-7 Days Later	Days 8-27	Day 28
COVID-19	DHSC Pillar 2/LFD	DHSC Pillar 2/LFD	DHSC Pillar 2 /LFD	DHSC Pillar 2
	Staff & Residents	Staff & Residents	Staff	Staff & Residents
Influenza A and B	PHE NW Up to 5 Symptomatic Residents			

Testing in Care Homes with Suspected ARI Outbreak

Symptomatic Residents and Staff After Round 2 Testing

- Residents who become symptomatic after round 2 testing while the outbreak is still ongoing can be tested for COVID-19 tested as individuals via DHSC.
- Staff members who become symptomatic after round 2 testing while the outbreak is still ongoing should immediately self-isolate at home and arrange COVID-19 testing via the NHS online portal.

Declaring an Outbreak Over

- For details on when outbreaks may be declared over see pg.14.
- CIPCT will liaise with care homes and local partners where there have been no new cases or contacts identified (residents or staff) within a setting for **at least** 14 days. Joint measured decision between CIPCT and care home partners will be made at this point around potential to re-open a facility or single units within the setting.
- The outbreak testing process will begin again if 2 or more residents or staff become symptomatic or have a new positive COVID-19 result during routine testing within 14 days.

Persistent Positive COVID-19 Results

Refer to Guidance

Coronavirus (COVID-19): getting tested (particularly the document: 'care home COVID-19 testing guidance for testing of staff and residents' and Coronavirus (COVID-19) tests available for adult social care in England'
COVID-19 management of staff and exposed patients or residents in health and social care settings

- PCR positivity can persist for 90 days following COVID-19 infection, which may not indicate infectiousness.
- Immunocompetent staff/residents that have previously tested PCR COVID-19 positive are **exempt from PCR and LFD re-testing for 90 days** from symptom onset/test date, unless they develop new COVID-19 symptoms.
- If staff member is LFD tested within 90 days from their initial symptom onset/test date and **found to be LFD positive**, they and their household should self-isolate, and they should arrange a confirmatory PCR test:
  - If **PCR test is negative**, they and their household can stop isolating and they can return to work.
  - If **PCR test is positive**, consider possibility of COVID-19 re-infection and seek advice from an infection specialist.
- If a staff member or resident develop new possible COVID-19 symptoms within 90 days from their initial symptom onset/ test date, they should self-isolate and be tested again for a new infection.
- Staff and residents that test COVID-19 positive more than 90 days after the initial positive result should be managed as a new case.

Visiting

Refer to Guidance

COVID-19 Winter Plan
Visiting care homes during COVID-19
Visits out of care homes
National lockdown: stay at home
COVID-19 lateral flow testing of visitors in care homes

- Lateral Flow Device (LFD) testing has been provided to care homes to test visitors. It involves processing a throat and nasal swab sample and if COVID-19 is detected, a coloured strip will appear on the test.

- All test providers have a legal duty to notify the results of a valid Point of Care Test for COVID-19 to Public Health England: COVID-19 and influenza point of care testing results: how to report

- General guidance on visiting may be found at: Visiting care homes during COVID-19. Visiting policies should be in line with local and national restrictions and guidance.

Visiting

- Care home must complete a dynamic risk assessment in relation to both whole care home visiting and visiting for each individual resident, which formally considers the advice of the local DPH.
- Testing does not completely remove the risk of infection associated with visiting and it is essential that visitors wear appropriate PPE, observe 2-metres social distancing and follow good hygiene throughout the visit.
- All visits should adhere to the local and national restrictions and guidance as appropriate (see slide 29).
- **In the event of an ARI outbreak, visits in and out of the care home, and visiting LFD testing should be stopped, apart from exceptional situations such as end of life.**

Visiting – Local Policy

Bolton along with all other Greater Manchester local authorities follows the national guidance on visiting.

Guidance states:

- Every resident will be allowed one, named, regular indoor visitor from 8 March (this must remain the same person while these rules are in place)
- Visitors will be required to have a lateral flow test beforehand, wear PPE during the visit and avoid close contact other than holding hands.
- Outdoor, pod and screen visits will be able to continue in line with the published guidance which has been in place during lockdown, meaning there will be chances for residents to see more than just the one person they nominate.
- Vaccination is not mandatory and will not be a condition of visiting.
- Visiting will be suspended during local outbreaks in individual homes.

Transfers During an ARI Outbreak

Refer to Guidance

Admission and care of residents in a care home during COVID-19
COVID-19: our action plan for adult social care
COVID-19: guidance for stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings
Discharge into care homes: designated settings
Discharge into care homes for people who have tested positive for COVID-19

- Government policy also recommends **testing all residents prior to admission to care homes** via local processes.
- There are requirements around hospital discharge into designated settings for those who test positive.
- Immunocompetent patients who have received a positive PCR test for COVID-19 within a period of 90 days from their initial illness onset/positive test date should be assessed using three questions to determine whether discharge should be to a care home or designated setting.
- Residents being discharged from hospital/interim care facilities to a care home and new residents admitted from the community should be **isolated within their own room for 14 days.** This should be the case unless they have already undergone isolation for a 14-day period in another setting, and even then, the care home may wish to isolate new residents for a further 14 days.
- Residents visiting hospital for outpatient appointments do not require a test to return to the home and **do not need to self isolate** on return, as long as IPC precautions are undertaken.

Resources

Infection Prevention and Control

Information resource for care home workers about preventing and controlling infection in care homes
5 moments for hand hygiene
Catch it. Bin it. Kill it. Poster

Flu Vaccination

The Flu vaccination, who should have it and why leaflet
The Flu vaccination, who should have it and why leaflet (Braille version)
Guide to having your flu vaccination (jab) during the coronavirus pandemic (Easy Read leaflet for people with learning disabilities)

COVID-19 Vaccination

COVID-19 vaccination posters
COVID-19 vaccination leaflet

Appendix 1: Care Home and Resident Information Template

In the event of an outbreak, the table will ensure that important information is recorded in one place and is easily accessible

Name of Care Home	Type Residential / Nursing	Manager of Care Home	Name of ARI Coordinator	Name of Person Completing Template	Date Completed	Date Updated

Room	Full Name	DOB	NHS Number	Medical Conditions	GP Practice	Flu Vaccine Given Y/N Date	Kidney Function (eGFR)/Creatinine Clearance/Serum Creatinine Date of Last Blood Test	Weight

Appendix 2: Daily Log Template (Residents with suspected/confirmed ARI infection)

In the event of an outbreak, the table will ensure that important information is recorded in one place and is easily accessible

Room Number	Name	NHS number	Date of onset of symptoms	Symptoms*	Flu Vaccine Yes/No	Kidney Function	Date GP informed	Date Swabbed**	Date Anti-virals Commenced	Date CIPCN informed

Symptoms * T = Temp (>=37.8 C), C = Cough, NC = Nasal Congestion, ST = Sore Throat, W = Wheezing, S = Sneezing, H = Hoarseness, SOB = Shortness of Breath, CP = Chest Pain, AD = Acute Deterioration in physical or mental ability (without other known source) **If Swabbed