# Care Home Provider Webinar

## Summary of recent PHW and WG guidance changes for residential settings


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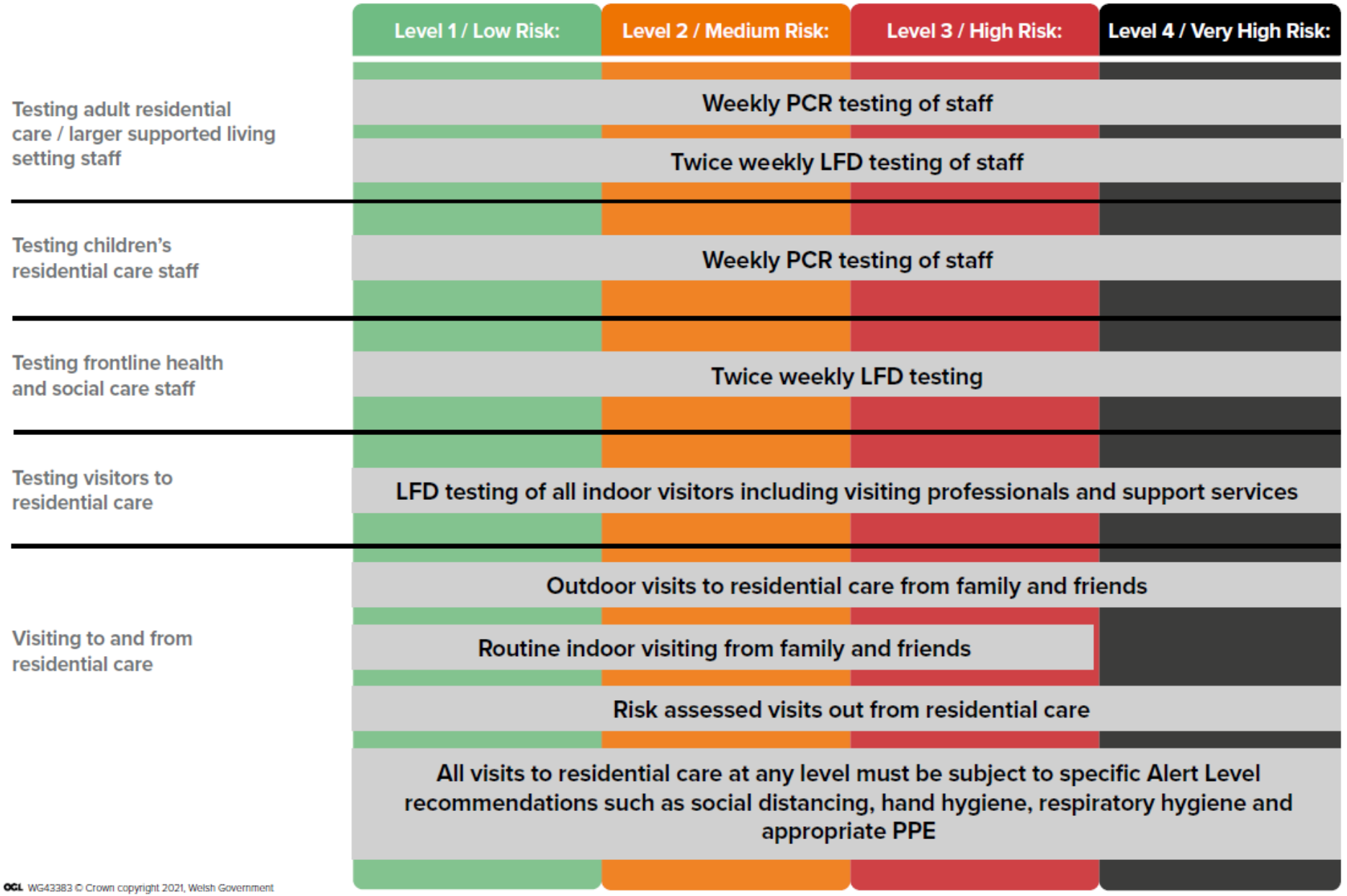
# Preventative measures (1)

- Operational guide for the transition of healthcare environments in preparation for Autumn/Winter 2021/22 incorporating COVID-19 measures
  - Hierarchy of controls
  - IP&C [UK IPC Guidance last updated 24/11/21]
  - Environmental modifications
  - Ventilation
- COVID-19 vaccinations including the booster dose and annual influenza vaccinations
- Self isolation guidance for staff and visitors who are symptomatic or identified as close contacts
- Routine testing in line with Welsh Government policy

# Social care alert level summary



# Discharge requirements – testing and self isolation (2)

Two scenarios:

1. No evidence of COVID-19 who are ready for the next stage of care: discharge to an existing or new placement, where the individual has received a negative COVID-19 test result prior to discharge, undertaking a 14-day isolation period with the option to 'test to release' with a negative LFT on day 3

2. For patients who have had COVID-19 infection, are ready for the next stage of care and are confirmed as non-infectious: discharge to an existing or new placement or care package, with no need for an isolation period

# Scenario 1 – Patients with no evidence of COVID-19

- Refer to the table for testing and isolation requirements where patients are admitted for elective care, emergency care or routine appointments.
- Points to consider for 'test to release' and where isolation will be a challenge for those discharged after an elective pathway.
  - Is the person being admitted fully vaccinated (i.e. primary course) plus 2 weeks. How much time has elapsed since the primary course? Have they received a booster and when?
  - Has the person had contact with a COVID-19 positive patient or staff member within the last 14 days? When was the last confirmed or suspected case on the ward? Does the hospital IP&C team have any concerns about potential exposure?
  - Has the patient received a negative Covid LFT result? When was the last PCR test on the ward?
  - How will the care home team practically implement isolation after discharge? Does the patient walk with purpose? Will additional staffing be required? Has there been a discussion with commissioners about how this can be supported?
  - What is the risk to other residents/service users? Are there specific admissions beds / unit segregated from other parts of the home?
  - Is there a confirmed COVID-19 outbreak? Is it contained? Are there areas of the home unaffected? Has there been discussion with the patient (and family) or through a BIA? Can the patient's need be met due to staffing levels?
- Depending on your local arrangements the MDT may be able to advise and help coordinate complicated discharges

# Scenario 2 – Patients who have had COVID-19 infection

- The same criteria apply for discharge of patients (other than those who are severely immunocompromised) who have had COVID-19 during admission will be defined ‘non-infectious’ and discharged into social care settings without a subsequent requirement to self-isolate (based on previous TAG report)
- All of the following must apply:

1) At least 14 days have elapsed since either (a) first onset of symptoms or (b) first positive Covid test; AND
2) The patient has had resolution of fever for at least three days; AND
3) The patient has experienced clinical improvement of symptoms other than fever; AND
4) An RT-PCR test is negative or ‘low positive’ with a Ct value ≥35

- Discharge arrangements for severely immunocompromised patients should be subject to individualised discussion and assessment between clinical and microbiology teams.

# Responding to a single case (3)

- Remain alert to signs and symptoms and promptly isolate suspected cases and arrange multiplex testing through the Health Board
- Immediately isolate asymptomatic staff cases if identified through routine LFD or PCR testing
- Apply initial control measures to prevention onwards transmission (e.g. reinforce IP&C precautions, staff briefing, enhanced cleaning, resident observations, signage, staff symptom screening, situational update, etc.)
- Review potential lapses of PPE in the setting or any social interaction outside work to inform the risk assessment AND to identify potential contacts – use Annex C
- Check vaccination status of staff and resident that are identified as contacts and for staff follow the WG guidance regarding isolation and testing
- Isolate residents that are (a) symptomatic; (b) identified as a “household type” contact; or (c) return a positive test
- Bring forward portal testing ASAP and repeat at Day 7 to assist with case finding
- If you have residual concerns about exposure risk or possible transmission refer to local arrangements for advice

# Stop and think – after Annex C!

- Where has this case acquired the infection?
- Who else may now have it?
  - Staff to staff e.g. car sharing, changing rooms, handover, break times or social events
  - Staff to resident e.g. Not wearing full PPE or lapses whilst providing personal care
- How can we stop the case, and anyone else who may now have it, passing it on to anyone else?

# Responding to an outbreak (4)

- Change to incident / outbreak definition - two or more resident or staff cases that occur within the care home setting and **where infection / ongoing transmission is linked within the care home setting.**
- Review and update **Annex C** to determine whether the cases are linked (e.g. shift patterns, floor/unit/wing, personal care) AND the risk of onward transmission (remember previous slide!)
- Where there is evidence of transmission in the setting:
  (a) notify the PHW AWARe team and submit Annex C (see SOP);
  (b) implement enhanced IP&C measures / outbreak plan;
  (c) consider daily LFD testing for asymptomatic staff
  (d) isolate and arrange **multiplex testing for symptomatic cases** – do not use LFD or portal testing
- An acknowledge email will be sent from AWARe with an incident number and initial advice
- Due to vaccination coverage there will be a more nuanced approach to management of “Red” care homes with admissions being considered as part of this process
- **Whole home testing** will not be the default but can be requested to assist with outbreak investigation and management (e.g. to determine is a outbreak is contained to a specific floor/unit/wing)

# Responding to an outbreak – multi agency support

- Work with your MDT (PHW, Environmental Health, Health Board) and IP&C teams (where available) who can undertake reactive visits if required
- Remember to keep primary care colleagues informed so they can clinically assess residents, monitor deteriorating patients, administer antivirals, etc.
- Continue to link with commissioners if there are concerns about staffing levels to support residents with self-isolation, backfill staff and ensure fundamentals of care
- According to local escalation processes MDTs may co-opt additional members to assist with the outbreak (e.g. local authority commissioners, complex care, GPs/district nurses, hospital ward or discharge teams and regulators (i.e. CIW/HSE)
- Continue to notify CIW of confirmed cases in line with regulations
- Closing an incident - there should be no new symptomatic or confirmed cases **associated** with the outbreak for a **minimum period of 14 days** from the last potential exposure to a case. Whole home testing after Day 14 will not necessarily be required to declare an outbreak over.

# Infection Prevention and Control for Seasonal Respiratory Infections including SARS-CoV-2 for Care homes - Autumn/Winter 2021/2022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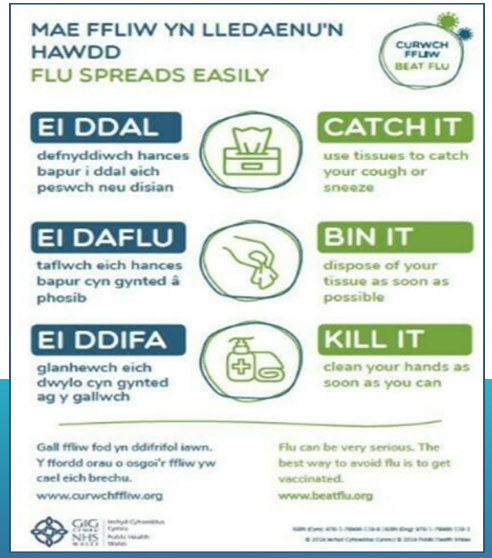
# Infection Prevention

- **Vaccination**
  - Encourage / ensure COVID-19 vaccinations including boosters
  - Influenza vaccination
- **Ventilation**
  - Respiratory viruses including SARS CoV-2 spread more readily in indoor crowded spaces – natural ventilation important plus minimising crowding.
- **Cleaning**
  - Ensure that high touch surfaces are regularly cleaned and robust cleaning schedules in place.
- **Testing and Screening**
  - Follow the visitor testing guidance and act early re resident symptoms.
- **Respiratory Etiquette**
  - **Catch it, Bin it, Kill it –** sensible advice for all respiratory viruses



# UK COVID-19 IP&C Guidance

## Updated version November 2021


COVID-19: infection prevention and control (IPC) - GOV.UK (www.gov.uk)

# Key Messages

- removal of the 3 COVID-19 specific care pathways (high, medium and low). This is in response to stakeholder feedback and to facilitate local application of the guidance by organisations/employers. The use of, or requirement for, care pathways should be defined locally
- addition of a section on the criteria to be applied within the 'hierarchy of controls' to further support organisations/services with maximum workplace risk mitigation
- recommendation for universal use of face masks for staff and face masks/ coverings for all patients/visitors to remain as an IPC measure within health and care settings over the winter period. This is likely to be until at least March/April 2022
- recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to 2 metres across all health and care settings
- recommendation that physical distancing should remain at 2 metres where patients with suspected or confirmed respiratory infection are being cared for or managed
- recommendation that screening, triaging and testing for SARS-CoV-2 continues over the winter period. Testing for other respiratory pathogens will depend on the health and care setting according to local / country-specific testing strategies / frameworks and data

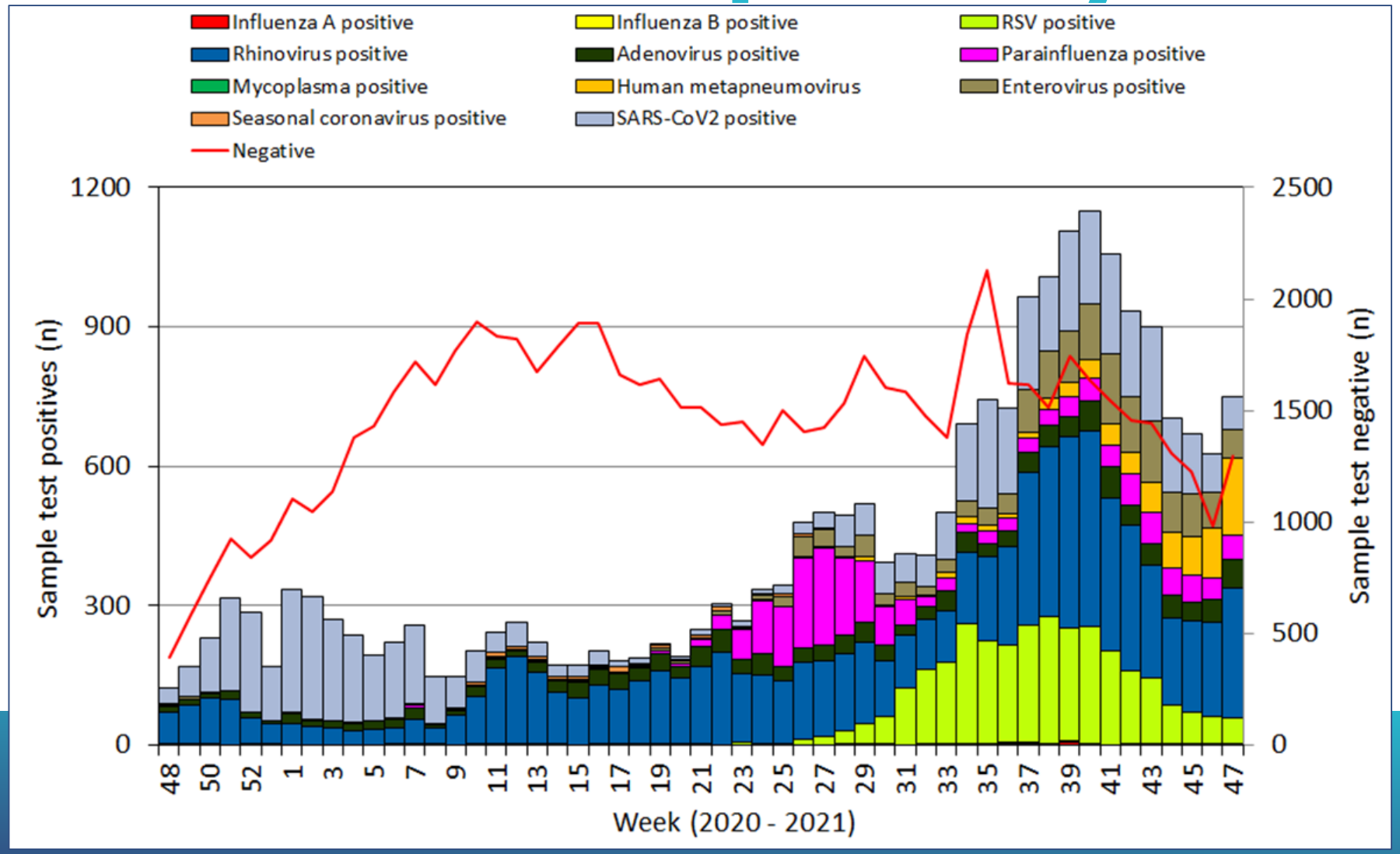
# Implementing in Care Home Settings

- Maintaining key learning from COVID pandemic experience.
- Embedding high standards of Infection Prevention and Control Practices.
- Bringing management of SARS CoV-2 in line with winter respiratory virus management.

# Main Symptoms of Coronavirus remain:

- a **high temperature**: this means you feel hot to touch on your chest or back (you do not need to measure your temperature)
- a **new, continuous cough**: this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)
- a **loss or change to your sense of smell or taste**: this means you've noticed you cannot smell or taste anything, or things smell or taste different to normal

# But there is an overlap with symptoms of other respiratory viruses



# Symptoms of Seasonal Viral Infections

**Respiratory symptoms**

- Runny Nose
- Sore throat
- Cough
- Difficulty breathing (more than usual)
- COVID-19 – high temp/ new/ continuous cough/ change in smell/taste
- Elderly may have non-specific presentations

**Norovirus symptoms (winter vomiting bug)**

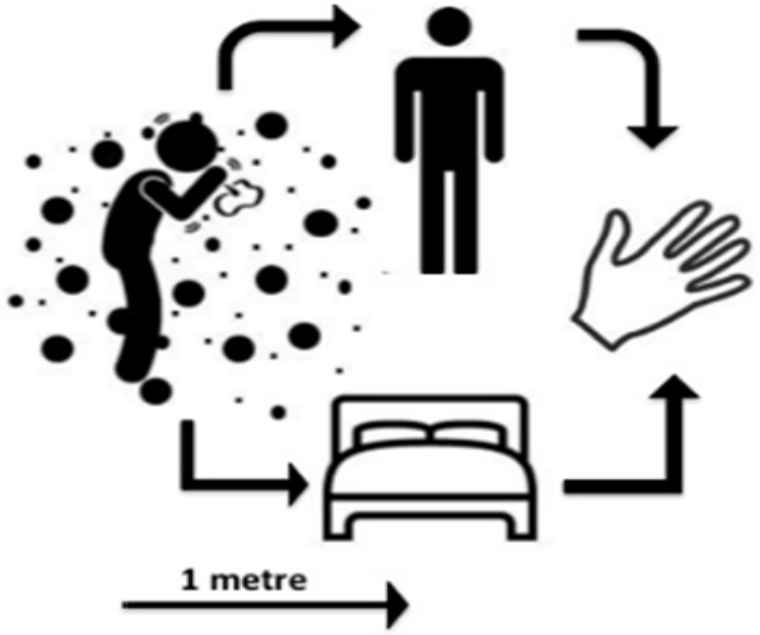
Starts 1-2 days of infection

- Feeling sick (nausea)
- Diarrhoea
- Being sick (vomiting)
- My also have a high temp/ headache

# How do respiratory pathogens spread?

- Exposure to **respiratory droplets** (coughing/ sneezing) within 2m
- Aerosol generating procedures (AGPs) performed on infected residents
- Contact with **respiratory secretions** via hands and then touching ones face, nose, eyes

**New-variants of virus may be more transmissible, as with Omicron - but to date no evidence the mode of spread has changed.**

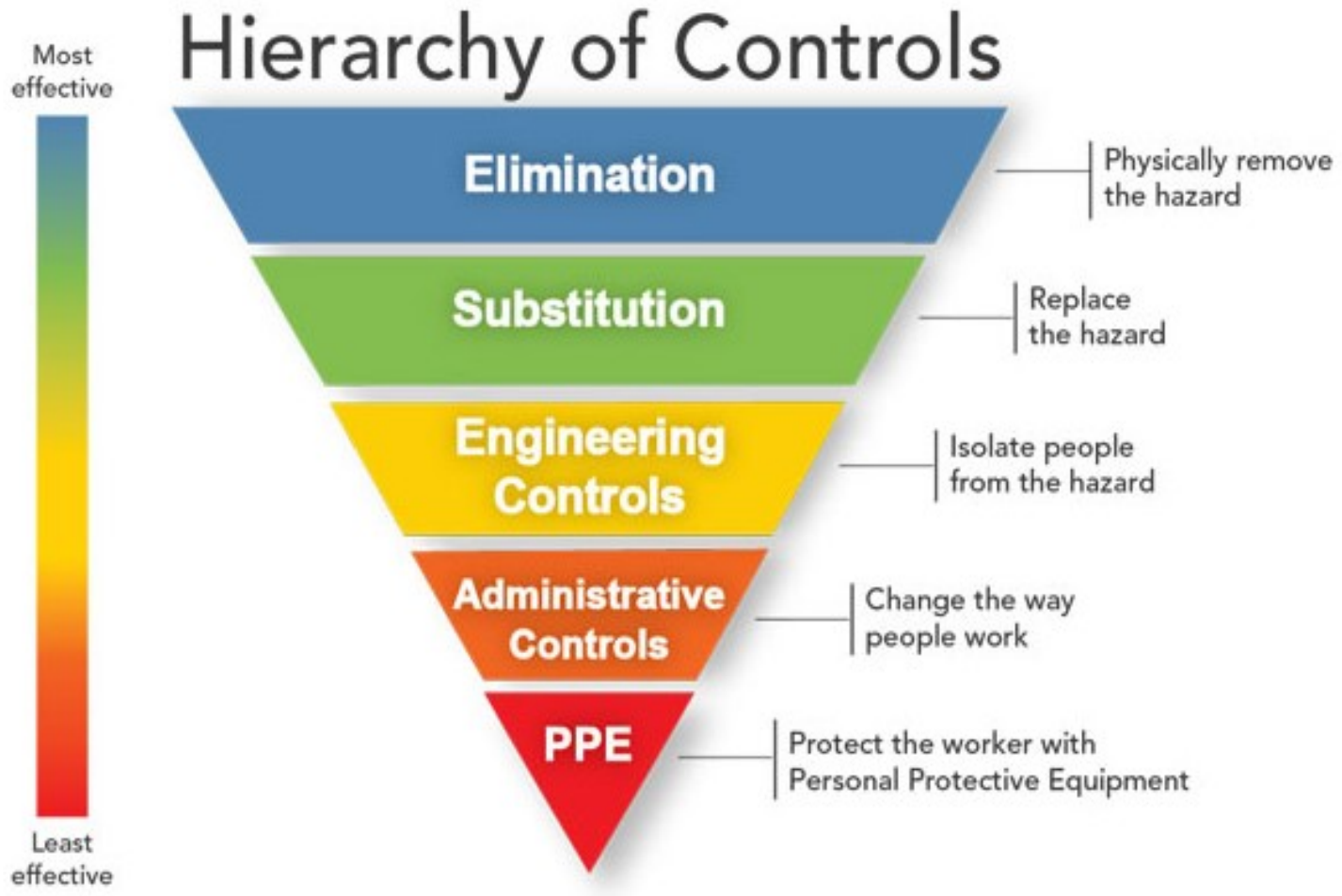


# Standard IP&C Measures

- patient placement and assessment for infection risk screening/triaging/testing)
- hand hygiene
- respiratory and cough hygiene
- PPE
- safe management of the care environment
- safe management of care equipment
- safe management of healthcare linen
- safe management of blood and body fluids
- safe disposal of waste (including sharps)
- occupational safety: prevention and exposure management

**The National Infection Prevention and Control Manual for Wales is available at:**
NIPCM - Public Health Wales (nhs.wales)

# Control measures to prevent the spread of infection




**Elimination:** Screening for COVID-19 / respiratory symptoms in patients and residents. Follow staff testing requirements; vaccination for staff and residents.

**Substitution:** Encourage use of virtual visiting if symptomatic relatives / visitors. Virtual GP consultations.

**Engineering Controls:** Ventilation – improving through engineering solutions, but also natural ventilation – open windows 15mins x3/day. Maintain use of screens / separators in key areas (reception). Hand hygiene stations.

**Administrative Controls:** Staff allocation to areas with COVID-19 or respiratory symptoms. Appointment schedules for visiting. Self-isolation and sickness reporting.

**PPE:** Use according to training and recommendations of IP&C Guidance.

https://gov.wales/preparing-health-care-environments-autumn-and-winter-2021-2022-operational-guidance

**Table 1: PPE required while providing direct care for patients with suspected or confirmed respiratory infection**

| PPE required by type of transmission/exposure | Disposable gloves | Disposable/reusable fluid-resistant apron/gown | FRSM/RPE | Eye/face protection (goggles or visor) |
|---|---|---|---|---|
| Droplet PPE | Single use | Single use apron or fluid-resistant gown if risk of extensive spraying/splashing | Single use FRSM Type IIR for direct patient care (1) | Single use or reusable (1) |
| Airborne PPE (When undertaking or if AGPs are likely) (3) Or if an unacceptable risk of transmission remains following rigorous application of the hierarchy of controls (4) | Single use | Single use fluid-resistant gown | Single use FFP3 (2) or reusable respirator/powered respirator hood (RPE) | Single use or reusable (2) |

(1) FRSM can be worn sessionally (includes eye/face protection) if providing care for cohorted patients. All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

(2) RPE can be worn sessionally (includes eye/face protection) in high risk areas where AGPs are undertaken for cohorted patients (see footnote 4). All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

(3) Consideration may need to be given to the application of airborne precautions where the number of cases of respiratory infections requiring AGPs increases and patients cannot be managed in single or isolation rooms.

(4) Where an unacceptable risk of transmission remains following the hierarchy of controls risk assessment, it may be necessary to consider the use of RPE for patient care in specific situations when managing respiratory infectious agents. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area.

# When providing direct/ personal care, which requires you to be in direct contact with the resident(s) when the resident has no respiratory symptoms.

| PPE required by type of transmission/ exposure | Disposable gloves | Disposable apron/ reusable gown | FRSM/ RPE | Eye/ Face Protection (goggles or Visor) |
|---|---|---|---|---|
| **Contact PPE** | Single use | Single use apron<br>For extensive splashing/spray – fluid resistant gown | Single use<br>FRSM 11R<br>For direct patient care | No |

**Table 2: When within or visiting a *clinical or care area* of a social care establishment or client's home, but not providing direct/ personal care: e.g. serving meals, chatting to the resident, delivering mail, visiting**

| Recommended PPE items | Explanation |
|---|---|
| **Disposable Gloves*** ✗ | *Required if for other reasons set out in standard infection prevention and control precautions (e.g. contact with residents' blood or other bodily fluids) |
| **Disposable plastic apron*** ✗ | *Required if for other reasons set out in standard infection prevention and control precautions (e.g. contact with residents' blood or other bodily fluids) |
| **Fluid-repellent surgical mask (FRSM) Type IIR** ✓ | The mask is worn to protect you, the care worker, and can be used while caring for a number of different residents. You should not touch your face mask unless it is to put it on or remove it. It must be disposed of when leaving the care home setting<br><br>FRSM can be used continuously while providing care, until you take a break from duties (e.g. to drink, eat, for your break time or end of shift)<br><br>If you are providing homecare visits (or visiting different people living in an extra care scheme) you should remove and dispose of your mask after visiting each individual<br><br>You should remove and dispose of your mask if it becomes damaged, soiled, damp or uncomfortable to use. You need to use a new mask when you re-start your duties after a break. |
| **Eye protection** ✗ | Not required |

**Table 3: When working in "indoor public spaces" within the health and social care facility e.g. reception areas/ waiting rooms/ care home dining areas - no direct contact**

| Recommended PPE items | Explanation |
|---|---|
| **Disposable Gloves** ✗ | Not required |
| **Disposable plastic apron** ✗ | Not required |
| **Type I or Type II surgical mask*** ✓ | Type I or Type II surgical masks can be used continuously until you take a break from duties (e.g. to drink, eat, for your break time if stepping outside of the care home or at end of shift when leaving the care home). 2m social distancing is still required when wearing a Type I or Type II surgical masks and when masks are removed for breaks<br><br>You should not touch your face mask unless it is to put it on or remove it.<br><br>You should remove and dispose of the mask if it becomes damaged, visibly soiled, damp, or uncomfortable to use.<br><br>You need to use a new mask and put it on immediately after you have finished eating/ drinking or you are re-entering the care home after a break.<br><br>If you have been providing care duties to residents (wearing PPE as per previous PPE tables) and now are going to take a break or change duties to be working away from residents/ in staff only areas, you should remove your gloves, apron and FRSM, clean your hands and put on a new Type I or Type II face mask.<br><br>*Note: if only fluid-repellent Type IIR surgical masks are available then these may be used in this scenario if stocks are sufficient – local decision. |
| **Eye Protection** ✗ | Not required |

Table 4: **When undertaking an Aerosol Generating Procedure (AGP) e.g. managing someone on long-term non-invasive ventilation/ CPAP or with tracheostomy in a home where there are suspected or confirmed cases of COVID-19.**

| Recommended PPE items | Explanation |
|---|---|
| ***Disposable gloves** ✓ | Single use to protect you from contact with resident's body fluids and secretions |
| **Single-use gown** ✓ | Single use to protect you from contact with resident's body fluids and secretions |
| **Filtering face piece (FFP3) mask or hood*** ✓ | Required to protect your from aerosolised virus particles generated by the procedure.<br><br>all staff who are required to wear an FFP3 respirator must be fit tested for the relevant model to ensure an adequate seal or fit (according to the manufacturers' guidance); fit checking (according to the manufacturers' guidance) is necessary when a respirator is put on (donned) to ensure an adequate seal has been achieved. Staff must be trained to safely remove the PPE also.<br><br>* If the care home does not have any suspected or confirmed COVID cases in last 14 days then with regular testing of staff it can be considered **low risk**. In this situation, following risk assessment an FRSM can be worn in place of the FFP3 mask for AGP's. |
| **Visor** ✓ | Single use or re-usable.<br><br>If you are provided with a visor that is reusable, then you should be given instructions on how to clean and disinfect following the manufacturer's instructions or local infection control policy and how to store them between duties.<br><br>If the visor is labelled as for single use then it should be disposed of after removal. |

# Fluid Resistant Surgical Masks (FRSM)

- Masks protect:
  - your nose & mouth from respiratory droplets from residents
  - residents and other staff from respiratory droplets from your mouth and nose (as you might be carrying the infection)
- You can wear a mask for caring for different residents BUT do not touch the mask
  - you could transfer virus to your hands
- Wear the mask on your face – NOT around you neck
- Remove and discard the mask when:
  - you take a break or finish your shift
  - it is damp, soiled, uncomfortable, difficult to breathe

# Disposable Gloves

## Standard infection prevention and control

Do’s

- Wear when exposure to blood/body fluids and non-intact skin or mucous membranes
- Change immediately after each resident contact or completion of a task (even on the same resident)
- Wear when touching invasive devices (urinary catheter) or wounds

Don’t’s

- Gloves not required for admin tasks (writing in charts)
- Giving oral medication
- Vaccinations
- Distributing or collecting trays
- Avoid touching your face with your gloved hands
- Do not reuse/gel/double glove

# PPE for Aerosol Generating Procedures

Some procedures on patients who have COVID-19 or other infectious agent can generate tiny particles from the respiratory tract which might be inhaled by people in the room

- Undertake these procedures in single room
- Only people involved in procedure should be present
- Training and fit-testing of the masks is required.
- Wear high level PPE
  - Long-sleeved gown (single use)
  - Eye protection (visor or goggles)
  - FFP3
  - Gloves

**Aerosol Generating Procedures**

Tracheostomy suctioning

Intubation & extubation

High flow nasal oxygen

Sputum induction (by physiotherapists)

Non-invasive ventilation (BiPAP, CPAP)

# Sessional use of PPE

- DO Make sure that PPE is comfortably put in place and will not need adjustment
- DO Take a comfort break before putting it on and remain well hydrated
- DO NOT  take it off and leave it on surfaces
- DO NOT walk out with a mask below your nose or hanging off your chin or with goggles on top of your head.

**Gloves and apron should NEVER be used on a *sessional basis*.  Single use only**

**Hands should be washed or *gelled* between residents and *AFTER* REMOVING gloves**

# Diolch am Wrando / Thank you for listening.
# Cwestiynau? / Questions?

Further advice and support re IP&C
HARP Community Lead IP&C Nurse – Amanda Daniel – Amanda.Daniel@wales.nhs.uk or HARP@Wales.nhs.uk