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| Buckinghamshire Council |
| **COVID-19 (SARS-CoV-2) Outbreaks Control Plan for Care Homes In Buckinghamshire** |

**July 2020 (V09a-Final)**

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| Public Health Team and Integrated Commissioning Team, Buckinghamshire Council |

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# 1. Introduction

Care home residents are particularly vulnerable to COVID-19 as a consequence of their complex medical problems and advanced frailty. It is therefore important to have robust plans in place to a) effectively respond to an outbreak and b) prevent reoccurrence.

This document provides operational guideline for the management of outbreaks of COVID-19 in care homes in Buckinghamshire. The plan consists of two main sections; each section can be used as a standalone document:

* [Section A,](#_Section_A:_Operational) provides operational guideline for Buckinghamshire Council and partners on how to respond to an outbreak of COVID-19 in care homes.
* [Section B,](#_Section_B:_Operational) provides operational guideline for Care Homes on how manage outbreaks of COVID-19 in Care Homes.

This document should be read in conjunction with [Buckinghamshire offer for care and support settings](https://www.buckinghamshire.gov.uk/coronavirus/social-care-providers-hub/additional-support/covid-19-support-offer/).

## 1.1 Definitions

What constitutes an outbreak?

An ‘outbreak’ is an incident in which two or more persons have the same disease, that are thought to be linked either in terms of time or place.

In the context of COVID-19 outbreak in care home, two or more cases which meet the case definition of possible or confirmed case, within a 14-day period among either residents or staff in the care home.

What constitutes an incident?

An ‘incident’ has a broader meaning, encompassing events or situations which warrant investigation to determine if action is needed to manage the risk. In some instances, only one case may prompt the need for incident management and public health measures.

COVID-19 Case definition: Public Health England have suggested that COVID-19 should be suspected in any resident with a new continuous cough and/or high temperature (at least 37.8°C), and/or a loss of, or change to, sense of smell or taste), or new onset of influenza like illness or worsening shortness of breath. However, COVID-19 in care home residents may commonly present with non-respiratory tract symptoms, such as new onset/worsening confusion or diarrhoea. Care home staff with detailed knowledge of residents are well-placed to intuitively recognise these subtle signs (‘soft signs’) of deterioration.

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 meters of an infectious case**.**

Staff contacts: Staff contacts are care home staff that have provided care within 2 meters to a possible or confirmed case of COVID-19 for more than 15 minutes (unless wearing the recommended PPE).

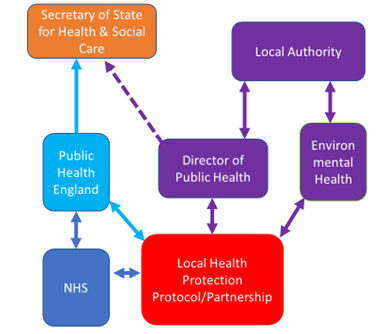
## 1.2 Legal Context

The legal context for managing outbreaks of communicable disease which present a risk to the health of the public requiring urgent investigation and management sits:

* Under the Health and Social Care Act 2012 the Secretary of State has a duty to protect the health of the population and carry out activities as described in the Health Protection Agency Act 2004. In practice these functions will be carried out by Public Health England (PHE).
* Under section 6 of the Health and Social Care Act 2012 Directors of Public Health (DsPH) in upper tier and unitary local authorities have a duty to prepare for and lead the local authority (LA) public health response to incidents that present a threat to the public’s health.
* Under the amended Public Health (Control of Disease) Act 1984 and associated regulations, the majority of statutory responsibilities, duties and powers significant in the handling of an outbreak lie with the LA, including appointment of Proper Officer whose powers include the receipt of notifications.
* With Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984
* With NHS Clinical Commissioning Groups to collaborate with Directors of Public Health and Public Health England to take local action (eg testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012
* Under Coronavirus Act 2020.

The diagram below describes the legal context for Health Protection which underpins the foundational leadership of the local Director of Public Health in a local area, working closely with other professionals and sectors.

Diagram 1: Local health Protection System



## 1.3 Aim and Objectives

The aim of the plan is to protect the health of the residents and staff in Care Homes by taking an effective and coordinated approach to managing outbreaks of COVID-19 from initial detection to formal closure and review of lessons identified.

The specific objectives are:

1. Recognise and respond to an outbreak of COVID-19 in Care Homes.
2. Define the outbreak’s important characteristics by investigating the source, cause and extent through use of a range of epidemiological methods
3. Control the outbreak i.e. stop the further spread of the infection.
4. Prevent recurrence of the infection
5. Maintain satisfactory communication with multi-agency partners
6. Ensure coordinated communications to the public and press
7. Ensure that the response can be escalated if required

## 1.4 Activation of the plan

In the event of an outbreak of COVID-19 (suspected or confirmed) in a Care Homes this plan will be activated by Local Health Protection Team, in consultation with Director of Public Health (DPH)/Deputy.

# Section A: Operational Guideline for Buckinghamshire Council and Partners

## 1. Standards for Managing Outbreaks:

The table below describes the standards for managing outbreaks of infectious disease defined by Public Health England. These standards are applicable for managing COVID-19 outbreaks in Care Homes in Buckinghamshire. The table summarises the standard approach to managing outbreak.

[Appendix 1](#_Appendix_1:_Outbreak) describes the process for reporting and managing outbreaks and [Appendix 2](#_Appendix_2:_The) explains the role of local Health Protection Team and the local system in managing outbreaks of COVID-19 in Buckinghamshire.

Table 1: Standards for managing outbreaks[[1]](#endnote-1):

|  |  |  |  |
| --- | --- | --- | --- |
| Stage | Action | Who leads | Timescale |
| Outbreak Notification | * Care Home Manager notify local Thames Valley Health Protection Team (TV HPT)   Tel: 0344 225 3861  E: [tvphe@phe.gov.uk](mailto:tvphe@phe.gov.uk) | Care Home Manager | Immediately |
| Outbreak Recognition | * Initial investigation to clarify the nature of the outbreak * Immediate risk assessment undertaken and recorded following receipt of initial information. * Advice on immediate control measures | Local Health Protection Team (TV HPT) | within 24 hours of notification |
| Outbreak Declaration | * Decision made and recorded at the end of the initial investigation regarding outbreak declaration and convening of outbreak control team * Inform the DPH | TVHPT | Immediately Following initial investigation |
| Convening of Outbreak Control Team (OCT) | * Identify relevant agencies/disciplines and invite to Outbreak Control Team (OCT) meeting * TVHPT/Consultant in Control of Communicable Disease (CCDC) to chair meeting * Roles and responsibilities of outbreak control team members agreed and recorded * Lead organisation with accountability for outbreak management agreed and recorded * assess the risk to the public’s health * ensure that that the cause, vehicle and source of the outbreak are investigated and control measures implemented as soon as possible * seek legal advice where required | TV HPT / Chair of Outbreak Control Team | Within three working days of decision to convene. |
| Outbreak Investigation and Control | * Case definition agreed and recorded * Control measures documented with clear timescales for implementation and responsibility – these will then be reviewed at each OCT until the end of outbreak is declared * Additional system support for setting identified and deployed with clear timescales for implementation and responsibility. These will then be reviewed at each OCT until the end of outbreak is confirmed. * Descriptive epidemiology undertaken and reviewed at outbreak control team to include: number of cases in line with case definition; description of key characteristics including gender, geographic spread, pertinent risk factors; hypothesis generated. * Analytical study considered and rationale for decision recorded | All members of OCT with input and guidance from Buckinghamshire Public Health Team and TV HPT | At the first and subsequent meetings of OCT |
| Communications | * Agree communication strategy including deciding the most appropriate organisation/team to lead. * Ensure handover of cases and incidents between members of PHE/HPT and Local LA PH team is consistent with PHE handover standards. | TV HPT/OCT Chair with input and guidance from local PH team | At the first meeting of OCT |
| End of Outbreak | * Final outbreak report completed (only required for significant outbreaks) * Report recommendations and lessons identified, review. | TV HPT/OCT Chair | If required, within 4-6 weeks of the formal closure of the outbreak. |
| The overarching joint approach to managing complex cases and outbreaks will be as follows:   * If clinically indicated, PHE will arrange swabbing and testing for symptomatic individuals when first advised of a suspected outbreak (within a particular setting, or particular cohort), linked in with regional/local arrangements for testing, including Mobile Testing Units or the CCG-commissioned swabbing teams (Fed Bucks). * PHE will undertake the initial risk assessment and give advice to the setting and the local system on management of the outbreak. Based on the risk assessment the local HPT will decide if an OCT meeting is required. * The Local Authority (LA) or CCG, depending on the situation, will follow-up and support the setting to continue to operate whilst managing the outbreak, including support with infection prevention and control. * PHE will work collaboratively with the LA both proactively and reactively to ensure two way communication about outbreaks as well as enquiries being managed by the local authorities and wider issues/opportunities, and will continue to give advice on complex situations on request from local systems, including advice on closing and opening care homes to admissions, as well as other settings. | | | |

## 2 Management Arrangements for COVID-19 Outbreaks

The protection of the public’s health takes priority over all other considerations. The primary objective in outbreak management is to protect public health by identifying the source and implementing control measures to prevent further spread or recurrence of COVID-19.

Secondary objectives include refining outbreak management, training, adding to the evidence base about sources and transmission and lessons learnt for improving outbreak control measures.

Responsibility for managing outbreaks is shared by all organisations who are members of the OCT. This responsibility includes the provision of sufficient financial and other resources necessary to bring the outbreak to a successful conclusion.

### 2.1 Risk Assessments

All activities should be underpinned by a comprehensive risk assessment. Risk assessments should be agreed by the OCT and regularly reviewed throughout the outbreak investigation. The OCT should agree a standard format for risk assessment.

### 2.2 Recognition of an Outbreak and Initial Response

Outbreaks may be recognised by Public Health England, Local Authority or NHS or Care Homes. Immediate contact between these parties is essential as soon as it becomes apparent that an outbreak may exist.

Immediate control measures should be implemented as per relevant guidance and investigation by local Health Protection Team (HPT) should begin within 24 hours of receiving the initial report. The following steps should be undertaken by HPT to establish key facts and inform the decision to declare an outbreak:

* confirm the validity of the initial information
* consider the tentative diagnosis and whether all cases have the same diagnosis
* conduct preliminary interviews to gather basic information including any common factors
* collect relevant clinical specimens
* carry out an initial risk assessment
* manage initial communication issues

### 2.3 Declaration of an Outbreak

Outbreaks will usually be recognised and declared by the Consultant in Communicable Disease Control / Health Protection Team. HPT should inform the DPH.

### 2.4 Convening an Outbreak Control Team (OCT)

An OCT may be a formal meeting of all partners to address the control, investigation and management of an outbreak, or a discussion between two or more stakeholders following the identification of a case or exposure of concern. All such discussions should be appropriately recorded.

Following the recognition and declaration of an outbreak, a decision regarding the need and urgency to convene an OCT will be made by HPT. This decision will be guided by the risk assessment. The rapid establishment of an OCT is appropriate if an outbreak is characterised by:

* immediate or continuing significant risk to the health of the population
* a large number of cases
* cases identified over a large geographical area suggesting a dispersed source
* significant public, political or reputational interest

When a decision has been made not to declare an outbreak, the responsible consultant should review the situation at appropriate intervals and be prepared to declare an outbreak if required. This may involve consulting with the other parties to assist with on-going surveillance.

Membership of OCT may include the following:

* Consultant in Communicable Disease – (CCD) HPT
* Director of Public Health/Consultant in Public Health – LA
* Care Home Providers representative
* Care Home Commissioners reprehensive – LA
* Quality and Patient Safety Manager – CCG
* Associate Director of Quality and Safeguarding - CCG
* Head of Nursing, Buckinghamshire Healthcare NHS Trust
* Representative from FedBucks
* Communications – LA/CCG

### 2.5. Role of the Outbreak Control Team (OCT)

The purpose of the OCT is to agree and coordinate the activities involved in the management, investigation and control of the outbreak. The OCT will:

* assess the risk to the public’s health
* ensure that that the cause, vehicle and source of the outbreak are investigated and control measures implemented as soon as possible
* ensure that any wider system support for the setting is identified, implemented and reviewed
* seek legal advice where required

The chair of the OCT should be appointed at the first meeting. This will usually be the CCD/Consultant in Health Protection (CHP), however it may be another OCT member if appropriate.

Key considerations:

* members must be of sufficient seniority to implement decisions and allocate resources
* at the first meeting terms of reference should be agreed, a preliminary risk assessment conducted and incident level decided (according to NIRP or other organisational incident levels as appropriate)
* a communications strategy should be agreed early and reviewed as necessary

The action plan for any incident will be specific to the particular circumstances. For each incident an action plan will be developed and implemented using the detailed checklist and action plan template which accompany this document.

### 2.6 Investigation and Control of the Outbreak

Outbreak investigations will vary depending on circumstances, however an outline of actions and key points are summarised below.

* A case definition including a description of time, place, person and clinical features should be agreed early on in the investigation and reviewed throughout.
* Review initial information and establish the number of probable and confirmed cases based on the agreed case definition
* Describe the outbreak in terms of person (eg age, sex, ethnicity or other relevant factors), time (preferably onset date) and place (geographical distribution of cases)
* Form preliminary hypotheses based on descriptive epidemiology
* Control measures should be documented with clear responsibilities and timescales for implementation.
* Conducting an analytical study should be considered early in the investigation. A written protocol for any analytical study should be drawn up at the earliest possible point, with level of detail appropriate to the nature of the outbreak.

### 2.7 Outbreak Prevention and Control Measures**[[2]](#endnote-2)**:

Buckinghamshire’s Offer of Infection Prevention and Control(IPC)and Care Home Testing should be implemented across care homes. Information on IPC measures for care homes including training of care homes staff, and testing for COVID-19 can be found on the Buckinghamshire Council [website](https://www.buckinghamshire.gov.uk/coronavirus/social-care-providers-hub/infection-prevention-control-testing/personal-and-protective-equipment/).

#### 2.7.1 Enhanced Offer

The enhanced offer is delivered by system partners across Buckinghamshire and includes resources and support across a range of areas.

For infection control system partners are committed to delivering the following offer to support outbreak prevention and control in care settings.

##### Level 1 – Universal: Information, advice and guidance available across all care and support settings

* Access to the latest information and guidance on PPE and infection control via the [Buckinghamshire Council website](https://www.buckinghamshire.gov.uk/coronavirus/social-care-providers-hub/) and regular email communication to highlight changes in guidance and new resources.
* A series of [webinars](https://www.buckinghamshire.gov.uk/coronavirus/social-care-providers-hub/workforce/covid-19-adult-social-care-training/) across a range of topics including infection control. These will promote current guidance and provide a forum for problem solving and sharing good practice.
* Infection control training (covering PPE and swab testing) offered to all care homes and wider care and support settings.

##### Level 2 - Specialist Offer: more in depth advice which is tailored to the needs of individual settings

* Advice through local Health Protection Teams at the point of initial outbreak.
* Advice through the Buckinghamshire Healthcare NHS Trust infection control line. This offers 1:1 consultations to care and support settings.

##### Level 3 - Multi-professional Team around the Setting

The Council and CCG will offer an enhanced support offer through a multi-professional team for settings which are struggling to manage using the resources available across the universal and specialist elements of our offer. This will be a bespoke approach that will be discussed and planned with each setting on an individual basis. This approach could include a mix of telephone / Skype consultation, bespoke support with training or skills development or direct support into the setting. In exceptional circumstances, it could include the deployment of a bespoke team who could provide direct care for a short amount of time.

The Council will work proactively with health partners to identify homes that may benefit from elements of this offer in order to support signposting and referrals where necessary. This offer will continue to be developed based on changing need and feedback from the sector.

#### 2.7.2 Care Home Testing

[National Guidance](https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested%5d) states that all care home staff and residents, both symptomatic and asymptomatic, should have access to COVID-19 testing. In Buckinghamshire this requires testing for 131 care homes, with up to 4500 residents and a large staff group.

Testing includes:

* Testing for essential workers who have symptoms of COVID-19. This is undertaken via a test site, mobile testing unit or home testing kit.
* Testing for care homes who suspect they have a new coronavirus outbreak or where it has been 28 days or longer since the previous case and there are new cases. This is organised by Thames Valley Health Protection where they assess that this is the most appropriate course of action.
* Regular re-testing in care homes – every 7 days for staff and every 28 days for residents. To access this testing, eligible homes need to register via the [Government’s online portal](https://www.gov.uk/apply-coronavirus-test-care-home)**.**

A flowchart describing testing pathways for care homes in Buckinghamshire is included in [Appendix 3.](#_Appendix_3:_Care)

The Government has also published a flow diagram to show [current testing routes](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/885172/Care_Homes_Testing_Matrix_v2.1.pdf).

These processes should be applied to all care homes in Buckinghamshire.

In addition to this local testing capacity through Fed Bucks will be used to complement national care home testing where there is an identified local need.

Roles and responsibilities for care home testing

The Local Authority Public Health Team will:

* Take a view on health protection risk using all sources of data
* Provide context specific interpretation of policy and guidance
* Provide overview of risk assessment process through the Director of Public Health

The Integrated Commissioning Team will:

* Encourage and support care homes to complete the NHS Capacity Tracker to provide regular information on their current situation
* Work with health and social care partners to gather intelligence as part of arranging ICP and clinical support needs and feed information to risk assessment
* Ensure eligible care homes are registered through the portal
* Support regular testing and re-testing of staff and residents in care homes as per national guidance.
* Keep in contact with care homes to ensure swab kits have been delivered and administered and to record an overview test results.

Buckinghamshire health and social care partners will work collaboratively to support effective access to testing. This includes identifying gaps or challenges with national testing provision in order to escalate concerns and where necessary seek to implement local solutions.

### 2.8. Communications

* It is essential that effective communication is established between all members of the OCT, partners, the public and the media and maintained throughout the outbreak.
* A communications lead should be part of the management of an outbreak from the outset and a strategy developed for informing the public and key stakeholders should be discussed and agreed at the OCT.
* The Chair should ensure that minutes are taken at all OCT meetings and circulated to participating agencies as soon as possible afterwards. All key decisions should be recorded, the minute-taker is accountable to the Chair for this. It is recommended that administrative support be provided to the OCT as standard.
* Standard communications protocols should be followed for dissemination of critical information.
* Communication between all partners involved in the outbreak investigation will be according to locally agreed arrangements for responding to health protection incidents.

### 2.9 End of outbreak

The OCT will decide when the outbreak is over and will make a statement to this effect. An outbreak can be declared over once 28 days have passed since the onset of symptoms in the most recent case. The decision to declare the outbreak over should be informed by on-going risk assessment and when:

* There is no longer a risk to the public health that requires further investigation or management of control measures by an OCT.
* The number of cases has declined and the probable source has been identified and managed.

### 2.10 Consequence Management

* Throughout the investigation process, OCT will need to identify impact on Care Home services due to high proportion of staff quarantining and activate local agreements/escalation for mutual aid as per local procedures.
* Coordinate any likely Media or political concerns/interest e.g. deaths in care homes through relevant cells and according to locally agreed arrangements.

# Section B: Operational Guideline for COVID-19 (SARS-CoV-2) Outbreak Management in Care Homes

Case definition: Public Health England have suggested that COVID-19 should be suspected in any resident with a new continuous cough and/or high temperature (at least 37.8°C), and/or a loss of, or change to, sense of smell or taste), or new onset of influenza like illness or worsening shortness of breath. However, COVID-19 in care home residents may commonly present with non-respiratory tract symptoms, such as new onset/worsening confusion or diarrhoea. Care home staff, with detailed knowledge of residents, are well-placed to intuitively recognise these subtle signs (‘soft signs’) of deterioration.

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 meters of an infectious case.

Staff contacts:Staff contacts are care home staff that have provided care within 2 meters 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.

## 1. Outbreak Management Checklist for Care Homes

Inform

* + Report outbreak to Local Health Protection team.
  + Inform Commissioners and local PH team using [AFW mailbox](mailto:afwresilience@buckinghamshire.gov.uk) and [PH mailbox](mailto:publichealth@buckinghamshire.gov.uk)
  + Inform staff, residents and visitors of the outbreak.
  + Put up advisory notices about infection control (e.g. hand hygiene and appropriate use of PPE etc).
  + Advise visitors not to attend (especially young children, the immuno-compromised).
  + Ask visitors to report any symptoms to staff.
  + Advise visiting GP.

Handwashing

* + Ensure all staff and visitors wash their hands before and after all resident contact.
  + Ensure sufficient soap and/or alcohol-based hand rubs or gels, and hand-drying facilities are available.

Additional infection control measures

* Train staff in additional contact precautions.
* Provide sufficient gloves, gowns, aprons, masks, goggles, face shields, disposal facilities for used PPE and ensure that they are easily accessible.
* Visibly displaying information/posters for staff and visitors on hand hygiene, social distancing and PPE.
* Ensure cleaning and other relevant staff members are aware of the correct cleaning procedures and the importance of handwashing.
* Ensure catering staff members are aware of the precautions required in food service area and the importance of handwashing.

Cohorting

* + Separate well residents from unwell residents; avoid moving residents around during an outbreak.
  + Allocate dedicated staff to affected residents and restrict staff movement between different care sites.
  + Ensure that members of staff work in only one care home wherever possible and extend these restrictions to agency staff.

Restrict movements

* + Close off dining room and common areas.
  + Suspend communal activities, visiting programs to the facility.

Exclude sick staff

* + Exclude staff with COVID for at least 7 days from the onset of symptoms. Follow the national guidance[[3]](#endnote-3) for information on when staff can return to work.
  + Encourage symptomatic staff to access testing through national testing sites.

Cleaning

* + Implement additional cleaning procedures, including: increased cleaning requirements for high contact points such as door handles; cleaning of body fluid spills.
  + Instruct cleaning and other relevant staff about correct cleaning procedures and the importance of handwashing.
  + Ensure catering staff are aware of the precautions required in food service area and the importance of handwashing.

Linen

* + Instruct staff about precautions required when handling soiled linen.
  + Ensure adequate numbers of linen containers and leak proof bags for waste dispossal.
  + Ensure laundry staff are aware of the correct laundering procedures and the importance of handwashing.

Transfers

* + Avoid transferring residents to other institutions while the outbreak is in progress; if a transfer is necessary, ensure receiving institution is notified of the outbreak.
  + For admissions from hospitals Care Homes should follow the guidance on [Admission and Care of Residents during COVID-19 Incident in a Care Home.](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886140/admission__and_care_of_residents_during_covid19_incident_in_a_care_home.pdf)

Recording and pathology testing

* + Report outbreak to local Health Protection Team (HPT) promptly and follow HPT advice.
  + Ensure laboratory testing has been arranged.

## 2. Management and Control of Outbreaks

* It is critical that any suspicion of an outbreak is discussed with the Health Protection Team (HPT) or out of hours on-call team as soon as possible for completion of an appropriate risk assessment.
* The HPT will advise on testing and appropriate control measures in order to contain spread of infection in a care home.
* The Health Protection Duty Team will consider the facts and undertake a risk assessment. The HPT will decide whether there is a need for a co-ordinated response and will initiate and co-ordinate any necessary action, led by the Duty Consultant supported by the local Public Health Team in Buckinghamshire Council.
* If there is insufficient evidence to confirm an outbreak, it is necessary to collect further evidence before the occurrence can be excluded. It may be necessary to discuss the issues with the key agencies in an informal meeting or teleconference, without or before formally convening an Infection Control Meeting.
* Staff and patient movement will need to be restricted during an outbreak. If an outbreak has been declared, the rotation of staff or the discharge/ transfer of patients should be discussed with the Health Protection Team or Local Public Health Team in local authority.
* In outbreak situations it may be necessary to close a ward /unit / care home. This recommendation will be guided by a risk assessment carried out by the Health Protection Team. (If an outbreak control team is established it will decide on closures to admissions / transfers and staff movement restrictions).
* 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.
* On the advice of the local Director of Public Health (in collaboration with HPT), Care Homes may need to suspend visiting as a result of an outbreak, either in their own setting or due rising levels of community transmission of infection.

Once care home have a suspected case, they should follow infection prevention and control measures described below. Additional work is created during an outbreak and increased staff numbers will probably be necessary to cope with additional pressures.

### 2.1 Infection Prevention and Control (IPC) Measures**[[4]](#endnote-4)**,**[[5]](#endnote-5)**

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 meters of a resident with possible or confirmed COVID-19. Guidance on PPE can be accessed via the [social care provider’s hub](https://www.buckinghamshire.gov.uk/coronavirus/social-care-providers-hub/).
* 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 meters 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.
* Entry and exit from the room should be minimised during care, specifically when these care procedures produce aerosols or respiratory droplets.
* 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.
* It is essential that communication with patients / residents, the public and staff are clear and that messages are consistent.
* Extra cleaning and domestic staff may be required during and immediately following the outbreak. Guidance on the decontamination of affected area/s will be determined the Health Protection Team.
* It may be necessary to order / purchase additional personal protective equipment. If specialist respiratory equipment is required, then access to fit-testing and training will also be necessary.
* Visiting may need to be restricted and visitors should receive information regarding any risks to them of being exposed to potentially pathogenic micro-organisms.
* It may be necessary to record the details of contacts of cases if advised to do so by the Health Protection Team.

### 2.2 Isolation of COVID-19 symptomatic residents**[[6]](#endnote-6)**

a. Single case- Isolation of a symptomatic resident: All symptomatic residents should be immediately isolated for 14 days from onset of symptoms (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).

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.
* 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.
* 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.

### 2.3 Personal Protective Equipment (PPE)**[[7]](#endnote-7)**

[The Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881004/Putting_on_PPE_Care_Homes.pdf) on how to work safely during this period of sustained transmission of COVID-19 should be followed by all care home staff.

*The recommendations from this guideline apply:*

* whether the resident has symptoms or not, and includes all residents including those in the ‘extremely vulnerable’ group and those diagnosed with COVID-19.
* whenever you are within 2 metres of any resident who is coughing, even if you are not providing direct care to them.
* to all direct care, for example: assisting with getting in/out of bed, feeding, dressing, bathing, grooming, toileting, applying dressings etc. and or when unintended contact with residents is likely (e.g. when caring for residents with challenging behaviour).
* These recommendations assume that care workers are not undertaking aerosol generating procedures (AGPs).

Note: PPE is only effective when combined with: hand hygiene (cleaning your hands regularly and appropriately).

### 2.4. 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.

### 2. 5 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.

### 2. 6 Testing for COVID-19

Care Homes can apply for coronavirus testing kits to test the residents and staff whether or not any of their residents or staff have coronavirus symptoms.

[National Guidance](https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested) states that all care home staff and residents, both symptomatic and asymptomatic, should have access to COVID-19 testing.

Testing includes:

* Testing for essential workers who have symptoms of COVID-19. This is undertaken via a test site, mobile testing unit or home testing kit.
* Testing for care homes who suspect they have a new coronavirus outbreak OR where it has been 28 days or longer since the previous case and there are new cases. This is organised by Thames Valley Health Protection where they assess that this is the most appropriate course of action.
* Regular testing in care homes – every 7 days for staff and every 28 days for residents. Homes need to register via the Government’s [online portal](https://www.gov.uk/apply-coronavirus-test-care-home) to access this testing.

A flowchart describing testing pathways for care homes in Buckinghamshire is included in [Appendix 3.](#_Appendix_3:_Care)

The Government has also published a flow diagram showing [current testing routes](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/885172/Care_Homes_Testing_Matrix_v2.1.pdf).

These processes should be applied to all care homes in Buckinghamshire.

In addition to this local testing capacity through Fed Bucks will be used to complement national care home testing where there is an identified local need.

**Testing residents:** The new guidance on testing and retesting expects regular testing of residents in care homes every 28 days. Homes need to register via the Government’s [online portal](https://www.gov.uk/apply-coronavirus-test-care-home) to access this testing.

For homes with anew outbreak, testing is carried out by Fed Bucks following guidance by PHE. The testing of an initial outbreak will include whole home testing of all symptomatic and asymptomatic residents and asymptomatic staff.

#### Testing Staff:

Asymptomatic staff: The new national guidance on testing in care homes expects weekly testing of staff in care homes. Homes need to re-register via the Government’s [online portal](https://www.gov.uk/apply-coronavirus-test-care-home) to access this testing.

Care home workers with symptoms should be self-isolating and can access testing through the [self-referral](https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested#self-referral) or [employer referral](https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested#employer-referral) portals.

If a member of staff develops symptoms, they should be tested for SARS-CoV-2. Testing is most sensitive within 3 days of symptoms developing. Guidelines on who can get tested and how to arrange for a test can be found in the [COVID-19: getting tested guidance.](https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested)

If their symptoms do not get better after 7 days, or their condition gets worse, they should speak to their occupational health department if they have one or use the NHS 111 online coronavirus service. If they do not have internet access, they should call NHS 111. For a medical emergency they should call 999.

Staff who have previously tested positive should still self-isolate and be tested again if they become symptomatic.

Advice has been published on the [management of staff and patients or residents in health and social care settings according to exposures, symptoms and test results](https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings).

If staff are symptomatic when tested

In line with the [return to work](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/885823/Flowchart_for_return_to_work_symptomatic.pdf) guidance staff who test negative for SARS-CoV-2 can [return to work](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/885823/Flowchart_for_return_to_work_symptomatic.pdf) when they are medically fit to do so, following discussion with their line manager and appropriate local risk assessment. Interpret negative results with caution together with clinical assessment.

Symptomatic staff who test positive for SARS-CoV-2 or who have an inconclusive test result, and symptomatic staff who have not had a test, can return to work:

* no earlier than 7 days from symptom onset, provided clinical improvement has occurred and they have been afebrile (not feverish) without medication for 48 hours and they are medically fit to return
* if a cough or a loss of or a change in normal sense of smell (anosmia) or taste is the only persistent symptom after 7 days (and they have been afebrile for 48 hours without medication), they can return to work if they are medically fit to return (these symptoms are known to persist for several weeks in some cases)

All members of a household shared with the individual should self-isolate for 14 days from the day the individual’s symptoms started. However, if any household member develops symptoms of COVID 19, they should isolate for at least 7 days from the onset of their symptoms, in line with the [stay at home guidance.](https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance)

If staff are asymptomatic when tested

Staff who test negative for SARS-CoV-2 and who were asymptomatic at the time of the test can remain at work or return to work immediately as long as they remain asymptomatic if they were tested as part of routine testing. If they were tested as part of contact tracing investigation then they should follow instructions from the [local Health Protection Team.](https://www.gov.uk/health-protection-team)

Staff who test positive for SARS-CoV-2 and who were asymptomatic at the time of the test must self-isolate for 7 days from the date of the test. If they remain well, they can in accordance with the [return to work](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/885824/Flowchart_for_return_to_work_asymptomatic.pdf) guidance return on day 8.

If, during the 7 days isolation, they develop symptoms, they must self-isolate for 7 days from the day of symptom onset. They can return to work:

* no earlier than 7 days from symptom onset, provided clinical improvement has occurred and they have been afebrile (not feverish) without medication for 48 hours and they are medically fit to return
* if a cough or a loss of or a change in normal sense of smell (anosmia) or taste is the only persistent symptom after 7 days (and they have been afebrile for 48 hours without medication), they can return to work if they are medically fit to return (these symptoms are known to persist for several weeks in some cases)

All members of a household shared with the individual should self-isolate for 14 days from the day the individual’s test was taken. However, if any household member develops symptoms of COVID-19, they should isolate for at least 7 days from the onset of their symptoms, in line with the [stay at home guidance.](https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance)

### 2.7 Visiting Care Homes during Covid-19

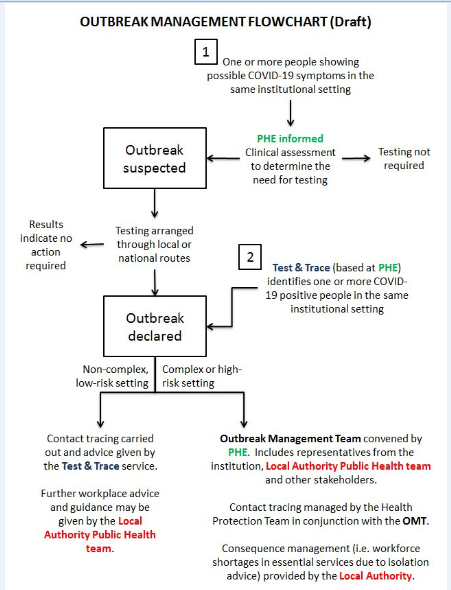
The government has published national guidance for [visiting arrangements in care homes](https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus/update-on-policies-for-visiting-arrangements-in-care-homes).

The process of considering visitors will be led by the relevant local director of public health, who should give a regular professional assessment of whether visiting is likely to be appropriate within their local authority, taking into account the wider risk environment such as number of cases, infection growth rates, infection in the local community and/or outbreaks or hotspots which may increase risk of infection in visitors to care homes in the area.

Actions for Care Homes:

1. Ensure the care home Capacity Tracker is up to date and communicate results of tests to commissioners on a regular basis.
2. When advised to restrict visiting, care homes should rapidly impose visiting restrictions (the ultimate responsibility and decisions sits with the provider and managers of each individual setting).
3. If visits do go ahead, this should be limited to a single constant visitor, per resident. Where a decision is made by a provider to allow visiting, such visits should continue with appropriate infection-control precaution.
4. The care home’s visiting policy should be made available and/or communicated to residents and families, together with any necessary variations to arrangements.
5. Care homes should keep a temporary record (including address and phone numbers) of current and previous residents, staff and visitors, as well as keeping track of visitor numbers and staff
6. Care homes should consider how they will support remote contact (for example, wifi access for all residents).

## Appendix 1: Outbreak Management Flowchart



## Appendix 2: The role of local Health Protection Team and the local system in managing outbreaks of COVID-19 in Buckinghamshire

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| Thames Valley Health Protection Team (TV HPT) Role   1. Risk assessment of Complex Cases and Situations    1. On initial notification, the HPT will do the risk assessment.    2. The HPT will give infection control advice (verbal and email) to the individual or organisation to minimise spread of infection.    3. The HPT will inform the local authority by daily summary by e-mail and by phone if urgent action is required.    4. In complex situations a joint discussion on control measures will take place between LA/CCG lead and PHE. An example indicating poor outbreak control would include sudden high attack rate, increase in deaths or other operational issues. These will be the subject of regular proactive meetings between PHE and local authority public health teams, to discuss outbreaks, local intelligence, alongside enquiries being managed by local authorities, alongside wider issues/opportunities.    5. An IMT for an incident in the community may be held to support co-ordination of investigation and control measures. An IMT can be convened by PHE or the DPH if either of them have concerns.      1. Swabbing/testing of new outbreaks (notified via all routes)    1. PHE will advise on the need for swabbing in an outbreak, and arrange for it to be carried out in collaboration with the LA and/or CCG if required.    2. The partner organisation identified as responsible for follow-up (as confirmed and recorded by PHE at the outset of the outbreak) will also follow-up the results of testing, and provide advice to the setting based upon the results. If the LA or CCG have taken on this responsibility they will also undertake to feedback the results and actions to PHE so that all parts of the outbreak response are recorded in one place. |

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| --- |
| Operational Reporting to Local Systems  A daily summary table listing new outbreaks and situations in the Local Authority area will be provided to the DPH to aid operational management.  Operational Enquiries  Enquiries received by HPT relating to operational issues, such as listed below, will be forwarded to LA or CCG’s Single Point of Contact (see [Contacts details](#_Contact_details) section)   1. Sourcing PPE 2. Operational issues relating to staff capacity and other support to business 3. Removal of dead bodies 4. Care provision |
| Local System Role  Local authorities have been working to support a range of settings (e.g. schools, care homes, workplaces) and communities, both proactively and reactively as part of the overall COVID-19 response. This activity will continue, working closely with PHE. The focus of both the proactive and reactive work, however, will need to change as contact tracing programmes are established and workplaces and schools open requiring support with ensuring this is done safely.  Local authority areas have been asked to develop local COVID “outbreak management plans” by the end of June 2020, which focus on the following themes:   1. Care homes and schools – Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, potential scenarios and planning the required response including testing). 2. Identification of high- risk places, locations and communities, e.g. homeless shelters, migrant worker dormitories/accommodation for vulnerable migrants, high-risk workplaces (e.g. meat packing plants, slaughter-houses among others), places of worship, ports and airports. Defining preventative measures and outbreak management strategies. 3. Local Testing Capacity – to prioritise and manage deployment of testing capacity quickly to the places that need it for outbreak management (e.g. NHS, pop-up, mobile testing units etc). 4. Local Contact Tracing – Led by PHE, but for LAs to consider mutual aid and support structures - identifying specific local complex communities of interest and settings. There is a need to develop assumptions to estimate demand, developing options to scale capacity if needed. 5. Data and integration – national and local data integration; links with Joint biosecurity centre work (to include data management planning, data security and data linkages) 6. Vulnerable people – supporting medically vulnerable people to self-isolate (e.g. facilitating NHS and local support, identifying relevant community groups etc) and ensuring services meet the needs of diverse communities. 7. Local Boards - Establishing governance structures led by existing Covid-19 Health Protection Boards and supported by existing Gold command forums and a new member-led Board to communicate with the general public.   The plans will capture the themes above under initial suggested headings (may change) of:   * Roles and responsibilities and Governance Arrangements (to include links with LA and NHS response structures, COVID Health Protection boards and Member-led boards) * Key principles and protocols for response in different settings to include   + Proactive preventative response   + Reactive response (including community support for shielding and to support isolation)   + Enforcement and Detention * Testing * Data/Intelligence * Financial Plan * Workforce considerations   Local authorities will:   1. Continue with wider proactive work with particular settings and communities in order to minimise the risk of outbreaks/clusters of cases 2. Work with PHE to support complex cases and outbreak management (in a range of settings/communities) as highlighted in above Standard Operating Procedure (SOP), looking to mobilise/re-purpose existing capacity within public health, environmental health, trading standards, infection control, education, as well as wider professional workforces as appropriate (school nursing, health visiting, TB nursing and sexual health services, academia). 3. Support swabbing of contacts (e.g. school contacts) where necessary, by using commissioner-provider relationships to organise and/or negotiate access for community swabbing teams, or by directing mobile testing units in the case of large-scale swabbing being required. 4. Provide a single point of access for communication with the local authority on matters relating to the reactive response, as well as out of hours contact (through Directors of Public Health and Health protection leads, or other local arrangements as they emerge) 5. Establish regular proactive meetings with “link” PHE colleagues to discuss complex outbreaks, local intelligence, alongside enquiries being managed by local authorities, alongside wider issues/opportunities. This may be at both local and sub-regional footprints 6. Develop local COVID “outbreak” plans rapidly alongside PHE, ensuing appropriate PHE representation on COVID health protection boards.   Underpinning this work will be a need to consider workforce planning to ensure capacity in the system for delivery of the above. |

### Contact details

Local authority single point of contact (in normal office hours)email: [publichealth@buckinghamshire.gov.uk](mailto:publichealth@buckinghamshire.gov.uk)

Out of hours or in an emergency please contact the Duty Resilience Officer on 07738 501318

Contact details for PHE are telephone0344 225 3861 or if the matter is not urgent you can email [TVPHE@phe.gov.uk](mailto:TVPHE@phe.gov.uk)

## Appendix 3: Care Homes Testing Pathways Flowchart

Suspected Outbreak

HPT

Whole Home Testing

Routine testing

[Digital Portal](https://www.gov.uk/apply-coronavirus-test-care-home)

Week 1 Staff

Week 2 Staff

Monthly residents

Week 3 Staff

Week4 Staff

NEGATIVE

NEGATIVE

Rescreen at 4-7 days

POSITIVE

NEGATIVE

Residents – isolate 14 days

Staff – isolate 7 days

Rescreen at 28 days after last case using [digital portal](https://www.gov.uk/apply-coronavirus-test-care-home)

No further screening of confirmed positives for 6 weeks

## Appendix 4: Relevant Guidelines

1. [Communicable Disease Outbreak Management, Operational guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/343723/12_8_2014_CD_Outbreak_Guidance_REandCT_2__2_.pdf)
2. [COVID-19: infection prevention and control guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886668/COVID-19_Infection_prevention_and_control_guidance_complete.pdf)
3. [COVID-19: how to work safely in domiciliary care in England](https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-domiciliary-care)
4. [COVID-19: putting on and removing PPE – a guide for care homes (video)](https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-care-homes/covid-19-putting-on-and-removing-ppe-a-guide-for-care-homes-video)
5. [Guidance on infection prevention and control for COVID-19. Sustained community transmission is occurring across the UK](https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance?utm_source=6afb01f3-932e-4440-93b6-9eee2513a005&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate#guidance-for-health-professionals)
6. [COVID-19: infection prevention and control guidance Appendix 2](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886370/COVID-19_Infection_prevention_and_control_guidance_Appendix_2.pdf)
7. [COVID-19: management of staff and exposed patients or residents in health and social care settings](https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings)
8. [Coronavirus (COVID-19): care home support package](https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes/coronavirus-covid-19-care-home-support-package#annex)
9. [NHS test and trace: workplace guidance](https://www.gov.uk/guidance/nhs-test-and-trace-workplace-guidance?utm_source=3ad1e505-7776-4963-b366-f718239cf904&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate#guidance-for-employers)
10. [COVID-19: management of staff and exposed patients or residents in health and social care settings](https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings)
11. [Visiting Care Homes During COVID-19:](https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus?utm_source=9fbd729e-7dbe-47b1-8be7-711bd7f8f25f&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate)

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2. <https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan> [↑](#endnote-ref-2)
3. <https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings>) [↑](#endnote-ref-3)
4. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886140/admission__and_care_of_residents_during_covid19_incident_in_a_care_home.pdf> [↑](#endnote-ref-4)
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7. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881004/Putting_on_PPE_Care_Homes.pdf> [↑](#endnote-ref-7)