Department of Health & Social Care

Guidance

COVID-19 supplement to the infection prevention and control resource for adult social care

Updated 15 December 2022

Applies to England

Contents

This publication is available at https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement/covid-19-supplement-to-the-infection-prevention-and-control-resource-for-adult-social-care

Services should follow this updated guidance by 22 December 2022.

Summary of changes

This table outlines the changes to this guidance since 11 October 2022.

Guidance section	Overview of changes
Outbreak management	Updated to reflect policy change to enable care homes to initiate their own risk assessments and determine outbreak measures should they feel able to do so. Updated to add detail on when cases may or may not be linked within a care home. Updated to add sub-sections to distinguish between 'if an outbreak is suspected' and 'if an outbreak is identified'.
If a member of staff is symptomatic or tests positive for COVID-19	New section to move information previously under 'Staff movement' to distinguish what staff should do in the event of symptoms or a positive test. Updated to remove symptoms list and instead link to NHS guidance on COVID-19 symptoms. Updated to move 'If a staff member receives a negative or inconclusive test result' to COVID-19 testing in adult social care guidance.
Personal Protective Equipment	Updated to reflect policy change to remove recommendation for universal masking at all times.

Introduction

This guidance should be used to help reduce the spread of COVID-19 in adult social care settings.

This guidance applies to adult social care settings and services in England and should be read in conjunction with the infection prevention and control (IPC): resource for adult social care (/government/publications/infection-prevention-and-control-in-adult-social-care-settings) guidance, which should be used as a basis for any infection prevention and control response. The devolved administrations will each

set out their own guidance. If an infection in the setting is not due to COVID-19, guidance for the particular infection should be consulted (if available) to determine whether any specific additional IPC measures are appropriate.

This supplement provides additional information regarding safe working when caring for people with COVID-19 in the provision of adult social care services. This guidance will be kept under review.

The supplement includes guidance on:

- staff IPC considerations:
  - vaccination
  - personal protective equipment (PPE)
  - staff movement
  - testing
- IPC considerations for people receiving care:
  - vaccination
  - testing
- environmental considerations:
  - ventilation
  - waste management
- considerations specific to care homes:
  - admissions
  - testing
  - visiting
  - outbreak management

This supplement should also be read in conjunction with the adult social care testing guidance (/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings), which details the testing regimes for all staff, as well as any service user, resident and care home outbreak testing where applicable.

IPC considerations for adult social care staff

Vaccination

Vaccination remains a primary protection measure against COVID-19, reducing the risk of serious illness, hospitalisation and death. The Secretary of State for Health and Social Care, along with the Chief Medical Officer, the Chief Nurse for Adult Social Care and others, have been clear that all people working in health and social care settings, including volunteers and unpaid carers, have a responsibility to be vaccinated against COVID-19.

To minimise risk to people who receive care and support, health and social care providers should encourage and support all their staff to get a COVID-19 vaccine and a booster dose as and when they are eligible, as well as a vaccine for

seasonal flu. Providers can do this by putting in place arrangements to facilitate staff access to vaccinations, and regularly reviewing the immunisation status of their workforce in line with immunisation against infectious disease ('the Green Book') (/government/collections/immunisation-against-infectious-disease-the-green-book).

Everyone eligible for a COVID-19 vaccination can either book their first dose, second dose and an autumn booster dose online via the national booking service (https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/book-coronavirus-vaccination/) or by phoning 119.

The seasonal flu vaccine should be provided to staff by employers as part of the organisation's policy to prevent the transmission of infection. However, where frontline social care staff do not have access to an employer-led occupational health scheme, they can access the flu vaccine through the NHS, free of charge. Everyone eligible can book an appointment at a participating pharmacy, online via the national booking service, or by contacting their GP.

To ensure the safety of people who receive care, providers should undertake risk assessments wherever possible. These should take into account the COVID-19 vaccination status of both staff members and the people they care for. Relevant clinical advice should be considered, including whether any individuals are at higher risk of severe COVID-19 infection. Further information about assessing the risk of individuals can be found below in the risk assessment section of 'IPC considerations for people receiving care'. Providers should also consider whether any of the people they support are eligible for COVID-19 treatments (/government/publications/highest-risk-patients-eligible-for-covid-19-treatments-guide-for-patients) and how to ensure they are supported to access treatment (/guidance/access-community-based-treatments-for-coronavirus-covid-19) if they test positive.

Personal protective equipment

Appropriate PPE should be worn by care workers in all settings, as well as visitors to residential care settings, subject to a risk assessment of likely hazards such as the risk of exposure to blood and body fluids. The advice below provides guidance on the type of PPE that is recommended, to help protect care workers and care recipients and prevent the transmission of infectious diseases, with particular advice regarding care of people suspected or confirmed to be COVID-19 positive.

For PPE to be effective, it is important to use it properly and follow instructions for putting it on (donning) and taking it off (doffing) (/government/publications/ppe-guide-for-non-aerosol-generating-procedures).

All used PPE should be disposed of appropriately according to the waste management section below.

Gloves, aprons and eye protection

In addition to recommendations for standard precautions (https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings) (for example, when there is a risk of contact with blood or body fluids), gloves and aprons should be worn when the care worker or visitor is providing close care for a person who has suspected or confirmed COVID-19, or when cleaning their room. These should be removed and disposed of upon leaving the room or care recipient's home.

In addition to recommendations for standard precautions, eye protection should be worn when providing close care to someone who has suspected or confirmed COVID-19, or when cleaning their room. Eye protection used in these circumstances should be removed after leaving the room, or home of the care recipient.

Reusable eye protection should be cleaned and disinfected as per the manufacturer's instructions between use.

Face masks

Care workers and visitors to care homes do not routinely need to wear a face mask at all times in care settings or when providing care in people's own homes. However there remain a number of circumstances where it is recommended that care workers and visitors to care settings wear masks to minimise the risk of transmission of COVID-19. These are:

- if the person being cared for is known or suspected to have COVID-19 (recommended Type IIR fluid-repellent surgical mask)
- if the member of staff is a household or overnight contact of someone who has had a positive test result for COVID-19
- if the care setting is in an outbreak – see section on outbreak management for further information

If a care recipient is particularly vulnerable to severe outcomes from COVID-19 (for example, potentially eligible for COVID-19 therapeutics (/government/publications/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk)) mask wearing may be considered on an individual basis in accordance with their preferences.

Mask wearing may also be considered when an event or gathering is assessed as having a particularly high risk of transmission.

If the care recipient would prefer care workers or visitors to wear a mask while providing them with care then this should be supported. Providers should also support the personal preferences of care workers and visitors to wear a mask in scenarios over and above those recommended in this guidance.

As per the recommendations for standard precautions, type IIR masks should always be worn if there is a risk of splashing of blood or body fluids.

If masks are being worn due to an outbreak or risk assessment, consideration should be given as to how best to put this into practice while taking account of the needs of individuals and minimising any negative impacts. If a person receiving care finds the use of PPE distressing, or their use is impairing communication, a local risk assessment regarding this can be made. This may be more likely to be relevant when caring for people with learning disabilities or cognitive conditions such as dementia, or supporting individuals who rely on lip reading or facial recognition. If, following a risk assessment, it is determined that the use of face masks should be limited while caring for an individual, appropriate and proportionate mitigations should be considered (/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care) such as limiting close contact and/or increasing ventilation to maintain adequate infection prevention and control. The needs of the person receiving care should be recognised and they should be as involved as they wish to be and/or are able to be in determining their needs in these circumstances.

It may be appropriate in certain circumstances to consider transparent face masks, some of which could be considered for use as an alternative to type IIR surgical masks (see below for more detail).

Transparent face mask technical specification (/government/publications/technical-specifications-for-personal-protective-equipment-ppe) offers further guidance.

All face masks should:

- be well fitted to cover nose, mouth and chin
- be worn according to the manufacturer's recommendations (check which side should be close to the wearer)
- not be allowed to dangle around the neck at any time, or rest on the forehead or under the chin
- not be touched once put on
- be worn according to the risk-assessed activity
- be removed and disposed of appropriately, with the wearer cleaning their hands before removal and after disposal

Face masks should be changed:

- if they become moist
- if they become damaged
- if they become uncomfortable to wear
- if they become contaminated or soiled
- at break times
- between different care recipients
- between different people's homes
- after 4 hours of continuous wear

Type IIR face masks

Type IIR fluid-repellent surgical masks protect the wearer by providing a fluid repellent barrier between the wearer and the environment. This protects the wearer against blood or body fluid splashes and against the respiratory droplets of others reaching their mouth and nose. These masks also protect others from the wearer's respiratory droplets should they have asymptomatic COVID-19 infection. In addition to standard precautions (/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care), care workers should wear a type IIR fluid-repellent surgical face mask when providing close care for people who are suspected or confirmed as having COVID-19 or when cleaning their rooms.

Type I and type II face masks

Type I and type II masks are not considered PPE and are worn to provide source control – that is, to protect others from the wearer's respiratory droplets should they have asymptomatic COVID-19 infection. These masks can be worn when universal masking is in effect, for example due to an outbreak, or due to a risk assessment or preference on the part of the staff member or the recipient of care. As they are not fluid repellent, they should not be worn for activities where there is a risk of splash of blood, body fluids or hazardous cleaning products, or when caring for an individual with suspected or confirmed COVID-19.

Use of face masks for care 'sessions'

Sessional use of masks only applies when working in a communal setting, for example a care home, and caring for a cohort of clients who are all suspected or confirmed to have COVID-19, or if 'universal masking' is in place, for example during an outbreak. After 4 hours, or after leaving the room (or cohorted area) of someone with suspected or confirmed COVID-19 (whichever is sooner) masks should be disposed of and hand hygiene performed before putting on a new mask (if required).

Aerosol-generating procedures (AGP)

An AGP is a medical procedure that can cause the release of virus particles from the respiratory tract and can increase the risk of airborne transmission to those in the immediate area. AGPs in the community setting include tracheostomy procedures (insertion or removal) and open suctioning beyond the oro-pharynx.

Filtering face piece class 3 (FFP3) respirators are required when undertaking an AGP on a person with suspected or confirmed COVID-19 infection, or another infection spread by the airborne or droplet route. FFP3 respirators should be removed outside of the room where the AGP was carried out and disposed of.

The use of FFP3s is governed by health and safety regulations and they should be fit tested to the user to ensure the required protection is provided. The Health and Safety Executive (HSE) provides information and tools to help select and manage

the use of respiratory protective equipment (RPE) (https://www.hse.gov.uk/respiratory-protective-equipment/).

Workers should wear a type IIR mask when carrying out an AGP on someone who is not suspected or confirmed to have COVID-19 or another infection spread via airborne or droplet routes.

If undertaking an AGP in someone's own home, FFP3 respirators or face masks should be removed and disposed of when leaving the house.

Workers should wear gloves, aprons and eye protection when carrying out AGPs. Where there is an extensive risk of splashing, workers should wear fluid repellent gowns instead of aprons.

Following an evidence review commissioned by NHS England and Improvement, the list of procedures which are currently classed as AGPs in relation to respiratory infections and are most likely to be relevant to ASC are:

- awake bronchoscopy (including awake tracheal intubation)
- awake ear, nose, and throat (ENT) airway procedures that involve respiratory suctioning
- awake upper gastro-intestinal endoscopy
- dental procedures (using high-speed or high-frequency devices, for example ultrasonic scalers or high-speed drills)
- induction of sputum
- respiratory tract suctioning
- tracheostomy procedures (insertion or removal)

'Awake' includes conscious sedation (excluding people who are anaesthetised with secured airway).

The available evidence relating to respiratory tract suctioning is based on individuals who are ventilated. In line with a precautionary approach, open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current (COVID-19) AGP list. It is the consensus view of the UK IPC cell that open suctioning beyond the oro-pharynx is currently considered an AGP – that is, oral or pharyngeal suctioning is not an AGP.

Certain other procedures or equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk for COVID-19. In care settings, procedures commonly undertaken which are not classified as AGPs include:

- non-invasive ventilation (NIV)
- bi-level positive airway pressure ventilation (BiPAP) and continuous positive airway pressure ventilation (CPAP)
- high flow nasal oxygen (HFNO)
- oral or pharyngeal suctioning (suctioning to clear mucus or saliva from the mouth)

- administration of humidified oxygen
- administration of Entonox or medication via nebulisation

PPE recommendations summary

The tables below detail some common scenarios in care and the appropriate PPE to be worn.

In circumstances where universal masking (for source control) is in place, follow the recommendations for mask use in the tables and in addition wear a type I, II or IIR surgical mask for activities where the use of a mask is not normally recommended. See section on Use of face masks for care ‘sessions’ for guidance on sessional use of masks.

Table 1: PPE requirements when caring for a person not known or suspected to have COVID-19 (see Table 3 for aerosol generating procedures).

For people with an infectious illness other than COVID-19, follow the principles in Table 1 and seek additional advice for the specific infection.

For the scenarios in Table 1, change PPE between tasks and between caring for different care recipients. Hand hygiene should be carried out before putting on and after removing PPE.

Activity	Face mask	Eye protection	Gloves	Apron
Social contact with clients, staff, visitors	No	No	No	No
Care or domestic task involving likely contact with blood or body fluids (giving personal care, handling soiled laundry, emptying a catheter or commode)	Risk assess – Type IIR if splashing likely	Risk assess if splashing likely	Yes	Yes

Activity	Face mask	Eye protection	Gloves	Apron
Tasks not involving contact with blood or body fluids (moving clean linen, tidying, giving medication, writing in care notes)	No	No	No	No
General cleaning with hazardous products (disinfectants or detergents)	Risk assess – type IIR if splashing likely or if recommended by manufacturer of cleaning product	Risk assess or if recommended by manufacturer of cleaning product	Risk assess or if recommended by manufacturer of cleaning product	Risk assess or if recommended by manufacturer of cleaning product

> For people with an infectious illness other than COVID-19, follow the above principles and any additional advice for the specific infection.

Note: sessional use of masks applies to communal care settings only.

Table 2: PPE requirements when caring for a person with suspected or confirmed COVID-19 (see Table 3 for aerosol generating procedures)

For a list of symptoms, please see guidance on people with symptoms of a respiratory infection including COVID-19 (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19).

Masks and eye protection used while providing care for people with suspected or confirmed COVID-19, as listed in Table 2, should be removed on leaving the room or cohort area. Gloves and aprons may need to be changed between tasks, as per standard precautions (/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care), and should always be removed on leaving the room or cohort area. Hand hygiene should be carried out before putting on and after removing PPE.

Activity	Face mask	Eye protection	Gloves	Apron
Giving personal care to a person with suspected or confirmed COVID-19	Yes – type IIR	Yes	Yes	Yes
General cleaning duties in the room where a person with suspected or confirmed COVID-19 is being isolated or cohorted (even if more than 2 metres away)	Yes – type IIR	Yes	Yes	Yes
For tasks other than those listed above, when within 2 metres of a person with confirmed or suspected COVID-19	Yes – type IIR	Yes	Risk assess (if contact with blood or body fluids likely)	Risk assess (if contact with blood or body fluids likely)

Table 3: PPE requirements when undertaking Aerosol Generating Procedures (AGP)

The PPE listed in Table 3 should be removed on leaving the room where the AGP was undertaken and before undertaking any other tasks or caring for any other care recipients. Hand hygiene should be carried out before putting on and after removing PPE.

Activity	Face mask	Eye protection	Gloves	Apron
Undertaking an AGP on a person who is not suspected or confirmed to have COVID-19 or another infection spread by the airborne or droplet route	Yes – type IIR to be used for single task only	Yes	Yes	Yes (consider a fluid repellent gown if risk of extensive splashing)
Undertaking an AGP on a person who is suspected or confirmed to have COVID-19 or another	Yes – FFP3 RPE to be used for	Yes – goggles or a visor should always be worn If there is a risk of	Yes	Yes (consider a fluid repellent gown if risk

Activity	Face mask	Eye protection	Gloves	Apron
infection spread by the airborne or droplet route	single task only	contact with splash from blood or body fluids and the FFP3 is not fluid resistant this needs to be a full-face visor (which covers the eyes, nose and mouth area)		of extensive splashing)

Staff movement

Care services are not normally required to limit staff movement between sites or services. However, there may be instances where a care home limits staff movement if, for example, there is high prevalence of COVID-19 locally or in an outbreak. This may also be advised by the local Director of Public Health or Health Protection Team (HPT). For further information see below on outbreak management.

If a member of staff is symptomatic or tests positive for COVID-19

This section outlines what adult social care staff should do if they are symptomatic or test positive for COVID-19. Please see Coronavirus (COVID-19) testing for adult social care services (/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings) for further details on when and how individuals should test across adult social care services.

Free lateral flow tests have been provided for symptomatic testing. Staff should ensure they have some at home so that they can test if they are concerned they may be experiencing symptoms of COVID-19. For more information on accessing COVID-19 tests, see ‘Coronavirus (COVID-19) testing for adult social care services’.

Anyone who has symptoms of a respiratory infection (https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/main-symptoms) and has a high temperature, or anyone who has symptoms of a respiratory infection and does not feel well enough to carry out normal activities is advised to try to stay at home and avoid contact with other people.

Social care staff should take a lateral flow test as soon as possible if they have either:

- symptoms of a respiratory infection and have a high temperature
- symptoms of a respiratory infection and they do not feel well enough to attend work

If staff meet either of the above, they are advised to stay at home, avoid contact with other people, and not go to work. If this develops while at work, they should leave as soon as possible and wear a mask (for source control).

These staff should take 2 lateral flow tests 48 hours apart.

If the lateral flow test result is negative, they should take another lateral flow test 48 hours later, staying away from work during this time.

If the second lateral flow test is also negative, they can return to work if they do not have a temperature and are well enough to do so, subject to discussion with their line manager or employer and a local risk assessment.

If either test is positive, they should follow the guidance in the section 'If a staff member receives a positive lateral flow or PCR test result'.

Staff do not need to take a COVID-19 test and can continue to work subject to a local risk assessment if they have symptoms of a respiratory infection, but do feel well enough to work and do not have a high temperature. A risk assessment may include advising the use of masks.

Free lateral flow tests have been provided for symptomatic testing and staff should ensure they have some at home for this purpose. For more information on accessing COVID-19 tests, see the COVID-19 testing for adult social care services (/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings).

For staff who test negative (on day 0) but have a temperature or feel too unwell to work on the first day but then feel better the following day, in exceptional circumstances and subject to the risk assessment below, these staff may be able to work.

If a risk assessment indicates a serious risk to social care service delivery, symptomatic staff who test negative on day 0, who do not have a temperature and feel well enough to do so may be asked to return to work. The risk assessment should consider how to avoid contact between these members of staff and people at higher risk of serious illness as far as possible, including using a mask for source control. On returning to work, the staff member must continue to comply rigorously with all relevant infection control precautions. The staff member should take another lateral flow test 48 hours after their first test and if this second test is negative, they can remain working.

If staff members are concerned about their symptoms, they should seek medical advice.

If a staff member receives a positive lateral flow or PCR test result

Staff who receive a positive lateral flow or PCR test result should follow the advice regarding staying at home and avoiding contact with other people (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19) from the day they test positive (if they do not have symptoms) or develop symptoms (day 0) to avoid

passing on the virus. There is no need to take a PCR test after a positive lateral flow test result.

In addition, social care staff with COVID-19 should not attend work until they have had 2 consecutive negative lateral flow test results (taken at least 24 hours apart), they feel well, and they do not have a high temperature. The first lateral flow test should only be taken from 5 days after day 0 (the day their symptoms started, or the day their test was taken if they did not have symptoms). If both lateral flow tests results are negative, they may return to work immediately after the second negative lateral flow test result, if their symptoms have resolved, or their only symptoms are cough or anosmia which can last for several weeks.

If the staff member cares for people who are at higher risk of becoming seriously unwell with COVID-19 (seek clinical advice as necessary), careful assessment should be undertaken, and consideration given to redeployment until 10 days after their symptoms started (or the day their test was taken if they did not have symptoms). The staff member should continue to comply with all relevant infection control precautions and PPE should be worn properly throughout the day. Further information about assessing the risk of individuals can be found below in the risk assessment section of ‘IPC considerations for people receiving care’.

A positive lateral flow test in the absence of a high temperature after 10 days is unlikely. If the staff member’s lateral flow test result remains positive on day 10, they should continue to take daily lateral flow tests. They can return to work after a single negative lateral flow test result.

The likelihood of a positive lateral flow test after 14 days is considerably lower. If the staff member’s lateral flow test result is still positive on day 14, they can stop testing and return to work on day 15. If the staff member works with people who are at higher risk of becoming seriously unwell with COVID-19 (seek clinical advice as necessary), a risk assessment should be undertaken, and consideration given to redeployment.

Managers can undertake a risk assessment of staff who test positive between 10 and 14 days and who do not have a high temperature or feel unwell, with a view to them returning to work depending on the work environment.

Staff who are contacts of confirmed COVID-19 cases

People who live in the same household as someone with COVID-19 are at the highest risk of becoming infected because they are most likely to have prolonged close contact. People who stayed overnight in the household of someone with COVID-19 are also at high risk.

If staff are a household or overnight contact of someone who has had a positive COVID-19 test result it can take up to 10 days for an infection to develop. It is possible to pass on COVID-19 to others, even if the member of staff has no symptoms.

Staff who are identified as a household or overnight contact of someone who have had a positive COVID-19 test result should follow advice for the general population (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19) and discuss ways to minimise risk of onwards transmission with their line manager. This may include applying measures known to reduce risk such as distancing, maximising ventilation, wearing a mask for source control.

Providers should carefully consider measures if the staff member works with people who are at higher risk of becoming seriously unwell with COVID-19 (seek clinical advice as necessary). Providers should also consider redeployment of staff in these circumstances during the 10 days following household or overnight contact with the case.

Providers should ensure consideration of appropriate measures are included in general risk assessments for responding to infectious diseases and ensuring safe staffing levels are maintained. Further information about assessing the risk of individuals can be found below in the risk assessment section of 'IPC considerations for people receiving care'.

Staff must continue to comply rigorously with all relevant infection control precautions (https://www.england.nhs.uk/publication/national-infection-prevention-and-control/) while they are attending work and follow the advice for staff with symptoms of a respiratory infection, including COVID-19 (/government/publications/covid-19-managing-healthcare-staff-with-symptoms-of-a-respiratory-infection/managing-healthcare-staff-with-symptoms-of-a-respiratory-infection-or-a-positive-covid-19-test-result) if they develop any symptoms.

Care workers living with individuals they provide care and/or support to

Care workers who provide care and/or support to the person they live with may need to follow different guidance detailed in this section. This is due to the close proximity of the care and the relationship between carer and the individual receiving care.

In addition, care workers and their employer, where relevant, will need to undertake a risk assessment to determine which PPE to use and this should involve the supported person's views and preferences. This risk assessment may include wearing of type I or II masks for source control (that is, the mask is worn to protect others from the wearer). This might be at the start of a placement or for short placements.

If a care worker is living with the supported individual and they are considered a part of the household, they do not normally need to wear PPE when doing domestic duties. However, they should wear PPE if the person they support, or a member of their household, develops symptoms of COVID-19 (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19) or tests positive for COVID-19 – in which case follow the guidance in Table 2 above. It remains important that they continue to use the PPE needed for the care they provide. For example, gloves and an apron should be worn if they are handling soiled linen, or if they may come into contact with body fluids such as urine, faeces or blood. Refer to

the PPE recommendations summary section in the infection prevention and control: resource for adult social care (/government/publications/infection-prevention-and-control-in-adult-social-care-settings) guidance for further information.

All care workers should follow the same symptomatic testing guidance, regardless of whether they are living with the person they provide care and/or support to.

If a care worker becomes symptomatic or tests positive they should stay away from the individual they provide care for. The care worker should wear a face mask and leave the individual's home where possible and follow the guidance for staff who are symptomatic or have tested positive provided above.

If the individual who is receiving care and/or support is living in the care worker's home (for example, this may happen in Shared Lives arrangements), and the care worker has tested positive, the supported person should leave the home if possible and they should follow the guidance for people receiving care who are contacts of those with COVID-19 (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19). If they are unable to leave the home, they should continue to follow the guidance for contacts (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19). Providers and care workers, in discussion with people in their care where possible, should ensure there are contingency plans in place should this need to happen and this should be a part of the risk assessment at the outset.

IPC considerations for people receiving care

Vaccination

Vaccines are the best way to protect people from COVID-19 and people receiving care are encouraged to get their COVID-19 vaccinations, including boosters, as soon as they are eligible. Furthermore, wherever possible they are encouraged to get their COVID-19 vaccines ahead of entering adult social care settings. See the COVID-19 vaccination: guide for adults (/government/publications/covid-19-vaccination-guide-for-older-adults) for advice on who is eligible for, and where to book vaccines.

Risk assessment of severe disease

When assessing if a person is at higher risk of severe COVID-19 infection, use Who is at high risk from coronavirus (COVID-19) (https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/who-is-at-high-risk-from-coronavirus/) as a guide, but allow for individual risk assessment and judgement. Other factors may also be relevant (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19) and should be taken into account – seek clinical advice as required.

Individuals who are in the highest risk group from COVID-19 should be supported to access COVID-19 therapeutics if they test positive by contacting 119 or a local GP as required. Please refer to Access community-based treatments for

coronavirus (COVID-19) (/guidance/access-community-based-treatments-for-coronavirus-covid-19) and Highest-risk patients eligible for COVID-19 treatments: guide for patients (/government/publications/highest-risk-patients-eligible-for-covid-19-treatments-guide-for-patients).

If a person receiving care is symptomatic or tests positive for COVID-19

This section applies to people receiving care who are not living in care homes. For residents in care homes, please refer to 'considerations specific to care homes' section. Please also see Coronavirus (COVID-19) testing for adult social care services (/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings) for further details on when and how individuals should test across adult social care services.

People who are older or frail, or have cognitive conditions, such as dementia, may present with atypical symptoms or feel different from usual which should also be considered as part of assessing whether they should be tested for COVID-19. Changes in wellbeing, behaviour and clinical signs with or without a high temperature should all be considered when undertaking an assessment about testing. If necessary, clinical advice should be sought, for example from the GP if the person is unwell.

If someone receiving care who does not live in a care home has symptoms of a respiratory infection (https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/main-symptoms) and has a temperature, or has symptoms of a respiratory infection and is too unwell to carry out their usual activities, or tests positive for COVID-19, they should be encouraged to follow the advice for the general population (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19) which is to stay at home and avoid contact with others. As noted above, atypical symptoms should also be considered.

In addition, in extra care and supported living, symptomatic residents have access to free lateral flow testing to check if they have COVID-19. Residents who have symptoms of a respiratory infection and have a high temperature, or residents who have symptoms of a respiratory infection and are too unwell to carry out their usual activities should take a lateral flow test as soon as they feel unwell (day 0). As noted above, atypical symptoms or generally feeling unwell should also be considered for people who are older or frail, or have cognitive conditions, such as dementia, and clinical advice sought if necessary.

Residents should immediately take a lateral flow test as soon as they develop symptoms. If this first test is negative, they should take another lateral flow test 48 hours after the first test.

If the second test is also negative they can return to their usual activities if well enough to do so. An individual with respiratory symptoms who tests negative for COVID-19 may have another infection like flu. Clinical advice should be sought.

If either test is positive, they should follow the advice for the general population to stay at home and avoid contact with others (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19).

If the individual lives in a residential setting that is similar to a care home, such as in an extra care and supported living service, providers may wish to follow all or some of the guidance for symptomatic care home residents as set out in the section below on care home residents who are symptomatic or test positive for COVID-19.

Environmental considerations

Ventilation

In addition to standard precautions, particular attention should be given to how ventilation can be improved. Ventilation is an important control to manage the threat of COVID-19. Letting fresh air from outdoors into indoor spaces can help remove air that contains virus particles and prevent the spread of COVID-19.

Where possible rooms should be ventilated with fresh air from outdoors after any visit from someone outside the setting, or if anyone in the care setting has suspected or confirmed COVID-19. This is because ventilation is particularly important in spaces that are shared with other people for longer periods of time.

The comfort and wishes of the person receiving care should be considered in all circumstances, for example balancing with the need to keep people warm. Rooms may be able to be repurposed to maximise the use of well-ventilated spaces.

Further information regarding ventilation can be found in Infection prevention and control: resource for adult social care (https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings) and Ventilation of indoor spaces (/government/publications/covid-19-ventilation-of-indoor-spaces-to-stop-the-spread-of-coronavirus).

Waste management

In addition to standard precautions the following should be observed:

- in a care home that is registered for nursing, waste generated when supporting a person with confirmed COVID-19 should enter the hazardous waste stream (usually an orange bag) if one is available. Other care homes may have a hazardous waste stream and should use it if available
- waste visibly contaminated with respiratory secretions (sputum, mucus) from a person suspected or confirmed to have COVID-19 should be disposed of into foot-operated lidded bins which should be lined with a disposable waste bag
- if there is not access to a hazardous waste stream, such as waste generated in people's own homes, this should be sealed in a bin liner before disposal into the usual waste stream

IPC considerations specific to care homes

Admission of care home residents

Residents should take both of the following:

- a PCR test within the 72 hours before they're admitted (or a lateral flow test if they have tested positive for COVID-19 in the past 90 days)
- a lateral flow test on the day of admission (day 0)

These tests should be provided by the care home if the individual is being admitted from the community. These tests will be provided by the hospital if the individual is being discharged into the care home.

If an individual tests positive on either of these tests and continues to be admitted to the care home, they should be isolated on arrival and follow the guidance on care home residents who are symptomatic or test positive for COVID-19.

Urgent care home admissions from the community

For urgent admissions to a care home from the community, the care home manager should find out whether the resident being admitted has had a lateral flow or PCR test and, if so, when and what the result was.

If the individual has taken a lateral flow or PCR test within 72 hours of the urgent admission into the care home, the care home manager should share the result with the relevant and responsible person. This may be a delegated responsibility.

If a PCR or lateral flow test has not been taken or was taken more than 72 hours before urgent admission, the individual should be tested again with a lateral flow test by the care home. If the test result is positive, the individual should isolate in the care home and follow the guidance below on care home residents who are symptomatic or test positive for COVID-19.

Discharge from hospital into a care home

The hospital will do a PCR test within 48 hours prior to an individual's discharge into a care home, or a lateral flow test if the individual has tested positive for COVID-19 in the last 90 days.

The test result should be shared with the individual themselves, and usually with their key relatives or advocate and the relevant care provider before the discharge takes place.

If an individual tests positive prior to discharge, they can be admitted to the care home, if the home is satisfied they can be cared for safely.

If an individual returning or being admitted to a care home has tested positive for COVID-19, they should be isolated from others for a total period of 10 days from the day symptoms started or the day of the positive test if asymptomatic (counting

the day of symptom onset or the original positive test, if they did not have symptoms as day 0). This isolation period should include days in the hospital, so when entering a care home, they only need to isolate for the remainder of the 10 days since symptoms or positive test.

However, if an individual who is isolating can participate in testing, they may undertake daily lateral flow testing from day 5 (counting the day of symptom onset or the original positive test if they did not have symptoms as day 0). They can end isolation after receiving 2 consecutive negative tests 24 hours apart.

Any individual who is unable to test should be isolated for the full 10 days following symptom onset or a positive test if they did not have symptoms. Isolation should only be stopped when there is an absence of fever (less than 37.8°C) for 48 hours without the use of medication.

If an individual tests negative for COVID-19 and has no symptoms of COVID-19 and is being discharged to a care home from a location in the hospital where there was an active outbreak, they should be isolated for up to 10 days from the date of admission to the care home, regardless of whether their overnight hospital stay was planned (elective) or unplanned. This is to prevent possible introduction of infection into the care home. Information about hospital outbreak status should be provided as part of the discharge process. Individuals who are isolating for this reason and who are able to participate in daily testing should test with lateral flow tests from day 5 (counting the day of admission to the care home as day 0). They can end isolation after 2 consecutive negative tests 24 hours apart from day 6. If they are unable to test, they can end isolation after 10 days if they remain asymptomatic. If the individual tests positive, guidance below on what to do ‘If a care home resident is symptomatic or tests positive for COVID-19’ should be followed.

During isolation, residents should be able to receive one visitor at a time (this does not need to be the same visitor throughout the isolation period) and have access to outside space to assist rehabilitation if possible.

Care home residents who are contacts of confirmed cases

Care home residents who are close contacts of a COVID-19 case are not advised to isolate nor undertake additional testing. Instead, it is advised that they:

- minimise contact with the person who has COVID-19
- avoid contact with anyone who is at higher risk of severe COVID-19 infection (see the risk assessment section of ‘IPC considerations for people receiving care’)
- follow the advice regarding testing and isolation if they develop symptoms of COVID-19

If a care home resident is symptomatic or test positives for COVID-19

This section outlines what care home residents should do if they are symptomatic or test positive. Please see Coronavirus (COVID-19) testing for adult social care services (/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings) for further details on when and how individuals should test across adult social care services.

Residents who have symptoms of a respiratory infection (https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/main-symptoms/) and have a high temperature, or residents who have symptoms of a respiratory infection and are too unwell to carry out their usual activities, should take a lateral flow test as soon as they feel unwell (day 0).

People who are older or frail, or have cognitive conditions, such as dementia, may present with atypical symptoms or feel different from usual which should also be considered as part of assessing whether they should be tested for COVID-19. Changes in wellbeing, behaviour and clinical signs with or without a high temperature should all be considered when undertaking an assessment about testing and clinical advice sought, if necessary, for example from the GP if the person is unwell.

If the lateral flow test result is negative, they should take another lateral flow test 48 hours later, avoiding mixing with others during this time.

If the second test is also negative, they can return to their usual activities if well enough to do so. A symptomatic individual with respiratory symptoms who tests negative for COVID-19 may have another infectious illness like flu. If a resident is unwell, seek clinical advice and consider testing for other infections such as influenza.

If either test is positive, the guidance below should be followed regarding isolation and support for residents who test positive.

All residents who test positive for COVID-19 with either lateral flow or PCR tests, regardless of whether they are symptomatic or asymptomatic, should isolate in the care home for 10 days from when the symptoms started, or from the date of the test if they did not have symptoms. The care home manager should inform the resident's GP and should:

- support the resident to self-isolate for up to 10 days within their own room with tests available to end the period of isolation earlier (see below for further information)
- closely monitor the resident's symptoms
- consider if the resident is eligible for COVID-19 antiviral treatments. Please refer to Access community-based treatments for coronavirus (COVID-19) (/guidance/access-community-based-treatments-for-coronavirus-covid-19) and Highest-risk patients eligible for COVID-19 treatments: guide for patients (/government/publications/highest-risk-patients-eligible-for-covid-19-treatments-guide-for-patients)

During periods of isolation, wellbeing may be supported by:

- receiving one visitor at a time (this does not include visiting professionals)
- going into outdoor spaces within the care home grounds through a route where they are not in contact with other care home residents – this should be supported where safe and possible given its importance in rehabilitation and to minimise the deconditioning impact of isolation

Individuals who test positive for COVID-19 should take part in daily lateral flow testing from day 5 (counting the day the symptoms started or the day of the original positive test if they did not have symptoms as day 0). They can end isolation after receiving 2 consecutive negative tests 24 hours apart, or after 10 days' isolation. Any individual who is unable to test should be isolated for the full 10 days from when the symptoms started, or from the date of the test if they did not have symptoms. Isolation should only be stopped when there is an absence of fever (less than 37.8°C) for 48 hours without the use of medication. For residents who continue to have a fever, clinical input should be sought early, to ensure best treatment and to avoid prolonging isolation.

Please note that different considerations apply for small care homes (defined as 1 to 10 beds). It is up to a service to determine and be prepared to evidence that small care home guidance applies to them if the size of the care home is above 10 beds. For example, if there are individual units or floors with completely separate staff and residents who do not mix with other staff and residents outside of this unit or floor.

For small care homes, if a resident has symptoms of a respiratory infection and has a temperature, or has symptoms of a respiratory infection and is too unwell to carry out their usual activities, or tests positive for COVID-19, they should be encouraged to follow the advice for the general population (/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19) which is to stay at home and avoid contact with others, especially those at higher risk of becoming seriously unwell if they are infected with COVID–19. Managers of small care homes should consider with residents and relatives on how best to apply this.

Small care homes should continue to act quickly to support individuals diagnosed with COVID-19 and are potentially eligible for COVID-19 antiviral treatment. Please refer to Access community-based treatments for coronavirus (COVID-19) (/guidance/access-community-based-treatments-for-coronavirus-covid-19) and Highest-risk patients eligible for COVID-19 treatments: guide for patients (/government/publications/highest-risk-patients-eligible-for-covid-19-treatments-guide-for-patients).

Care home residents who test positive for COVID-19

If a care home resident tests positive for COVID-19, it should be checked whether the resident is eligible for COVID-19 antiviral treatments. Please refer to Access community-based treatments for coronavirus (COVID-19) (/guidance/access-community-based-treatments-for-coronavirus-covid-19) and Highest-risk patients eligible for COVID-19 treatments: guide for patients (/government/publications/highest-risk-patients-eligible-for-covid-19-treatments-guide-for-patients). If they are eligible, support

should be given to ensure they can access treatment as quickly as possible. Their positive test should be reported (/report-covid19-result) as soon as possible which will enable a member of the COVID Medicines Delivery Unit (CMDU) to identify them and contact them within 24 hours. If not contacted within 24 hours, please contact the resident's GP or NHS 111 who can provide further support and assistance. Consideration should be given to having a smaller number of workers dedicated to supporting the person during their infectious period.

Pulse oximeters will be available to care homes through their named clinical lead, or local Integrated Care Board (ICB), as part of COVID oximetry at home. One oximeter per 10 beds with a minimum of 2 oximeters per home is recommended. Equipment which is used to support the monitoring of residents will need to meet infection control and decontamination standards and guidance.

The Care Provider Alliance has produced guidance on COVID oximetry at home (https://careprovideralliance.org.uk/coronavirus-oximetry-at-home-guidance-for-care-homes). Health Education England and West of England AHSN have also produced training and support for care home staff using pulse oximetry (https://portal.e-lfh.org.uk/Component/Details/679015).

Care homes should have a weekly check-in with the home's Primary Care Network (PCN) or multidisciplinary team, who can support staff to understand the RESTORE2 (https://www.hantsiowhealthandcare.org.uk/your-health/schemes-and-projects/restore2) and NEWS2 (https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/) scoring system as a way of monitoring residents with symptoms. If a patient's symptoms worsen, it is important to contact NHS 111 or the registered GP for a clinical assessment either by phone or face to face.

The resident's GP should give further advice on escalation and ensuring decisions are made in the context of the resident's advance care plan. In a medical emergency, the care home should dial 999.

Visiting arrangements in care homes

Access inside the care home

Contact with relatives and friends is fundamental to care home residents' health and wellbeing and visiting should be supported. There should not normally be any restrictions to visits into or out of the care home. The right to private and family life is a human right protected in law (Article 8 of the European Convention on Human Rights). In the event of an outbreak of COVID-19, each resident should (as a minimum) be able to have one visitor at a time inside the care home. This visitor does not need to be the same person throughout the outbreak. They do not need to be a family member and could be a volunteer or befriender. Additionally, end-of-life visiting should always be supported in all circumstances. See the section on 'Outbreak management' below.

It is important that any visitor follows the IPC processes put in place by the care home, such as practicing hand hygiene and wearing appropriate PPE and masks as outlined in the section on PPE recommendations. Visitors should consider taking up any COVID-19 and flu vaccines they are eligible for.

Visitors should not enter the care home if they are feeling unwell, even if they have tested negative for COVID-19, are fully vaccinated and have received their booster. Transmissible viruses such as flu, respiratory syncytial virus (RSV) and norovirus can be just as dangerous to care home residents as COVID-19. If visitors have symptoms that suggest COVID-19, they should avoid the care home until at least 5 days after they feel better. For other suspected or confirmed infections follow advice specific to that infection.

Precautions for visitors

Care homes should ask visitors to follow the same PPE recommendations as care workers, to ensure visits can happen safely, noting that additional requirements for face masks may be in place if the care setting is in an outbreak. This should be based on individual assessments, taking into account any distress caused to residents by use of PPE or detrimental impact on communication.

In the event that visitors are being asked to wear face masks, children under the age of 11 who are visiting may choose whether to wear face masks. However, they should be encouraged to follow other IPC measures such as practicing hand hygiene. Face coverings for children under the age of 3 are not recommended for safety reasons.

Care home residents should not usually be asked to isolate or take a test following high-risk visits out of the care home.

Individuals being discharged from hospital should continue to follow the guidance above on ‘Discharge from a hospital to a care home’.

Health, social care and other professionals may need to visit residents within care homes to provide services. Visiting professionals should follow the same advice as in the section above on visiting precautions. PPE usage is recommended in line with guidance above. NHS staff and Care Quality Commission (CQC) inspectors also have access to symptomatic testing and should follow the same guidance as staff about staying away from work if they test positive.

Outbreak management

Outbreak definition

An outbreak consists of 2 or more positive or clinically suspected linked cases of COVID-19, within the same setting within a 14-day period (this means where the cases are linked to each other and transmission in the care setting is likely). This applies to both staff and residents and includes PCR and lateral flow test results.

If an outbreak is suspected

If an outbreak is suspected, the care home should undertake a risk assessment as soon as possible to determine if the situation can be considered an outbreak and if outbreak management measures are needed. The provider should inform the HPT or other local partner of a suspected outbreak, but they are not required to wait for advice from the HPT (or other relevant local partner) should they feel able to initiate the risk assessment independently.

The risk assessment can be undertaken directly by the care home provider with the expertise of relevant care home staff, with further support also available from the local HPT (or other local partner such as community IPC team, local authority or ICB, according to local protocols) at the care home's request.

The risk assessment should determine if the cases are likely to have been the result of transmission within the care home. This is to assess whether the cases are linked. The risk assessment should consider whether:

- there is a known source of infection
- the initial individual with suspected or confirmed COVID-19 may have infected others while in the setting. For example, if the individual was in the setting while they were likely to be infectious (up to 2 days before symptoms onset or a positive test, and up to 10 days after)
- the initial individual had contact with the other individual or individuals with suspected or confirmed COVID-19 while they were likely to have been infectious
- the initial individual may have picked up the infection from the setting. This may be possible if the individual was in the setting during their incubation period (up to 14 days prior to symptom onset and/or a positive test)
- there are any factors which may increase the risk of transmission occurring in the setting

Cases would not be considered linked if:

- the cases were more than 14 days apart, from the earliest of symptom onset or a positive test
- the cases were in people who had not been in the care setting in the last 14 days
- the cases were among different staff members or residents in discrete units, floors or sections who are completely separate and do not mix
- a case or the cases were recently discharged from hospital and safely isolated under the care of cohorted staff

As noted above, the care home should inform the HPT (or other relevant local partner) of the outbreak with the option of contacting them for further advice if there are specific issues of concern. For example if:

- there is a higher number of deaths or hospitalisations than expected
- cases are increasing rapidly making it difficult to control the outbreak
- there are staffing shortages or concerns about safety within the care home

- there is a suspected outbreak of another infection in addition to COVID-19

The HPT may also provide advice if a variant of concern is identified or suspected.

If an outbreak is identified

If the risk assessment suggests that there are 2 linked positive cases of COVID-19 within the same setting within a 14-day period, then an outbreak should be declared.

In the event an outbreak is identified, the care home should implement whole home outbreak testing (alongside rapid response staff testing in the event of a single positive case as outlined in COVID-19 testing for adult social care services (/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings)) and consider further measures which may include, subject to decisions by relevant staff within the care home (with support from the HPT or another relevant local partner if and where required):

- proportionate reductions in communal activities
- proportionate reductions in admissions which may include temporary closure of the home to further admissions
- restriction of movement of staff providing direct care to avoid risk of outbreaks spreading between different settings
- proportionate changes to visiting: some forms of visiting should continue. One visitor at a time per resident should always be able to visit inside the care home. This number can be flexible in the case that the visitor requires accompaniment (for example if they require support, or for a parent accompanying a child). End-of-life visiting should always be supported

Any measures that the care home chooses to implement must be proportionate, consider resident wellbeing, the care home's legal obligations, and be risk-based. The care home manager should ensure staff, residents and their loved ones are informed of the outbreak and any relevant measures that have been implemented.

As noted above, in specific situations, where the local or national risk assessment indicates that cases may be caused by a variant with vaccine escape potential or other concerns, additional measures may be advised by the HPT or other local partner.

In the event of an outbreak in a care home, outbreak restrictions will be in place for different lengths of time. Please refer to 'COVID-19 testing for adult social care services' link above, for further details on declaring the outbreak over.

Outbreak testing

Outbreak testing is in place to help prevent further transmission once COVID-19 is within a setting, and to enable an outbreak to be declared over. This includes specific guidance for small care homes (defined as 1 to 10 beds). For information on testing in an outbreak and outbreak recovery testing, please see the 'COVID-19 testing for adult social care services' link above.

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