ARHAI Scotland

Antimicrobial Resistance and Healthcare Associated Infection

NHS National Services Scotland

COVID-19: Care Home Infection Prevention and Control (IPC) Addendum

Version 1.1, 25 January 2021

The purpose of this addendum is to provide COVID-19 specific Infection and prevention control (IPC) guidance for care home staff and providers on a single platform to improve accessibility.

IMPORTANT: Whilst guidance contained within this addendum is specific to COVID-19, staff must consider the possibility of infection associated with other respiratory pathogens spread by the droplet or airborne route and therefore Transmission Based Precautions (TBPs) should not be automatically discontinued where COVID-19 has been excluded.

Any resident who has a coinfection with COVID-19 must not be cohorted with other COVID-19 residents.

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6.1 COVID-19 case definitions and triage questions

6.1.1 Definition of a confirmed case

A laboratory confirmed (detection of SARs-CoV-2 RNA in a clinical specimen) case of COVID-19.

6.1.2 Definition of a suspected case

An individual meeting one of the following case criteria taking into account atypical and non-specific presentations in older people with frailty, those with pre-existing conditions and residents who are immunocompromised;

Community definition:

Recent onset new continuous cough

OR

Fever

OR

Loss of/change in sense of taste or smell (anosmia)

Definition for residents who may require hospital admission:

Clinical or radiological evidence of pneumonia

OR

Acute Respiratory Distress Syndrome

OR

Influenza like illness (fever ≥ 37.8°C and at least one of the following respiratory symptoms, which must be of acute onset; persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing)

OR

A loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms

6.1.3 Triaging of residents being admitted to a care home

Residents being admitted to the care home must complete a total of 14 days of isolation either starting on or including the date of transfer. Screening of residents for transfer purposes may only provide partial reassurance as infection may still develop subsequently at any time during the incubation period. See step down guidance for further details.

To aid single room prioritisation for residents who may be at most risk, admission triage should be undertaken to enable early recognition of potential COVID-19 cases. Wherever possible, triage questions should be undertaken prior to arrival at the care home. If the resident has capacity issues this should be undertaken with the individual's guardian or power of attorney.

Suggested questions for triage:

- **Do you or any member of your household/family have a confirmed diagnosis of COVID-19?**

  If yes, wait until self-isolation period is complete before admission or if urgent transfer is required, follow high risk category.

- **Are you or any member of your household/family waiting for a COVID-19 test result?**

  If yes, follow the high risk category.

- **Have you been an inpatient in hospital in the past 14 days?**

  If yes, follow the high risk category.

- **Have you travelled internationally to any country which isn't exempt from self-isolation rules in the last 14 days?**

  If yes, should wait for 14-day quarantine before admission to care home, or if urgent transfer is required, follow high risk category.

- **Have you had contact with someone with a confirmed diagnosis of COVID-19, or been in isolation with a suspected case in the last 14 days?**

  If yes, wait until self-isolation period is complete before admission or if urgent transfer is required, follow high risk category.

- **Do you have any of the following symptoms?**

  - High temperature or fever
  - New, continuous cough
  - A loss or alteration to taste or smell

  If yes, provide advice on who to contact (GP/HPT) and follow high risk category.

The Scottish Government website details quarantine (self- isolation) rules and information on the process for people entering the UK.

6.2 Resident Placement/Assessment of Infection Risk

Defined risk categories have been agreed at UK level to inform resident placement and the precautions required. Any other known or suspected infections must be taken into consideration before resident placement within each of the risk categories.

Examples of risk categories for care homes are described below and staff should familiarise themselves with these.

Details of the Low Risk Category are included here however it is expected that all residents in care home settings will fall into the Medium (Amber) or High (Red) risk categories. Guidance beyond this section will only refer to the medium and high risk categories.

1. **Known as the High Risk COVID-19 risk category in the UK IPC remobilisation guidance and is more commonly known as the red risk category.**

    a) Residents admitted from community or hospital and who are within the 14-day isolation period. (See Care Home Guidance for more information)

    b) Confirmed COVID-19 residents.

    c) Symptomatic or suspected COVID-19 residents (as determined by hospital or community case definition or clinical assessment where there is a suspicion of COVID-19 taking into account atypical and non-specific presentations in older people with frailty those with pre-existing conditions and patients who are immunocompromised).

    d) Those who are known to have had contact with a confirmed COVID-19 individual and are still within the 14-day self-isolation period and those who have been tested and results are still awaited.

    e) Residents who may be symptomatic but who decline or refuse the offer of testing.

2. **Known as the Medium Risk COVID-19 risk category in the UK IPC remobilisation guidance and may be commonly known as the amber risk category.**

    a) All residents who do not meet the criteria for the pathways above and who **do not** have any symptoms of COVID-19.

    b) Asymptomatic residents who refuse testing or for whom testing cannot be undertaken for any reason.

6.2.1 Staff cohorting

Efforts should be made as far as reasonably practicable to dedicate assigned teams of staff to care for residents in each of the high and medium risk categories. There should be as much consistency in staff allocation as possible, reducing movement of staff and the crossover between risk categories. Rotas should be planned in advance wherever possible, to take account of different risk categories and staff allocation. For staff groups who need to go between risk categories, efforts should be made to see residents on the medium risk categories, then the high risk category. Facemasks should be changed between risk categories.

6.2.2 Requirements for risk categories

Any resident on the medium risk category who develops symptoms of COVID-19 should be isolated on the high risk category immediately and tested for COVID-19 and notify your local Health Protection Team (HPT). Any resident who is asymptomatic and tests positive for COVID-19 should be then cared for as per the high risk category.

Care homes are likely to have residents with dementia and/or cognitive impairment and so staff are advised to conduct a local risk assessment to ascertain appropriate placement. This does not mean resident needs to move their room or be moved to a different area but advises of the relevant risk category precautions that require to be put in place.

6.2.3 Resident Cohorting

Any resident who has a coinfection with COVID-19 and any other known or suspected infectious pathogen **must not** be cohorted with other COVID-19 residents.

Cohorting in care homes should be undertaken with care. Residents who are shielding (extremely high risk of severe illness) must not be placed in cohorts and should be prioritised for single occupancy rooms.

Where all single room facilities are occupied and cohorting is unavoidable, then cohorting could be considered whilst ensuring that:

- Confirmed COVID-19 residents are placed in multi-occupancy rooms together.

- Suspected COVID-19 residents are placed in multi occupancy rooms together.
- Confirmed and suspected residents should not be cohorted together.

6.2.4 Discontinuing IPC precautions in care homes for residents who are COVID-19 positive

Before IPC control measures are stepped down for COVID-19, it is essential to first consider the ongoing need for **transmission based precautions** (TBPs) necessary for any other alert organisms, e.g. MRSA carriage or *C. difficile* infection, or patients with ongoing diarrhoea.

Key notes to be referred to in conjunction with table 1 below;

- **Completing the 14 day isolation period** - – In care homes residents must complete 14 days isolation. This is because there are considerable numbers of immunocompromised and vulnerable residents who will be at risk of nosocomial infection.

- **COVID-19 clinical requirements for stepdown** – Clinical improvement with at least some respiratory recovery. Absence of fever (>37.8oC) for 48 hours without use of antipyretics. A cough or a loss of/ change in normal sense of smell or taste may persist in some residents, and is not an indication of ongoing infection when other symptoms have resolved.

- **Testing required for stepdown** – No testing is required routinely to stepdown IPC precautions in a care home. Additional testing may be required during outbreaks. See **Interim guidance on COVID-19 PCR testing in care homes and the management of COVID-19 PCR test positive residents and staff.**
  For adults without the capacity to consent to a test, see **Coronavirus (COVID-19): clinical and practice guidance for care homes** for further information.

Table 1 Stepdown requirements for care homes

	Number of isolation days required	COVID-19 Clinical requirement for stepdown*1	Testing required for stepdown	Transferring between risk categories on stepdown
Care home residents	14 days from symptom onset (or first positive test if symptom onset undetermined)	Absence of fever for 48 hours without use of antipyretics & at least some respiratory recovery	Not routinely required unless being discharged from hospital	Residents should be managed on the high risk category until criteria described in this table is met and can then transfer to the medium risk category
Care home staff	10 days from symptom onset (or first positive test if symptom onset undetermined)	Absence of fever for 48 hours without use of antipyretics & at least some respiratory recovery	Not routinely required	Staff can return to work as normal once criteria is met

Residents discharged from hospital to care homes

COVID-19 residents being discharged from hospital into a care home should have 2 negative tests prior to transfer back to the care home, unless there are overriding clinical reasons where this is not appropriate, prior to discharge. Note: an admission to hospital is considered to include only those patients who are admitted to a ward. An attendance at A&E that didn't result in an admission would not constitute an admission. On return to the care home, the resident must be managed as per the high risk category until the 14 day self-isolation period (Day 14 from date of symptom onset or date of positive test if asymptomatic) is complete.

6.3 Hand Hygiene

Hand hygiene is considered one of the most important practices in preventing the onward transmission of any infectious agents including COVID-19. Hand hygiene should be performed in line with section 1.2 of SICPs.

Hand hygiene is essential to reduce the transmission of infection in care home settings. All staff, residents and visitors should clean their hands with soap and water or, where this is unavailable, alcohol-based hand rub (ABHR) when entering and leaving the care home and when entering and leaving areas where care is being delivered.

Hand hygiene must be performed immediately before every episode of direct care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of personal protective equipment (PPE), equipment decontamination and waste handling.

Before performing hand hygiene:

- expose forearms (bare below the elbows)
- remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene)
- ensure finger nails are clean, short and that artificial nails or nail products are not worn
- cover all cuts or abrasions with a waterproof dressing

If wearing an apron rather than a gown (bare below the elbows), and it is known or possible that forearms have been exposed to respiratory secretions (for example cough droplets) or other body fluids, hand washing should be extended to include both forearms. Wash the forearms first and then wash the hands.

Staff should support any residents with hand hygiene regularly where required.

6.4 Respiratory and cough hygiene

Respiratory and cough hygiene is designed to minimise the risk of cross transmission of respiratory pathogens including COVID-19. The principles of respiratory and cough hygiene can be found in section 1.3 of SICPs.

Residents, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures which are:

- disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose – used tissues should be disposed of promptly in the nearest waste bin
- tissues, waste bins (lined and foot operated) and hand hygiene facilities should be available for residents, visitors and staff
- hands should be cleaned (using liquid soap and water if possible, otherwise using alcohol based hand rub (ABHR) after coughing, sneezing, using tissues or after any contact with respiratory secretions and contaminated objects
- encourage residents to keep hands away from the eyes, mouth and nose

Some residents may need assistance with containment of respiratory secretions; those who are immobile will need a container (for example a plastic bag) readily at hand for immediate disposal of tissues.

6.5 Personal Protective Equipment (PPE)

PPE exists to provide the wearer with protection against any risks associated with the care task being undertaken. PPE requirements as per standard IPC are detailed in section 1.4 of SICPs. PPE requirements during the COVID-19 pandemic are determined by the care pathways and are detailed in 6.5.1.

6.5.1 Extended use of Face Masks for staff and visitors

New and emerging scientific evidence suggests that COVID-19 may be transmitted by individuals who are not displaying any symptoms of the illness (asymptomatic or pre-symptomatic). The extended use of facemasks by all health and social care workers and the wearing of face coverings by visitors is designed to protect staff and residents and the full guidance and associated FAQs can be found at the following link on the Scottish Government's COVID-19 web page;

A poster detailing the 'Dos and don'ts' of wearing a face mask is available.

Extended use of face masks relates to the specific guidance that staff should wear Fluid Resistant (Type IIR) Surgical Mask (FRSM) at all times for the duration of their shift in the care home setting. Face masks must be removed and replaced as

necessary (observing hand hygiene before the mask is removed and before putting another mask on).

In Scotland, health and social care staff, within a care home setting, should be provided with Type IIR masks for use as part of the extended wearing of facemask.

6.5.2 Face masks for residents

Individuals receiving care are not required to wear a face mask/covering in their own home (which includes residents in a care home - unless in a medium or high-risk category). However, they may choose to and this should be respected.

Further information can be found in https://www.gov.scot/publications/coronavirus-covid-19-interim-guidance-on-the-extended-use-of-face-masks-in-hospitals-and-care-homes/.

Residents in a care home on medium or high risk categories would not be expected to wear a mask 24/7. Face masks, for those on a medium or high-risk category, should be used when receiving direct care or when unable to maintain 2 metre distancing. However, this may not always be possible and the guidance states: "if this can be tolerated and does not compromise care". Appropriate physical distancing and wider IPC measures are critical, with the use of face masks being a further line of defence

Where clinical waste disposal is not available, used face masks should be double bagged and disposed of in domestic waste.

6.5.3 PPE determined by COVID-19 risk categories

Table 2 details the PPE which should be worn when providing direct resident care in each of the COVID-19 care risk categories.

Type IIR facemasks should be worn for all direct care regardless of the risk category. This is a measure which has been implemented alongside physical distancing specifically for the COVID-19 pandemic. FRSMs should be changed if wet, damaged, soiled or uncomfortable and must be changed after having provided care for a resident isolated with a suspected or known infectious pathogen and when leaving resident areas on high risk categories.

Further guidance on glove use can be found in Appendix 5.

Table 2 PPE for direct resident care determined by risk category

	Gloves	Apron	Face mask	Eye face protection
Medium Risk Category	If contact with blood and body fluids (BBF) is anticipated, then Single use.	If direct contact with resident, their environment or BBF is anticipated, (Gown if splashing spraying anticipated), then Single use.	Always within 2 metres of a resident - Type IIR fluid resistant surgical face mask.	If splashing or spraying with BBF anticipated. Single use or reusable.
High Risk Category	Worn for all direct care. Single use.	Always within 2 metres of a resident (Gown if splashing spraying anticipated). Single-use.	Always within 2 metres of a patient - Type IIR fluid resistant surgical face mask.	Always within 2 metres of a resident. Single-use, *sessional or reusable following decontamination.

*Sessional use see section 6.4.7

6.5.4 Aerosol Generating procedures (AGPs)

An Aerosol Generating Procedure (AGP) is a procedure that can result in the release of airborne particles from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.

Below is the list of procedures for COVID-19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

- Respiratory tract suctioning*
- Dental procedures (using high speed devices such as ultrasonic scalers and high speed drills)
- High Flow Nasal Oxygen (HFNO)
- High Frequency Oscillatory Ventilation (HFOV)

- Induction of sputum using nebulised saline
- Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- Tracheal intubation and extubation
- Upper ENT airway procedures that involve respiratory suctioning

* NB: The available evidence relating to Respiratory Tract Suctioning is associated with ventilation. 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 only open suctioning beyond the oro-pharynx is currently considered an AGP i.e. oral/pharyngeal suctioning is not an AGP. The evidence on respiratory tract suctioning is currently being reviewed by the AGP Panel

Chest compressions and defibrillation (as part of resuscitation) are not considered AGPs; first responders can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other personnel who will undertake airway manoeuvres. On arrival of the team, the first responders should leave the scene before any airway procedures are carried out and only return if needed and if wearing AGP PPE.

Chest compressions and defibrillation (as part of resuscitation) are not considered AGPs; first responders (any setting) can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other clinicians to undertake airway manoeuvres. This recommendation comes from Public Health England and the New and Emerging Respiratory Viral Threat Assessment Group (NERVTAG). The published evidence view and consensus opinion can be found at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/phe-statement-regarding-nervtag-review-and-consensus-on-cardiopulmonary-resuscitation-as-an-aerosol-generating-procedure-agp--2.

Certain other procedures/equipment may generate an aerosol from material other than an individual's secretions but are not considered to represent a significant infection risk and do not require AGP PPE. Procedures in this category include:

- administration of humidified oxygen;
- administration of medication via nebulisation.

Note: During nebulisation, the aerosol derives from a non-resident source (the fluid in the nebuliser chamber) and does not carry resident-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol.

Staff should use appropriate hand hygiene when helping residents to remove nebulisers and oxygen masks.

For residents with suspected/confirmed COVID-19, any of the potentially infectious AGPs listed above should only be carried out when essential. The required PPE for AGPs should be worn by those undertaking the procedure and those in the room, as detailed above. Where possible, these procedures should be carried out in a single room with the doors shut. Only those staff who are needed to undertake the procedure should be present.

It is the responsibility of care home providers to ensure that all staff have been fit tested for FFP3 respirators, when appropriate. If you do not anticipate the need for FFP3 respirators and are not caring for anyone currently receiving AGPs such as CPAP, these should not be ordered or stockpiled and any surplus stock should be returned.

A Situation, Background, Assessment and Recommendations (SBAR) has been produced by Health Protection Scotland (HPS)/ARHAI Scotland and agreed by New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) specific to AGPS during COVID-19.

The NERVTAG consensus view is that the HPS document accurately presents the evidence base concerning medical procedures and any associated risk of transmission of respiratory infections and whether these procedures could be considered aerosol generating. NERVTAG supports the conclusions within the document and supports the use of the document as a useful basis for the development of UK policy or guidance related to COVID-19 and aerosol generating procedures (AGPs).

Airborne precautions **are required** for the medium and high risk categories where AGPs are undertaken and the required PPE is detailed in table 3.

Table 3: PPE for Aerosol generating Procedures determined by pathway

	Gloves	**Apron/ Gown**	**Face mask/ Respirator**	**Eye face protection**
Medium Risk Category	Single use	Gown – Single use	FFP mask or Powered respirator hood	Single use or re-useable
High Risk Category	Single use	Gown – Single use	FFP mask or Powered respirator hood	Single use or re-useable

6.5.6 Post AGP Fallow Times (PAGPFT)

Time is required after an AGP is performed to allow the aerosols still circulating to be removed/diluted. This is referred to as the post AGP fallow time (PAGPFT) and is a function of the room ventilation air change rate.

The post aerosol generating procedure fallow time (PAGPFT) calculations are detailed in table 4. It is often difficult to calculate air changes in areas that have natural ventilation only. All point of care areas require to be well ventilated. Natural ventilation, provides an arbitrary 1-2 air changes per hour. To increase natural ventilation in many community health and social care settings may require opening of windows. If opening windows staff must conduct a local hazard/safety risk assessment.

If the area has zero air changes and no natural ventilation, then AGPs should not be undertaken in this area.

The duration of AGP is also required to calculate the PAGPFT and staff are therefore reminded to note the start time of an AGP. It is presumed that the longer the AGP, the more aerosols are produced and therefore require a longer dilution time. During the PAGPFT staff should not enter this room without FFP3 masks. Residents, other than the resident on which the AGP was undertaken, must not enter the room until the PAGPFT has elapsed and the surrounding area has been cleaned appropriately. As a minimum, regardless of air changes per hour (ACH), a period of 10 minutes must pass before rooms can be cleaned. This is to allow for the large droplets to settle. Staff must not enter rooms in which AGPs have been performed without airborne precautions for a minimum of 10 minutes from completion of AGP. Airborne precautions may also be required for a further extended period of time based on the duration of the AGP and the number of air changes (see table 4). Cleaning can be carried out after 10 minutes regardless of the extended time for airborne PPE.

Table 4: Post AGP fallow time calculation:

Duration of AGP (min)	Air change rate (AC/h)									
	1	2	4	6	8	10	12	15	20	25
3	230	114	56	37	27	22	18	14	10	8* (10)
5	260	129	63	41	30	24	20	15	11	8*(10)
7	279	138	67	44	32	25	20	16	11	9*(10)
10	299	147	71	46	34	26	21	16	11	9*(10)
15	321	157	75	48	35	27	22	16	12	9*(10)

*The minimum fallow time (to allow for droplet settling time) is 10 minutes

6.5.7 Sessional use of PPE

During the peak of the pandemic, some PPE was used on a sessional basis and this meant that these items of PPE could be used moving between residents and for a period of time where a member of staff was undertaking duties in an environment where there was exposure to COVID-19. A session ended when the member of staff left the care setting or exposure environment.

As supplies of PPE are now sufficient, sessional use of PPE **is no longer required** other than when wearing a visor/eye protection in a communal area where residents in high risk pathway and when wearing a fluid resistant surgical face mask (FRSM) across all pathways.

FRSMs can be worn sessionally when providing direct care or as part of extended use of facemask policy. FRSMs and visors or eye protection must be changed if wet, damaged, soiled compromised or uncomfortable or after having provided care for a resident isolated with a suspected or known infectious pathogen and when leaving high-risk (red) pathway areas. The same principles should be observed for staff post toilet and meal breaks, when a new face mask should be put on, once removed the FRSM must **never** be reused.

Employers are encouraged to plan breaks in such a way that allows 2 metre physical distancing and therefore staff not having to wear a face mask, with natural ventilation where possible.

6.6 Safe management of Care Equipment

Care equipment is easily contaminated with blood, other body fluids, secretions, excretions and infectious agents. Consequently, it is easy to transfer infectious agents from communal care equipment during care delivery. All care equipment should be decontaminated as per Table 5.

Table 5– Equipment cleaning determined by risk category

Pathway	Product
Medium Risk Category	Combined detergent/disinfectant solution at a dilution of 1000 ppm av chlorine or general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm av chlorine.
High Risk Category	Combined detergent/disinfectant solution at a dilution of 1000 ppm av chlorine or general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm av chlorine.

6.7 Safe Management of the Care Environment

There are many areas in care homes that become easily contaminated with micro-organisms (germs) for example toilets, waste bins, kitchen surfaces.

Furniture and floorings in a poor state of repair can harbour micro-organisms (germs) in hidden cracks or crevices.

To reduce the spread of infection, the environment must be kept clean and dry and where possible clear from litter or non-essential items and equipment.

Maintaining a high standard of environmental cleanliness is important in care homes as residents living there are often elderly and vulnerable to infections.

During this ongoing pandemic, cleaning frequency of the environment should be increased across **all** risk categories. A minimum of 4 hours should have elapsed between the first daily clean and the second daily clean. Where a room has not been occupied by any staff or residents since the first daily clean was undertaken, a second daily clean is not required.

It is the responsibility of the person in charge to ensure that the care environment is safe for practice (this includes environmental cleanliness/maintenance). The person in charge should consider and implement what improvements are required if this is deficient.

The care home environment should be:

- visibly clean, free from non-essential items and equipment to facilitate effective cleaning;
- well maintained and in a good state of repair.

Environmental cleaning in the Medium and High Risk COVID-19 categories should be undertaken using either a combined detergent/disinfectant solution at a dilution of 1000 ppm available chlorine or a general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm.

Cleaning across the categories is summarised in table 6.

Table 6 – Environmental cleaning determined by risk category

	1st daily clean	**2nd daily clean**	**Product**
Medium Risk Category	Full clean.	High Risk Touch Surfaces within resident areas.	Combined detergent/disinfectant solution at a dilution of 1000 ppm av chlorine or general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm av chlorine.

	1st daily clean	2nd daily clean	Product
High Risk Category	Full clean.	High Risk Touch Surfaces within resident areas.	Combined detergent/disinfectant solution at a dilution of 1000 ppm av chlorine or general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm av chlorine.

*High risk touch surfaces as a minimum should include door handles/push pads, taps, light switches, lift buttons. Resident areas should include the resident bedroom and any treatment areas and staff rest areas.

Any areas contaminated with blood and body fluids across any of the 2 pathways require to be cleaned as per Appendix 9 of the National Infection Prevention Control Manual (NIPCM).

Decontamination of soft furnishings may require to be discussed with the local HPT/ICT. If the soft furnishing is heavily contaminated, you may have to discard it. If it is safe to clean with standard detergent and disinfectant alone then follow appropriate procedure.

6.8 Safe Management of Linen

All linen should be handled as per section 1.7 of SICPs – Safe Management of Linen

Linen used on residents in the High and Medium Risk categories should be treated as infectious.

6.9 Safe Management of Blood and Body Fluid Spillages

All blood and body fluid spillages across the 3 pathways should be managed as per section 1.8 of SICPs – Safe management of Blood and Body Fluid Spillages and Appendix 9.

6.10 Safe Disposal of waste (including sharps)

Waste should be handled in accordance with SICPs. All waste belonging to the confirmed and suspected residents/individuals should be disposed of as clinical

waste where clinical waste contracts are in place. If the care home has a clinical waste contract, all waste belonging to the affected individuals can be placed in the clinical waste and disposed of immediately. There is no need to hold waste for 72 hours where a clinical waste stream is available.

If the care home does not have a clinical waste contract, ensure all waste items that have been in contact with the resident (e.g. used tissues and disposable cleaning cloths) are disposed of securely within disposable bags. When full, the plastic bag should then be placed in a second bin bag and tied. These bags should be stored in a secure location (not a resident's bedroom) for 72 hours before being put out for collection.

6.11 Occupational Safety

Section 1.10 of SICPs remains applicable to COVID-19 residents.

Occupational risk assessment guidance specific to COVID-19 can also be found here

PPE is provided for occupational safety and should be worn as per Tables 2 and 3.

6.11.1 Car/vehicle sharing for Staff

Wherever possible, car sharing should be avoided with anyone outside of your household or your support bubble. This is because the close proximity of individuals sharing the small space within the vehicle increases the risk of transmission of COVID-19. All options for travelling separately should be explored and considered such as:

- Staff travelling separately in their own cars to and from work;
- Geographical distribution of visits (if this is required)– consider if these can be carried out on foot or by bike;
- Use of public transport where social distancing can be achieved via use of larger capacity vehicles;

However, it is recognised that there are occasions where car sharing is unavoidable such as:

- Staff who carry out community visits;
- Staff who are commuting with residents as part of supported care;
- Staff who are commuting with students as part of supported learning/mentorship;
- Staff living in areas where public transport is limited and car sharing is the only means of commuting to and from the workplace;

Where car sharing cannot be avoided, individuals should adhere with the guidance below to reduce any risk of cross transmission;

- Staff (and students) must not travel to work/car share if they have symptoms compatible with a diagnosis of COVID-19;
- Ideally, no more than 2 people should travel in a vehicle at any one time;
- Use the biggest car available for car sharing purposes;
- Car sharing should be arranged in such a way that staff share the car journey with the same person each time to minimise the opportunity for exposure. Rotas should be planned in advance to take account of the same staff commuting together/car sharing as far as possible;
- The car must be cleaned regularly (at least daily) and particular attention should be paid to high risk touch points such as door handles, electronic buttons and seat belts. General purpose detergent is sufficient unless a symptomatic or confirmed case of COVID-19 has been in the vehicle in which case a disinfectant should be used;
- Occupants should sit as far apart as possible, ideally the passenger should sit diagonally opposite the driver;
- Windows in the car must be opened as far as possible taking account of weather conditions to maximise the ventilation in the space;
- Occupants in the car, including the driver, should wear a fluid resistant surgical mask (FRSM) provided it does not compromise driver safety in any way;
- Occupants should perform hand hygiene using an alcohol based hand rub (ABHR) before entering the vehicle and again on leaving the vehicle. If hands are visibly soiled, use ABHR on leaving the vehicle and wash hands at the first available opportunity;
- Occupants should avoid eating in the vehicle;
- Passengers in the vehicle should minimise any surfaces touched – it is not necessary for vehicle occupants to wear aprons or gloves;
- Keep the volume of any music/radio being played to a minimum to prevent the need to raise voices in the car;

Adherence with the above measures will be considered should any staff be contacted as part of a COVID-19 contact tracing investigation.

6.12 Caring for someone who has died

The IPC measures described in this document continue to apply whilst the individual who has died remains in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living individuals. Where the deceased was known or suspected to have been infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted. Body bags may be used for other practical reasons such as maintaining dignity or preventing leakage of body fluids.

For further information, please see the following guidance produced by Scottish Government Coronavirus (COVID-19): guidance for funeral directors on managing infection risks.

6.13 Visiting in care homes

The Scottish Government has produced **COVID-19: adult care homes visiting guidance** which outlines a staged approach to the re-introduction of extended visiting to adult care homes. The phasing allows for increased numbers of visitors, frequency of visits and outdoor and window visits progressing to indoor visits over time. Care homes should familiarise themselves with the content to ensure resident, staff and visitor safety. The Scottish Government guidance can be found here. This includes guidance and information leaflets for family and friends.

The guidance follows a staged process towards a return to communal life, providing there is no ongoing outbreak.

Non-essential visiting can be suspended if an outbreak is declared by the local HPT. A care home may only consider visiting if they have been COVID free / or fully recovered as agreed with the local HPT for 14 days from last date of COVID symptoms and subject to a Health Protection Team (HPT).

There are two main sets of guidance for care homes, focussed on resuming:

- visiting by friends and family
- visits into the home by volunteers, spiritual/faith representatives and professionals
- wellbeing activities.

Visitors must be informed of and adhere to IPC measures in place, including face coverings, hand hygiene, physical distancing and not attending with COVID-19

symptoms or before a period of self-isolation has ended, whether identified as a case of COVID-19 or as a contact. Visitors should wear face coverings in line with current Scottish Government guidance (see section 6.5.1)

A log of all visitors must be kept, which may be used for **Test and Protect** purposes.

All visitors must:

- Not visit if they have suspected or confirmed COVID-19 or if they have been advised to self-isolate for any reason;
- Wear a face covering on entering the facility;
- Be provided with appropriate PPE, if required (see table 7 below);
- Perform hand hygiene at the appropriate times;
    - on entry to the facility
    - Prior to putting on PPE
    - After removing PPE
- Observe physical distancing;
- Not move around the care home or the communal areas and should stay within the areas advised by staff;
- Not visit other residents in the facility;
- Not touch their face or face covering/mask once in place;
- Avoid sharing mobile phone devices with the individual unnecessarily – if mobile devices are shared to enable communications with other friends and family members, the phone should be cleaned between uses using manufacturer's instructions.

Table 7 – Visitor PPE

	Gloves	Apron	Face covering/mask	Eye/Face Protection
Medium Risk category	Not required*1	Not required*2	Face covering or provide with FRSM if visitor arrives without a face covering	Not required*3
High Risk category	Not required*1	If within 2 metres of patient	FRSM	If within 2 metres of patient

*1 unless providing direct care to the patient which may expose the visitor to blood and/or body fluids i.e. toileting.

*2 unless providing care to the patient resulting in direct contact with the patient, their environment or blood and/or body fluid exposure i.e. toileting, bed bath.

*3 Unless providing direct care to the patient and splashing/spraying is anticipated.

6.14 Physical distancing

All staff working in the care home must maintain 2 metres physical distancing wherever possible. This does not apply to the provision of direct resident care where appropriate PPE should be worn in line with section 6.5. Outbreaks amongst staff have been associated with a lack of physical distancing in recreational areas during staff breaks and when car sharing. There are many areas within a care home where maintaining 2 metres physical distancing is a challenge due to the nature of the work undertaken. Where 2 metres physical distancing cannot be maintained, staff must ensure they are wearing face masks/coverings in line with the extended use of facemasks guidance. See section 6.5.1.

Staff must adhere to physical distancing as much as possible and should;

- stagger tea breaks to reduce the number of staff in recreational areas at any one time.
- maintain 2 metre physical distancing when removing FRSMs to eat and drink.
- not care share with colleagues when commuting to and from work unless absolutely necessary. Where this is absolutely necessary, staff should sit as far apart as possible, wear a face covering or FRSM and keep windows open in the car to improve ventilation.

6.15 Resources & Tools

Additional COVID resources for care home settings can be found https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/information-and-guidance-for-other-settings/#title-container

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6.16 COVID-19 Compendium

Additional IPC resources can be found https://www.hps.scot.nhs.uk/web-resources-container/covid-19-compendium/