COVID-19: GUIDANCE FOR NURSING AND RESIDENTIAL CARE HOMES IN NORTHERN IRELAND

Contents

Version control

Version Control	Date of issue
Version 1.0	17th March 2020
Version 2.0	26th April 2020
Version 2.1 Changes made at Annex E - Contact Points for Independent Sector Staff Testing	3rd May 2020
Version 2.2 Changes made at Annex E – Trust testing contact points	7th May 2020
Version 2.3 Changes made at Paragraph 32 – to confirm that patients returned to Care Homes following attendance at ED	29th June 2020
Version 2.4 Paragraph 32 – clarifying that for residents who attend hospital for a short appointment/ assessment for non-COVID symptoms, and who are not admitted, are not required to isolate on return to the home in these circumstances. Paragraphs 62-63 provide updated advice on managing an outbreak. References to Reuse of Patients' Own Drugs Protocol removed (paragraph 65 in previous version) following withdrawal of this protocol. Paragraphs 72-86 – updated to reflect revised visiting guidelines published on 30 June 2020 (guidelines included at Annex J). Paragraphs 106-117 – PPE advice for staff updated.	16th July 2020

Paragraph 125 – amended to clarify that CEC COVID-19 programmes free of charge for all sectors. Annex B – updated pre-admission infection prevention and control risk assessment proforma. Annex E – updated contact advised for Western HSC Trust. Annexes F and G re-ordered – criteria for shielding now at Annex F and list of AGPs at Annex G.	
Version 2.5 Annex E – updated hyperlink to Employer Referral Portal	21st July 2020
Version 2.6 Paragraph 72 – Update to remind readers to refer to recently issued correspondence on visiting from the Department.	11th September 2020
Version 2.7 Paragraphs 73 to 83 – Inclusion of guidance on Christmas visiting to care homes	10th December 2020

Version 2.8 Paragraphs 25 – 34 setting out revised Discharges from a hospital setting Paragraphs 76 - 81 setting out further revisions to the guidance on Christmas visiting to care homes Annex B – Revised pre-admission infection prevention and control risk assessment proforma added.	21st December 2020
Version 2.9 Paragraph 75 – Setting out revisions to restrictions to visitors Paragraphs 76-79 – Setting out updated revisions to visiting to Care Homes from 15th January 2021	15th January 2021

COVID-19: Key messages for providers of residential and nursing care in Northern Ireland

- **Co-ordination** between care providers, the voluntary and community sector, and the HSC is critical to the success of the strategy for delaying and treating COVID-19.
- **Workforce:** providers and Trusts must plan in partnership, making the best use of all available assets, to ensure the availability and adequate training of staff.
- **Discharge:** Revised arrangements from hospital settings now in place based on latest scientific advice
- **Support:** The RQIA's Service Support Team (SST), which was operational during the crisis, has been stood down. However, Duty Desk Inspectors are available to support nursing and residential care home providers during this crisis.
- **Access to PPE:** Providers should work with suppliers to secure an adequate supply of PPE but will be supported by Trusts where they are unable to source items.

Introduction

1. This guidance is aimed at Health and Social Care Trusts and registered providers of accommodation for people who need personal or nursing care. In addition, there are also important messages for relatives and friends of those in nursing and residential homes.

For Health and Social Care Trusts

2. Trusts must continue to collaborate with all care home providers throughout the period of the COVID-19 pandemic. The Health and Social Care Board has sought approval to free up Trust resources in a number of areas to enable them to rapidly respond to, focus on and prioritise the needs and staff requirements associated with the impact of COVID-19.

Workforce

3. Trusts should continue to maintain contact with all registered nursing and residential homes in their Trust area, and with the RQIA's Service Support Team, to discuss and facilitate plans for support. This should

include ensuring each care home has a named contact in the Trust who can assist that care home in relation to staffing issues or other business continuity issues.

4. Trust should have developed robust contingency plans to support nursing and residential care homes in situations where the home's individual contingency plans have been exhausted. This may mean temporarily redeploying Trust staff to nursing and residential homes to ensure continuity of service. This may include support service staff such as cooks, catering and nursing assistants, as well as professional staff, such as nurses, occupational therapists and physiotherapists. Care homes should not be charged for Trust employed staff who move to work in a care home as a result of COVID-19 pressures.

5. Trusts should seek to ensure that multi-disciplinary support, including any appropriate medical input, is available to homes. Infection control support to homes is essential and Trusts should focus on ensuring homes that do not currently have an outbreak have the best possible infection control practices in place. Trusts will want to particularly consider the needs of residential homes, who will not have nursing support onsite.

6. Trusts should also consider whether domiciliary care workers, including those from the independent sector, could be deployed to support care homes.

7. Trusts should continue to make best use of all the assets available to the community. This will include the voluntary, community and social enterprise sectors as well as friends, families, carers or other volunteers where it is safe to do so. Trusts should consider how they can use existing contracts with the voluntary, community and social enterprise sector to support work related to COVID-19, including supporting residential and nursing homes.

8. Trusts should prioritise those identified through the HSC workforce appeal, and who have the right skills, for deployment with independent social care providers; or for use as backfill for existing members of staff who can be deployed. In addition Trusts should work with homes to consider whether any of the 3,000 volunteers who have registered with Volunteer Now can be deployed to support social care (but not in posts that are usually paid). Any deployment of staff or volunteers in this way must be in line with, and underpinned by, the signed agreement at **Annex A** which will ensure that appropriate safeguards are in place for both employees and employers.

9. This should include ensuring appropriate induction, clear delegation and supervision arrangements. Employers have responsibilities to ensure their staff are trained and supervised properly until they are competent in the particular environment. Employers should ensure, in particular, that there is an agreement with care homes that ensures work is appropriately delegated. For

nurses, this should be in line with guidance from Northern Ireland Practice and Education Council for Nursing and Midwifery (http://nipec.hscni.net/download/projects/currentwork/provideadviceguidanceinformation/delegationinnursingandmidwifery/documents/NIPEC-Delegation-Decision-Framework-Jan-2019.pdf). Most tasks carried out by 6 social care staff will not require any delegation process and will be carried out as part of their core duties and functions as agreed. However if delegation of a complex task to a care worker by another professional is required then Circular (OSS) 2/2018, *The Framework for the delegation of complex tasks to social care workers in Northern Ireland* should be followed. Staff will maintain their existing terms and conditions. Some common questions and answers on COVID-19 related staffing issues are available at https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff/questions-and-answers-hsc-staff#what-pay-will-i-receive-if-i-am-absent-from-work-due-to-covid-19-09-04-2020 which confirms staff will be paid if they off work because they are self isolating.

10. Trusts should ensure staff and volunteers are deployed to homes in a way which minimises the risk of transferring infections between care homes. This should mean staff only working in one home, as far as is practicable. It may also mean cohorting staff for care homes with and without infections or isolating some staff between working in different care homes.

11. Where Trusts have block booked hotels for staff who may need to live away from their family home, they should work with independent sector providers to make available any spare capacity for their use. Providers should not be charged for this.

Personal Protective Equipment (PPE)

12. Trusts must work with nursing and residential homes on the provision of appropriate PPE, where they are unable to source their own supplies. This must include ensuring providers are able to hold a buffer of stock, and ensure provision of PPE is in line with the advice provided on its use in the sections below. Trusts must work with care homes to understand requirements and prioritise stock across organisations, where there are any short term limitations on stock. Trusts should continue to ensure all nursing and residential homes have a named point of contact with whom to discuss PPE provision. Homes should not be charged for the provision of PPE from Trust stocks. The HSCB will work with Trusts to ensure all Trusts work towards a consistent approach in the provision of PPE – including how the level of stock to be held by providers is judged. The Department and the HSC are continuing to pursue all feasible PPE supply routes in order to ensure all providers will continue to be able to access the PPE they need.

Financial Support

13. Support should also be provided to ensure the financial resilience of care home providers. Where, as a result of the COVID-19 outbreak a nursing or residential care home's income reduces by greater than 20% below the past 3 months' average then Trusts should block purchase 80% of the vacated beds at the regional tariff. The Trust should then fill these beds as required over the next three months, taking account of the factors set out in this guidance and provided it is clinically safe to do so. If beds are still vacant at the end of that period a further review would be undertaken by the Trust working with the HSCB. Further consideration is being given to financial support for the sector to help meet the increased costs that providers are facing. These financial measures are time limited.

Discharge

14. Trusts will need to work with families and friends to ensure they understand that those deemed medically fit and waiting on a residential placement may be allocated the first place that is available, where clinically appropriate. This may not necessarily be the first choice for the individual, their family or friends but it is important to note that people can subsequently move to the home of their choice, once it becomes available. The timing of any move will need to take into account the need to limit movement between homes to ensure COVID-19 is not spread. Trusts will arrange any transfers as and when appropriate.

15. Trusts must, however, ensure that all individuals discharged to a care home have been subject to a COVID-19 test. Where the care home has the resources to isolate an individual they should accept new or returning residents discharged from hospital while test results are awaited. All new residents in care homes should be subject to isolation for 14 days as per infection control advice. The RQIA is currently assessing care homes to consider their ability to provide isolation facilities and will work with Trusts as necessary on this issue. Where care homes are unable to isolate individuals, Trusts should make arrangements for isolation of such patients in a suitable setting until they can be admitted to the care home.

16. A pre-admission infection prevention and control risk assessment proforma will assist nursing and residential care home managers to record relevant information regarding past or current infection. The risk assessment proforma is attached at **Annex B** for completion by the care home.

For Care Homes

Access to PPE

17. Where providers are unable to source appropriate Personal Protective Equipment (PPE) HSC Trusts will work with care homes to ensure they have the appropriate equipment available to them. The provision of PPE should reflect the relevant guidance https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe. Public Health England (PHE) issued guidance on 17 April 2020 regarding the reuse of PPE. Advice issued by the Chief Medical and Nursing Officers on the 19th April confirms this guidance has not been implemented in Northern Ireland at this point in time.

18. Providers must identify any particular issues (such as the requirement for PPE related to Aerosol Generating Procedures) (AGPs) in good time to Trusts.

19. A single point of contact (SPOC) available both in and out of hours has been identified in each Trust to be contacted directly by the providers to secure supplies. Details have been circulated to registered providers separately. Contact can be made both in and out of hours. Care homes will not be charged for any provision of PPE from Trust stocks. This is a time limited approach, related only to COVID-19.

20. In addition to this support, RQIA has set up a system whereby they will be notified daily by the Department of Finance of all offers of external assistance on PPE which are not deemed of a suitable scale for the HSC's Business Services Organisation to engage on. RQIA will notify all registered providers of these offers so they have the opportunity to engage directly with suppliers to purchase products. One hour later this information will be released to the wider procurement sector in the public sector.

21. The Department is continuing to monitor the provision of PPE to the independent care home sector. A very significant volume of PPE has been and will continue to be delivered to the independent sector.

Maintaining services

22. Care home providers should continue to implement contingency plans and continue to work with their usual suppliers, to secure long-term supplies of food,

pharmaceuticals, bed linen and other essential supplies. If there are any disruptions in supply, care homes should work with their local HSC Trust to consider how any essential support can be provided. Any disruptions should be flagged immediately.

23. Business continuity plans should be kept under review, with a specific focus on the workforce. Providers should continue to consider how they can increase capacity in the event of staff illness or absence. Providers should also assess their ability to isolate or cohort residents and be ready to do so.

24. Legislation has been changed so that workers can start after a barred list check and check of the Northern Ireland Social Care Council (NISCC) register, provided they are appropriately supervised and the normal pre-employment vetting information has been requested. Care homes should encourage new workers to apply for registration with the NISCC and they must do so within 6 months if still working.

25. NI Social Care Council (NISCC) registration fees have also been deferred for new applicants.

Discharges from a hospital setting

26. All hospitalised care home residents should be discharged as soon as they are fit, whether they are COVID-19 positive or not. Hospital staff will clarify with care homes the COVID-19 status of an individual, and any COVID-19 symptoms, during the process of transfer from a hospital to the care home. See Appendix B

27. Hospital staff should communicate to care home staff about the estimated date of discharge as soon as possible after admission and diagnosis. This communication should include the date and result of the first swab and the planned date of pre-discharge swab.

28. All hospitalised care home residents who have previously tested negative as part of hospital routine screening or the investigation of a recent illness should be tested for SARS-CoV-2 again 48 hours prior to discharge and the result of this repeat test relayed to the receiving organisation.

29. If a person is re-tested **within** 90 days from their initial illness onset or test date and found to still be positive for SARS-CoV-2, a clinically led approach should be used to interpret the result and inform subsequent action taking into account several factors, such as COVID-19 symptoms, underlying clinical

conditions, immunosuppressive treatments and conditions, and additional information such as cycle threshold values. The responsible clinician (e.g. GP or hospital consultant) should seek clinical advice from an infection control specialist/microbiologist as required.

30. Immunocompetent residents who have tested positive within the previous 90 days, and remain asymptomatic, should not be re-tested, unless advised by a clinician if they develop new respiratory symptoms. This is because fragments of inactive virus can be persistently detected by PCR in respiratory tract samples following infection, well after a person has completed their isolation period and is no longer infectious.

31. For asymptomatic people discharged into a care home and who have tested negative it is recommended that the individual still isolates for 14 days. Most homes will have the facilities to accept these discharges in line with assessments from the RQIA, Trust or PHA staff.

32. Any resident who tests positive and is being discharged within their 14 days isolation period should only be discharged to care homes that can provide effective isolation strategies or cohorting policies, in line with the current COVID-19 prevention policies.

33. Care homes should treat new residents in the following way:

    a) In the very small number of cases where individuals are discharged from hospital within the 14-day period from the onset of COVID-19 symptoms they should only be discharged to care homes that can provide effective isolation strategies or cohorting policies, in line with assessments from RQIA, Trust or PHA staff

    b) For asymptomatic people discharged into a care home and who have tested negative it is recommended that the individual still isolates for 14 days. Most homes will have the facilities to accept these discharges in line with assessments from the RQIA, Trust or PHA staff.

    c) For people who have previously tested positive for COVID-19, they should continue to appropriately isolate. Most homes will have the facility to accept these discharges in line with assessments from the RQIA, Trust or PHA staff.

    d) Most individuals being admitted to care homes from their own homes will have been self-isolating. However, care homes will want to risk assess the individual circumstances and agree with the new resident and their family whether it is appropriate to apply a 14 day isolation policy in each case.

34. A cough or a loss of, or change in, normal sense of smell or taste (anosmia) may persist in some individuals, and is not an indication of ongoing infection when other symptoms have resolved. . Seek clinical advice as required.

35. Cooperation between healthcare providers, the care home sector and other care providers–such as community palliative and hospice care is crucial in managing safe discharges from hospitals and ensure that potential impacts on patient flow are minimised. These collaborations should also have a long-term benefit, helping to improve medical care for care home residents by strengthening relationships between all those who provide them with care.

Reporting of COVID-19 cases

36. Where a single resident has been identified with symptoms of COVID-19, the requirement for testing should be discussed with the local Trust Care Home Support Team or equivalent. In the event that a test result is positive Health Protection Duty Room at the PHA on I&S must be notified.

37. It is important that potential clusters of cases are identified early so that immediate steps can be taken to prevent spread. If the definition of an outbreak (i.e. two or more cases within a 14 day period) is met for residents and/or staff, the person in charge of the care home should first contact the GP of each affected individual case to arrange clinical assessment. Liaison between the care home manager, GP, PHA and the Trust needs to be clear to ensure good communications and consistent practice when clusters emerge. Primary care services should be accessed as set out in paragraph 37. The care home management should then notify the Public Health Agency (PHA) duty room where a clinical risk assessment will be undertaken by the PHA duty officer with the care home manager (and if required, GPs). The PHA duty officer will advise the care home of what further appropriate action to take.

38. All staff and residents in a home where there is an outbreak will now be tested.

39. Where the PHA has requested that several residents are tested, PHA will be notified of the results. The home will receive notification of results via normal processes.

Support from GPs

40. GPs will continue to provide support to their patients in care homes. In particular, GPs will provide each patient with an Advanced Care Plan. GP practices will also provide care homes with telephone triage, advice and support throughout a patient's illness.

41. However, unless the practice deems it inappropriate, any call requiring a visit to the care home will be passed to the relevant Covid Centre. Care homes may be asked to submit a standard template of information to support the GPs clinical decision making.

Caring for residents, depending on their COVID-19 status

COVID-19 positive cases

42. If you are caring for a resident who has been discharged from hospital and has tested positive for COVID-19, the discharging hospital will provide you with the following information upon discharge: -

- The date and results of any COVID-19 test;
- The date of the onset of symptoms; and
- A care plan for discharge from isolation.

43. **Annex C** provides further information on the appropriate isolation required for care home residents who have been discharged from hospital following treatment for COVID-19.

Keeping asymptomatic residents safe and monitoring symptoms

44. Care home providers should follow social distancing measures (https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults) for everyone in the care home, wherever possible, and the shielding (https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19) guidance for those in the extremely vulnerable group.

45. Enhanced measures should be put in place to seek to protect residents. This should include additional cleaning, restricting residents to their rooms as far as

possible and strictly limiting any use of communal areas (in line with social distancing guidance). Homes may wish to encourage residents to take meals in their rooms (provided this can be overseen safely) and should manage any use of communal dining rooms to ensure social distancing is maintained. Homes may wish to encourage staff to change their clothes on arrival to homes and to ensure they continue to wash their uniforms before each shift in line with the infection control manual (https://www.niinfectioncontrolmanual.net/).

46. As far as possible homes should seek to limit turnover in staff they use and seek to limit the number of staff moving between different homes. This might include block booking agency staff to ensure consistency. We recognise that there may be a tension between ensuring homes are appropriately staffed and minimising the number of different staff members working in the home.

47. As far as possible staff should work in groups who are limited to particular groups of patients and/or parts of the care home.

48. We are also strongly supportive of care home workers sleeping in homes, providing that can be done safely and with due regard to the need to ensure social distancing between staff when not working and with the agreement of workers. We are considering how we can provide support to these initiatives.

49. As part of their employer's duty of care, providers have a role to play in ensuring that staff understand and are adequately trained in safe systems of working, including donning and doffing of personal protective equipment.

50. **All care homes should be monitoring unaffected residents and staff twice daily.** Staff working while symptomatic is a key risk for the spread of infection in a home. Monitoring should involve temperature taking, asking about and looking out for the following symptoms:

    - a fever (≥37.8°C)
    - a new persistent cough, or worsening of an existing cough
    - new or worsening shortness of breath

    However, staff should be aware that symptoms may be atypical in care home residents (see paragraph 56).

51. Staff and residents should made aware of what to do if someone develops any of the above symptoms. Homes may wish to display the poster available at https://www.publichealth.hscni.net/publications/guidance-management-covid-19-care-homes-and-other-residential-facilities

52. Monitoring is particularly important for residents with dementia and cognitive impairment who may be less able to report symptoms because of communication difficulties. Staff should be alert to the presence of other signs that the resident is unwell as well as symptoms of the virus. This could include delirium and changes in behaviour, which people with dementia are more prone to suffer from if they develop an infection.

53. For people with a learning disability, autism or both we suggest that you read this guidance https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0031Specialty-guideLD-and-coronavirus-v1-24-March.pdf which has good information about the additional things to do if you are caring for this group of people.

54. For residents with dementia, a learning disability or mental health issues there may be challenges maintaining the protective measures. Implementing measures including isolation and social distancing may have adverse effects that need to be considered.

55. These factors may be more marked for these residents who may be at increased risk of becoming anxious, frustrated and distressed by isolation or social distancing measures. Therefore consistency in familiar and daily routines should be maintained as much as possible. The appropriate use of language and suitable methods of communication, such as easy read or pictorial literature, or communication passports, will need to be considered.

56. The use of PPE may also increase anxiety and distress in a resident with dementia, learning disability or with mental ill health, or evoke an unexpected reaction. Staff should implement proactive measures that explain their appearance in ways that the person understands, in trying to minimise any negative reaction.

57. It may also be more difficult to implement and monitor measures like isolation, social distancing, frequent hand hygiene and good respiratory hygiene. Consideration should be given to cohorting where possible, regular assistance with hand washing and provision of individualised activity.

58. Where it has proved difficult or detrimental to help residents stay in their own room, social distancing measures must be implemented in any shared spaces. Alternative ways to meet specific and sensory needs should be explored. Restraint should not be used to manage social distancing.

Symptomatic residents

59. Symptoms may be atypical or more nuanced in older people with co-morbidities in care homes who may present with Influenza Like Illness (ILI),

respiratory illness, new onset confusion, reduced alertness, reduced mobility, increased falls, delirium, or diarrhoea and sometimes do not develop fever. A dry cough may develop late. Such changes should alert staff to the possibility of a new COVID-19 infection. Homes therefore need to be extremely vigilant to changes in residents and be particularly alert to any unexplained deaths. Definitions of COVID-19 cases and contacts are at **Annex D**.

60. Any resident presenting with symptoms of COVID-19 should promptly be isolated. This should be in in a single room with an ensuite bathroom, where possible. Staff should immediately instigate full infection control measures to care for the resident with symptoms, which will avoid the virus spreading to other residents in the care home and stop staff members becoming infected.

61. Advice is available on the PHA website (https://www.publichealth.hscni.net/) or from the RQIA (https://www.rqia.org.uk/) or through the Service Support Team (SST). NHS 111 can be contacted for advice. If further clinical assessment is required, the resident's GP should be contacted.

62. Homes should continue to monitor the resident and if symptoms worsen during isolation or are no better after 7 days, contact the resident's GP for further advice around escalation and to ensure person-centred decision making is followed.

63. For residents with dementia, learning disability or mental ill health there may be challenges in maintaining a period of isolation. Support with regular handwashing and good respiratory hygiene will be essential. Anticipating needs such as hunger, thirst, pain, or wishing to use the toilet, alongside provision of purposeful activity and appropriate levels of supervision for both the individual and throughout the care home may help to facilitate isolation. Virtual methods for contacting family and friends should be explored. Consideration may have to be given to use of fluid resistant surgical masks for a resident who cannot tolerate isolation and who will agree to wear a mask. Restraint should not be used to manage isolation.

64. Useful guidance developed by the Northern Trust on COVID-19 and dementia will be issued separately.

Managing an outbreak

65. COVID-19 should be suspected in any resident with a persistent cough (with or without sputum), nasal discharge or congestion, hoarseness, sore throat, wheezing, sneezing, loss of sense of smell or taste, or high temperature (at least 37.8°C). However, COVID-19 in care home residents can present with non-respiratory symptoms. These include loss of appetite, new onset/worsening confusion, or diarrhoea. Care home staff, with detailed

knowledge of residents, is well-placed to intuitively recognise these subtle signs ('soft signs') of deterioration. We encourage care home managers/senior staff to discuss any atypical symptoms of concern with the dutyroom for advice and risk assessment.

66. It is important to identify both single cases and potential clusters of cases. Early identification allows immediate steps to be taken to prevent spread. If you have single cases or potential clusters of cases in residents and/or staff, the person in charge of the facility should:

    - contact the GP of each affected individual case to arrange clinical assessment.
    - For a medical emergency dial 999 and advise the call handler of the presence of COVID-19 symptoms.
    - In the event of a suspected outbreak (defined as 2 or more people meeting the case definition for a possible or probable case of COVID-19, within the same 14 day period amongst staff or residents), the Health Protection Duty Room, PHA must be notified on I&S I&S This line is open Monday-Friday 9am-5pm. The PHA will provide expert advice and support.

Supporting existing residents who may require hospital care

67. If you think one of your residents may need to be transferred to hospital for urgent and essential treatment, consider the following checklist:

(a) If a resident shows signs of deterioration

Assess the appropriateness of hospitalisation: consult the resident's Advance Care Plan/Treatment Escalation Plan and discuss with the resident and/or their family member(s) as appropriate following usual practice to determine if hospitalisation is the best course of action for the resident. Consider whether support from services such as Acute Care at Home teams is appropriate.

(b) If hospitalisation is required and the resident has suspected or confirmed Covid-19:

- Follow Infection Prevention and Control guidelines for patient transport; and
- Inform the receiving healthcare facility that the incoming patient has COVID-19 symptoms.

(c) If hospitalisation is not required and the resident has suspected or confirmed Covid-19:-

- Follow infection prevention and control, and isolation procedures and consult the resident's GP for advice on clinical management / end of life care as appropriate.

(d) If a resident requires support with general health needs:-

- Consult the resident's Advance Care Plan;
- Consult the resident's GP and community healthcare staff to seek advice.

(e) Postpone routine non-essential medical and other appointments:-

- Review and postpone all non-essential appointments (medical and non-medical) that would involve residents visiting the hospital or other health care facilities; and
- If medical advice is needed to manage routine care, consider arranging this remotely via a phone call with the GP or named clinician.

Medicines Management

68. Existing arrangements should be used for the supply and delivery of medicines to care homes from community pharmacies. Good relationships between homes and pharmacies have been developed over many years and should be utilised and built upon at this time.

69. It is recognised that there will be particular medicines related challenges for patients with COVID-19 infection which may require medicines to be stopped or changed. Work will be undertaken to mobilise the skills of clinical pharmacists in Trusts and general practice to support staff and prescribers requiring medicines advice for critically ill patients.

Oxygen

70. It ~~is recognis~~ed that the demand for oxygen will be increased as COVID cases emerge within care settings. Work is being undertaken to enhance home oxygen services provided by BOC and community pharmacy in order to meet this need and ensure there is a reporting system to highlight risks of supply issues http://www.hscbusiness.hscni.net/pdf/letter%20oxygen%20NH%20covid%20patients%2010%20April.pdf

Providing care after death

71. The infection prevention and control (IPC) precautions described in this document continue to apply whilst an individual who has died remains in the care home. This is due to the ongoing risk of infectious transmission via contact, although the risk is usually lower than for those living.

72. Public Health England's (PHE's) Rare and Imported Pathogens Laboratory has assessed the post-mortem risk from people who have died of coronavirus (SARS-CoV2) infection and has identified little residual hazard apart from:

- potential droplet generation from artificial air movement during the initial care of the deceased; and
- post-mortem examination where the use of power tools take place, which is a risk for aerosol generation.

73. Guidance surrounding deaths and COVID-19 is available here https://www.health-ni.gov.uk/publications/covid-19-guidance-surrounding-death. Registered Nurses who have completed relevant training will still be able to verify life extinct (VLE) in the appropriate circumstances. (DoH (2020) Guidelines for Verifying Life Extinct (VLE) during COVID-19 pandemic).

74. The Public Health Agency advises the following actions upon the death of a care home resident with suspected or confirmed Covid-19:-

a. Once the person has died, all visits to the deceased person must stop. This includes visits from close family and friends.

b. The deceased person must:-

> remain in isolation in their own room if this is already in place.

> if not already isolated, this should be put in place immediately:-

- advise others not to enter the room.
- place signage on the door restricting entrance.

> if death occurs outside of the deceased's own room:

- all other residents in the vicinity should be moved to another room;
- they must maintain a distance of 2 metres from the deceased whilst in the same room and whilst being moved to another room; and
- They must continue to socially distance from each other in the room they are relocated to.

c. Care home staff must:

- not enter the deceased's room unless they are wearing appropriate PPE in line with standard infection control precautions. This includes disposable gloves, plastic apron, fluid resistant surgical mask and eye protection (if there is a risk of splashing);
- if not already done, place surgical mask over face and nose of the deceased;
- limit time in the isolation room and limit exposure to the environment in the isolation room;
- restrict access to the minimum essential staff only; and
- put a "do not enter" sign on the door.

d. Funeral Arrangements:-

- ensure that funeral directors are notified of the suspected or confirmed infectious condition including COVID-19;
- ensure funeral directors are wearing appropriate PPE when moving the deceased; and
- ensure a safe route for transfer of the deceased person from the premises to the funeral directors' vehicle. This should ensure that other residents and staff remain socially distanced.

e. Terminal Cleaning:-

- It is estimated that viable virus could be present for up to 48 to 72 hours on environmental surfaces in "room air" conditions. Once the room is vacated, terminal cleaning as per PHA guidelines is required. Appropriate PPE should be worn.

Restrictions on Visitors

75. All nursing and residential care homes should follow the Regional Principles for Visiting in Care Settings in Northern Ireland, originally published on 23 September 2020 and recently updated with effect from 15 January 2021. The full guidance is available on the Department of Health's website at https://www.health-ni.gov.uk/Covid-19-visiting-guidance

Visiting Care Homes - updated 15th January 2021

76. On 17 December 2020, the Executive announced new public health measures to take effect from 00.01 on 26 December 2020, and are intended to be reviewed after four weeks. The rationale for these additional restrictions is the need to respond to the increasing level of positive Covid-19 cases in NI, and to reduce the rapid spread of a new variant of coronavirus which has been identified. This new strain has been confirmed as more easily transmitted than other variants.

77. Following the early January recommendation of the 4 UK Chief Medical Officers to lift the Regional Alert level to Level 5, the Department has reviewed and revised the COVID Visiting Guidelines Unfortunately the updated guidelines introduce a much tighter set of restrictions, which will remain in place while the risk of transmission remains high.

78. In relation to Care Homes, the Alert Level 5 restrictions require that:

    (a) Indoor visiting in resident rooms for end of life visiting only;

    (b) Where the home is not in an outbreak, visiting should be facilitated where there are well ventilated designated rooms/visiting pods; and

    (c) Alternatives to face-to-face visiting for all others should be provided

79. As the situation remains extremely fluid there is a need to continually review and revise the approach to visiting arrangements within care homes

End of life visits

80. A resident may have indicated in their Advance Care Plan who they would like to visit as they approach end of life. If this has not been recorded, a resident approaching end of life should be asked where possible who they would like to visit. Family, next of kin and/or appropriate others may be able to advise where a resident is unable to provide this information themselves. All requirements in terms of the care home's visiting policy, which includes IPC measures, use of PPE etc. must be adhered to.

Communication with families and other visitors

81. Care homes should ensure good communication with families and friends on these restrictions and ensure ongoing communication to assure families and friends about the ongoing quality of care and wellbeing of residents. Care

homes should communicate the detail of their visiting policies to residents, family and other visitors.

82. Friends and family should be advised that their ability to visit care homes is still being controlled in accordance with regional guidance and the care home's risk assessment, and is subject to the specific circumstances of the care home and those living and working within it.

83. Where care homes are proposing to take a bespoke approach to a specific resident, it should seek to engage family and other likely visitors, as well as the resident where appropriate, in this decision.

84. We recognise that where homes have reduced staffing levels because of illness or self-isolation, families may find that opportunities to speak to staff or their relatives are more limited than they would wish. Trusts should consider how they can support homes with communication to families, just as they should be considering support in delivering care to residents.

85. As set out in paragraph 56 presentation of COVID-19 in care home residents may be atypical. Close communication with families may help to identify changes in behaviour, which could be an early indication of infection and allow care homes to better support the individual and guard against any spread of infection within the home.

Visits by Health and Social Care Professionals

86. Providers must ensure relevant Health and Social Care professionals continue to have access to residents where they need to in order to carry out any essential assessments or deliver care. In order to maintain a reduced footfall through Care Homes, virtual appointments should continue where the relevant HSC professional deems it appropriate and is able to facilitate. This will not be the case in all circumstances. Visiting professionals must adhere to all of the Care Home's IPC requirements, where it is necessary that they undertake a face to face appointment with a resident. Care Homes should not allow through-premises deliveries.

When it may be appropriate to move someone to a different home or facility

87. Advice on cohorting and isolation is included at **Annex C**. Cohorting and isolation within a nursing or residential home in order to limit spread of infection may in itself present unintended consequences, such as changes in behaviour, distress from being in an unfamiliar environment or increased levels of anxiety. This will also be the case if the option to move a resident out

of their usual care home to another facility is available and is being considered.

88. In extreme circumstances such moves can contribute to a rapid and critical deterioration in a resident's physical and mental health. Ideally care homes should aim to maintain as many usual routines as is possible. Where cohorting, isolation or relocation are under consideration, a discussion between the resident, and/or their relative/representative, the care home, the Trust and any other relevant persons should include holistic consideration of the benefits and risks of the proposed protective measure.

89. Interventions and measures that aim to limit unintended consequences should be agreed. All parties involved will need to understand that in most circumstances, these decisions will need to be taken quickly. It may therefore be helpful to undertake and record discussions that consider all available options in advance of such a situation arising.

Infection Prevention and Control (IPC) Measures

90. Care homes are not expected to have dedicated isolation facilities for people living in the home. However, they should implement isolation precautions when someone in the home displays symptoms of COVID-19 in the same way that they would operate if an individual had influenza or diarrhoea and vomiting, implementing the following precautions: -

- If isolation is needed, a resident's own room can be used. Ideally the room should be a single bedroom with en-suite facilities. Where this is not available, a dedicated bathroom near to the person's bedroom should be identified for their use only.
- Protective Personal Equipment (PPE) should be used in line with current guidance which can be accessed.
- Room door(s) should be kept closed where possible and safe to do so. Where this is not possible ensure the bed is moved to the furthest safe point in the room to try and achieve a 2 metres distance to the open door as part of a risk assessment.
- All necessary procedures and care should be carried out within the resident's room. Only essential staff (wearing PPE) should enter the resident's room.
- Entry and exit from the room should be minimised during care, specifically when these care procedures produce aerosols or respiratory droplets (AGPs).
- Ensure adequate appropriate supplies of PPE and cleaning materials are available for all staff in the care home.

- All staff, including domestic cleaners, must be trained and understand how to use PPE appropriate to their role to limit the spread of COVID-19.
- Dedicate specific medical equipment (e.g. thermometers, blood pressure cuff, pulse oximeter, etc.) for the use of care home staff for residents with possible or confirmed COVID-19. These should be single use devices only, provided they are available. It is no longer appropriate to share such equipment.
- Restrict sharing of personal devices (mobility devices, books, electronic gadgets) with other residents.

PPE disposal, cleaning and laundry

91. It is essential that used PPE is stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste within the room. This should be put aside for at least 72 hours before being disposed of as normal. Homes should have well-established processes for waste management. See https://www.niinfectioncontrolmanual.net/cleaning-disinfection

92. Nursing and residential homes should clean frequently touched surfaces. Personal waste (such as used tissues, continence pads and other items soiled with bodily fluids) and disposable cleaning cloths can be stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and disposed of as clinical waste. For those care homes that do not have clinical waste facilities, used PPE should be double waste bagged, tied securely and stored in the waste disposal area for 72 hours before placing in the waste disposal bin.

93. Dirty laundry should not be shaken. This will minimise the possibility of dispersing virus through the air. Items should be washed as appropriate in accordance with the manufacturer's instructions. Dirty laundry that has been in contact with an ill person can be washed with other people's items. Items heavily soiled with body fluids, such as vomit or diarrhoea, or items that cannot be washed, should be disposed of, with the owner's consent. If a resident has symptoms of COVID-19, staff should advise families who normally take their relative's laundry home to wash that the laundry must be washed by staff on-site.

Support and advice

94. Queries and contacts related to individual case management should continue to be directed to HSC Trusts.

95. RQIA has set up a Service Support Team. The work of this team will include provision and coordination of support to independent sector providers of nursing and residential care homes. This will involve (a) provision of guidance, advice and resolution, collation and coordination of information from Trusts for providers; and (b) collation of information for Trusts and Department from the sector to support clarity.

96. Care homes should contact a central RQIA number I&S or RQIA Update App https://rqiani.glideapp.io for all matters related to operational management of services. The SST service is available 7 days a week from 8.00am to 6.00pm and is supported by a range of inspectors with knowledge and expertise of the sector.

97. The Public Health Agency co-ordinates a dedicated team of infection and prevention control nurses, who will provide advice and guidance in the event of an outbreak.

98. In addition, the PHA will continue to re-direct resources previously focused on working to support care home transformation, to support homes in how they manage COVID-19 outbreaks and minimise the likelihood of infection.

Regulatory oversight

99. RQIA will work with providers to support them to make risk-assessed and evidence-based decisions using their professional judgement and knowledge and understanding of the people they provide services to. This will include RQIA working with providers to come to solutions to issues that may be outwith the letter of standards or regulations but which provide safe, pragmatic remedies to issues that could never have been planned for on this scale.

100. NISCC have made clear that their fitness to practice process will focus on high risk concerns.

For Care Staff

Testing for Care Home Staff

101. All symptomatic care home staff or care home staff who are self-isolating because a member of their household is symptomatic have access to testing. **Annex E** provides details of contact points to arrange these tests.

102. The significance of the results of any test will need to be considered. All care homes should have access to a Single Point of Contact in their local

Trust for return to work advice. Updates to the testing protocol will be provided as necessary to care homes, through the RQIA.

PPE – Advice for Staff

103. The use of PPE in Northern Ireland reflects UK-wide guidance, which is updated in line with new evidence. Staff working in care homes are advised to refer to the online guidance regarding PPE. Referring to the online guidance will ensure staff have access to the most up-to-date information. The most recent guidance is available at https://www.gov.uk/government/collections/coronavirus-covid-19-personal-protective-equipment-ppe.

Note: PPE is only effective when combined with:

> hand hygiene (cleaning your hands regularly and appropriately);
> respiratory hygiene
> avoiding touching your face with your hands, and
> following standard infection prevention and control precautions https://www.niinfectioncontrolmanual.net/

104. Public Health England (PHE) issued guidance on 17 April 2020 regarding the reuse of PPE. Advice issued by the Chief Medical and Nursing Officers on the 19th April, confirms this guidance has not been implemented in Northern Ireland at this point in time however proportionate and appropriate use of PPE is encouraged at all times based on risk assessment..

105. For direct patient/ resident care e.g. personal care, toileting and physical assistance (or within 2 metres of a patient/ resident who is coughing) with possible or confirmed cases of COVID-19 staff should use:

- Disposable gloves (single use)
- Disposable plastic apron (single use)
- Fluid-resistant (Type 11R) surgical mask (sessional use)
- Eye/face protection (sessional use if deemed required after a risk assessment because of e.g. the risk of contamination with splashes, droplets or blood or body fluids)

When performing a task requiring you to be within 2 metres of a resident but no direct contact with the patient/resident (i.e no touching) with possible or confirmed cases of Covid-19, e.g. meal rounds, medication rounds, prompting people to take their medicines, staff should use:

- Fluid-resistant (Type 11R) surgical mask (sessional use)
- Eye/Face protection (sessional use if deemed required after a risk assessment because of for example the risk of contamination with splashes, droplets or blood or body fluids).

- Disposable colour coded aprons in line with standard IPC precautions and/or food hygiene principles

Working in a communal area with possible or confirmed cases Covid-19 and unable to maintain 2 metres social distance staff should use a

- Fluid resistant (Type 11R) surgical mask (sessional use)

106. For direct care to any individual meeting criteria for 'shielding' (that is, those who are in a vulnerable group) in any setting, as a minimum, single use disposable plastic aprons and gloves, sessional use fluid resistant surgical mask must be worn for the protection of the patient. The criteria for an individual to be classed in a vulnerable group and subject to shielding in Northern Ireland are set out at **Annex F**. All individuals in this group should have received a letter from their GP stating that is the case.

107. If an individual is not in one of the vulnerable groups defined at **Annex F** they may still be in a group at increased risk of severe illness from coronavirus. This should be taken into account when making any risk assessments. Those at increased risk are defined in social distancing guidance: https://www.gov.uk/government/publications/covid-19-guidance-onsocial-distancing-and-for-vulnerable-people/guidance-on-social-distancing-foreveryone-in-the-uk-and-protecting-older-people-and-vulnerable-adults.

108. A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. In this guidance document, we refer to wearing masks and eye protection continuously until you take a break. The period of duty between your breaks is the equivalent to what we refer to as a "session" in the main PPE guidance.

109. Where you need to remove your mask (e.g. to take a drink or eat) then you need to replace it. Do not dangle your mask or eye protection around your neck or otherwise, and do not place it on a surface for later re-use.

110. When performing an Aerosol Generating Procedure (AGP) on an individual with a possible or confirmed case staff should use:

- Disposable gloves (single use)
- Disposable fluid repellent coverall gown (single use)
- Filtering face piece respirator (single use)
- Eye/face protection (single use)

111. HSC Trusts will act as a point of contact for all nursing and residential care homes to arrange to "fit test" of FFP3 masks for AGP equipment for staff, ensuring that each individual member of staff uses the appropriate size of protective equipment to ensure maximum protection from infection. Thereafter, where a filtering face piece respirator is necessary, it should be fit checked every time it is used. A list of AGPs is at **Annex G.**

112. A visual guide to PPE for both AGP and non-AGP patients can be found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachmentdata/file/878056/PHECOVID-19visualguideposterPPE.pdf. The PHA poster and factsheet provides guidance on protecting your skin from damage which can be caused by wearing a respirator mask https://www.publichealth.hscni.net/publications/keep-calm-and-protect-your-skin-poster-and-factsheet

113. In clinical areas, communal waiting areas and during transportation, it is recommended that residents with possible or confirmed COVID-19 cases wear a fluid resistant surgical face mask if this can be tolerated. The aim of this is to minimise the dispersal of respiratory secretions, reduce both direct transmission risk and environmental contamination.

114. A face mask should **not** be worn by patients if there is potential for their clinical care to be compromised (for example, when receiving oxygen therapy via a mask). A face mask can be worn until damp or uncomfortable.

Staff who come into contact with a COVID-19 patient

115. Care home staff who come into contact with a COVID-19 patient while not wearing PPE can remain at work. This is because in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing. These are guiding principles and there should be an individual risk assessment based on staff circumstances, for example staff who are vulnerable or at risk should be carefully assessed when assigning duties, and where a possible or confirmed COVID-19 case is present in a care home, efforts should be made to cohort staff caring for that person. Testing may be considered on the basis of a risk assessment which must be undertaken with the line manager, taking account of the care settings and a range of other factors. Further guidance on vulnerability can be found in the link above.

Staff safety

116. A risk assessment is required for health and social care staff at high risk of complications from COVID-19, including pregnant staff. Employers should:

- refer to the Government guidance on social distancing for vulnerable people at https://www.gov.uk/government/publications/covid-19-guidanceon-social-distancing-and-for-vulnerable-people
- ensure that advice is available to all staff, including specific advice to those at risk from complications.

117. Bank and agency staff should follow the same deployment advice as permanent staff.

118. In the event of a breach in infection control procedures, staff should be reviewed by their occupational health service where they have one.

119. As part of their employer's duty of care, providers have a role to play in ensuring that staff understand and are adequately trained in safe systems of working, including donning and doffing of personal protective equipment.

Staff training

120. All care home staff, including volunteers and temporary staff, should receive or refresh training and/or guidance on: a) infection prevention and control, and b) the use of PPE equipment.

121. The Northern Ireland Social Care Council has published a free resource on its learning zone on infection control, hand hygiene and using PPE - https://learningzone.niscc.info/learning-resources/96/supporting-good-infection-control.

122. The HSC Clinical Education Centre (CEC) provides training, including on-line infection prevention and control programmes (these are available at www.hsclearning.com). In addition there are new programmes from the CEC aimed at those staff who do not regularly look after respiratory patients and/or have limited ward/community based experience alongside a number of clinical skills type programmes to support staff dealing with respiratory patients. CEC programmes related specifically to COVID-19 are open free of charge to all sectors across Northern Ireland.

123. Care home providers should ensure that all domestic and catering staff have received up-to-date training and/or guidance on infection control in the context of food preparation and service and cleaning.

Professional Regulation

124. The Nursing & Midwifery Council (NMC) has provided guidance for nursing staff regarding their regulatory role during the Covid-19 emergency period. In addition, Northern Ireland Social Care Council (NISCC) has confirmed that their fitness to practice process will focus on high risk concerns.

Support for staff

125. Trusts should continue to open up their internal resources to care home staff. Psychological Support Helplines which are staffed by psychologists and psychological therapists are available to staff in the independent sector. They are available to provide appropriate support throughout the surge phase of the crisis. Helpline numbers and other resources are available on the PHA

website: https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff/staff-health-and-wellbeing

126. Free travel is available to those working as art of the health and social care system. A letter providing further details has recently been reissued to all care home providers.

Guidance on Deprivation of Liberty (DOL) provisions under the Mental Capacity Act

127. Where any admission to a care home amounts to deprivation of liberty, the Mental Capacity Act 2016 – Deprivation of liberty Safeguards must be adhered to. Any deprivation of liberty under the Mental Capacity Act / Deprivation of Liberty Safeguards must be authorised. The Act contains emergency provisions providing protection from liability even if all additional safeguards are not met. If a person takes all reasonable steps to put the additional safeguards in place the person is protected from liability. That means in some circumstances a deprivation of liberty can be treated as authorised, even if not authorised by a Trust panel.

128. However, the situation is only an emergency if all reasonable steps have been taken to put the safeguards in place. In all cases the person doing the deprivation of liberty must have reasonable belief that the person lacks capacity, that the deprivation of liberty is in the best interests and that the prevention of serious harm condition is met. Also, the use of the emergency provision must be considered on a case by case basis and cannot be used as a blanket measure not to put certain additional safeguards in place, such as authorisations.

129. Temporary measures are in place for the detentions under the Mental Capacity Act. Temporary Codes of Practice have, together with temporary forms, been published on the Department of Health's website www.health-ni.gov.uk/mca

Staff who experience Covid-19 symptoms

130. Advice is available on the PHA website (https://www.publichealth.hscni.net/news/covid-19-what-situation-northern-ireland#preventing-the-spread-of-infection) for staff who believe they have Covid-19 symptoms or who have a household member who experience symptoms. Staff who have COVID-19 symptoms should:

- Not attend work if they develop relevant symptoms, even if they are mild.

- Notify their line manager immediately.
- Seek appropriate testing (as below).
- If necessary, self-isolate for 7 days and follow the guidance for household isolation (https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection#laundry).

131. Care workers in critical frontline roles can access COVID-19 tests. However, using a negative result to allow someone to return to work is not completely without risk and will need to be carefully considered in line with advice from the Trust. The RQIA SST will also be able to provide advice if needed.

Annex A – Agreement between HSC and TUS - Transfer of staff to Independent Sector re COVID-19

TERMS OF AGREEMENT BETWEEN THE HSC AND AGENDA FOR CHANGE TRADE UNIONS REGARDING PROVISION OF PUBLIC-EMPLOYED STAFF TO SUPPORT THE INDEPENDENT CARE SECTOR IN THE CONTEXT OF COVID-19

This is a regional agreement and covers all HSC employers. There will be no variation from this document

1. The requirement for HSC staff to be deployed to the independent care sector will be based on an assessment by any independent sector care facility and the relevant area HSC Trust of the vulnerability of that facility caused by Covid-19. This will include a recorded assessment of the viability of the facility to provide a safe level of service, taking account of residents' illnesses, staffing issues, etc. The Department of Health, the Public Health Agency and/or the Regulation and Quality Improvement Authority should be consulted as required.

2. Trusts and providers will need to work together to ensure that any staff who are deployed in the independent sector have a full induction, guidance and skills training, and that all relevant registration requirements are followed. This must include issues such as fire training, how to escalate concerns, registration with the appropriate regulator, professional policy and practice and governance of the care home. Trusts and providers will agree on a framework and assurance process for this.

3. It is agreed that the requirement for HSC staff to deploy should only arise as a last resort, following the exhaustion of all other reasonable available avenues to source staff, including agency staff. This should form part of the recorded assessment mentioned in point 1. There should be a clear agreement in advance of the commencement of any redeployment as to the specific role to be undertaken by a worker.

4. The HSC agrees that before deploying staff to the independent sector, necessary risk and needs assessments will be carried out, and recorded to ensure that there is no unacceptable risk or unreasonable service impediment in publicly-provided services.

5. Any staff so deployed will maintain direct and professional line management from within the trust, continue to report to HSC management, and continue to be employed under Agenda for Change terms and conditions. They may take reasonable direction from independent care sector managers to ensure that they safely discharge their agreed role whilst in any independent care sector facility or service.

6. Staff redeployed will continue to carry out their role as HSC employees and are consequently fully indemnified in their role.

7. Staff will be asked to work within their sphere of competence and an assessment and agreement of appropriate staffing levels will facilitate this.

8. Most tasks carried out by social care staff will not require any delegation process and will be carried out as part of their core duties and functions as agreed. However if delegation of a complex task to a care worker by another professional is required the relevant guidance should be followed.

9. Registered nurses and nursing assistants must work to the Northern Ireland Practice and Education Council "Deciding to Delegate Framework: a decision support framework for nursing and midwifery". Nursing support may be required in a residential home where registered nurses are not normally employed.

10. It is agreed that in so far as possible, staff are not deployed on their own and that any deployment should involve a minimum of two staff.

11. Staff deployed will be given all reasonable information in relation to the status of the facility they are being asked to attend, including number of deaths, number of COVID-19 positive patients, number of suspected COVID patients and patient profile. This should also include comparable staff data. Trusts and providers shall address any information governance issues.

12. All staff must be provided with appropriate PPE and supply as required and as per Government and Trust guidelines

13. The HSC confirms that all Agenda for Change terms and conditions of employment continue to apply during such redeployments.

14. It is agreed that deployments will be voluntary and the process set out at Appendix 1 below should be followed and documented

15. Each HSC area Trust shall have a single point of contact for the independent care sector in its area and this shall be communicated to all necessary parties.

16. The operation of this agreement shall be monitored by a weekly teleconference between the Department of Health, HSC employers and Agenda for Change trade unions. Earlier contacts may be activated if required through existing local and regional structures.

17. It is recognised that trade union cooperation is dependent on strict adherence to the provisions of this agreement and trade union side reserve the right to withdraw from it if HSC are operating in breach of this agreement.

April 2020

Appendix 1 – **PROCESS FOR DEPLOYMENT**

1. The appropriate area Trust and independent sector contacts will discuss and agree any staffing needs that have been identified, in accordance with paragraph 1 of the agreement.
2. Trusts should prioritise those identified through the HSC Workforce Appeal, and who have the right skills, for deployment with independent social and nursing care providers; or for use as backfill for existing members of staff who can be deployed. In addition Trusts should work with homes to consider whether any of the 3,000 volunteers who have registered with Volunteer Now can be deployed to support social care – but explicitly not in roles that are paid.
3. Staff who agree to redeployment shall be recorded on a deployment register. This should also include the details of the risk assessments as detailed in paragraph 1 – 3 of the agreement.
4. Staff who agree to redeploy will be given the option to be assigned to a particular facility and reserve the right to refuse same, at any stage, without detriment.
5. Staff who agree to redeploy should be given as much notice as possible, and should be informed of the intended duration of the redeployment, to allow them to make the necessary arrangements at home and in their current workplace.
6. Redeployment should be kept under review and staff should have the options to give reasonable notice to end the deployment with no detriment.
7. Staff who agree to redeploy should be assigned hours of work in line with their existing contract of employment unless they agree to vary same. Existing overtime rates will be paid for any additional hours worked over full time hours. Unsocial hours worked will be paid in accordance with agenda for change terms and conditions
8. No member of staff will suffer financial detriment as a result of redeployment Staff who agree to redeploy will be paid any additional travel at the full business rate to the redeployed base from their current workplace.
9. Staff who incur additional travel time as a result of redeployment should have this paid.
10. Staff who agree to redeploy will receive subsistence, as per Agenda for Change terms and conditions, for each day of deployment.
11. At all times, all existing conditions of employment will be honoured and respected.

Annex B – Pre-admission infection prevention and control risk assessment proforma

Infection Prevention and Control Pre-Admission/Admission Risk Assessment

To be completed by the Care Home staff pre-assessing/ admitting the person

Person Details	**Admitted From Details**
Name:	**Admitted From:**
Date of Birth:	**Consultant/GP:**
Home Address:	**If from Hospital, reason for admission:**
Date of Admission:	**Date of hospital admission if applicable:**

Acute Respiratory Illness (ARI)

During admission, has the patient had OR Does the patient currently have?	**YES/NO**	**DATE OF ONSET (IF NOT KNOWN, PROVIDE DATE WHEN TEST PERFORMED)**
NEW CONTINUOUS COUGH		
WORSENING OF EXISTING COUGH		
TEMPERATURE OF 37.8 or ABOVE		
LOSS OF TASTE AND/OR SMELL		
OTHER RESPIRATORY SYMPTOMS: (Describe)		

Has the patient been tested for?	**YES/NO**	**RESULT**
FLU-A		
FLU-B		
RESPIRATORY SCREEN		

If yes to any of the above give details on treatment incl. isolation

_____

—

Is isolation required on admission to the Care Home? (give details, including

duration)

_____

___

Details of any planned follow up e.g. further testing:

_____

Date of last 'flu vaccination (obtain details if during 'flu season): _____

Infective Diarrhoea and/or Vomiting

Is the Person in Care currently having diarrhoea and/or vomiting where infection has not been ruled out as cause? YES / NO

Has the Person in Care been in contact with others having diarrhoea and/or vomiting in the past 72 hours? YES /NO

Have the Person in Care's family had diarrhoea and/or vomiting in the past 72 hours? YES / NO

Clostridium difficile

Active C diff: YES/NO History of C Diff: YES/NO No. of Type 6/7 stools in last 72 hours:____

Date of last positive Clostridium difficile toxin specimen:_____ Ribotype:_____

Treatment Received:_____ Treatment completed: YES/NO

If treatment ongoing give details:- Treatment details_____

Date Commenced_____

Length of Course_____

Details of planned follow-up:_____

MRSA/MSSA

Colonised: YES/NO Infected: YES/NO

Date of last positive swab:_____

Site(s) MRSA positive:_____

Treatment Received:_____ **Treatment completed: YES/NO**

If treatment ongoing give details:- Treatment details_____

Date Commenced_____
Length of Course_____

Details of planned follow up:_____

_____

COVID-19

Date of last COVID-19 test:_____ **Result:** _____

Date of first positive test:_____

Is the person experiencing symptoms: YES / NO

If yes – please list:_____

Date for routine testing to resume (90 days after first positive test):_____

Has COVID vaccine been administered: First Dose: Yes / No
Date_____

Second Dose: Yes / No Date
_____

Type of Vaccine administered _____

Known History of Multi-Drug Resistant Organisms or Other Infection Risk

Has the Person a history of having:- ESBL ☐ **VRE/GRE** ☐ **CPE** ☐

Other_____

Other relevant information (e.g. current treatment, planned screening, GIVE DETAILS OF ANY RECENT ANTIBIOTIC THERAPY):

Is the Person / their family aware of any infection diagnosis?	**Yes / No / N/A**

Environmental Factors	
Does the Person require a single room on admission?	**Yes/No**
Does the Care Home have facility to isolate the Person in a single room?	**Yes/No/N/A**
If the Person requires isolation but there is no facility for this, can the Person be cohorted with those of same infection status?	**Yes/No/N/A**
Does the care of the Person involved Aerosol Generated Procedures? (refer to PHE guidance)	**Yes/No/N/A**
Does the Care Home have sufficient staff to manage any identified risk?	**Yes/No**

Person Providing Information:

Person Completing Risk Assessment:

Designation:

Date:

Annex C – Isolation of COVID-19 symptomatic patients

Isolation of residents:-

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

b. More than one case - Cohorting of all symptomatic residents:

- Symptomatic residents should ideally be isolated in single occupancy rooms.
- Where this is not practical, cohort symptomatic residents together in multi-occupancy rooms. Residents with suspected COVID-19 should be cohorted only with other residents with suspected COVID-19. Residents with suspected COVID-19 should not be cohorted with residents with confirmed COVID-19.
- Do not cohort suspected or confirmed patients next to immunocompromised residents.
- When transferring symptomatic residents between rooms, the resident should wear a surgical face mask.
- Clearly sign the rooms by placing IPC signs, indicating droplet and contact precautions, at the entrance of the room.
- Staff caring for symptomatic patients should also be cohorted away from other care home residents and other staff, where possible/practical. If possible, staff should only work with either symptomatic or asymptomatic residents. Where possible, staff who have had confirmed COVID-19 and recovered should care for COVID-19 patients. Such staff must continue to follow the infection control precautions, including PPE as outlined in this document.

Isolation and cohorting of contacts:-

Careful risk assessment of the duration and nature of contact should be carried out, to put in place measures such as isolation and cohorting of exposed and unexposed residents. Please refer to the definition of contacts in **Annex D**. There are broadly three types of isolation measures:

- **Isolation of contacts individually in single rooms for 14 days after last exposure to a possible or confirmed case:** This should be the preferred option where possible. These contacts should be carefully monitored for any symptoms of COVID-19 during the 14-day period as described earlier.

- **Cohorting of contacts within one unit rather than individually:** Consider this option if isolation in single rooms is not possible due to shortage of single rooms when large numbers of exposed contacts are involved.

- **Protective cohorting of unexposed residents:** Residents who have not had any exposure to the symptomatic case can be cohorted separately in another unit within the home away from the cases and exposed contacts.

- Extremely clinically vulnerable residents should be in a single room and **not share bathrooms with other residents**.

Annex D – Definitions of COVID-19 cases and contacts

- **Possible case of COVID-19 in the care home:** Any resident (or staff) with symptoms of COVID-19 (high temperature or new continuous cough), or new onset of influenza like illness or worsening shortness of breath.

- **Confirmed case of COVID-19:** Any resident (or staff) with laboratory confirmed diagnosis of COVID-19.

- **Infectious case:** Anyone with the above symptoms is an infectious case for a period of 7 days from the onset of symptoms.

- **Resident contacts: Resident contacts are defined as residents that:**

- Live in the same unit / floor as the infectious case (e.g. share the same communal areas).

or

- Have spent more than 15 minutes within 2 metres of an infectious case.

- **Staff contacts:** Staff contacts are care home staff that have provided care within 2 metres to a possible or confirmed case of COVID-19 for more than 15 minutes.

- **Outbreak:** Two or more cases which meet the case definition of possible or confirmed case as above, within a 14-day period among either residents or staff in the care home.

Annex E – Contact Points for Independent Sector Staff Testing

NEW: DIGITAL PORTAL for Coronavirus testing for essential or key workers who are self-isolating because they are symptomatic, or household members over 5 years of age who are symptomatic.

Essential or key workers can now book tests for themselves and their household via a new online portal. This will make the process of getting an appointment quicker and easier, while reducing the burden on business.

We would encourage you to advise your self-isolating staff to get a test if they or someone in their household have symptoms.

Please communicate this new service to your eligible workforce and colleagues. This new service also offers limited home postal test kits which you may be useful for non-drivers.

The new digital portal has two booking options:

- Employee Self-Referral Portal: https://self-referral.test-for-coronavirus.service.gov.uk/
- Employer Referral Portal: coronavirus invite https://coronavirus-invite-testing.service.gov.uk/

Organisations need to send registration enquires to be emailed to portalservicedesk@dhsc.gov.uk to get the username and password before using the portal.

If you need further guidance and support, please contact DHSC at opshub@dhsc.gov.uk. Telephone help desk - I&S

For further information please see the Public Health Agency website.
https://www.publichealth.hscni.net/covid-19-coronavirus/coronavirus-national-testing-programme-key-workers

In addition it is possible to book through Trusts if required:

Belfast Trust

The Belfast Trust has a single telephone line entry to service, triage and booking.

Communication has been issued to all Belfast locality Independent Sector providers

giving them the details of how to access the testing and the direct line telephone numbe[I&S]to book appointments.

Northern Trust

Independent Sector Care Workers in the Northern Trust area who require COVID-19 testing should e-mail their details to **HCW.testing@northerntrust.hscni.net**

Southern Trust

The Southern Trust are testing all Health Care Workers including Independent Sector Care Workers, who are symptomatic or have a household member who is symptomatic. This can be availed of by contacting **covid19.screening@southerntrust.hscni.net.**

South Eastern Trust

Independent Sector Care Workers in the South Eastern Trust who need advice or testing should contact[I&S]and press option 1 for screening and testing or option 2 for advice by a registered nurse.

Western Trust

Independent Sector Care Workers in the Western Trust area should inform line management of COVID related symptoms or symptoms experienced by a Household Contact, who will then provide details by email to **covid19.test@westerntrust.hscni.net**

Annex F – Criteria for shielding vulnerable people in Northern Ireland

All those in the most at risk criteria will have received a letter from their GP. Those most at risk are:

1. Solid organ transplant recipients
2. People with specific cancers
    - People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer
    - People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - People having immunotherapy or other continuing antibody treatments for cancer
    - People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
    - People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD
4. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell)
5. People on immunosuppression therapies sufficient to significantly increase risk of infection
6. People who are pregnant with significant heart disease, congenital or acquired
7. People with Motor Neurone Disease

In addition to these criteria, GPs may have written to some individuals they have identified as at particular risk because of a combination of factors.

Any changes or updates to this list will be put on the Departmental and PHA websites.

Annex G – Aerosol Generating Procedures (AGPs)

The following procedures are currently considered to be potentially infectious AGPs for COVID-19:

- intubation, extubation and related procedures, for example manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)
- tracheotomy or tracheostomy procedures (insertion or open suctioning or removal)
- bronchoscopy and upper ENT airway procedures that involve suctioning
- upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract
- surgery and post mortem procedures involving high-speed devices
- some dental procedures (for example, high-speed drilling)
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- induction of sputum
- high flow nasal oxygen (HFNO)

Neither nebulisation nor long term oxygen therapy are considered AGPs.

Privacy Advisory Committee (PAC) Guidance on the disclosure of COVID-19 infection status & ICO Position on Sharing Information

April 2020

COVID-19. The present COVID-19 pandemic presents a serious threat to life to all our citizens, particularly older people and people with a variety of health conditions. The current principal means of public protection is reduction of spread through reducing contact between individuals, particularly reducing contact with individuals known or suspected to be infected with the virus.

Patient confidentiality and information sharing. Trust is an essential part of the service user health care professional relationship and confidentiality is central to this. Those who have, or may have, COVID-19 infection might be concerned about their privacy. This guidance sets out how the principles of confidentiality apply when a health professional is considering disclosing information about the infection status of patients who have or are suspected of having COVID-19 infection.

Disclosure of COVID-19 infection status

As with all health care information you should make sure that information you have about a patient's infection status is at all times protected against improper disclosure. If you disclose information about a patient's infection status you must keep disclosures to the minimum necessary for the purpose.

Disclosing information on a patient's infection status to others involved in that patient's care is part of the usual sharing necessary to provide their care. There may be other circumstances where the sharing of confidential information is justified because there is an overriding public interest in protecting life. If the circumstances permit you should discuss the situation with your line manager or Personal Data Guardian.

You should inform your patient of the need for this very limited sharing of their health information to reduce the spread of infection, unless you consider it inappropriate or impracticable to do so.

Information Commissioner's Position

The Information Commissioner has provided assurance that she cannot envisage a situation where she would take action against a health and care professional clearly trying to deliver care. You can read the statement from the Information Commissioner's Office, alongside their Q&A resource. Health and Social Care regulators across the UK have also published a joint statement.

Annex I - Additional sources of training, support and guidance

- Clinical Education Centre www.cec.hscni.net
- Department of Health NI https://www.health-ni.gov.uk/
- Northern Ireland Social Care Council https://niscc.info/
- Nursing and Midwifery Council www.nmc.org.uk
- Public Health Agency https://www.publichealth.hscni.net/
- Public Health Agency: Take 5 Steps to Well-being https://www.publichealth.hscni.net/publications/take-5-steps-wellbeing-looking-after-your-mental-health-while-you-stay-home
- Royal College of Nursing www.rcn.org.uk https://www.rcn.org.uk/northernireland
- World Health Organisation: Mental health and psychosocial considerations during the COVID-19 outbreak: https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf?sfvrsn=6d3578af2