PROTOCOL FOR DEALING WITH COVID OUTBREAK IN CARE HOMES

Context

1. This protocol is required in order to ensure timely, effective and coherent support is provided by Health & Social Care to providers of residential care, nursing care and in extra care settings, wherein the risk of transmission of COVID-19 is considered to be escalating and/or problematic to manage.

2. Its content is based on lessons learned in the first few weeks of the current pandemic. The protocol was created in emergency circumstances, has evolved during implementation and will require dynamic review by those working under it, in order to ensure that it remains both proportionate and effective.

3. The protocol covers all such provision in Wokingham Borough and for ease of reference is divided into four phases.

4. Phase one relates to proactive work in the default stage of no new outbreak in a setting, whereby a daily dialogue with providers reviews current circumstances and concerns in a home, collating this information and offering initial problem solving advice/signposting where required..

5. Phase two relates to the dynamic triage of the information collated to identify emerging risks or concerns, further problem solve if appropriate and/or escalation to the task force if required.

6. Phase three will be initiated as soon as two (likely) cases of COVID-19 are identified in a setting or if the information collated is suggestive of preventative measures being problematic to implement in a setting. It will be initiated either via sharing of information from phase one via phase two into the pathway, or via direct contact from a Provider based on their own concerns.

7. Hospital discharges whether for new admissions, or for those returning to their care setting will interface with phase three and transfers between care homes will also be included. No hospital discharge will progress without the current COVID status of the person concerned being confirmed. Each individual will need to be risk assessed in the context of both the risk their transfer poses *to the* setting, but also in relation to what risk the setting *may pose to them.* This phase will be undertaken by a 'Taskforce' which will be jointly staffed by Health & Social Care and which will offer vital and dynamic support to the provider to mitigate risk around the (potential for) outbreak as far as possible. Care providers will also be encouraged to engage with the Task Force around any proposed admissions from the community, including for self-funders, in order to ensure that the provider is supported in the same way.

8. Phase 4 will be initiated following application of the Task Force, wherein it is identified that the impact of the COVID-19 situation has resulted in the need for 'recovery and resilience' support to a Provider prior to support reverting to being maintained via phase 1 again.

Resource Requirement

9. The Task Force is made up of staff from both Health & Social Care. There is a core membership, with additional involvement from community based Health Services on an 'as required' basis for each individual provider setting.

10. Core Membership consists of:

    - Adult Safeguarding Lead, WBC (Chair)
    - Senior Social Worker – Adult Safeguarding Hub (ASH), WBC
    - Social Worker, Health Liaison Team
    - Quality Assurance Specialist – Commissioning, WBC
    - Senior Specialist – Strategy & Commissioning Team, WBC
    - DoLS & MCA Lead – Adult Social Care, WBC
    - Infection Control specialist – Clinical Commissioning Group
    - Care Home Support x 2 – Berkshire Healthcare Foundation Trust
    - Rapid Response & Treatment Service

11. 'As Required' membership is likely to include:
    - General Practitioner – relevant surgery/surgeries
    - Other primary Health Services where these are considered beneficial

Phase 1

12. A team of call handlers has been established and each call handler has been assigned a set of care providers with whom they will make daily contact. This will allow for relationships and rapport to be established and will assist with consistency and less repetition of content.

13. The template attached at Appendix 1 will be used to support callers to obtain information that can be dynamically used to inform risk assessment from a *practice* perspective. This covers the various indicators of risk that early learning has identified. This information will be collated and stored in Microsoft Teams where it is directly accessible by those professionals involved in the task force work.

14. Should straightforward queries or issues concerning for example staffing, PPE, testing etc. be identified during these calls, the call handlers will problem solve and/or signpost the provider accordingly. Should an issue be beyond what they can deal with, or appear significant, they will escalate to the triage team.

15. In addition to these proactive calls, all Providers are also advised that should they reach a position wherein they have two or more cases of suspected or confirmed COVID-19 in their setting or any concerns about their ability to manage (risk of) COVID-19 reactively or proactively, they will refer directly into the Task Force for advice, guidance and support.

16. Copies of the promotion leaflets issued to all care providers can be found at Appendix 2.

Phase 2

17. The members of the team responsible for triaging the information collated, can access it directly via Microsoft Teams in order to perform this function.

18. Each member of this part of the team is aligned to a set of call handlers and therefore a set of care settings.

19. As part of their function, they will offer additional problem-solving, advice, guidance and signposting for any issues or queries being identified via phase one that the call handlers are unable to resolve, but which do not require a Phase 3 approach.

20. The triage team will also ensure that they monitor national trackers and review any differences in data, to ensure that nothing has been reported via the national tracker that we are not aware of and to which we need to respond.

21. The Commissioning Specialist within the triage team will ensure weekly review of what is known about providers likely financial viability (based on data about deaths, voids, difficulties with admissions, size of company etc.) and provider AD Commissioning with a 'top 10' list of providers that would benefit from further contact to discuss this.

22. They will provide a daily summary of significant highlights within the care settings they are covering. This will include the number of new deaths, but also any other significant information.

23. This information will form the basis for the daily briefing to the DASS, which will be submitted by the Task Force lead at the end of each day.

24. A template for the daily briefing can be seen at Appendix 3.

25. The triage team will trigger a Task Force wherein it is identified that this is required and/or would be beneficial.

Phase 3

26. This phase may be initiated as a result of:

    - Triage of phase 1 data suggesting (potential) escalating risk in a setting
    - direct contact from a Provider as a result of two or more suspected/confirmed cases of COVID-19 in their setting
    - direct contact from a Provider struggling to manage a COVID-19 situation that has not been raised/identified via conversations within phase 1 but requires support
    - direct contact from a Provider concerning any proposed new admission from the community or another care setting (other than hospital – see below), in order to consider COVID status and ensure they can be appropriately transferred into the setting
    - request for assistance from the Health Liaison Team (HLT) with risk assessing and managing a hospital discharge in relation to a new placement, to ensure they can be appropriately isolated and cared for in the setting

- an individual in hospital needed to be transferred back to a care setting where they were previously residing, whereby their COVID status needs to be understood and risk to both themselves and others already in the setting managed appropriately
- request for assistance from a Primary Healthcare Professional who has identified concerns of emerging/increasing risk in a care setting

27. Within this phase, the task force will work collectively alongside the Provider to consider and address any issues across the following areas:

    - Customer COVID-19 status evaluation, risk assessment and consideration of testing requirements not already addressed
    - Review of ability to effectively implement social distancing, screening of the most vulnerable and isolation of suspected or positive COVID-19 customers
    - Observational review of Infection Control practice for adherence to guidelines and problem-solving around any difficulties implementing this, including in relation to customer-specific challenges. This will involve triangulation of provider experience, clinical input, safeguarding and MCA/DoLS advice to proactively ensure the Provider is supported to safeguard all residents whilst adhering to legislation and reducing anxieties about being later challenged over decisions made. This will also include review of required PPE, supply continuity of this and ensuring staff are competent and confident in its use
    - Staffing levels to ensure continuity of care, particularly in relation to nutrition, hydration and maintaining regular contact with families unable to visit
    - Staff wellbeing and requirement/opportunity for additional support
    - Resident wellbeing and requirement/opportunity for additional support
    - Consideration of COVID-19 testing requirements for staff, if not already addressed
    - Consideration of further clinical input/support where this has not already been considered or achieved.

28. At the time it is identified that a Task Force Provider Support Planning Meeting is required to bring agencies together, a risk assessment/action plan template will be populated with information already known. A copy of this template can be found at Appendix 4

29. This template will be used by the Task Force as an agenda for structured discussion around what is currently known and what agencies feel could be offered to support the Provider. This will be populated during the course of the meeting as an action plan, which will then be discussed with the Provider as the offer of what support, advice and guidance can be given. The action plan will be RAG rated dependent on progress against each action and residual risk; where actions are completed but residual risk remains (at an acceptable level) they will remain AMBER.

30. The completed action plan will be uploaded to Microsoft Teams, whereby those people assigned actions can upload status updates dynamically.

31. Those care settings for which an Infection Control Audit visit is going to be undertaken by the CCG, wil be notified to the CCG and added to the schedule. The template held at Appendix 5 will be used to undertake these visits. The completed template will be

shared with the Provider and a copy uploaded to Microsoft Teams where in can be viewed by Taskforce members.

32. Current Action Plans will be reviewed on a weekly basis to ensure that care settings move through the task force and are confirmed as ready to accept new discharges/admissions as soon as they are ready.

33. All hospital discharges when individually risk assessed for any setting (whether for a new placement or a returning to previous setting from hospital) will utilise the bespoke risk assessment template at Appendix 6 – this enables the Task Force to consider both the risk of the individual *to* the setting, but also the risk of the setting *to* the individual. Wherein any risk identified cannot be safely managed (for the person concerned and others in that setting), the discharge will not be agreed until the individual has undergone a suitable period of isolation either in hospital or in an alternative agreed location.

Phase 4

34. Phase 4 will commence with a 'Recovery & Resilience Planning meeting' between a small membership of the Task Force and the Registered Home Manager to look at what additional input or support would be helpful.

35. The four phases should be considered a fluid process and a care setting may move through phases 2 and 3 more than once, as changing circumstances require.

Appendix 1 – structured conversation template

To follow

Appendix 2

See attached PDF

Appendix 3 – template for daily briefing

Data

Home	Home capacity	Deaths (K)	Current positives (O)	Current symptoms (Q)

Deaths in past 24 hours (included in above)

- [number and name of home]

Recovered in past 24 hours (removed from data)

- [number of cases and name of home]

New cases

- [number of cases and name of home]

Headlines

- [name of home and relevant information]

Released for hospital discharges

- [name of home released by task force]

Hoping to release in coming days

- [name of home]

Individual hospital discharges agreed

- [number, hospital name and home returned to]

Appendix 4 – risk assessment / action plan for Task Force

Risk area	Comments	Issues	Action/Decisions	Who	Date added	Date to be reviewed	RAG	Status update
Social distancing								
Isolation of positive or suspected residents								
Anticipated hospital discharge or other admission								
PPE, soap, hand gel, paper towels, wipes, cleaning materials								
Effective decontamination zone								
Donning & Doffing of PPE								
Staffing levels; including provision of basic care, maintaining dignity and facilitating contact with families								
Resident wellbeing								
Staff wellbeing								
GP contact								
Financial sustainability								

Appendix 5 – Infection Control

Name of care home	
Date of visit	
Visiting team	
Care home lead during visit	

Risk area	Prompts and comments	Observation / feedback	Issues	Action	Task	Who	Date Added	Due completion or review	Complete Y / N	Status update
Entrance										
Notification and hand gel										
Social distancing isolation										
Social Distancing of all residents										
Isolation of COVID positive or suspected residents										
Hand Hygiene										
Strict hand hygiene using soap and water and/or hand gel as per WHO 5 moments										
Are staff bare below elbow?										
Are Hand wash facilities adequate and available to staff in or near residents rooms?										
Is hand Gel available to staff and is this easily accessible?										
PPE										
Is PPE being worn/ disposed of appropriately										
Are staff confident in the use of and how to don and doff PPE										

Uniforms										
Is there a dedicated changing area for staff?										
Deceased										
Verification of expected death										
Process										
Environment										
Is the general environment clean and dust free										
Are all hand touch surfaces clean and regularly cleaned throughout the day e.g. rails, door handles										
Is resident care equipment clean and dust free?										
Is there a planned cleaning routine for all areas?										
Are there adequate and appropriate rubbish bins?										
Is clean and contaminated waste /linen stored separately?										
Appropriate cleaning materials are available to staff and staff know how and when to use them?										
There is no evidence of inappropriate use or storage of communal items e.g.										

single use cream, talcum powder										
Communal equipment is cleaned after each use and stored appropriately e.g. Hoist, wheel chairs										
Is there an effective decontamination zone										
Staff well being										
Staffing levels to support provision of basic care and COVID IP&C requirements										
Emotional impact on staff										
Residents well being										
Maintaining dignity and facilitating contact with families/friend										
Can residents call for staff effectively? Do they have call bells?										
Health care professional support										
Good Practice										
Other feedback/comments raised										

Appendix 6

Hospital discharge risk assessment

Individual (to be completed by the key worker).

	Description of risk	**Proposed solution**
Name and Mosaic no.		
Date and outcome of the latest Covid-19 test		
Are they currently symptomatic?		
If positive, have they completed 14 days isolation period and remained symptom free?		
Cognitive impairment which may impact on individual's ability to follow instructions and adhere to safety precautions? In what way?		
Can the person consent to and follow any measures put in place to keep them safe, such as being confined to one room, barring the door to other residents etc.*		
Mobility? Can they walk unaided? Do they walk around the ward? Are they likely to walk around the care home as well?		
Can they use the call-bell system to summon help? If not, please consider how their safety		
Any other factors? MFFD?		
Care homes proposed by Operational Commissioning		

The home (to be completed by task force):

	Description of risk/situation	**Proposed actions**
Proposed care home(s)		
How will the home manage isolation for this individual 14 days post-discharge and/or 14 days post symptoms?		
Home Covid-19 status (info can be gained from the placement triage team)? If the home have Covid-19 positive residents and your customer is negative, how are they going to remain so?		
*Consider if any residents within the facility like to walk around, how will they be prevented from entering your customer's room?		
Does the proposed room have an en-suite bathroom? If not, how will the individual's personal care needs be met? If positive, is there a separate bathroom for all positive residents and ditto if negative.		
How does the home manage social distancing for all residents?		
What is the situation with PPE (Supply, correct use, correct donning and doffing?)		
Care home cleaning schedule? Infection control issues?		
How will the individual's medical needs be met, i.e. does the home get regular visits by GPs, Rapid Response etc.?		
Staffing levels – will there be enough staff on duty to meet this individual's needs without a negative impact on other residents?		