Questions arising out of the 'Admission and Care of Residents during COVID-19 Incident in a Care Home' guidance

1) Why is there a conflict between this guidance and other guidance? For example, the draft National Clinical Risk Panel states assessing for C-19 is being requested up to 4 times per day by some GP's, rather than the once a day.

2) The document assumes there is some testing capacity available for Care Home residents when in practice that is not available or not available widely.

3) In Section 1 it states: "If an individual has no COVID-19 symptoms or has tested positive for COVID-19 but is no longer showing symptoms and has completed their isolation period, then care should be provided as normal." Should the person supported not also be put on observations?

4) In Section 1 of the guidance it states: "Negative tests are not required prior to transfers/ admissions into the care home." How are care homes to assure themselves COVID-19 is not entering the home?

5) In Section 1 of the guidance it states that "All of these patients can be safely cared for in a care home if this guidance is followed." The guidance takes no account of the very real situation on the frontline of care in terms of staffing pressures, PPE shortages, the lack of testing in social care settings, the ability to isolate effectively and the potential impact on existing residents and the providers' legal duties to both staff and residents. Please amend to recognise the following: "It is only the care provider who can make this decision, based on their ability to provide safe, effective care, for the person potentially being discharged, the existing population in the care home and the staff caring for them."

6) In Section 2 of the guidance, how will you ensure that choice is given to those supported? There seems to be room for the person supported to be able to choose whether they would like to reside within a care service whilst symptomatic with COVID-19.

7) In Section 2 of the guidance it states that COVID-19 discharges will come with a care plan. Please could we receive further details what this care plan will look like?

8) In Section 2 of the guidance it states: "Assess each resident twice daily." Additional effort (in regard to training) and cost will need to be covered. How does the Government intend to cover these costs?

9) In Section 2 of the guidance it states: "Testing may be offered following contact with NHS 111 or according to local protocol for swabbing and testing." Care service experiences indicates that staff might be asked to hold for a significant period of time when calling 111. This is an issue operationally due to workforce pressures. How will you ensure that the 111 service is improved in efficiency?

10) In Section 2 of the guidance it states: "Staff should immediately instigate full infection control measures to care for the resident with symptoms." Infection control differs at an organisational level and requires that organisations consider healthcare associated COVID-19 risk at local level and according to the local context. Greater guidance is needed around this.

11) In Section 2 of the guidance it states that "More than one symptomatic resident: Inform the Health Protection Team (HPT)." There is inconsistent PHE guidance around this, and advice needs resolution for national providers to implement national communications to

all homes effectively.

12) In Section 2 of the guidance it states that: "*Keeping asymptomatic residents safe and monitoring symptoms Care home providers should follow Social distancing measures for everyone in the care home.'* It is simply not realistic or desirable for residents who do not have symptoms to have to practice social distancing in their homes. Can cause additional distress to many residents including those who cannot walk, talk or have conditions such as dementia. Please provide more helpful clarity on this advice.

13) In Section 2 of the guidance on testing, it is not not good enough on this point. Suggesting that testing 'may' happen is totally unacceptable. It MUST happen, for both residents and staff.

14) In Section 2 of the guidance on symptomatic residents, the guidance seems a little unclear – on p5 the period referenced is 7 days, in Annex D the period referenced is 14 days. Why does the guidance not require isolation for ALL discharged from hospital except those who have had confirmed COVID and completed isolation? Surely our duty to isolate them would seem to require a 14 day isolation period, not 7 days. This is really important and again has implications for providers in terms of lack of PPE and staffing pressures. Please clarify the period of isolation needed and explain why it is not 14 days as a matter of course? And presumably PPE would be needed for the whole 14 days?

15) In Section 3 of the guidance it states that "The Health Protection Team will advise on further communication to local infection control teams and local authority colleagues and CCGs." Providers need to understand how information is shared with LAs in this context and what support is locally available prior to an outbreak so this can be considered and local operational procedures amended to deal with local factors.

16) In Section 5 it states: "efforts should be made to cohort staff caring for that person [symptomatic with COVID-19]." Although this is a sensible suggestion, this is not always practical given increasing staff vacancies. If this was to be applied widely, the cost would scale at a very significant rate and would require additional funding.

17) In Section 5 it states: "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." The guidance cannot simply state this. Putting this in guidance does not make it true. It's all depends what sort of 'contact' we are talking about. Exposure in care homes will not necessarily be 'short-lived'. This is a very unhelpful assumption and gives the guidance a real lack of credibility. The droplet risk to care home staff is just as high as it is for ward staff, community workers and other frontline members of the NHS.

18) In Section 6 of the guidance it states that: "If you think one of your residents may need to be transferred to hospital for urgent and essential treatment." Greater clarification is needed around the definitions of "urgent" and "essential."

19) In Section 6 of the guidance it states that: "consult the resident's Advance Care Plan/Treatment Escalation Plan and discuss with the resident and/or their family member(s) or Lasting Power of Attorney as appropriate following usual practice to determine if hospitalisation is the best course of action for the resident." This seems to place the onus of responsibility onto the provider and leaves hospitalisation open to a subjective assessment by the provider. Greater guidance is needed given the indemnity of the issue.

20) In Annex C on isolation of COVID-19 symptomatic patients, there is not consideration given to those supported who may have a learning disability and/or autism, or those who present challenging behaviours (such those with dementia). There is no guidance on how to make decisions for those supported in isolation which comply with the Mental Capacity Act, for example.

21) In Annex C it the cohort principles are discussed, which although helpful seems to omit the notion that the rooms of those supported are their homes and they may become distressed if moved.

22) In Annex C it states: “Where this is not practical, cohort symptomatic residents together in multi-occupancy rooms.” Additional funding will be required if existing shared rooms require splitting into two if one becomes positive.

23) In Annex F on PPE supplies and availability, reference is made to the 300 masks delivered to every care home and care home provider in order to tackle immediate pressures. The reality is that this supply of facemasks will be consumed in hours in some homes. This highlights a lack of understanding around PPE requirements as it is not just front-line staff who require protection, it is everyone who interacts with the care system, from cleaners to carers, residents to end of life visitors. This problem is further heightened by the lack of staff and resident testing. Greater assurance is needed that a suitable level of PPE will reach all care homes and care home providers in the immediate future.

24) In Annex G laundry and waste management is discussed without consideration of the additional costs borne out of such practices. How will this additional cost be reprimanded?

25) In Annex I it states that care services must report staff isolation and sickness via Capacity Tracker (CT). Greater attention needs to be lent to how providers input information into CT regarding staff numbers. There are particular issues around part-time workers.

Additions that need to be made to the guidance:

1) Please add specific duties for PHE, the local HPT and LA /CCG/ local resilience forum to absolutely prioritise emergency supplies of PPE to care homes with COVID positive cases if needed

2) Please strengthen the guidance to reference to the specific duties of community health and primary care to continue to support care homes as usual and advise on what should happen in the event that CVID cases are in the care home, PPE is not available and the care home staff cannot care for them safely.