

123 care-home respiratory incidents in one week: turning infection-control training into tested competence

The latest UKHSA surveillance is a timely reminder that infection prevention depends on everyday practice, not training records alone. Care England’s SMART Care Intel tool can help providers test what staff understand, find knowledge gaps and target practical support in minutes before those gaps contribute to avoidable spread.

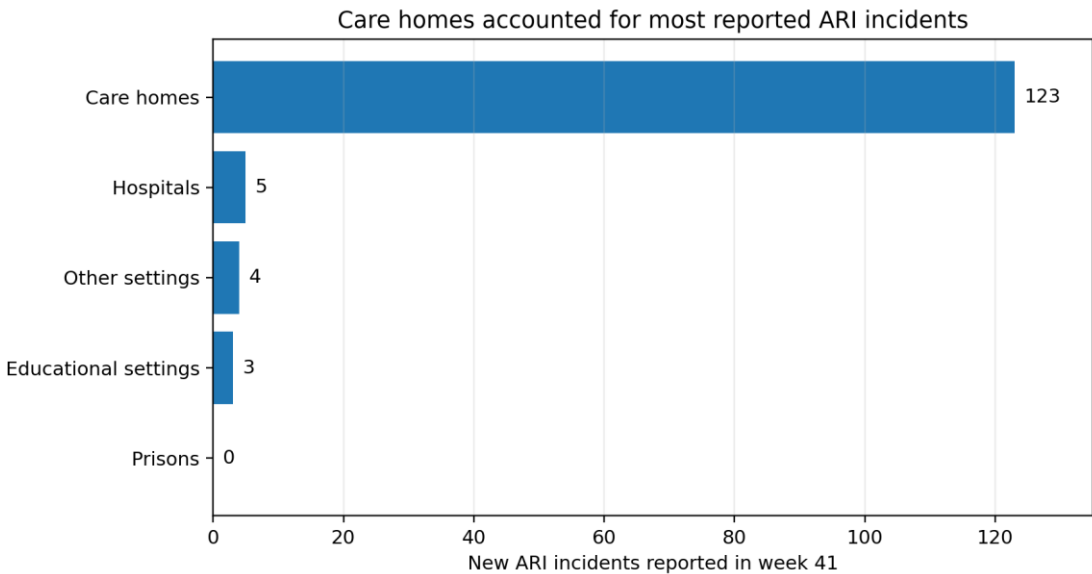


A strong signal for care providers

UKHSA’s week 42 surveillance report recorded 135 new acute respiratory infection (ARI) incidents in England during week 41, covering 5 to 11 October 2026. Of these, 123 were reported from care homes - just over 91% of all incidents reported across the settings listed in the publication.

Among the care-home incidents, 34 involved SARS-CoV-2, seven involved influenza A, two involved influenza where the type was not reported, 10 involved other pathogens and one involved multiple pathogens. No pathogen was reported in 69 incidents. It does not mean no pathogen was present; it means the surveillance return did not report one.

The wider picture is not one of uniform escalation. Influenza remained at baseline activity, COVID-19 indicators were mixed and circulating at low levels, and Respiratory syncytial virus (RSV) increased while remaining at baseline. COVID-19 hospital admissions increased from 2.13 to 2.46 per 100,000. The right response is therefore not panic, but prompt, proportionate assurance: are infection-control expectations understood and applied consistently across every shift and every service?



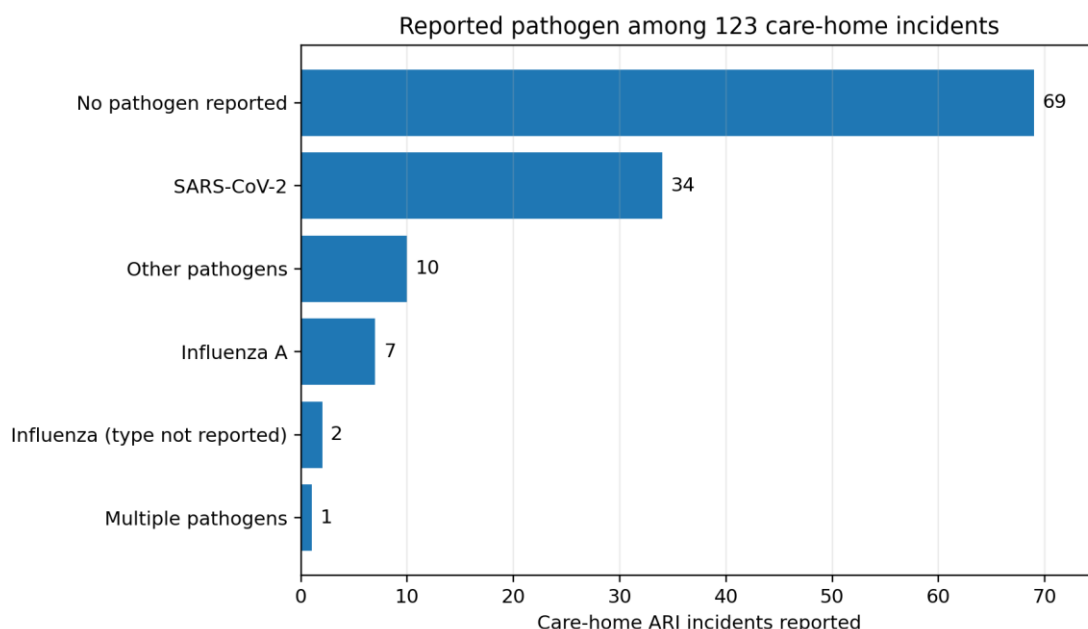
Source: UKHSA, National flu and COVID-19 surveillance report, 15 October 2026 (week 42).
Figure 1. Reported ARI incidents by setting, England, week 41. Graphic recreated from UKHSA published data.

Why training completed is not the same as competence demonstrated

Adult social care infection-control guidance identifies a group of standard precautions that should be used routinely: hand hygiene between tasks and between people, respiratory and cough hygiene, ventilation, cleaning of shared equipment and frequently touched surfaces, appropriate PPE, and the correct handling of waste and infectious linen.

A certificate can show that a staff member attended or completed training. It cannot, on its own, show that they remember when soap and water is required rather than or alongside alcohol-based hand rub, understand what to do after removing PPE, know how to respond to respiratory symptoms, or can apply the organisation's procedures under time pressure.

That distinction is critical for regulatory assurance. CQC's infection prevention and control quality statement expects providers to assess and manage infection risk, detect and control the risk of spread, and share concerns promptly with the appropriate agencies. Providers therefore need evidence not only that training was delivered, but that staff understand the required actions and that weaknesses lead to proportionate follow-up.



"No pathogen reported" does not mean no pathogen was present. Source: UKHSA week 42 report.

Figure 2. Reported pathogen among the 123 care-home incidents. Graphic recreated from UKHSA published data.

How SMART Care Intel turns a national warning into targeted local action

Care England's SMART Care Intel's competency engine contains more than 6,700 care-sector questions across more than 500 competency assessments and topics, including infection control. Providers can run short, controlled competency campaigns and send them by email for completion on a phone, tablet or computer. Three hand-hygiene assessments are already available, and providers can also create bespoke questions around their own policies, resident needs, outbreak procedures or operating standards. It is therefore possible to have a full picture of staff competence on a specific subject in minutes to establish where targeted input is needed.

The system records when an assessment was sent, opened, started and completed. Managers can review every answer, compare performance across a team or service, and see which questions are producing the highest failure rates. Every competency assessment is times to ensure responders do not have the ability to use AI or the internet to search responses. This changes the conversation from "everyone has completed the course" to "this is what our staff understand, this is where the gaps are, and this is what we did about them".

The result is not a replacement for accredited training, direct observation, supervision or professional judgement. A desk-based check cannot prove that somebody physically cleans every part of their hands correctly. It can, however, identify who needs practical observation first, what the observer should focus on and whether knowledge improved after support. Where care providers should best apply their resources to achieve the best possible outcomes.

A focused infection-control campaign could test whether staff understand:

- the key moments for hand hygiene and the correct hand-cleaning method for the task;
- when soap and water is required and when alcohol-based hand rub is appropriate;
- respiratory and cough hygiene, including support for people receiving care;
- PPE selection, safe removal and hand hygiene after PPE;

- cleaning and decontamination of shared equipment and high-touch surfaces;
- recognition, escalation and reporting of suspected respiratory infection incidents; and
- the provider's own outbreak, visiting, staffing and business-continuity procedures.

A practical 48-hour assurance cycle

1

Use the surveillance as a trigger

Do not wait for an incident in your own service. Use national or local respiratory surveillance, seasonal pressure or an internal near miss as the reason to check readiness now.

2

Send a short, targeted campaign

Select hand hygiene and relevant infection-control questions, choose the staff group, set a short completion window and issue the assessment across one service or the whole organisation.

3

Read the pattern, not only the pass mark

Review individual results and question-level failure rates. A common error across many staff may indicate unclear guidance, weak induction or a system issue rather than an isolated individual problem.

4

Target the response

Direct refresher material, supervision and practical observation to the people and subjects that need it. Avoid repeating blanket training where the evidence shows knowledge is already secure.

5

Observe practice

For physical skills such as handwashing, PPE and equipment cleaning, carry out direct observation. Use the knowledge results to prioritise who is observed and what the observer checks.

6

Retest and evidence improvement

Run a follow-up assessment after support. Keep the original results, actions, observations and retest outcome together so governance teams can see the full improvement cycle.

What targeted results can tell a provider

If most of the workforce misses the same question or answer incorrectly, the organisation may need to review how the rule or policy is communicated or whether the local procedure is practical. If one staff member performs poorly across several infection-control questions, supervision and direct observation may be appropriate. If a particular service performs differently from the rest of a group, local leadership, supplies, workload or environmental arrangements may need closer review.

This is where competency data becomes more valuable than a training spreadsheet. It helps providers distinguish between an organisation-wide knowledge gap, a service-level weakness and an individual development need. It also helps learning and development teams spend their time where it is most likely to improve safety and measurable outcomes.

From activity to assurance

A defensible record is not simply "IPC training completed". It is: risk identified; knowledge tested; gaps understood; practical competence observed where required; targeted action completed; and improvement retested. That is a much stronger governance story for managers, boards and for regulators to witness and review.

SMART Care Intel supports action - it does not replace outbreak management

SMART Care Intel does not diagnose infection, detect an outbreak, replace clinical advice or substitute for UKHSA and local health-protection guidance. Providers should continue to monitor symptoms, seek clinical advice, follow current IPC guidance and report suspected ARI outbreaks promptly through the appropriate route. Providers can use the

competency assessment where data shows attention is needed to ensure the right targeted attention and solutions are engaged.

UKHSA advises adult social care settings to report a new ARI outbreak where two or more people have symptoms beginning within five days of each other and the cases could be linked by spread within the setting. A single confirmed flu case should also be reported. Where there is doubt, providers should seek advice from their local health protection or community infection-control team.

See SMART Care Intel's competency tools in action

HR & Competence live demonstration | Thursday 22 October 2026 | 3:00-4:00 pm

[Book the SMART Care Intel HR & Competence demo](#)

Sources and further guidance

- [UKHSA, National flu and COVID-19 surveillance report: 15 October 2026 \(week 42\)](#)
- [UKHSA/DHSC, Infection prevention and control in adult social care: acute respiratory infection](#)
- [DHSC/UKHSA, Infection prevention and control: resource for adult social care](#)
- [CQC, Infection prevention and control quality statement](#)
- [UKHSA, Report an outbreak of acute respiratory infection in an adult social care setting](#)