



National Clinical and Practice Guidance for Adult Care Homes in Scotland during the COVID-19 Pandemic

Updated 15 May 2020

Version History

Version	Date	Summary of changes
1.1	13/03/20	First version of document
1.2	26/03/20	Updated to include: HPS advice on care home admissions, shielding advice, visiting
1.3	15/05/20	Updated to include updated advice on: advice on PPE; admissions and testing; strengthening advice on infection control; health care support for residents; caring for someone depending on their COVID-19 status; workforce; staff and resident wellbeing; mutual support for care homes; executive summary.

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Executive Summary

Purpose

This guidance provides advice and support for those working with adults in care homes during this pandemic. It was first published on 13 March and was updated on 26 March. This version was updated by the Chief Medical Officer and Chief Nursing Officer Care Homes Clinical and Professional Advisory Group (CPAG), a short life multi-disciplinary group, which has been established to provide clinical and professional advice throughout the evolution of the COVID-19 pandemic. The guidance is based on the Health Protection Scotland updated [Information and Guidance for Care Homes](#) but provides more detail on some practical steps that are required to support good infection control within care homes and ensure the provision of safe and effective person-centred care during this pandemic.

Background

It is recognised that adults living in care homes often have multiple health and care needs and many are frail with varying levels of dependence. Many are inevitably at greater risk of poorer outcome if they were to contract COVID-19 due to conditions such as frailty, multiple co-morbidity, pre-existing cardio-respiratory conditions or neurological conditions.

Many older people may not present with the commonly reported symptoms of COVID-19 (such as a new persistent cough and temperature). Reported symptoms include loss of appetite or smell, vomiting and diarrhoea, shortness of breath, falls, dehydration and increased confusion, delirium or excessive sleepiness.

Recent international and UK based experiences on the spread of COVID-19 in care homes points to the need for strict measures to protect all care home residents and staff from becoming infected and to reduce the incidence of further spread for affected care homes where outbreaks have occurred.

The evidence also points to the need for a whole system health and social care response to Covid-19 to support our care homes. In that regard, we will require different but supportive roles and responsibilities from senior clinical leaders to support care home staff to meet all care needs of residents during this pandemic. COVID-19 presents in an atypical fashion and affects the most vulnerable and therefore requires a different clinical model for care homes, a different staff complement and different approaches to supporting residents. This will require additional staffing, expansion of infection prevention and control processes to minimise transmission and may require increased clinical input to support any affected residents and identify and manage any deterioration in their condition.

This updated guidance provides advice on the approaches for doing that, recognising that enhanced mutual support from the NHS and Local Authorities and other partners for care homes is essential at this time.

Summary of prevention strategies based on international experience

A summary of overall prevention strategies required for care homes to reduce the spread and impact of the virus is outlined below. More details on the practical application of these measures is provided in the remainder of the document.

Staff

- Staff should not work while even mildly symptomatic and should follow guidance on self isolation
- Staff should not work in more than one facility and movement between care homes e.g. through agency staff working across facilities must be restricted. This has been shown to increase the risk of imported transmission into care home.
- Staff must be trained in and familiar with Infection Prevention Control (IPC) processes including Personal Protective Equipment (PPE) guidance and shown how to use it including how to don and doff safely.
- Staff should change into uniform when arriving at the care home and change out of it again before leaving the care home. Uniforms should be transported home in a disposable bag for laundering. Uniforms should be laundered separately at the maximum temperature tolerated by the fabric.
- Supportive visible leadership has been shown to be important especially where adherence to Infection Prevention and Control measures is encouraged.

Hygiene / Environment and cleaning

- As this is a droplet infection, surfaces can become contaminated, and therefore reducing the number of surfaces/ items for cleaning will be important at this time, So, it will be necessary to strike the balance between enabling a homely environment, and reducing the risk of infection at this time.
- Strict and frequent hand hygiene for staff ensuring bare below the elbow at all times.
- Alcohol-based hand sanitizers between contacts when hand-washing is not available.
- Rigorous and daily disinfection and cleaning of frequently touched surfaces e.g. door handles light switches, chairs arms, communal areas. Where communal areas exist, wipeable furniture should be in use.
- Environmental decontamination of affected areas and frequent cleaning of most touched surfaces using products described in the HPS care home guidance.

Detection/ testing

- Early recognition of symptoms of COVID-19 in residents.
- A recognition that older people **may not** present with typical symptoms but may have other symptoms so staff need to recognise this and seek early advice.
- Symptomatic or self-isolating workers being tested, they must stay off work for 7 days until well and with a normal temperature (without anti-pyretics) for 48 hours.
- One suspected case of COVID-19 must be considered by care homes as the trigger for contacting the local Health Protection Team in order to initiate an investigation. Local NHS Boards and Health and Social Care Partnerships have responsibility for coordinating and delivering testing, this may include training care home staff how to undertake tests.

Staffing

- Staff allocated to one care home consistently, will reduce spread across several locations and care homes, cohort staffing can support these measures within a care home. Dedicated staff teams for those with symptoms / confirmed cases and those without.
- In-reach health care services should continue and be enhanced during this pandemic to ensure the clinical needs of residents are met. This may include technological approaches or in person visiting ensuring compliance with IPC processes.
- Sufficient staff to cope with increased demands of supporting residents to socially distance or to isolate and to care for residents who become physically unwell. This may require additional registered nursing support. Care home managers will be required to identify their staffing requirements to the care inspectorate and to the local hubs led by directors of Public Health.
- NHS Boards and Local Authorities must support care homes with staffing requirements as a result of this pandemic.

Visitors and communal activities

- Restriction of visitors to only emergency/critical dying or distressed situations.
- Avoidance of use of communal areas and communal activities.

Wellbeing

- Support for resident wellbeing and measures to reduce anxiety.
- Support for care home staff.

What's changed in this version of the guidance

The main changes to the guidance include:

Area	section
Strengthening advice around: <ul style="list-style-type: none"> • visiting policy; • communal activity, • infection control, cleaning, environment • organising staff teams to minimise transmission. 	Section 8 (8.7, 8.8, 8.9, 8.10, 8.11) Section 7 Section 9 Sections 2.7, 2.8 Section 12
Testing <ul style="list-style-type: none"> • Updates on testing arrangements following recent announcements on care home admissions and enhanced surveillance testing; 	Section 10 (10.4, 10.8, 10.10) Section 11 (11.2, 11.3, 11.4) Annex 5
Workforce <ul style="list-style-type: none"> • importance of adequate staffing during the COVID outbreak to ensure the safety and wellbeing of residents. • education and training 	Section 12 (12.1, 12.2, 12.3, 12.4, 12.6, 12.9) Section 2.7 Section 8.10
Support for care home sector <ul style="list-style-type: none"> • role of all partners to ensure that the care home sector is supported at this time; 	Section 12.2
Wellbeing <ul style="list-style-type: none"> • supporting staff and resident wellbeing including residents with dementia 	Sections 8.12, 8.13, 11.3, 14.2, 15.4, 15.5 Section 19 Annex 4

Conclusion

The care home sector is vital to the wider health and care system and it is essential that it is supported to continue to function in a safe and effective way to ensure the safety, dignity and that high standards of care for residents are maintained during this pandemic.

1. Purpose and aim

1.1 This guidance which is based on the emerging evidence UK and international experiences of COVID- 19 (**Annex 1**) aims to provides advice and support for those working with adults in care homes during this pandemic. It should be read in conjunction with current infection prevention control guidance developed by Health Protection Scotland (HPS) - [Information and Guidance for Care Homes](#). This version was updated by the Care Homes Clinical and Professional Advisory Group (CPAG), and approved by the Chief Medical Officer and Chief Nursing Officer. The guidance provides more detail on some practical steps that are required to support good infection control within care homes and ensure the provision of safe and effective person-centred care during this pandemic.

1.2 Whilst Local Authorities have a duty of care to residents in care homes should services be compromised, as this is a public health emergency it is necessary that collaboration between Health Boards, Local Authorities, Health and Social Care Partnerships and care homes takes place to ensure the safety of residents. To that end, roles and responsibilities for senior clinical leadership have been enhanced during this pandemic.

1.3 This is a live document and is hosted on the Scottish Government website. It will be regularly updated to reflect the changing situation as this pandemic develops.

2. Background and context

2.1 It is recognised that adults living in care homes often have multiple health and care needs and many are frail with varying levels of dependence. Current estimates are that over 40,000 residents live in the 1083 adult care homes across Scotland. The vast majority of adult care homes are for older people (75%) but care homes also include those for people with learning disabilities (14%) and physical disabilities / sensory impairment (3.3%). The majority of adult care homes are run by the private / independent sector (63%) - this rises to 75% in care homes for older people - followed by third/ voluntary (24%) and local authority/ health board (14%) sectors. In some care homes there are registered nurses who work alongside social care workers and in others there are no registered nurses in the care home and nursing support is provide through an in-reach district nursing/ care home liaison model.

2.2 The average age of residents is estimated to be 84 years. Fifty percent of residents have a formal diagnosis of dementia however, the actual numbers of residents with a formal diagnosis or a significant cognitive impairment is thought to be much higher. Ordinarily annual mortality rates for these residents is between 13 and 17% illustrating the vulnerability of people living in care homes.

2.3 In addition to the general vulnerability of care home residents they are inevitably at greater risk of a poorer outcome if they were to contract COVID-19 due to conditions such as frailty, multiple co-morbidity, pre-existing cardio-respiratory conditions or neurological conditions. In addition, some of those residents with cognitive impairment including learning disability and dementia may be at greater risk of contracting COVID-19 because of difficulty in understanding and following the infection prevention and control guidelines.

2.4 People with learning disabilities have higher rates of morbidity and mortality than the general population and die prematurely. People with learning disabilities also have a higher prevalence of asthma and diabetes, and of being obese or underweight; all these factors make them more vulnerable to COVID-19.

2.5 For some residents the most appropriate clinical decision in response to an event or a deterioration in health may involve a decision to transfer to hospital. However it is understood that for many older and frail residents this has to be balanced alongside the impact of that transfer on the individual, their potential clinical outcomes and their personal choices. Where following clinical assessment it is in the best interest of the individual, in keeping with their choices and where the level of care required cannot be met in the care home then a transfer to hospital for further assessment, care and treatment should take place.

2.6 Decisions about care and treatment for residents who have a deterioration in their condition should be on an individual basis, based on the person's best interests and in consultation with the individual or their families/representatives, taking account of any expressed wishes contained in their Anticipatory Care Plan. For many older and frail residents, hospital admission may not be appropriate, however additional support within the care home setting may be preferred and deemed a more appropriate response. This may require the need for more health care input from primary and secondary care to support the option for the acutely unwell and/or dying resident. It is recognised that care homes may require more clinical input to manage residents' needs at this time. NHS Boards and Health and Social Care Partnerships must work closely together to ensure those needs are met.

2.7 As we understand more about the spread of COVID-19 infections in the UK, we have also seen the emergence of increased spread within the care home sectors. This development is similar to that experienced in other countries. There is an expectation that each care home will have resilience plans in place for adverse events or circumstances. However, recognising the unprecedented nature and likely impact of this pandemic, in addition to care home resilience planning, the impact on care homes must also be factored into the Health and Social Care Partnership, Local Authority and NHS Board resilience plans to ensure the maintenance of safe care for residents during this pandemic.

2.8 Resilience plans must also take into consideration the changing demands on the workforce within care homes. This should include staffing capacity, capability and competency and may require rapid support around education and training, infection, prevention and control (IPC) measures and access to additional staff and equipment including PPE. Templates have been developed to support staffing decision making and escalation of concerns.

2.9 A recent development in Scotland has been the provision of increased support and enhanced clinical leadership from Health Board Directors of Public Health working alongside the Care Inspectorate, HSCPs, clinical partners and other key stakeholders to support care homes at this time. This increased support will help care homes to identify and escalate concerns to enable an appropriate response where required.

2.10 The care home sector is vital to the wider health and care system and it is essential that it is supported to continue to function in a safe and effective way to ensure the safety, dignity and that high standards of care for residents are maintained during this pandemic.

3. Presentation of COVID-19 in older people

3.1 Many older people **may not** present with the commonly reported symptoms of COVID-19 (such as a new persistent cough and temperature). Reported symptoms include

loss of appetite or smell, vomiting and diarrhoea, shortness of breath, falls, dehydration and increased confusion, delirium or excessive sleepiness.

3.2 Staff and family members who know the resident well will often be able to recognise and highlight changes in their health, behaviour or mood. Staff should be vigilant for any change or deterioration in a resident's condition and escalate concerns seeking clinical advice as necessary. In the meantime where COVID-19 is suspected full infection control measures including isolation of the resident should be taken.

3.3 The [RESTORE2](#) tool (**Annex 2**) may be useful in identifying new illness in older residents. This NEWS scoring part of the RESTORE2 tool must only be used in homes with registered nurses or carers trained and competent in its use. Page one of the tool can help assess changes in the residents condition. It is recognised that other validated clinical assessment tools may already be being used.

3.4 The Healthcare Support tool (**Annex 3**), has been tested by the Care Inspectorate working with care teams and the wider multi-disciplinary team to enable improved clinical decisions regarding the response and level of support required for an individual where care home staff have noted a change in their condition. The tool should be completed prior to contacting the local general practice or Out of Hours Service. It can be agreed locally if a telephone call or email is preferred. The tool can be used along with the RESTORE tool, particularly the body chart on the first page. Development of this tool is an iterative process and updated versions may follow. Please note this is **NOT** a substitute for an emergency situation.

4. Engagement of Residents and their families in discussion care and treatment

4.1 **Anticipatory Care Plans** (ACPs) should be in place for as many residents as possible. This allows the needs and wishes of residents and families to be taken into account in the event of changing circumstances. In many cases the care home staff will already have these in place for residents or are able to start these conversations with involvement of families and community healthcare teams.

4.2 In response to COVID-19 Healthcare Improvement Scotland (HIS) have revised and simplified their Anticipatory care template [Anticipatory Care Template has been developed by Healthcare Improvement Scotland](#). This includes good practice guidance on completing a ACP.

4.3 Anticipatory care plans do not assume or limit individual choice or decisions. They allow those who provide care to explore and understand what matters most to individuals. In the current pandemic commencement or completion of an ACP may need to be done by telephone or Near Me technology (see below) because of the requirements to minimise non-essential face to face contact to reduce potential disease transmission. It is recognised that, this is not ideal, as these sensitive conversations would usually happen in person, over time, often with family members present to support. Completed ACPs should be shared with the GP practice to allow recording on the electronic Key Information Summary (eKIS). This allows relevant and proportionate sharing of key information about individuals with other services including out of hours GP services, NHS24, the Scottish Ambulance Service (SAS) and hospital Emergency Departments ensuring individual's choices and wishes are known. It is good practice to obtain informed consent from the individual or Power of Attorney to activate sharing of the eKIS.

5. Receiving care and treatment in hospital settings

5.1 Care home staff will have established relationships with their residents which is key in identifying and supporting changes in their need and also in appropriately seeking additional clinical support. There are various models of community in-reach health care support for residents in care homes, these include primary care (GPs, Advance Practitioners, District Nurses, community mental health nursing and care home liaison teams) and in some areas secondary care support such as from hospital at home and palliative care teams may also be available. Every effort should be made to deliver care and treatment to individuals within their homely setting. Where this is not possible and in the best interest of the individual a transfer to hospital may be necessary to meet their care needs and in keeping with their choices. Nevertheless, it is important to recognise that this may be a traumatic experience for older people with advanced frailty or cognitive impairment.

6. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

6.1 For those nearing the end of life, conversations about whether to resuscitate in the event of changing circumstances will be helpful including the individual (where possible) and their family. These discussions should be held by a senior clinician, for example: an experienced community or specialist nurse, Advanced Nurse Practitioner, a GP, a hospital consultant or palliative care team. There should never be a blanket approach to completing these forms.

6.2 We recognise that DNACPR discussions are always difficult ones to have, even more so when being done over the telephone. It is also recognised that CPR has a very low chance of success when cardiopulmonary arrest is in the context of severe COVID illness. It is important to note that there is no specific requirement to have a DNACPR discussion as part of this ACP conversation, unless the individual raises this and wishes to discuss it, or the clinician feels strongly that they need to discuss it. Instead the focus should be on supportive discussions with residents about what matters to them should they fall ill with COVID-19. The [HIS ACP template](#) provides a framework for discussions, with the option to complete the DNACPR section, if this is discussed.

7. Infection prevention and control

7.1 COVID-19 is a respiratory virus which is spread by the droplet route. Routes of infection are through the nose, mouth and eyes. There are simple IPC measures which will prevent the risk of transmission. These include, hand and respiratory hygiene and physical distancing of 2 metres. Where less than 2 metres, PPE must be used, as per (Annex 4). Physical distancing should be practised by all staff within the care home e.g. during tea breaks and in rest rooms, in addition sharing food is not recommended. Information can be found on the [NHS Inform](#) and [HPS](#) websites. It is vitally important that you do not go to work in the care home if you have symptoms of COVID-19 and staff should be aware of atypical presentations.

7.2 The [National Infection Prevention and Control Manual](#) provides information and evidence on Standard Infection Prevention Control (SIPC) measures which should be applied in the care home setting. Additionally HPS have produced specific COVID-19 guidance for [care homes which should be adopted and implemented](#) during this pandemic.

There is growing evidence that as we are now seeing sustained transmission of COVID-19, some people may be carrying the virus in their nose and throat but not displaying symptoms. Food can become contaminated by the virus via the hands or via droplets from the mouth of an asymptomatic individual. If the contaminated food is then ingested by another staff member or resident, their chances of acquiring the virus are higher. It is important that staff do not leave open or exposed, food such as cakes, sweets or crisps within the care home setting, either in the staff rest areas or in resident's rooms. Ensure thorough hand hygiene before preparing or eating food.

7.3 PPE used for sessional use

Aprons, gloves, masks and eye protection are standard PPE for the care home setting. HPS guidance regarding their use must be followed at all times, as outlined in HPS guidance tables [2](#) and [4](#) and the poster summarising IPC measures including PPE in Annex 4. We recommend that these are printed off and laminated so that they are available for staff in the home.

7.4 Information on how to access PPE can be found [here](#).

7.5 The evidence suggests that where optimal IPC measures are undertaken, infection and spread of COVID-19 is greatly reduced (**Annex 1**). Given the learning from across the world on COVID-19 continues to evolve, as does the evidence base, it is important that care home staff keep up to date with HPS guidance which is updated regularly as the pandemic progresses.

7.6 NHS Board Directors of Public Health in their leadership role should ensure that care homes are notified of any changes to the HPS guidance. In addition, working alongside the Care Inspectorate, HSCPs, clinical partners and other key stakeholders to support care homes at this time, including support with IPC measures.

7.7 Information on environmental/equipment cleaning and disinfection, linen, waste and staff uniforms can be found in the [HPS Care Home guidance](#).

7.8 IPC measures for the care of someone who has died

IPC precautions for the deceased are the same as already outlined in [HPS guidance](#) and should be followed when caring for a deceased resident. Further information on the safe handling of the deceased is set out within the Scottish Government's [Guidance for Funeral Directors](#).

7.9 Any personal items belonging to the deceased should be cleaned appropriately using a combined detergent disinfectant solution at a dilution of 1000ppm available chlorine OR a detergent followed by disinfection with 1000ppm available chlorine before being returned to the family. Ideally, clothing should be laundered before being returned to family where possible.

7.10 For information about Aerosol Generating Procedures (AGPs) within the care home, please see [HPS Care Home Guidance](#).

8. Other measures to protect residents including those in the shielding category

8.1 Many of the residents in care homes are at high risk of becoming very unwell if infected with COVID -19. For this reason we have been recommending '**physical distancing**' and '**shielding**' to reduce the risk of infection spreading within care homes.

8.2 **Physical Distancing:** This measure reduces social interaction between people in order to reduce droplet transmission of the virus. Physical distancing should be adhered to as much as possible, except in instances where the effect on mental, emotional or physical health of the resident would be very detrimental, for example would cause acute stress and distress, would lead to an event requiring hospital admission, would shorten life. Further information can be found on NHS [Inform](#) and on the [HPS website](#).

8.3 **Shielding:** This is a measure to protect people who are at extremely high risk of severe illness from COVID-19 because of a specific subgroup of underlying conditions. The aim of shielding is to minimise interaction between individuals and others to protect them from coming into contact with the virus and to reduce mortality in this group. Information on which people are in this category and what to do are on the NHS Inform [website](#). Discretion must be applied on an individual basis whether this control measure should be in place since it involves significant social isolation to individuals at the end of their lives and will have an additional impact on those with sensory or cognitive impairment as well as loneliness.

8.4 HPS [care homes guidance](#) states that the following measures should be followed for residents in the shielding category:

- Residents - Should have their own single room with en-suite facilities or provided with a dedicated commode where possible
- Must not be placed in cohorts
- Staff - Must minimise interaction to essential purposes only
- Must wear PPE when entering their room and within 2m of the resident

8.5 In the care home setting every resident is likely to be encouraged to follow physical distancing and a smaller subgroup following shielding. This means that those in the shielding group require different measures or should be prioritised where there are concerns about risk to an individual. In practice this might mean using PPE for a shielded resident to protect them. It is also important to note that additional staff are likely to be required to support measures such as shielding, physical distancing and caring for those being isolated to support and enable compliance with IPC measures.

8.6 In support of these measures the following should be adopted:

8.7 **Visiting policy** – As per HPS guidance, visiting must be restricted to essential visitors only. Essential visitors include appropriate health and care staff based on resident need, for a person receiving end-of-life care, to support someone with a mental health issue such as dementia, a learning disability or autism where not being present would cause the resident to be distressed. It must be recognised that visiting will carry a risk to visitors, particularly in care homes where there is an outbreak. Therefore appropriate risk assessment should be carried out and PPE issued where necessary. It is expected that homes will use sensitivity in balancing the risks to individuals with the need to show compassion in certain situations. Alternatives to in-person visiting should be explored, including the use of telephones or video calls.

8.8 Where families or friends are permitted to visit to be with their loved one, the following steps are recommended.

- The dying person should be asked, where possible, if they would like to receive a visit from family or a friend and this should be recorded in their care plan.
- Anyone who is showing symptoms of coronavirus (a new continuous cough or a high temperature) should not visit, even if these symptoms are mild or intermittent, due to the risk they pose to others.
- The number of visitors at the bedside at any given time is limited to one person. However, where it is possible to maintain social distancing throughout the visit, a second additional visitor could be permitted.
- Visitors must agree to wear appropriate personal protective equipment and follow any isolation or quarantine rules necessary.
- Visitors should visit the resident in their own room directly upon arrival and leave immediately after the visit.
- Visitors to minimise contact with other residents and staff (2 metres etc.)
- Visitors should be reminded to wash their hands for 20 seconds on entering and leaving the home and catch coughs and sneezes in tissues which should be discarded immediately.
- Visitors should be supported to safely discard PPE in the resident's room.
- It is worth staggering visits across the day so that there are not too many visitors in a home at any one time.
- Where a relative is visiting someone at the end of life, it may be helpful to make clear the purpose of the visit so that precious time is used well and to ask the visitor to relay messages to or from family. [These guiding principles produced by the Royal College of Physicians Edinburgh, the Scottish Academy of Medical Royal Colleges, Marie Curie & Scottish Care](#) on visiting at end of life are considered particularly helpful.

8.9 **Residents should remain in rooms as much as possible** in all care homes but particularly where there is an outbreak. Where this is not possible due to the resident's needs, physical distancing measures should be in place. There is a high risk in care homes that infections are spread between residents through communal areas such as lounges and dining areas. Meals should be served in residents' rooms and communal sitting areas avoided where possible. We recognise that this must be risk assessed based on the needs of residents, as for some residents with dementia for example, the act of watching others eating encourages those residents who may require these prompts to eat. It may be practical to stagger mealtimes to allow staff to manage this and also maintain physical distancing. Servicing meals in residents own rooms may impact on staffing requirements and the impact of this should be considered to ensure that residents who need support with meals receive this in a timely way.

8.10 Communal activities or the use of communal space should be avoided especially where there is an outbreak and alternative arrangements for entertainment and activities be put in place. If communal areas are required to be used then it is important that furnishings are wipeable to reduce the spread of infection, and that a physical distance of 2 metres is maintained at all times.

8.11 We recognise infection prevention and control measures are causing significant restrictions in all areas such as family and friends' visiting, familiar daily routine and sensory stimulation, all of which are extremely important for people with dementia and learning disabilities in normal times and even more so during the pandemic. If necessary it may be helpful to have a case discussion in whatever format appropriate to discuss an individual's

unique circumstances and identify ways to mitigate the impact of such measures. Strategies for promoting the wellbeing of residents during this pandemic are contained in Annex 5.

8.12 We know that reduced activity decreases muscle mass and functional decline and is heightened in the elderly population. Whilst it is essential all shielding and physical distancing precautions are adhered to, supporting individuals to remain active within a reduced space remains vital for their health and wellbeing e.g. encouraging regular sit to stand, moving around the room, breaking up time spent between bed and a chair etc. For advice on physical movement see [CAPA](#).

8.13 The Mental Welfare Commission has published a series of COVID-19 advice notes for practitioners in line with its purpose in protecting and promoting the human rights of people with mental illness, dementia, learning disabilities and other related conditions across all care settings. A common theme within the advice notes is that restrictions on human rights during this time should be carefully considered, from a legal and ethical perspective. You can access the advice [here](#).

9. Management of a COVID-19 outbreak in a care home

9.1 Residents with suspected (including those who may not have a typical presentation) or confirmed COVID-19 infection should be managed in line with [HPS guidance](#). This will include testing regimes and enhanced cleaning schedules to reduce transmission of infection. All suspected or symptomatic residents in the care home should be isolated immediately for 14 days from the date of symptom onset (or date of first positive test if symptom onset undetermined). The Care Inspectorate and the NHS Board Director of Public Health should be notified and the HPS guidance followed. NHS Boards are required to support all testing and tracing as required for the care home setting.

9.2 The HPS guidance also includes information about cohorting residents in care homes during an outbreak.

9.3 Additional information on testing can be found in section 11 below and on the [HPS website](#).

10. Admissions, discharges and transfers for care home during this pandemic

10.1 Summarised information about admissions can be found in **Annex 6**.

10.2 The care home sector is a vital part of the health and social care system. It is imperative that the care homes put in place clear processes to facilitate the return of their residents from an acute setting and to accommodate the admission of new residents where it is clinically safe to do so. Residents can be safely cared for in a care home. The [HPS guidance](#) on care home settings can help support care homes to do this. All transfers from acute hospital or new admissions should have a risk assessment to ensure sufficient resources are available within the care home to support social distancing and isolation.

10.3 The Health Secretary's statement on 21st April stated that the following groups should be tested:

- All COVID-19 patients in hospital who are to be admitted to a care home

- All other admissions to care homes

10.4 The presumption should be that all residents being admitted to a care home should have a negative test before admission unless it is in the clinical interests of the person to be moved and then only after a full risk assessment.

10.5 Admission of COVID-19 recovered patients from hospital

Patients should always be isolated for a minimum of 14 days from symptom onset (or first positive test if symptoms onset undetermined) and absence of fever for 48 hours (without use of antipyretics). They **do not** require to spend the 14 days in hospital but should ideally have 2 negative tests before discharge from hospital (testing can be commenced on day 8). Tests should have been taken at least 24 hours apart and preferably within 48 hours of discharge. **Where testing is not possible** (e.g. patient doesn't consent or it would cause distress) and following risk assessment for discharge to care home within the 14 day isolation period, then there must be an agreed care plan for the remaining period of isolation up to 14 days in the home.

10.6 For an adult without the capacity to consent to this test, the responsible clinician will have to consult the patient's welfare attorney and crucially decide if the test is the best interest of the patient - this would be an individual clinical decision. Where a test would be too painful or distressing and not in the interest of a patient it would be reasonable to return to the care home after discussion with the Home manager/senior staff. The individual would have to continue the 14 days of isolation in the care home.

10.7 In all instances, the discharging hospital should provide the care home with the following information on arrival of the individual:

- Where a COVID test has been taken, the date and results of the test. (Dates of a negative test in a non-COVID-19 infected individual, or the dates of two negative tests in a previously infected individual)
- The date of the onset of any symptoms.
- A care plan for completion of the isolation period and any follow-up treatment and care required.
- Prior to discharge the hospital must ensure that the care home is able to provide the care required e.g. if the individual requires to be isolated, that there is a suitable physical space and staff available for the delivery of care and support to an isolated resident.

10.8 Further details can be found in [Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings](#).

10.9 Admission of non-COVID-19 patients from hospital

Testing should be done within 48 hours prior to discharge from hospital. A single test is sufficient. The patient may be discharged to the care home prior to the test result being available on condition that the care home is able to support all required care needs during this isolation period following discharge. Risk assessment prior to discharge from hospital should be undertaken in conjunction with care home staff to ensure that appropriate isolation facilities are available in the care home, taking into account requirements for the individual's care. See [Guidance for Sampling and Laboratory Investigations for information](#).

10.10 Admissions from the community

All other admissions from the community should have at least one test performed before or on admission, and be isolated on admission for 14 days. Risk assessment prior to admission

should be undertaken to ensure that appropriate isolation facilities are available in the care home, taking into account requirements for the individual's care.

10.11 New admissions should be considered for **retesting** if they become symptomatic including changes in the residents condition if indicated following a clinical assessment, after admission. The 14 day isolation period commenced on admission must be completed, even if a COVID-19 test result comes back negative. Staff should be alert to COVID-19 infection in older people in particular as it may be harder to detect (see earlier section on presentation). Where concerns exist that a resident may have COVID-19, they should be escalated and advice sought from the GP or other healthcare staff.

10.12 **Transfer from the care home to hospital**

If a transfer from the care home to hospital is required, the ambulance service must be informed if the individual is a suspected or confirmed COVID-19. Staff in the receiving ward/department should also be notified of this in advance of any transfer.

10.13 **Hospital assessment of care home residents**

Patients from a care home setting being assessed in an Acute Medical Unit (or other assessment unit) **not** requiring hospital admission **only require COVID testing prior to discharge if they are clinically suspected of having COVID** If they are admitted for another reason (e.g. a blocked catheter or a suspected DVT) with no clinical suspicion of COVID infection, then routine testing is not mandated. Clinicians should clearly stay alert to the fact that COVID frequently presents with atypical symptoms in the elderly.

10.14 Testing does not preclude the patient being discharged back to their care home, but they should isolate until the result is known (and the ability of the care home to undertake this should be confirmed prior to discharge). If the patient is still felt, clinically, to have COVID despite a negative test then they should be retested and continue isolation for 14 days as a subsequent test may be the confirmatory trigger for outbreak management. **The need for isolation must be communicated to the care home in this circumstance.** There may be circumstances where the risk assessment following discussion with the resident and/ or their family, that it is in the best interests of the resident to be transferred before the test is available.

10.15 **Wherever possible patients from care homes should be assessed in side rooms or individual assessment bays.** If a patient from a care home has been assessed in a multi-person bay in hospital then they should be isolated on return to the care home for fourteen days. The ability of the care home to undertake this should be confirmed prior to discharge.

10.16 **Residents who leave the facility** to attend an essential non-hospital or hospital day visit, e.g. attending a funeral or hospital appointment, do not require the same measures as a new admission. The guidance outlined on [NHS Inform](#) on physical distancing, shielding and household isolation must be followed during day visits. Any concerns about potential exposure to COVID-19 during a day visit may require a local risk assessment to determine whether additional measures are needed.

11. **Testing of residents and staff in care homes**

11.1 During the current phase of the pandemic, a single case in a care home (residents or staff) should raise the suspicion that there may be an outbreak in the care home. If you

suspect an outbreak please discuss with your local Health Protection Team (HPT). The Care Inspectorate also require to be notified of every individual case through e forms notifications. This outbreak definition should also include symptomatic cases who have either been transferred from the care home to hospital as a result of infection or an individual who has died.

11.2 The current testing approach as per the First Minister's statement on 1 May:

- All staff and residents in care homes will be routinely tested where cases of the virus have been identified.
- In addition where staff work between homes run by the same operator testing will also take place in those homes.
- Surveillance testing will also take place in care homes without cases of the virus. A sample of residents not displaying symptoms will be tested to track the spread of COVID-19.

11.3 If a resident finds testing intrusive or painful or refuses consent, they should not be forced to undergo a test. If you have reasonable concerns about a resident's health or wellbeing or you suspect they have COVID-19 you should discuss these with their GP or other health staff and isolate the resident until confirmation.

11.4 Testing does have its limitations and it can be helpful to be aware of that in understanding the role it plays in assessing people. Testing may not be as sensitive in someone early in the illness, particularly before they have symptoms. In a person that has been exposed, testing can be used to confirm that symptoms are due to COVID-19, however it cannot be used to rule out that they may go on to develop COVID-19 infection during the 14 day period following exposure. Testing tells you only about whether they have developed the illness at that particular time point. This is important to remember if a new admission comes into a home with a negative test. They should still be isolated for the full 14 days to make sure that they do not develop symptoms in that time. After 14 days they can come out of isolation. It is also absolutely vital to ensure handwashing and simple IPC procedures are carried out at all times.

11.5 Studies have shown that some residents can test positive even before they develop symptoms. Some people may remain without symptoms during an illness so vigilance and good IPC practice must be maintained at all times.

12. Workforce planning and safe staffing levels, staff deployment during COVID-19

12.1 It is recognised that as this pandemic progresses, staff absence is likely to increase. Like all services during the COVID-19 pandemic it is anticipated that care homes will require to adapt staffing models. The reasons for this will include increased staff absence, staff shielding, requirements to introduce social distancing measures, shielding residents, the need to isolate residents where there is suspected or confirmed cases of COVID-19, supporting people with dementia and increased numbers of residents who may become unwell and require end of life care. All of the above will impact significantly on the stability of services at this time. If services have concerns about staffing they should complete the Care Inspectorate's staffing RAG notification. This is shared with the SSSC to support additional staffing to be found from the SSSC portal.

12.2 It is estimated that staffing absence as the pandemic surges may be as high as 50% and it is therefore essential that workforce resilience planning for the sector factors in a

range of absence levels from 30% - 50%. Where staffing requirements exceed local care home resilience plans it is important that Health Boards, Local Authorities and Health and Social Care Partnerships work with local care homes to support workforce resilience. This can be achieved through 'mutual aid' to ensure residents receive appropriate care. Guidance about the deployment of Health Board staff to community settings can be found in DL letters ([DL\(2020\)10](#)) and ([DL\(2020\)13](#)). As part of mutual aid arrangements, NHS boards and Local Authorities are required to support care homes to maintain sufficient staffing levels to meet residents' needs during this pandemic.

12.3 Returners are being processed via NHS Education Scotland and Scottish Social Services Accelerated Recruitment Portals. This staffing resource can be accessed via the [Scottish Social Services Council](#) or the local Health and Social Care Partnerships.

12.4 The response to the pandemic will require senior leadership and clinical knowledge and skill to work in partnership to support social care teams to respond to the increased clinical care demands associated with an outbreak. This includes support with infection prevention and control measures, education and training and additional resources such as staffing and equipment where required.

12.5 It is likely that during this pandemic, current staffing models and in particular, skill mix, may no longer be appropriate and that a planned approach to changing staffing models and skill mix will be required to ensure that associated risks can be mitigated in a planned way either through additional staffing resource within the care home or more in-reach health support from General Practice and community nursing teams. Planning for this should be done in conjunction with the Care Inspectorate, Health and Social Care Partnership, the NHS board and the Local Authority to ensure the safest care for residents and appropriate deployment of staffing resource.

12.6 COVID-19 pandemic is a health emergency and as such may require a rapid health response. It is recognised that clinical response is normally through General Practice, District Nursing alongside other community health teams. The Community Nursing teams will need to be enhanced to enable additional in-reach support to care homes during this pandemic. In addition, support from secondary care teams e.g. hospital at home and palliative care teams may also need to be enhanced to provide additional support during this pandemic.

12.7 A safety huddle template and professional judgment template have been developed in conjunction with the care home sector and should be used to help care homes identify residents' care need and associated staffing requirements. This can also be used to identify where changes to skill mix and additional clinical input is required to support the changing needs or complexity of residents. The safety huddle template should be used on a daily basis to enable care homes to identify and escalate concerns. The template is designed to reduce the need to collect multiple sources of information as the information in the template can be used to inform the Care Inspectorate staffing 'rag status', Health and Social Care Partnerships and Public Health requirements.

12.8 Additional staffing requirements may include senior care workers, care workers, nurses, Allied Health Professionals (AHPs), Nursing, Medical or AHP students or volunteers where that is appropriate. These decision-making aids should always be used during this pandemic unless the care home has a similar process already in place. These templates are currently being tested and will be made widely available shortly.

12.9 Staff deployment to support care homes needs to ensure the ability to respond to the increasing demands associated with this pandemic as well as where possible restricting the foot fall into the care home. Staff who work across a number of locations including community nurses and temporary staff eg “bank” /agency staff can leave care homes particularly vulnerable to transmission of COVID-19. Where temporary staff need to be used, it is advised that their employment is restricted to one care home as the movement of staff between care homes can increase transmission. Care home managers must also ensure strict compliance with IPC measure for all staff unfamiliar with the care home.

12.10 As well as agency staff, the same principle should also be applied to any new staff or volunteers who work in one or more other care settings. Providers should if possible use the same staff or volunteers for each service and deploy them to care for the same restricted number of people. While decisions about recruitment and deployment will vary according to the circumstances of each service, providers should try to make informed assessments about who to recruit and how they should be deployed in order to minimise the risk of infection for everyone involved. This may involve asking new staff or volunteers about the different care services they have recently worked in and making deployment decisions accordingly.

12.11 It is recognised that this can be a fine balance in achieving appropriate staffing levels, service sustainability and reducing the risks of transmission. Public Health Directors have been asked to provide additional leadership support to care homes during this pandemic and have been in contact with care homes to identify additional support requirements in relation to IPC, education and training and staffing.

13. Indemnity for NHS Staff in Care Homes

13.1 Staff deployed from NHS Boards through mutual aid during this pandemic will have employee and professional indemnity covered through the NHS CNORIS employer indemnity scheme. Where NHS staff are deployed to the care home they will work as part of the care home team under the supervision of the care home management structure, but will retain line management through the NHS structures and arrangements for clinical supervision and professional line management will be through the allocated NHS professional lead. For social care staff recruited via the SSSC portal, they are employed directly by the care home provider and as the employers own terms and conditions are used staff are covered by employers’ indemnity.

14. Education and Training

14.1 The [Scottish Social Services Council \(SSSC\)](#) and [NHS Education for Scotland \(NES\)](#) have developed a range of educational and induction resources for all health and social care staff deployed or redeployed to support services. The websites are regularly reviewed and updated in line with current advice and as new material becomes available. Some of the items listed were launched pre COVID-19; however, many of the points will still be very relevant for practitioners in the current situation.

14.2 Some examples of current resources include:

- [Supporting wellbeing](#) which promotes looking after yourself; supporting resilience and wellbeing in social service workers.

- [Death, dying and bereavement resource](#) – particularly the emotional resource section which provides links and resources to support the workforce during the COVID-19 pandemic. Further resources on support around death can be found on the [NES website](#). The Scottish Academy has also produced a [resource](#) on caring for patients and bereaved families after death.
- [Personal Protective Equipment \(PPE\) video](#) – HPS has developed a short video to demonstrate the use of PPE which aligns with the National Infection Prevention and Control Manual.

14.3 Additional information and access to education resources for Registered nurses working in care homes can be accessed through the [NES Turas site](#) and further information including access to NMC updates can be accessed via the [National Clinical Guidance for Nursing and AHP Community Health Staff during COVID-19 Pandemic](#).

15. Staff Health and Well-being during COVID-19

15.1 Staff with underlying health conditions that put them at increased risk of severe illness from COVID-19, including those who are immunosuppressed, **should not provide direct care to residents with suspected or confirmed COVID-19**. A risk assessment should be undertaken as it may not be appropriate for them to work on-site at all. Please note that this group is wider than those that require shielding and details can be found on [NHS Inform](#).

15.2 Staff who think they may be at increased risk or who are pregnant should seek advice from their line manager, midwife or local Occupational Health service. Information for at risk or pregnant health and social care workers can be found in [Guidance for Staff and Managers on Coronavirus](#). Staff who fall into the shielding category should follow the specific advice for that group.

15.3 At this time where visiting by family is limited carers play a valuable and difficult role in supporting residents and their families who may also be feeling upset and distressed. This can place increased emotional demands on care home staff at this time.

15.4 At such unprecedented times of anxiety and uncertainty, it will be important that staff feel supported and connected with their colleagues. Within a care home setting staff will have built close relationships with residents and their families over time and therefore the impact of the death of residents, particularly where there are multiple deaths may be profound. Employers have a duty for the health and wellbeing of their staff and it is important at this time that access to appropriate support for staff is available at this time. [The National Wellbeing Hub](#) for Scotland's health and social care workforce has a wide range of support and wellbeing resources for staff.

15.5 The Scottish Social Services Council (SSSC) has developed a series of online resources and a [guide](#) on the wellbeing for the social care sector. The guide aims to help support staff to look after themselves, others for whom they provide support and care and colleagues.

15.6 There are a number of helplines which may be useful for staff if they have concerns or just want to talk - NHS 24's Mental Health Hub and helpline (111) as well as the Breathing Space telephone support service (0800 83 8587).

16. Clinical and health care support for care homes residents during COVID-19 Pandemic

16.1 Support from GP practices

GP practices remain the first point of contact for medical queries for care homes and will continue to provide the same high level of care and support. GPs along with the wider multi-disciplinary team know their patients well, including the complexities of their care needs, and are best placed to advise on ongoing COVID-19 and non COVID-19 related matters and the right care for people. GPs and the wider primary care team including district nurses will continue to provide personalised and individual care to residents, for all their health needs, working alongside care home staff.

16.2 Seeking advice about support from GP practices

For all NEW suspected COVID-19 patients, care homes are asked to contact 111 where calls will be triaged promptly or contact local GP practice or care home liaison team as per local guidance. Please be assured that 111 staff will ensure that your call is directed quickly to the most appropriate route, and they will link in to any existing local arrangements to ensure care home residents are assessed promptly, alongside any further health protection actions which may be required to support you.

16.3 If a resident with or without suspected COVID-19 condition is deteriorating care home staff should contact their local GP practice / care home team for advice and support or phone 111 depending on local arrangements. If out of hours then they should call 111.

16.4 GP practice and multi-disciplinary team support during the pandemic

Care home staff should inform the GP or link nurse if they have a significant concern about their residents. GPs and community teams will visit in person only when there is an absolute clinical need to do so, but in most cases will provide advice over the telephone or using digital technology (such as near me) to reduce the potential risk of bringing any infection into the home. This will also be the case for reviews carried out by out of hours services.

16.5 If a resident requires a face to face consultation, the GP or a member of the multi-disciplinary team will require to wear personal protective equipment (PPE) for all patients. GP practices are working closely with the new COVID Hubs (where the Covid 111 calls are handled) and the Covid assessment centres (where patients are seen for assessment, if needed).

16.6 Where the clinical need of a resident changes because of a COVID-19 infection outbreak it may be necessary to provide enhanced in-reach healthcare support for residents and care staff. This will mean community staff such as district nursing, Allied Health Professionals, and support from secondary care including hospital at home services or palliative care teams working alongside GPs. More details of the community clinical teams support for care homes can be found in the [National Clinical Guidance for Nursing and AHP Community Health Staff during COVID-19 Pandemic](#).

16.7 **Use of NHS Near Me** video consulting can be used to reduce the number of people attending the care home and risk of exposure of residents to coronavirus. It provides care homes with access to GPs, community Nursing and AHP teams and clinicians to help to reduce the number of visits whilst providing access to support and occasional clinical opinions. Out of hours services may also use Near Me consulting. Scenarios where video consulting may be beneficial in homes include:

- To protect residents from potential exposure to coronavirus from visiting clinicians in situations where non hands-on care can be given.
- To avoid transporting residents unnecessarily to NHS facilities.
- To maximise clinician capacity by avoiding travel time.
- The Care Inspectorate are using Near Me with services to have 'face to face' interactions which may support relationships and when appropriate 'see' inside a care providers premises.

16.8 Care homes should routinely ask if this is available, and use where appropriate. Guidance on the use of Near Me in care home is available [here](#).

17. Support for palliative and end of life care during the COVID-19 pandemic

17.1 Care homes have always played an important role in supporting residents at the end of their lives. Care home staff are skilled and experienced in supporting people to die well, focusing on good, compassionate, person-centred care. Palliative care in care homes is supported as necessary by other community health services such as general practice, district/ specialist community nursing, palliative care teams and pharmacy. In some areas there is active involvement of local hospices to advise and support care home staff through IT platforms such as ECHO (see example from [Highland Hospice](#)). Good communication and coordination of support for residents as well as access to the right supportive and palliative care medicines are essential during this stage.

17.2 A [palliative care toolkit](#) has been developed to help improve access to supportive and palliative care medicines, within the scope of the extant Human Medicines Regulations 2012, including the flexibilities provided during a pandemic situation, and the Misuse of Drugs Regulations 2001. There is a specific section on care homes.

17.3 The toolkit provides Health and Social Care planners with options that can be adapted and utilised locally in their response to COVID-19. To assist with this, several exemplars of documentation, policies, charts and flow diagrams have been included in the appendices.

17.4 The care home section details approaches to strengthening access to medicines in care home settings including:

- preparing anticipatory prescriptions for Just in Case Boxes (JICBs) for residents which are only dispensed if needed for that individual resident. These can be repeated every 28 days as necessary. This approach will minimise the waste of specific medicines expanding the use of homely remedies to Include a number of Pharmacy Only (P) and General Sales List (GSL) medicines to provide symptomatic relief;
- using the To Take Out (TTO) packs of medicines that are being provided to Emergency Departments (EDs) as a bridge to alleviate symptoms; and
- making use of the supply and administration of certain Prescription Only Medicine (POM) medicines under a specific protocol which has been approved by a Health Board.

18. Repurposing of medicines in care homes

18.1 The Care Inspectorate and the Scottish Social Services Council (SSSC) have released a joint [statement](#) to support the repurposing of medicines in care home settings as a last resort in order to provide a patient with access to a palliative medication that they require when other options to access stock cannot be made in a timely way to meet the patient needs.

18.2 [Guidance for Repurposing Prescription Only Medicines \(POMs\) in Care Homes and Hospices](#) has been developed by the Directors of Pharmacy to support the ethical and professional decision-making on repurposing of medicines.

18.3 Specific COVID-19 guidance has been produced on end of life care when a person is imminently dying from COVID-19 lung disease which draws on Scottish Palliative Care Guidelines and can be found [here](#).

19. Supporting residents' well-being and family and friends during this pandemic

19.1 Implementing these measures including physical distancing may have adverse effects on quality of life that need to be considered. These factors may be more marked for residents with dementia who may be at increased risk of becoming anxious, stressed, frustrated and distressed by physical distancing measures. Therefore the use of appropriate language will need to be carefully considered. The Care Inspectorate has produced a [guide](#) on supporting people to keep in touch when care homes are not accepting visitors.

19.2 The use of personal protective equipment may also increase anxiety and distress in someone who is confused or evoke an unexpected reaction. Staff should be aware of this, where possible explain their appearance in ways that the person understands, be thoughtful and try to minimise any negative reaction.

19.3 Family members and friends who may not be permitted to visit will also need reassurance and understanding. Many will be anxious about the wellbeing of the person they care about and worry about the impact on their relative or friend of measures to reduce contact with others. Utilising and proactively facilitating alternative ways that they can continue to stay in contact using phone or digital technology, letter will be essential for both the resident, their family and friends. Access to spiritual care through this means may be also be helpful.

19.4 Education of residents and families can aid compliance with mitigation strategies, and address considerations of quality of life and anxiety. More information on strategies for promoting the wellbeing residents is contained in **Annex 6**.

20. Adult Support and Protection

20.1 Staff should be mindful of their responsibilities around Adult Support and Protection during this challenging time and if necessary discuss and share with relevant statutory agencies, where they know or believe an adult is at risk of harm. Additional guidance on adult support and protection in response to COVID19 is available [here](#). The aim of this guidance is to support local decisions and the development of local guidance around safe, effective and proportionate adult support and protection activity at this time.

Professor Graham Ellis, National Clinical Advisor for Ageing and Health to the Chief Medical Officer in NHS Scotland

Diane Murray, Depute Chief Nursing Officer, Scottish Government

On behalf of the COVID Care Homes Clinical and Professional Advisory Group

Scottish Government

15 May 2020

Feedback

If you have any comments about this guidance please email:

CareHomesCPAG@gov.scot

Evidence underpinning this guidance

Recent international and UK based experiences on the spread of COVID-19 in care homes points to the need for strict measures to protect all care home residents and staff from becoming infected and to reduce the incidence of further spread for affected care homes where outbreaks have occurred.

One of the key reasons for strict measures is evidence to suggest that by the time a single symptomatic case is identified in a home, the virus will already be circulating amongst residents and staff. Furthermore there is potential **asymptomatic and presymptomatic transmission** of COVID-19 in care homes among both residents and staff. Droplet and indirect transmission through hands and surfaces are the primary modes of transmission. Strict compliance with infection, control and prevention measure which includes enhanced cleaning schedules are essential at this time.

It is recommended that based on these findings there are a number of overall prevention strategies required for care homes to reduce the spread and mortality from the pandemic. These are summarised below. More detail on the practical application of these measures is provided in the core guidance.

RESTORE2

Recognise Early Soft Signs, Take Observations, Respond, Escalate



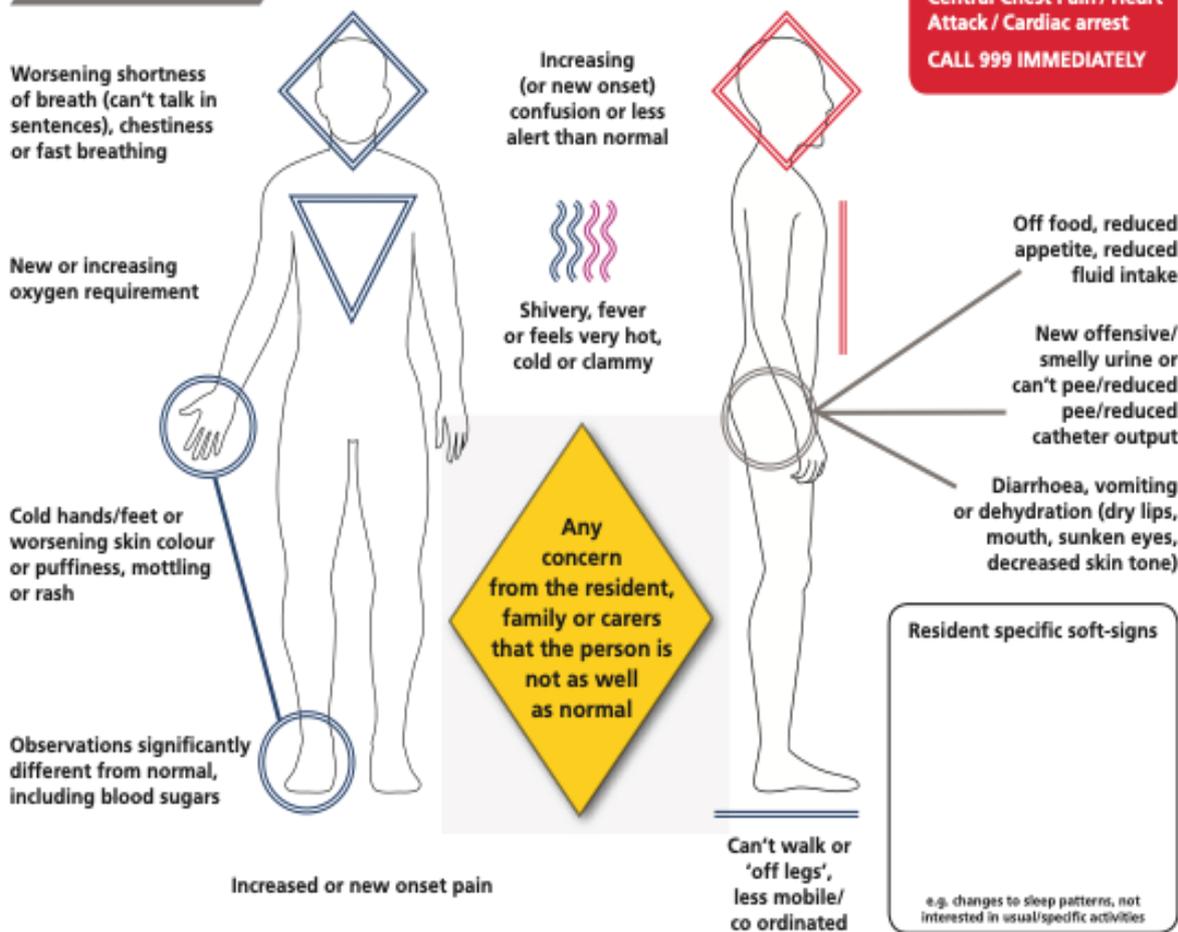
Adult Physiological Observation & Escalation Chart

Full Name:	<input type="text"/>		
NHS No.	<input type="text"/>		
DOB:	<input type="text"/>	Room No.	<input type="text"/>

Does Your Resident Have Soft Signs of Possible Deterioration

Worse than normal lethargy or withdrawal or anxiety/agitation/ apprehension or not themselves

NEW ONSET OF:
 Stroke (facial / arm weakness, speech problems)
 Central Chest Pain / Heart Attack / Cardiac arrest
CALL 999 IMMEDIATELY



If you answer YES to any of these triggers, your resident is at risk of deterioration



Full Name:

NHS No.

How to use RESTORE2

RESTORE2 which includes the National Early Warning Score (NEWS2) promotes a standardised response to the assessment and management of unwell residents. It is not a replacement for clinical judgement and should always be used with reference to the persons care/escalated plan and any agreed limits of treatment. If you are concerned about the resident or if one observation has changed significantly ALWAYS ACT ON YOUR CONCERNS AND SEEK ADVICE from a competent clinical decision maker e.g. GP, Registered Nurse or AHP.

- This chart uses aggregated (total) NEWS - it is important that you understand the residents normal NEWS (the score when they are stable and as well as usual) to support appropriate escalation. You should try and establish what is normal for residents on admission with a member of the multi-disciplinary team (e.g. General Practitioner, frailty practitioner).
- Only a Medical Professional can authorise use of the hypercapnic respiratory failure scale for residents who normally have low oxygen levels as part of a diagnosed condition (e.g. COPD)
- Use this chart for all your routine observations as per your local policy. If your resident shows ANY of the soft signs of deterioration, record their observations and NEWS immediately on the chart and follow the escalation tool as appropriate, using SBARD to communicate
- There may be a need to re-consider what is normal for the resident following any sustained improvement in their condition or non-acute deterioration.

What's normal for this resident



Print name: _____ Date: _____ Signature: _____

What is the resident normally like? What observations and NEWS are reasonable and safe for them? When would their GP want you to call them? What escalation has been agreed with the resident (or their advocate)?

End of Life (EOL) or Agreed Limit of Treatment

- All residents should have had the opportunity to discuss their end of life preferences in advance of any crisis
- RESTORE2 must be used in conjunction with the expressed wishes of the resident e.g. treatment escalation plans or advanced care plans.
- RESTORE2 can be used in residents with an agreed limit of treatment (e.g. not for hospital admission, not for resuscitation or not for intravenous antibiotics) to identify recoverable deterioration amenable to treatment. It is also useful for anticipating end of life to inform conversations with residents and their relatives - once the resident is on an EOL care pathway, RESTORE2 should be discontinued.

NEWS2 Escalation (get the right help early)

	Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0	Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	At least 12 hourly until no concerns
1	Immediate senior staff review, escalate if concerned. Repeat observations within 6 hours. If next observations remain elevated with no obvious cause arrange for GP review suggested within 24 hours. If NEWS is worsening, move to appropriate escalation point.	At least 6 hourly
2	Immediate senior staff review, if no improvement in NEWS (or the same) within 2 hours , seek GP telephone assessment within 2 hours +/- GP review within 6 hours. If NEWS is worsening, move to appropriate escalation point.	At least 2 hourly
3-4	Repeat observations within 30 minutes . If observations = NEWS +3 or more , seek urgent GP telephone or face to face review within 2 hours. If NEWS is worsening, move to appropriate escalation point.	At least every 30 minutes
5-6	Immediate clinical review/advice required. Refer to GP using surgery bypass number or use NHS 111 to contact out of hours. Urgent transfer to hospital within 1 hour may be required.	Every 15 minutes
7+	Admission to hospital should be in line with any appropriate, agreed and documented plan of care. Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	Continuous monitoring until transfer

Full Name:

NHS No.

Take observation + calculate NEWS

Authorising clinician
Signature & Date

ACVPU KEY

A
Alert
awake & responding, eyes open

C
Confusion
New onset of confusion (Do not score if chronic)

V
Verbal
moves eyes / limbs or makes sounds to voice

P
Pain
responds only to painful stimuli

U
Unresponsive
unconscious

		Date					
		Time					
A+B Respirations <i>Breathless</i> 	≥25						3
	21-24						2
	18-20						
	15-17						
	12-14						1
	9-11						
	≤8						3
A+B SpO ₂ Scale 1 Oxygen saturation (%)	≥96						1
	94-95						2
	92-93						3
	≤91						
SpO₂ Scale 2' Oxygen saturation (%) Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure <small>*ONLY use Scale 2 under the direction of a qualified clinician</small>	≥97 on O ₂						3
	95-96 on O ₂						2
	93-94 on O ₂						1
	≥93 on air						
	88-92						1
	86-87						2
	84-85						3
	≤83%						
Air or Oxygen?	A = Air						
	O ₂ L/min						2
C Blood pressure mmHg Score uses systolic BP only 	≥220						3
	201-219						
	181-200						
	161-180						
	141-160						
	121-140						
	111-120						
	101-110						1
	91-100						2
	81-90						
	71-80						3
	61-70						
	51-60						
	≤50						
C Pulse Beats/min 	≥131						3
	121-130						2
	111-120						
	101-110						1
	91-100						
	81-90						
	71-80						
	61-70						
	51-60						
	41-50					1	
	31-40					3	
	≤30						
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert						
	Confusion						
	V						3
	P						
	U						
E Temperature °C 	≥39.1						2
	38.1-39.0°						1
	37.1-38.0°						
	36.1-37.0°						
	35.1-36.0°						1
	≤35.0°						3
NEWS TOTAL							
Next observation due (Mins/Hrs)							
Escalation of care Y/N							
inbab							

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

Full Name:

NHS No.

										Date	
										Time	
3										≥25	A+B Respirations Breaths/min 
2										21-24	
										18-20	
										15-17	
1										12-14	
3										9-11	
										≤8	
										≥96	A+B SpO₂ Scale 1 Oxygen saturation (%)
1										94-95	
2										92-93	
3										≤91	
3										≥97 on O ₂	SpO₂ Scale 2[†] Oxygen saturation (%) Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure †ONLY use Scale2 under the direction of a qualified clinician
2										95-96 on O ₂	
1										93-94 on O ₂	
										≥93 on air	
										88-92	
1										86-87	
2										84-85	
3										≤83%	
										A = Air	Air or Oxygen? O ₂ L/min
2										O ₂ L/min	
3										≥220	C Blood pressure mmHg Score uses systolic BP only 
										201-219	
										181-200	
										161-180	
										141-160	
										121-140	
										111-120	
1										101-110	
2										91-100	
										81-90	
3										71-80	
										61-70	
										51-60	
										≤50	
3										≥131	C Pulse Beats/min 
2										121-130	
										111-120	
										101-110	
1										91-100	
										81-90	
										71-80	
										61-70	
										51-60	
1										41-50	
3										31-40	
										≤30	
										Alert	D Consciousness Score for NEW onset of confusion (no score if chronic)
3										Confusion	
										V	
										P	
										U	
2										≥39.1	E Temperature °C
1										38.1-39.0°	
										37.1-38.0°	
										36.1-37.0°	
1										35.1-36.0°	
3										≤35.0°	
										NEWS TOTAL	
										Next observation due (Mins/Hrs)	
										Escalation of care Y/N	
										Initials	

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

Page 4 of 6 - All pages must be present when printing

SBARD Escalation Tool and Action Tracker

(get your message across)

REMEMBER TO SAY: The residents TOTAL NEWS SCORE is...

Name:

NHS No.

Notes		Date, Time, Who
<p style="font-size: 2em; font-weight: bold; text-align: center;">S</p>	<p>Situation (briefly describe the current situation and give a clear, concise overview of relevant issues) (Provide address, direct line contact number) I am... from... (say if you are a registered professional) I am calling about resident... (Name, DOB) The residents TOTAL NEWS SCORE is... Their normal NEWS/condition is... I am calling because I am concerned that... (e.g. BP is low, pulse is XX, temp is XX, patient is more confused or drowsy)</p>	
<p style="font-size: 2em; font-weight: bold; text-align: center;">B</p>	<p>Background (briefly state the relevant history and what got you to this point) Resident XX has the following medical conditions... The resident does/does not have a care plan or DNACPR form / agreed care plan with a limit on treatment/hospital admission They have had... (GP review/investigation/medication e.g. antibiotics recently) Resident XX's condition has changed in the last XX hours The last set of observations was... Their normal condition is... The resident is on the following medications...</p>	
<p style="font-size: 2em; font-weight: bold; text-align: center;">A</p>	<p>Assessment (summarise the facts and give your best assessment on what is happening) I think the problem is XX And I have... (e.g. given pain relief, medication, sat the patient up etc.) OR I am not sure what the problem is but the resident is deteriorating OR I don't know what's wrong but I am really worried</p>	
<p style="font-size: 2em; font-weight: bold; text-align: center;">R -- D</p>	<p>Recommendation (what actions are you asking for? What do you want to happen next?) I need you to... Come and see the resident in the next XX hours AND Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services) Decision (what have you agreed) We have agreed you will visit/call in the next XX hours, and in the meantime I will do XX If there is no improvement within XX, I will take XX action.</p>	<p>Actions I have been asked to take (initial & time when actions completed)</p> <p style="text-align: right;">Initials</p>

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Page 5 of 6 - All pages must be present when printing

The SBARD technique provides an easy-to-remember standardised framework for critical conversations, including what key information will be communicated about a resident's condition and what immediate attention and action is required. Record all your actions and conversations.



Name: NHS No.

Notes		Notes			
Date, Time, Who		Date, Time, Who			
				S	
					B
				A	
				R	
				-	
				D	

Actions I have been asked to take (initial & time when actions completed)	Initials	Actions I have been asked to take (initial & time when actions completed)	Initials

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

Do not use in an emergency. In an emergency, call 999

Whenever possible, please call from next to the person you are supporting and have their care plan and medication sheet to hand

Situation	<p>For use for all calls Date: ___/___/___ Time: ___:___ I am (your name) _____</p>																			
	<p>I am a nurse/senior carer/carer from (name of care home) _____</p>																			
	<p>I am concerned about (full name of the person you are supporting) _____</p>																			
	<p>Address _____</p>																			
	<p>Postcode _____ Phone No: _____ Date of Birth ___/___/___</p>																			
	<p>For use for calls to the GP: The reason I am calling is to request: (complete all information if more than one reason)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Home visit</td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 30%;"></td> <td style="width: 10%;">Telephone call</td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"></td> </tr> <tr> <td>Near Me video appointment</td> <td><input type="checkbox"/></td> <td></td> <td>Prescription request</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Medication review</td> <td><input type="checkbox"/></td> <td></td> <td>Other (please specify):</td> <td colspan="2"></td> </tr> </table>		Home visit	<input type="checkbox"/>		Telephone call	<input type="checkbox"/>		Near Me video appointment	<input type="checkbox"/>		Prescription request	<input type="checkbox"/>		Medication review	<input type="checkbox"/>		Other (please specify):		
Home visit	<input type="checkbox"/>		Telephone call	<input type="checkbox"/>																
Near Me video appointment	<input type="checkbox"/>		Prescription request	<input type="checkbox"/>																
Medication review	<input type="checkbox"/>		Other (please specify):																	
	<p>Only use for OOH calls:</p> <p>I am concerned because (state what your observations are or what the person has told you, for example: fallen/very distressed/breathing not right/catheter has come out) _____ _____ _____</p>																			

What is your background knowledge of the person?

	<p>For use for all calls I have known (the name of the person you are supporting) _____: for _____ years/months This person's preferred place of care is _____ and has lived here since ___/___/___</p>
--	--

What is your assessment of the person?

Assessment

For use for all calls:

What are the symptoms and changes you see in front of you? Has the person's behaviour changed? What has the person told you? Write down everything that you see, or the person tells you. (Record what has changed in the last 24 hours. Have they eaten or drunk as normal? Do they have a temperature? Are they in pain/struggling to walk/not as responsive as normal?)

What are the observations / vital signs? (If appropriate and competent to do so) Please provide:

BP: _____ time taken: __:___ Pulse: _____ time taken: __:___

Resps: _____ time taken: __:___ Temp: _____ time taken: __:___

Urinalysis: _____ time taken: __:___ Oxygen Saturation: _____ time taken: __:___

Other (for example blood sugar) _____

Repeat observations:

What are the current circumstances?

Background	<p>Only for use for OOH calls: Does this person have a Key Information Summary (KIS)? YES / NO (Does it state anything relevant to this situation in the special notes?)</p> <p>_____</p>
	<p>This person was last reviewed by medical practitioner on ___/___/___ Who stated: _____</p>
	<p>Relevant medical history of this person (including, for example, the person has dementia / sight limitations / can get upset with strangers / communication needs / is diabetic / known allergies – have medication sheet to hand)</p> <p>_____</p>
	<p>Current medication of this person (have medication sheet to hand)</p> <p>_____</p>
	<p>This person has:</p> <ul style="list-style-type: none"> • An Anticipatory Care Plan YES / NO (what does it state that is relevant to this situation?) <p>_____</p> <ul style="list-style-type: none"> • a D.N.A.C.P.R. in place YES / NO • an AWI or Section 47 treatment plan YES / NO • a Power of Attorney/Welfare Guardian YES / NO (what does is state that is relevant to this situation?) <p>_____</p> <p>_____</p>

Guidance – who might provide support to the current situation?

Recommendation	<p>For use for OOH calls: Do you need advice or support?</p> <p>What do you, or the person needing support, think is needed? (is advice needed now/call GP tomorrow/nurse needed today/monitor the situation?)</p> <p>_____</p>
	<p>Date of phone call: ___/___/___ time: ___:___ To (state service) _____</p> <p>*OOH call - If you speak to a call handler pass on as much information about the person as you can</p> <p>Action suggested (ask the call handler to repeat to ensure your understanding):</p> <p>_____</p> <p>_____</p>

For use for all calls

If a practitioner visit is recommended: Time and date the person arrived: ___:___ ___:___

Outcome of visit?: _____

Nurse/carer signature: _____ Date: ___/___/___ Time: ___:___

Additional notes:

COVID-19: Safe Practice in Care Homes

Keeping staff and others in the care home safe

COVID-19 is spread when respiratory secretions from an infected person enters the mouth, nose or eyes of another. To prevent spread of COVID-19 remember to:

- Practice physical (social) distancing in the workplace and minimise close contact with colleagues wherever possible
- Avoid touching your eyes nose or mouth unless you have washed your hands immediately beforehand
- Catch coughs or sneezes in a tissue or the crook of your elbow

Providing care: Key Infection Prevention and Control Measures

 Hand Hygiene (HH)	<ul style="list-style-type: none"> • Ensure bare below the elbows (do not wear long sleeved clothing) • Carry out HH using soap and water (essential if visibly soiled) or alcohol based hand rub (ABHR) • Undertake HH; before and after touching an individual/their environment, after body fluid exposure risk, before an aseptic procedure • Extend HH to exposed forearms if contaminated
 Isolation	<ul style="list-style-type: none"> • Ensure suspected and confirmed individuals are isolated in a single room for 14 days from symptom onset • Wherever possible, keep the door to the isolation room/area closed • If no single rooms available, you may cohort confirmed individuals together or suspected individuals together provided they have no other known/suspected infections • Dedicated equipment where possible e.g. commode • Staff should be dedicated to COVID-19 areas wherever possible
 PPE	<p>When providing care within 2m of an individual who is shielding or who may be suspected or known to have COVID-19</p> <ul style="list-style-type: none"> • Fluid Resistant Surgical Mask (sessional) – can go between individuals in same item of PPE but must remove on leaving the COVID-19 area • Eye/face protection (sessional) – can go between individuals in same item of PPE but must remove on leaving the COVID-19 area • Apron (single use) – remove after individual care or cleaning • Gloves (single use) – remove after individual care or cleaning • Always perform Hand Hygiene after removing your PPE • See COVID-19 care home guidance for additional PPE required for aerosol generating procedures
 Cleaning	<p>Decontaminate equipment and the environment at least DAILY with</p> <ul style="list-style-type: none"> • general purpose detergent followed by or combined with a chlorine releasing agent at least 1000ppm av Chlorine • Ensure at least TWICE DAILY cleaning of frequently touched surfaces (e.g communal toilets, door handles, bed rails, tables) • Ensure COVID-19 areas are cleaned after non COVID-19 areas
 Waste	<p>Dispose of COVID-19 waste in clinical waste bags at point of use</p> <p>If you do not have a clinical waste stream, COVID-19 waste can be disposed of in the domestic waste stream. Once full, the bag should be placed in a second bag and tied. These bags should then be stored in a secure location for 72 hours before being put out for collection.</p>
 Linen	<ul style="list-style-type: none"> • Manage all COVID-19 linen as 'infectious' • Wear PPE when handling linen and do so within the individual's room • Do not shake linen • Change in and out of uniform at work and transport home in a bag to launder • Transport securely to laundry facility in linen receptacle
 Visitors	<ul style="list-style-type: none"> • Restrict visitors to essential only • Special consideration should be given for visitors to those with dementia or receiving end of life care • Consider the need to provide visitor with PPE if within 2m of a suspected/confirmed COVID-19 individual

Promoting the Wellbeing of Residents Including Those with Dementia and Learning Disabilities

This section provides information on potential strategies that could be used to support residents' wellbeing during the pandemic.

The adoption of necessary infection control and social distancing may have adverse effects on residents. These could include:

- increased immobility and higher falls risk for some residents
- low mood from social isolation
- boredom with a risk of declining psychological wellbeing
- loss of contact with family and friends
- anxiety from change of routine
- changes in continuity of care due to reduced workforce, unfamiliar staff and a changing workforce.

These factors may be more marked for residents with dementia and those with learning disabilities. For example those with dementia will be at higher risk of displaying behavioural psychological symptoms of dementia (BPSD) or stress/ distress which under normal circumstances would require a higher level of staff intervention.

Considerations for people living with dementia and those with learning disabilities

Some people living with dementia and those with a learning disability may find it particularly hard to understand or remember concepts like shielding and social distancing. Some may feel more lonely and frightened than other residents, if they are asked to stay in their room.

They may also be less able to communicate their anxiety, ask for emotional support or adhere to instructions and safety measures. All these factors may lead to anxiety and stress for examples in those with dementia it result in an increased risk of developing stress and distress symptoms, including delirium. Those with a learning disability, who may not be able to communicate their unhappiness with a situation particularly when they are stressed, may change their behaviour.

Acute and prolonged symptoms of stress and distress, including withdrawal and depression, should be recognised as emergencies and visiting restrictions should be reviewed as part of the treatment plan.

It will also be important to assess and manage any symptoms of stress and distress in the usual way, by following a person-centred approach as described in the Promoting Excellence training materials (see resources below).

Although staff contact should be minimised as much as possible, it is important that the need for contact is assessed on an individual basis to avoid or minimise distress as much as possible. In that case it should be seen as essential contact.

The use of physical barriers or restraint, like stair gates or locked doors should remain a measure of last resort, be strictly monitored, risk assessed and time limited.

Relevant guidance published by the Mental Welfare Commission should always be followed (<https://www.mwscot.org.uk/>)

Considerations for communicating when wearing PPE

Studies have shown that PPE can create barriers to effective communication, particularly for people living with dementia and those with hearing problems. Staff wearing facemasks, goggles, gloves, and aprons may appear frightening to people, particularly if the reason and context is difficult to understand.

Facemasks pose a particular challenge to communication. Staff should be mindful that a large part of communication between people is based on the understanding of non-verbal cues. This is particularly important for some people living with dementia or hearing problems or those with a learning disability. If only eyes are visible, it makes it difficult to correctly read emotions. This can easily lead to misunderstandings, anxiety, anger or embarrassment. Staff should be mindful of how they communicate with their eyes when wearing a facemask. This could easily be achieved by some experiential training.

The use of clear and self-aware body language is an important tool. It is even more important when wearing facemasks. Clear, calm gestures, like pointing or modelling what you are trying to say (e.g. shaving or washing gestures) can be helpful for some people.

Using photos or pictorial cards is an option, as well as using pen and paper. It is important that staff assess the impact of wearing PPE on individual people and develop clear and planned individual communication strategies where necessary.

As per guidance, any material used should be left in the person's room and cleaned as per guidelines.

Engaging in activities

Safely taking part in activities is important for providing a structure to the day, providing a sense of purpose and can help with maintaining residents' skills and abilities for longer.

Continuing dialogue between residents, staff and residents' families remains crucial to creating an environment and activities that prevent or minimise stress and distress. There are many different activities which can keep a person with dementia's mind and body active. (See resources below)

It is essential that proactive and preventative strategies are adopted that are person centred and reflect a knowledge of the person and an understanding of their needs. It will be important that the person continues to be engaged in activities that are meaningful to them including being able to move around the care home and access outside space where it is possible at the present time.

There is useful information available online to help people remain engaged in activities and key personal information should be available to aid person-centred care, through using a document such as *Getting To Know Me* or similar. Activities include online access to: galleries, puzzles, reminiscence resources, free newspapers and activities.

Access to spiritual care via video technology may also be helpful. Use of video technology for accessing relatives and others (some homes are supplying iPads to residents to allow face time) or 'playlist for life' personalised reminiscence therapy music can also be effective.

Families could send favourite objects from home such as family photos or sensory items such as Fidget Widgets©, stress balls, soft toys and doll therapy resources. Staff may

appreciate these as a distraction or way of comforting or reassuring the resident. Restricting or balancing excessive exposure to COVID news reporting may be appropriate when it impacts on wellbeing and heightens stress, in line with advice to the general public.

Further considerations for people with dementia

Where current restrictions mean that staff and managers cannot deliver appropriate, evidence-based therapeutic interventions for residents with dementia, they should seek support (via phone or video) for non-pharmacological person centred interventions, including support from NHS Care Home Liaison Nurses and NHS NES Practice Education Facilitators. There is also a range of resources and advice on therapeutic interventions in the national dementia *Promoting Excellence* Framework set of resources (see resources below).

The Scottish Government's Dementia Standards (see resources) state that people with dementia always have the right to receive a full range of therapeutic interventions to help alleviate stress and distress and that **psychoactive medications including antipsychotic medications should only be used if no alternative interventions are available**, guided by a Section 47 certificate (Adults with Incapacity Act (Scotland) Act 2000) . Carers should be fully involved – currently by phone, Facetime or similar - in discussions on the use of such medications including their benefit and associated risks.

Family and friends

The visiting restrictions are likely to have a significant impact on residents but also their families. Many will be anxious about the wellbeing of the person they care about and worry about the impact on their relative or friend of measures to reduce contact with others. Providing opportunities for increasing and facilitating telephone contact or online virtual video contact with family and carers will be important. However for those people who are very distressed, as noted above flexibility around visiting may be required with a named contact allowed to visit.

USEFUL RESOURCES:-

Clinical guide for front line staff to support the management of patients with a learning disability, autism or both during the coronavirus pandemic - <https://www.sclid.org.uk/wp-content/uploads/2020/03/Managing-patients-with-ID-FINAL.pdf>

NHS NES Supporting psychological wellbeing in adults with learning disabilities - <https://www.nes.scot.nhs.uk/media/4148312/LDFramworkPDF.pdf>

COVID-19 Guided Self-help Booklet Series - <https://www.sclid.org.uk/covid-19-guided-self-help-booklet-series/>

Resources for supporting people with learning disabilities during COVID-19 and Easy Read Resources - <https://www.sclid.org.uk/information-on-coronavirus/>

Clinical guidance on the use of restraint and seclusion which should be included - <https://www.gov.scot/publications/coronavirus-covid-19-clinical-guidance---using-physical-restraint-for-patients/>

A range of Dementia learning resources are available on the NHS NES website

<https://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/mental-health-and-learning-disabilities/our-work,-publications-and-resources/dementia.aspx>

Coronavirus (COVID-19) learning materials for staff working in health and social care are available on TURAS Learn <https://learn.nes.nhs.scot/27993/coronavirus-covid-19> this site is open access and is regularly reviewed and updated in line with current advice and as new material becomes available.

Dementia Care Standards

<https://www.gov.scot/publications/standards-care-dementia-scotland-action-support-change-programme-scotlands-national-dementia-strategy/pages/2/>

Care Inspectorate- Supporting people to keep in touch when care homes are not accepting visitors

<https://www.careinspectorate.com/index.php/news/5634-supporting-people-to-keep-in-touch-when-care-homes-are-not-accepting-visitors>

Dementia Allied Health Professionals national workforce framework

www.connectingpeopleconnectingsupport.online

Care Inspectorate Physical Activity resource

Reminiscence approaches - Promoting psychological wellbeing for people with dementia and their carers: an enhanced practice resource

https://www.nes.scot.nhs.uk/media/1559931/enhanced_resource_fullv2.pdf

Getting to know me

https://www.alzscot.org/sites/default/files/images/0002/7225/Getting_to_know_me_form_-_editable.pdf

Care Inspectorate – physical activities guide

http://www.capa.scot/?page_id=21

Health Innovations Network – Maintaining Activities for Older Adults

<https://healthinnovationnetwork.com/wp-content/uploads/2020/04/Maintaining-Activities-for-Older-Adults-during-COVID19.pdf>

Alzheimer’s Society: Coronavirus: Supporting a person with dementia in a care home

<https://www.alzheimers.org.uk/get-support/coronavirus-supporting-person-dementia-care-home#content-start>

Alzheimer’s Society: Activity ideas for people living with dementia

<https://www.alzheimers.org.uk/get-support/coronavirus-activity-ideas-people-living-dementia#content-start>

Alzheimer Scotland: Activities at Home

<https://www.alzscot.org/sites/default/files/2020-04/Activities%20at%20home%20v5.pdf>

Royal College of Occupational Therapists guidance

www.rcot.co.uk/about-occupational-therapy/living-well-care-homes-2019/a-z-activities

NHS NES: Coronavirus (COVID-19) learning materials for staff working in health and social care.

<https://learn.nes.nhs.scot/27993/coronavirus-covid-19>

SSSC: Workforce support and wellbeing during the COVID-19 outbreak

<https://learn.sssc.uk.com/wellbeing/>

NHS Health Scotland: steps to deal with stress

<http://www.knowledge.scot.nhs.uk/media/14232909/steps%20to%20deal%20with%20stress.pdf>

Summary of Admissions

The presumption should be that all residents being admitted to a care home should have a negative test before admission unless it is in the clinical interests of the person to be moved and then only after a full risk assessment.

<p>Admission of COVID-19 recovered patients from hospital</p>	<p>Patients should always be isolated for a minimum of 14 days from symptom onset (or first positive test if symptoms onset undetermined) and absence of fever for 48 hours (without use of antipyretics). They also require 2 negative tests before discharge from hospital (testing can be commenced on day 8). Tests should have been taken at least 24 hours apart and preferably within 48 hours of discharge.</p> <p>Where testing is not possible (e.g. patient doesn't consent or it would cause distress) and if discharged to care home within the 14 day isolation period then there must be an agreed care plan for the remaining period of isolation up to 14 days.</p> <p>Further details can be found in Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.</p>
<p>Admission of non-COVID-19 patients from hospital</p>	<p>Testing should be done within 48 hours prior to discharge from hospital. A single test is sufficient. The patient may be discharged to the care home prior to the test result being available. The patient should be isolated for 14 days from the date of discharge from hospital. Risk assessment prior to discharge from hospital should be undertaken in conjunction with the care home.</p> <p>Note: an admission to hospital is considered to include only those patients who are admitted to a ward. An attendance at A&E that didn't result in an admission would not constitute an admission.</p> <p>Further details on testing requirements can be found in Guidance for Sampling and Laboratory Investigations.</p>
<p>Admissions from the community</p>	<p>All admissions from the community should have at least one test performed before or on admission, and be isolated on admission for 14 days. Risk assessment prior to admission should be undertaken to ensure that appropriate isolation facilities are available, taking into account requirements for the patient's care.</p>
<p>Testing residents in the care home</p>	<p>All symptomatic patients in a care home should be tested for COVID-19.</p>