Implementing the staged approach to enhancing wellbeing activities and visits in care homes, including communal living

Guidance for Clinical and Professional staff

12th October 2020

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<th>Version</th>
<th>Date</th>
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<tr>
<td>1.1</td>
<td>03/09/20</td>
<td>First version of document</td>
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<td>1.2</td>
<td>12/10/20</td>
<td>Adult respite admission arrangements added</td>
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<td>Recommendations for singing updated</td>
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1. Introduction

This guidance outlines recommendations for the safe resumption of communal activities within care homes and of visiting people, professionals, and organisations into homes. The plan also provides advice about residents leaving the care home for day/overnight visits and residential respite.

Guidance on safely reintroducing visiting by friends and family of care home residents [hyperlink] is available online, and includes support to consideration of individual differences by care home providers as well as an example visiting information leaflet to share with family and friends.

Part 1 relates to the resumption of communal living and activities in communal areas, while Part 2 outlines what care homes should be doing to support safe entry of visiting people and professionals, including day/overnight visits and residential respite. As both parts are inter-related, they should be read together.

This guidance is part of a series that provides advice and support to those working with adults in care homes during the COVID-19 pandemic. Content has been developed by the Scottish Chief Medical Officer (CMO) and Chief Nursing Officer Care Homes Clinical and Professional Advisory Group (CPAG), a multidisciplinary group providing clinical and professional advice throughout. As with all guidance in this series, content aligns with Health Protection Scotland’s COVID-19 Information and Guidance for Care Homes [hyperlink] and draws on expert advice developed by SAGE, the Scottish CMO Advisory Group and others. The guidance also provides practical detail to support continued provision of safe, effective and person centred care locally during the pandemic.

Because the risks of contracting COVID-19 or developing more severe symptoms of the virus are significantly higher for care home residents (due to factors such as age, and/or high levels of comorbidity, physical dependence, living in shared accommodation and often receiving close personal care), a differential relaxation of restrictions between the general population and people living in care homes is necessary as we progress through the pandemic, in order to protect those at highest risk. In view of this, Scotland continues to take a national approach while community transmission rates remain changeable and unpredictable. This guidance seeks to provide clear recommendations but it is ultimately for local areas and care homes, where appropriate, to take account of any individual facts and circumstances of residents in considering application of any of these recommendations in all cases. In doing so, a full and robust risks assessment should be carried out.

The differences in approach outlined in this guidance are evidence based and developed on the basis of the clinical and professional advice available at the time the guidance was published. However, we are in a constantly evolving situation and as such, all guidance and recommendations remain under constant review as the pandemic progresses and further scientific advice and evidence becomes available.

This document has been undertaken with the following principles in mind:

- At all times a person-centred approach should be taken
- Resident, staff and visitor safety is crucial
• An evidence-based approach is used for both national and local implementation of visiting practice
• A staged approach to the reintroduction of visiting services is recommended as per table below; progression will be as fast as possible while fully taking into account the risks at key stages
• Flexibility will be necessary for example in the event of a case of COVID-19 in a care home and/or evidence of community hotspots or outbreaks, care homes may need to rapidly impose visiting restrictions. Local Health Protection Teams will guide and advise on this
• A clear national policy for the testing of care home staff and residents
• Monitoring of safety within the care home during the pandemic by the use and reporting of key indicators as contained in the safety huddle template.

Before resuming activities in this guidance, care homes should update their existing risks assessments to include protocols for communal living/respite and residential/ and visiting people/professionals/organisations as appropriate, and ensure sign-off by the appropriate group delegated by the Directors of Public Health. These teams will work with care home providers and provide a professional assessment of whether visiting is likely to be safe within their area, taking into account the wider risk environment such as prevalence and incidence of infection in the local community and/or outbreaks/hotspots which may increase risk of infection in visitors to care homes in the area. In the event of a case of COVID-19 in a care home and/or evidence of community hotspots or outbreaks, care homes may need to rapidly impose visiting restrictions. Where this needs to happen, consideration and review of the continued necessity of restrictions should take place in line with the wider local rhythm for reviewing community transmission and temporary, additional local measures. Local Health Protection Teams will guide and advise on this.

The following publications should also be referred to as care homes resume communal activities and increase visitation into homes (note: continue to check the [hyperlink] Scottish Government website for updated and additional publications):

These existing guidance documents provide important context and additional detail on a number of areas related to this guidance. These include, for example, actions to promote the wellbeing of residents with dementia and learning disabilities, and circumstances for exemptions to testing of residents.

[Note: This guidance does not supersede any legislation or statutory guidance which is put in place for the duration of any local lockdown restriction across Scotland where those laws or guidance place obligations or duties on any person in respect of any matters contained in this guidance. Given that new laws or statutory guidance may be put in place quickly, or updated quickly, in relation to any local lockdowns, it is important that anyone who uses this guidance seeks independent advice about what they are required to do in the event of a local lockdown].

The next section outlines recommendations for the resumption of communal activities in care homes.
2. Resuming communal living and communal activities

2.1 Purpose of guidance
This Part of the guidance sets out the recommendations for the reopening of communal areas to people who are resident in care homes.

The health benefits of social interaction need to be weighed against the risks of COVID-19 transmission. In care homes that participate in the staff testing programme and have been Covid-free for 28 days the conclusion is that, currently, the benefits of social interaction outweigh the risks of COVID-19 transmission, provided there are robust mitigations in place. Therefore the recommendation is that opening up of communal living takes place only in homes that meet these criteria. The measures outlined here aim to balance and safely manage risks to residents and continue to be based on expert advice and evidence.

Definition of communal areas: we use this term to mean any areas of a care home where residents gather e.g. for the purposes of eating and socialising.

Definition of communal activities: we use this term to mean all occasions where residents gather in groups of two or more, as a residential group activity.

2.2 Background
It has been shown that the use of communal areas in care homes – whilst they do not introduce infection into a home - are contributory to spreading the infection. While the areas themselves do not cause the risk, the movement and touch that happens within them creates a risk of transmitting any virus introduced into the space. Risk is increased due to multiple ‘touch points’, where hard surfaces, difficulty maintaining social distancing and close proximities for prolonged periods can result in person to person transmission. For this reason early guidance suggested that using communal areas should not be done in order to protect residents by reducing the risk of spreading COVID-19.

It is clear that, as measures are eased in care home life returning to a new normal will mean a different approach to utilising communal areas and communal life should be adopted where possible in order to minimise risks of the transmission of COVID-19. Since the use of communal areas does not introduce the virus into a home but helps to propagate its spread, it is recommended that the following key factors should be used to determine when it is safe to resume communal living, including seeking to control the introduction of the virus into the home (including through infection prevention and control) and maintaining safe and manageable physical distancing.

In terms of limiting virus entry into the home, factors like community rates of infection, staff screening programmes, appropriate infection control measures and visitor controls remain key in any risk assessment.
Where residents gather together – including people with dementia who walk about - managing a socially distant form of communal living will need careful planning and forethought, to continue to safely risk assess factors associated with transmission.

2.3 Overarching principles
In resuming communal living, the following principles should be kept in mind at all times:

- it is key is that all IPC/PPE (and agreed cleaning regimes) and physical distancing should be rigorously applied to communal areas
- wherever possible, outdoor gatherings should continue to be considered and held
- existing visiting risk assessments should be updated (as referred to above), for communal areas
- systems for monitoring and reporting of mitigation actions should be in place
- whilst the central importance of essential and designated visitors in the care of residents is acknowledged, this care should only be provided in communal areas when no communal activities are taking place. This also applies to health and social care professionals and other people and organisations visiting the care home
- the concept of creating resident bubbles - where residents and staff live and operate in discreet groups - is seen as a way to mitigate against the risks of transmission associated with communal living in care homes. However, the different types, sizes, and environments of individual care homes makes it difficult to provide guidance that will fit all settings. This guidance should therefore be seen as a way for care homes to plan and assess how they may implement the core principles of bubbles.

2.4 Accessing indoor communal areas

Note: As above, wherever possible outdoor gatherings should continue to be considered and held with all residents as the preferred choice, from an infection point of view, as long as wider conditions (such as weather) permit.

The following table outlines the recommendations that care homes put in place when resuming indoor communal activity safely.
Staffing considerations should be considered as part of the communal activity planning process. The Safety Huddle tool can be used as a way of facilitating this.

| Recommended care home actions to ensure communal activity is feasible and safe | Care homes should complete the following before resuming communal activities:  
  - only care home residents and staff allowed in communal areas when communal is taking place - no external visitors  
  - a risk assessment of communal areas is undertaken that takes into account staff capacity, cleaning regimes and resident activity scheduling and sets out ways to mitigate risks.  

Mitigating actions should include:  
  - limiting the number of residents and staff using the communal space at any one time to adhere to physical distancing  
  - wherever possible, limiting the flow of people to the communal area on the floor/wing on which are resident  
  - reorganising communal spaces so that chairs are placed 2 metres apart  
  - ensuring maximum ventilation to the outside within reason  
  - supervised use of the communal space at all times  
  - staff wearing PPE as per HPS guidance at all times  
  - ensuring a strict cleaning and disinfection regime of furniture, including garden furniture, and frequently touched surfaces or objects such as handles, handrails, remote controls and table tops  
  - careful choice of games or other activities that do not involve close physical contact  
  - assessing dining capacity and staggering meal times  
  - ensuring residents have washed their hands or use alcohol gel to clean their hands before entering and exiting communal areas  
  - updating existing visiting risk assessments for each stage, to include communal living, and signed off from the appropriate group delegated by the Directors of Public Health  
  - monitoring of observance of measures. |

| Context specific recommendations | Relaxation of lockdown restrictions and resumption of communal activity should take place only when care homes:  
  - are declared free of all COVID-19 cases by local health protection teams 28 days from last date of positive test result or, where appropriate, last symptoms of any resident or staff member. Where the last date of a positive test is a staff member, a risk assessment should be undertaken to determine whether this needs the full 28 days. This will involve discussion with the local Health Protection Team |
- are participating in testing programmes, including routine weekly testing of care staff
- have sufficient space to ensure residents can maintain a physical distance of two metres from each other in communal areas
- have procedures in place that seek to ensure that bank and agency staff only access communal areas if they are participating in the testing programme. Where temporary staff need to be used, and provided statutory, contractual or employment arrangements permit this and do not prejudice the temporary member of staff, where possible, consideration should be given to whether their employment or work can be restricted to one care home as the movement of staff between care homes can leave care homes particularly vulnerable to transmission of COVID-19 and increase transmission. Care home managers should also ensure strict compliance with IPC measures for all staff unfamiliar with the care home.
3. Visiting people, professionals and organisations

3.1 Purpose
This guidance provides a framework for a staged approach to the return of people and organisations who contribute to the health and wellbeing of residents in care homes; residents leaving the care home for day/overnight visits; and residential respite in care home settings.

3.2 Overarching principles
In resuming visitation by people, professionals and organisations, the following principles or points should be kept in mind at all times:

- for the purpose of this Part of the guidance, the definition of what constitutes a ‘care home’ is broad and includes residential and nursing care homes delivering a wide range of registered services for older people and those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems
- a staged approach to the return of people and organisations to care homes is proposed. Stage 3 is seen as the key time where healthcare professionals can begin to offer face to face routine care. Stage 4 is the key stage for other people and organisations to offer face to face activities and services
- decisions about visiting services will be informed by plans developed by care homes as part of their existing risk management structures and processes
- this guidance will develop alongside the Scottish Government (2020) [hyperlink] Adult care homes visiting guidance towards the longer term goal that residents should have opportunities during their day to take part in activities of their choice that help them stay well and feel satisfied with life.
- visiting people, organisations and professionals should maintain 2 metre distancing where appropriate. If this is not possible due to the nature of the visit, then PPE should be worn at all times.

3.3 People, organisations and professionals visiting care homes
The importance of involving a wide range of professionals and people in the life of the care home and the impact this has on the wellbeing of residents is well known. Many clinical health and care professionals who visit care homes have provided support and care to residents in different ways during the pandemic, i.e. wherever possible using NHS Near Me, and essential, emergency healthcare has continued when necessary.

People and professionals who visit the care home from organisations such as the NHS, voluntary organisations, Healthcare Improvement Scotland or Care Inspectorate inspectors, Scottish Fire and Rescue Service (SFRS), and workmen, may not always need to be tested for COVID-19 before accessing care homes, and should follow requirements for infection prevention and control, PPE, and symptom awareness. It is not recommended that all people and professionals who visit care homes should be tested due to the current scientific evidence. Among other things, this is also because those who will come into close proximity with residents to provide a service (e.g. health professionals) will have access to PPE equipment or they may be regularly tested as part of their own employment or work. This will remain under constant review.
There may be occasions when the local health protection team recommends that such visitors should be tested for COVID-19, in an area or in a particular home. Therefore, testing people and professionals who may need to visit care homes should be considered as part of the local risk assessment processes taking into account the prevalence and incidence of infection in the local community; including any outbreaks or hotspots which may increase risk of infection among visitors to care homes.

A local record of who has attended the home should be maintained. This should usually be done via a visitor’s book, recording name, role and telephone number should there be a necessity to follow-up as part of the Test and Protect strategy. These details should be retained for a minimum of 21 days. All visitors are expected to comply with infection prevention and control. Care home providers should ensure that any information which they obtain from visitors (including staff) and which constitutes personal data or sensitive personal data, as defined by the GDPR or the Data Protection Act 2018, is processed in accordance with any obligations under that legislation.

To support a safe relaxation of restrictions to visits into care homes, a staged approach is recommended, that varies by the type of visitor. Broadly, visitors have been organised into health and social care professions (who support with clinical and regulatory concerns), people and organisations (supporting with holistic and social activities), and site-related/contractors and maintenance professionals.

The following lists are not intended to be definitive but indicative of the types of roles and services that might be provided on a visiting basis in care homes and to which this guidance would apply. The table later in this section outlines recommended approaches to relaxing restrictions for each staff group.

Any recommendations in this guidance does not seek to supersede any legislation or other legal obligations which may regulate how any of these professions or organisations may be required to comply with. Nor does this guidance seek to override the terms and conditions of any contract which a care home provider and site-related or professional maintenance companies enter into for the provision of services to a care home. Care home providers should seek independent advice about how any terms and conditions of any contracts which have been entered into to provide goods or service may be impacted by the pandemic.

3.3.1 **Health and Social Care Professionals** (above essential visits)
- Primary Care Teams, includes District Nurses, Advance Nurse Practitioners, GPs, General Practice Nurses, Community mental health/learning disability nurses, Community pharmacists and Specialist community teams including care home liaison teams, Out of Hours services
- Scottish Ambulance Service
- Allied Health Professionals (AHPs) including Physiotherapy, Occupational Therapy, Speech and Language, Dietetics, Podiatry, Orthotics
- foot healthcare clinicians
• Community Mental Health and Learning Disability Team members
• other visiting specialists/practitioners to support those living with Dementia, Artificial Nutrition Support, Spinal Injury, Continence specialists, Sensory impairment etc.
• palliative care
• ophthalmology/opticians and community eye care
• geriatricians and Old Age Psychiatry Consultants
• social workers, mental health officers and other social work and social care professionals
• advocacy services
• safeguarding teams
• complementary therapies
• Care Inspectorate regulatory visits, local assurance visits, and other assurance roles

3.3.2 People and organisations (holistic and spiritual)
• meaningful activities (as outlined in [hyperlink]: NICE quality standards for mental wellbeing of older people in care homes)
  o For example, organisations which support cooking, exercise, reading, gardening, arts and crafts, conversation, and music
• hairdressing and beauticians
• volunteer visiting – including schools
• pet therapy
• community in-reach/outreach events
• social outings from care homes
• spiritual & faith representatives
• note: spiritual care visits should be supported at all stages of the pandemic, ensuring physical distancing is in place wherever possible and PPE is worn at all times. For clarity, spiritual visits are not limited to essential visits and people meeting with residents for this reason should not be counted as designated visitors. Spiritual care visits should be supported both indoors and outdoors.
• entertainment – musical, theatre
• Note: organised and/or group singing activities should not take place, for infection prevention and control reasons. We recognise that singing can be valuable and reassuring for some, particularly in relieving distress. To support singing to take place safely, it is recommended on a one-to-one basis only and when the carer (or visitor) is wearing full PPE.

3.3.3 Site-related/contractors and maintenance professionals
• equipment maintenance teams
• maintenance and upkeep of estates (in-house and external contractors) over and above emergency / essential repairs, including routine visits that were likely suspended during lockdown (for example, maintenance / service contracts)
• care equipment suppliers (the provision of environmental and mobility adaptations)
• Scottish Fire and Rescue Service.
The recommended relaxation of restrictions, by stage, are as follows, noting that:

- stages 1 to 3 should explore and utilise non-face to face methods such as telephone or near me consultation, wherever possible.
- in stage 4 additional consideration should be given to the benefits of personal contact on the overall well-being and quality of life of residents that face to face meetings, relationships and interactions brings.
- for all stages – the benefits of all virtual forms of consultations/interactions should be explored for long term and sustainable use not just in this acute phase of COVID restrictions. Studies show that, where video communication has been used, the sense of isolation is reduced.
- movement between stages and their recommended criteria are informed by scientific advisory committee and subject to review.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
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<tbody>
<tr>
<td>Group</td>
<td>Health and social care professionals</td>
<td>Health and social care professionals</td>
<td>Health and social care professionals</td>
<td>Health and social care professionals</td>
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<td></td>
<td>telephone / near me consultations wherever possible continues</td>
<td>telephone / near me consultations wherever possible continues</td>
<td>telephone / near me consultations wherever possible continues</td>
<td>telephone / near me consultations wherever possible continues</td>
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<td>essential visits by health and social care professionals only, including:</td>
<td>essential visits by health and social care professionals only, including:</td>
<td>essential visits by health and social care professionals only, including:</td>
<td>essential visits by health and social care professionals only, including:</td>
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<td></td>
<td>Adult Support and Protection;</td>
<td>Adult Support and Protection;</td>
<td>end of life care</td>
<td>end of life care</td>
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<td></td>
<td>end of life care</td>
<td>end of life care</td>
<td>other non-routine visits/consultations to prevent physical/mental deterioration or breakdown in placement</td>
<td>other non-routine visits/consultations to prevent physical/mental deterioration or breakdown in placement</td>
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<td></td>
<td>urgent/acute treatment e.g. dental</td>
<td>telephone / near me consultations wherever possible continues</td>
<td>urgent/acute treatment e.g. dental</td>
<td>urgent/acute treatment e.g. dental</td>
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Preventative and rehabilitation visits commence with appropriate mitigating actions:
- primary care includes care home liaison teams
- AHPs
- community mental health/learning disability team members
- other visiting specialists

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<tr>
<th>Group</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
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</table>
| People and organisations     | • spiritual care            | • spiritual care            | • spiritual care            | • spiritual care  
• routine fire safety audits (SFRS)  
• hairdressing/beautician  
• complementary therapies – as per specific guidance |
| Volunteers                   |                             |                             |                             | • volunteer visitors - for example drivers, pet therapist, social activity coordinators, schools, church, volunteer organisations, musicians, artists. |
| Contractors and Maintenance   | • emergency/essential repairs | • emergency/essential repairs | • emergency/essential repairs | • routine servicing and repairs  
• routine maintenance checks |
| Care equipment suppliers     | • emergency/urgent supplies | • emergency/urgent supplies | • routine assessment, supply and delivery | • routine assessment, supply and delivery |
| Community and Social Outings |                             |                             |                             | • older people’s care homes – no day or overnight visits are recommended during this stage.  
• all other settings - day and overnight visits following local individual assessment of the person’s need for this and an individual risk assessment of the visit, including a consideration of the differential risks of mixed homes.  
• Note: we recognise that some care homes have a mix of residents that means there are additional factors in the local translation of national guidance. Where this is the case, local health protection teams will support with development of approaches and risk assessment tailored to the home.  
• all settings - day and overnight visits following individual assessment of the person’s need for this and an individual risk assessment |
<table>
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<tr>
<th>Group activities/ visiting</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
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<tr>
<td><strong>Note:</strong> The varying risk of transmission between indoor and outdoor activities should be fully considered in any risk assessments.</td>
<td>• no activities in communal areas</td>
<td>• no activities in communal areas</td>
<td>• group activities in outdoor communal areas in limited numbers, to be determined by the ability to socially distance and should be risk assessed by each care home.</td>
<td>• controlled resumption of indoor group activities in limited numbers including activities coordinated by external (Covid symptom free) visitors (such as musicians) • outdoor group activities with families/external staff/volunteers in accordance with national guidance for Stage 4 • all residents’ use of indoor and outdoor communal areas in limited numbers in homes without active cases with full physical distancing and Infection Prevention and Control.</td>
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<tr>
<th>Residential respite – older people’s care home settings</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
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<tr>
<td><strong>Note:</strong> COVID-19: Information and Guidance for Social, Community and Residential Care Settings provides high level guidance for residential respite in non-care home settings.</td>
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<td>• where there is an essential and urgent need for respite, the <a href="https://www.gov.uk/government/publications/hps-covid-19-care-home-guidance">HPS COVID-19 Care Home guidance</a> should be followed (see in particular ‘admissions from a community setting’): • at least one test performed, with consent, before or on admission. <em>(Note – also refer to the <a href="https://www.gov.uk/government/publications/national-clinical-and-practice-guidance">National Clinical and Practice Guidance</a> which discusses testing on admission to care homes in more depth, including test exemptions at admission)</em> • be isolated on admission for 14 days • risk assessment should be undertaken prior to admission to ensure that appropriate isolation facilities are available, taking into account the individual’s care needs.</td>
<td>• consideration of residential respite should be considered in line with scientific advice.</td>
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| **Residential respite – stand-alone adult residential respite settings** (i.e. settings without long-term residents which are registered as care homes) |  | **Recommended that admissions arrangements do not now involve respite guests remaining in their rooms. The key changes to enable this are:**

- pre-admission testing arrangements - as before but needing a negative result prior to arrival;
- pre-admission risk assessment to be undertaken, to determine whether the individual’s care needs mean they should be isolated for the duration of their stay (or for 14 days from admission); and whether any specific enhanced infection prevention and control measures are needed;
- physical distancing between respite guests should be maintained (except those from the same household). |
The table below outlines the recommendation for care homes to move to stages 3 and 4, as well as recommended actions to support continued safety in all stages:

<table>
<thead>
<tr>
<th>Recommended care home conditions to ensure enhanced visiting is feasible and safe</th>
<th>Relaxation of lockdown restrictions and resumption of communal activity should take place only when care homes:</th>
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</table>
|  | • have no active cases.  
  • with previous COVID-19 positive cases are cleared by HPS/DPH teams 28 days from last date of exposure to a case, whether resident or staff member  
  • are actively participating in the care home worker testing programme (adults only). |

| Context specific recommendations | • PPE  
  • resident consent  
  • symptom awareness  
  • care home risk assessment | • visiting protocol and visitor log  
  • scheduled visits  
  • IPC and cleaning protocols  
  • sufficient access to hand hygiene facilities |