

COVID-19 / Influenza / ARI Care Home Outbreak Standard Operating Procedure v04.08

Authors: Programme Development Unit

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See appendix for details of changes made

AUDIENCE:

This standard operating procedure (SOP) is for UKHSA Health Protection Teams to guide the risk assessment and subsequent management of suspected or laboratory confirmed outbreaks of COVID-19 / Influenza / Acute Respiratory Infections (ARI) in care homes or other similar residential settings in the community.

RATIONALE:

To ensure a standard and comprehensive approach to outbreak risk assessment, management and documentation on HPZone of outbreaks of COVID-19 / Influenza / Acute Respiratory Infections (ARI) in care homes or other similar residential settings in the community.

The principles of public health action for COVID-19 / Influenza / Acute Respiratory Infections (ARI) are to:

1. Reduce onward transmission of infections
2. Identify the cause of the infection so that appropriate action can be taken as soon as possible

3. Protect the most vulnerable
4. Prevent an increased demand on healthcare resources

BACKGROUND TO INFECTIONS:

Transmission mode: close contact through droplet transmission from coughing and sneezing, direct human to human contact, touching contaminated surfaces or breathing aerosols generated by medical procedures

Common respiratory viruses include:

- Rhinovirus
- Adenovirus
- Parainfluenza
- Respiratory syncytial virus
- Human metapneumovirus
- Influenza
- COVID-19

Infections with these viruses may all cause symptoms including runny nose, sore throat, cough, wheeze, sometimes lethargy, body aches and fever.

Incubation periods vary between viruses but are usually between 12 hours and 5 days, extending up to 8 days for parainfluenza and RSV, and 14 days for COVID-19. Infectious periods also vary but often begin 12-24 hours prior to symptom onset and usually extend for around 5 days afterwards. For COVID-19, the infectious period is thought to begin 2 days prior to symptom onset and extend for up to 10 days post onset of symptoms.

DEFINITIONS:

1.CASE DEFINITIONS FOR A SYMPTOMATIC CASE

It is acknowledged that older persons may not always develop typical symptoms of COVID-19 or influenza. If a COVID-19/ ILI outbreak is suspected due to any COVID-19 or other respiratory symptoms or acute deterioration in physical or mental ability, with or without fever in the absence of a known cause, prompt laboratory testing is recommended to confirm the diagnosis.

Case definition for a possible COVID-19 case

New continuous cough

OR

High temperature ($\geq 37.8^{\circ}\text{C}$)

OR

A loss of, or change in, normal sense of taste (ageusia) or smell (anosmia)

In older persons with co-morbidities, acute deterioration in physical or mental ability may be an indication of COVID-19.

Case definition for influenza-like illness (ILI) in care home residents

Oral or tympanic temperature $\geq 37.8^{\circ}\text{C}$

AND one of the following:

acute onset of at least one of the following acute respiratory symptoms: cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing

OR

An acute deterioration in physical or mental ability without other known cause

2. OUTBREAK DEFINITIONS

Definition for Acute Respiratory Infection (ARI) Outbreak

Two or more cases that meet the clinical case definition of ILI or COVID-19, in people with an epidemiological link to the care home and onset dates within 14 days but without laboratory confirmation.

Definition for Outbreak of COVID-19

At least one laboratory confirmed case of COVID-19 AND one or more cases which meet the clinical case definition of COVID-19 among individuals (residents or staff) with an epidemiological link to the care home and with onset dates within 14 days.

NB: One confirmed or suspected case should be reported as an incident for further investigation and risk assessment.

<https://www.gov.uk/guidance/overview-of-adult-social-care-guidance-on-coronavirus-covid-19>

and

<https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings>

Definition for Outbreak of Confirmed Influenza

At least one laboratory confirmed case of influenza AND one or more cases which meet the clinical case definition of ILI, among individuals (residents or staff) with an epidemiological link to the care home, arising within the same 48-hour period.

Risk groups for complicated influenza include:

- People aged 65 years and older
- Children under the age of 6 months
- Pregnant women
- People living in long stay residential care homes
- People aged 6 months to less than 65 years of age with:
 - Chronic lung disease
 - Chronic heart disease
 - Chronic kidney disease
 - Chronic liver disease
 - Chronic neurological disease
 - Learning disability
 - Splenic dysfunction or asplenia
 - Immuno-suppression (whether caused by disease or treatment)
 - Diabetes mellitus
 - Body mass index > 40

3. LIFTING OF OUTBREAK RESTRICTIONS

COVID-19:

For alpha, delta **and omicron variant** outbreaks, if 14 days have passed since the onset of symptoms in the most recent case a round of PCR recovery testing of all residents and staff should be undertaken. If there are no PCR positive results, outbreak restrictions can be lifted (await PCR results before outbreak restrictions are lifted). At this point regular asymptomatic and symptomatic testing should be restarted.

NB: Due to the dominance of the **omicron** variant it is appropriate to assume all SARS-CoV-2 positives are the delta variant until reflex PCR or WGS is available. If WGS results are not available by day 14 testing, then assume that no Variant of Concern (VOC) has been detected (i.e. the outbreak has been caused by the alpha or delta variant) and lift outbreak restrictions if there are no positive PCR results.

If WGS or reflex assay results confirm a VOC in the outbreak (**other than the alpha, delta or **omicron** variants**) then the outbreak restrictions should remain in place until whole home recovery testing has been completed after a period 28 days with no new cases.

Influenza or other non-COVID-19 respiratory infection: Outbreak restrictions should remain in place for a minimum of 5 days after the onset of symptoms in the latest case. If there are risk factors for prolonged shedding, infection control measures should be maintained for longer than 5 days [Influenza-like illness \(ILI\): managing outbreaks in care homes](#)

It is important to maintain infection prevention and control measures at all times even when there are no cases. COVID-19 precautions should be maintained even after the declaration of the end of an outbreak.

TESTING IN CARE HOMES:

During the COVID-19 pandemic, all persons with respiratory symptoms should routinely be tested for COVID-19.

1. TESTING FOR COVID-19

a) PCR TESTING

In addition to the recommendation for PCR testing for symptomatic cases meeting the case definition, there is a regular cycle of testing recommended for staff and residents of care homes.

1. Regular repeat PCR testing of staff where there is **NO outbreak** is via **Pillar Two**: staff should be tested every week and residents every 28 days. At the same time as the regular repeat PCR testing staff should also undertake LFD testing as outlined in **section b** below.
2. Where there is a **confirmed or suspected outbreak**:
 - 2.1. PCR testing should be arranged through **Pillar Two**: for all residents (symptomatic and asymptomatic) and asymptomatic staff. Staff and residents should also undertake an LFD test at the same time as the PCR test.
 - 2.2. Symptomatic staff should be tested via **Pillar Two** (community testing):
<https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested>
 - 2.3. A second round of PCR and LFD testing (4-7 days later via **Pillar Two**) for residents and staff who test negative on the first round of testing or who missed testing. Those who missed the first round, and who then test negative will require a second test via Pillar Two, 4-7 days later.
 - 2.4. Following testing at days 4-7, staff should continue the regular repeat testing (PCR and LFD) on a weekly basis through **Pillar Two**.
 - 2.5. Recovery point PCR testing should be done via **Pillar Two** at a point 14 days on from the onset of symptoms in the ***last clinically suspected*** or confirmed case in residents or staff. If WGS or reflex assay results confirm a VOC in the outbreak (**other than the alpha, delta or omicron variants**) then the outbreak restrictions should remain in place until whole home recovery testing has been completed after a period 28 days with no new cases.
3. **Due to the protective effect of the vaccine many cases in care homes are now single cases among staff (also see section f below regarding detection of a VOC other than alpha, delta or omicron):**

One or more clinically suspected or confirmed cases in staff or residents should be reported to UKHSA. The national UKHSA Helpline will deal with single cases in staff members but refer any other incidents to the local HPT

3.1 A **single member of staff or resident** testing positive (PCR or LFD) should trigger **all staff LFD testing for 7 days**, ideally at the beginning of their shift. If no further positives are identified in the seven days, then the normal testing regime can be re-established.

3.2 **If a second or more cases are detected in staff** through LFD testing, or on initial report there is **more than one case**, then report **suspected/confirmed outbreak** to the HPT and implement outbreak control restrictions and outbreak testing regime (7 days of serial staff LFD testing until at least 5 days with negative results, plus whole home PCR and LFD testing on day 0/1 and repeat at day 4-7 for those who test negative)

A risk assessment should be completed to determine likelihood of transmission within the setting

Factors to consider may include (NB these levels of coverage are guidance only and other soft intelligence, local knowledge and the wider context will also need to be considered):

- levels of booster vaccine coverage in residents (ideally above 90%) and staff (ideally above 80%) NB: consider the care home's use of agency staff as their coverage can be lower.
- levels of participation in routine staff weekly PCR/regular LFD testing, ideally above 75%.
- compliance with IPC measures
- likelihood of cases either having picked up their COVID-19 infection within the care setting or having transmitted their infection to others in the setting.

If transmission within the setting is considered unlikely and there are no other concerning factors (e.g. factors above or VOC/VUI) AND first and second rounds of PCR testing **do not** detect any further cases **in residents or staff**, then outbreak control restrictions may be lifted. This may mean that outbreak measures may only be in place for about 7 days (depending on PCR turnaround times).

3.3 If further cases are detected in residents or staff on whole home testing, AND/OR transmission with the setting is considered a significant possibility, AND/OR there are other concerning factors, then outbreak restrictions should continue until at least 14 days after the latest case. At that point, whole home recovery testing should be carried out. If no further cases are identified, then outbreak restrictions can be lifted. If further cases are identified (and transmission within the setting cannot be ruled out), the outbreak restrictions should continue until a further round of recovery testing at 14 days after the latest case reveals no further cases.

For high priority VOCs, recovery testing would be at 28 days since the latest case.

b) Lateral Flow Device (LFD) Testing

In addition to the regular repeat PCR testing (outlined in **section a** above) regular Lateral Flow Device (LFD) testing should also be undertaken:

1. Staff should undertake three lateral flow device (LFD) tests per week, ideally at the beginning of their shift:
 - 1.1. One LFD test on the same day as the regular weekly PCR test.
 - 1.2. One LFD test midweek between PCR tests (i.e. 3-4 days after their regular PCR test).
2. Staff who have worked elsewhere since their last shift should undertake an LFD test before beginning their next shift at the care home.
3. Staff who have missed their last weekly PCR test because they have been on annual leave or sick leave should undertake an LFD on their first day back before beginning their return shift.
4. If there are any positive cases (residents or staff) found in a care home detected by LFD or PCR testing, this should trigger **staff** to undertake daily LFD testing for 7 days, ideally at the beginning of their shift. Daily LFD testing of staff should continue after the initial 7 days until no further positive cases (in residents or staff) are detected for 5 days.

5. If a staff member has a **positive LFD test**:

5.1. The staff member will need to undertake a confirmatory PCR test (registered to the care home's Unique Organisation Number) and immediately self-isolate at home until they receive their PCR result. Please note that the confirmatory PCR is in addition to the weekly PCR test that all staff undertake, unless they tested positive on the day they did their weekly PCR test.

5.2. For **asymptomatic staff** with no other contraindications:

5.2.1. If the PCR test is negative, the staff member can usually return to work.

5.2.2. If the PCR test is positive the staff member should follow existing guidance on self-isolation (<https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings>)

5.3. For **symptomatic staff**:

5.3.1. If the PCR test is positive the staff member should follow existing guidance on isolation (<https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings>)

5.3.2. If the PCR test is negative, then consideration should be given to whether this is another respiratory infection which needs investigating e.g. influenza. If no other infection is suspected, then in general they can return to work. In some circumstances i.e. outbreak situations a risk assessment may need to be undertaken to decide if the staff member can return to work. Issues that should be considered include:

- whether the person has had COVID-19 vaccination
- whether they are a recent contact of a laboratory confirmed case
- whether they have contacts in a setting that is experiencing a COVID-19 outbreak.

6. Where there is a **confirmed or suspected outbreak**:

6.1. Also see section a2 above. In addition to the whole home PCR testing (via Pillar 2), all staff and residents should also undertake immediate LFD tests.

6.2. Start daily LFD testing of staff for 7 days until no further positive cases (in residents or staff) are detected for 5 days.

6.3. Repeat PCR (via Pillar 2) and LFD testing of all residents and staff who test negative on the first round of testing or who missed testing should be undertaken on between 4-7 days after the first round of whole home PCR outbreak testing (this may coincide with a regular cycle of testing).

NB: In outbreak situations there may be times when different rounds of testing become scheduled at the same time, in these circumstances a pragmatic decision needs to be taken on which testing to undertake. A precautionary approach should be adopted.

c) Repeat PCR Testing within 90-days of a positive test

1. Immunocompetent staff, patients and residents who have tested positive for Covid should be **exempt from routine re-testing by PCR tests** (e.g. repeated whole setting screening) within 90 days from their initial illness onset or test (if asymptomatic) unless they develop new COVID symptoms. This is because fragments of inactive virus can be persistently detected by PCR and are no longer infectious. For further details on the management of repeat positives, see: <https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings>

d) Further guidance and resources for COVID-19 testing of staff and residents

The guidance for routine and outbreak testing in care homes are available at: [Coronavirus \(COVID-19\) testing in adult care homes - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/coronavirus-covid-19-testing-in-adult-care-homes).

Practical considerations:

- **For a single symptomatic case:** in absence of any other cases, it may be appropriate to test that individual case first and undertake a local risk assessment to decide if further testing is required.
- **Consent for testing:** There is no legal requirement for an asymptomatic person to be tested and therefore if people refuse, they should be given information and their wishes respected. For residents, consent should be taken to conduct the test from the resident, consulting family members and their GP as appropriate and in line with usual policies and procedures. Some residents, for example people with dementia, learning disabilities or mental health conditions, may lack the relevant mental capacity to decide about their own testing. If the person lacks the relevant mental capacity to consent to the test, and they are aged 16 or over, the care home have been advised (covered under the consent section in the testing guidance) to consider if the principles of the Mental Capacity Act 2005 allow them to make a 'best interests decision' (for the individual, not other residents or the wider population) to swab and receive results, on their behalf. There is provision under the Coronavirus Act to test people who are suspected of having the infection but who refuse to cooperate. These incidents are likely to be rare and should be dealt with on a case by case basis

e) Guidelines for testing care home visitors for COVID-19

To facilitate visiting to care homes Lateral Flow Device testing has been provided to care homes to test visitors.

Guidance is available here:

- <https://www.gov.uk/government/publications/coronavirus-covid-19-testing-for-adult-social-care-settings>
- <https://www.gov.uk/government/publications/coronavirus-covid-19-testing-in-adult-care-homes/testing-for-professionals-visiting-care-homes>

NB: Due to concerns about the sensitivity of Lateral Flow Device tests some local authorities have adapted this testing regime. Please refer to local guidance.

VOC and VUIs

- f) From the start of May 2021 positive PCR results with a CT Value less than 30 from care homes will be sent for whole genome sequencing to detect **VOCs and VUIs**. It should be noted that due to the required CT value then this will result in only a proportion of test results going for WGS (possibly in the region of 50-60%). Also note that the proportion of positives sequenced depends on sequencing capacity and when national case numbers are high then as few as 5-10% of cases may be sequenced.
- g) In addition to WGS, from the start of May 2021 reflex PCR testing will start to be rolled out for positive PCR results from care homes. Reflex PCR testing will detect the presence of some VOC / VUIs. The results of reflex testing are less reliable than WGS, but they will be available

in a more timely fashion and should be acted upon, rather than awaiting WGS confirmation (which may not become available because not all samples can be sequenced).

- h) Care home positive VOCs/VUIs will be notified to HPTs in the same way as others VOCs/VUIs are. The delta variant has displaced the alpha variant and is the most common strain circulating across much of England, therefore HPTs and **care homes should assume that all SARS-CoV-2 positives are delta or omicron unless proven otherwise** (either by results from the genotyping reflex assay or WGS).
- i) If a VOC **other than the alpha, delta or omicron** variants is detected in a care home then a new risk assessment should be undertaken to determine if further testing, contact tracing or IPC arrangements are required. Detection of a VUI does not automatically trigger any additional actions.
- **Outside an outbreak scenario:** If a **single case** is identified as being a VOC (other than the alpha, delta **or omicron** variants), **whole home PCR outbreak testing should be initiated, and outbreak restrictions should be implemented as soon as the reflex assay or WGS result is received.** As in an outbreak, whole home testing should be completed once on day 0 and again 4-7 days later. If no positives are detected (and therefore no outbreak is detected) then outbreak restrictions can be lifted immediately.
 - **In an outbreak scenario:** If a VOC is detected in an outbreak (other than the alpha, delta or **omicron** variants) then the outbreak restrictions should remain in place until whole home recovery testing has been completed after a period 28 days with no new cases. For alpha, delta and omicron VOCs, recovery testing can take place after a period of 14 days with no new cases.

2. TESTING FOR INFLUENZA AND OTHER ARI'S IN CARE HOMES

Obtaining viral swabs from symptomatic residents and/or staff at an early stage is important to distinguish influenza from COVID-19 or other respiratory viruses, and to decide if antivirals are required.

a) Testing for Influenza and other respiratory pathogens

Note that during the winter of 2021 to 2022, there may be simultaneous circulation of SARS-CoV-2 and influenza within a single care home outbreak. Detection of seasonal influenza with or without the detection of other respiratory viruses, supports the prompt use of antivirals.

HPTs should work with local system partners to operationalise testing for COVID-19, influenza and other respiratory viruses through local arrangements. Residents who have developed recent symptoms and/or those with symptoms most indicative of influenza should be tested for Influenza A and B, and COVID-19, and ideally for RSV, parainfluenza, human metapneumovirus, rhinovirus and adenovirus.

If COVID-19 is suspected or confirmed, then whole home testing for SARS-COV-2 should be conducted for asymptomatic and symptomatic residents and staff, as indicated by national COVID-19 policy (as above).

b) Antiviral prescribing

Where influenza is known to be circulating in the local area the use of antivirals should be considered without laboratory confirmation based upon a risk assessment, and their use reviewed on receipt of the laboratory results.

For guidance on the use of antivirals refer to Influenza guidance:

<https://www.gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes>

and PHE guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza is available here:

<https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents>

RECORDING ON HPZONE:

1. RECORDING CARE HOME SITUATIONS ON HPZONE

For all care home cases or situations, ensure HPZone principal context is entered as “care home” as well as the name of the care home added as a “specific context” in order that any future cases arising can be linked to a situation. Only facilities registered as care homes should have the principal context of care home applied.

Infectious Agent: If already laboratory confirmed, enter as per Lab confirmation. If no laboratory confirmation at time of entry, enter as Influenza A Seasonal, COVID-19, RSV depending on probability.

Confidence: Enter as suspected or confirmed (for COVID-19, confirmation is LFD or PCR positive). If confirmation is obtained later in the course of the case/outbreak, update to CONFIRMED at that stage

- 1) For a **single possible case** – this can be entered as a case or as a situation. If entered under situations enter as an exposure. If, following testing, the possible case is confirmed and further cases (possible or confirmed) are reported, this should be converted into an outbreak.
- 2) For a **single confirmed case** - this can be entered as a case or as a situation. If entered under situations enter as an exposure. If, following testing, further cases (possible or confirmed) are reported, this should be converted into an outbreak.
- 3) For **outbreaks/clusters** - enter in HPZone as situation - outbreak or cluster depending on likelihood of in-setting transmission. Scenario: Respiratory Tract Infection (not Influenza Like Illness)

2. WHEN TO CLOSE A CARE HOME SITUATIONS ON HPZONE

Close the situation when all HPT actions have been completed. This may not correlate with the end of the outbreak or when outbreak restrictions are lifted.

If new cases arise <14 days later, then add to existing HPZone situation.

If new cases >14 days after onset of latest case, then risk assess to decide if likely to be a new outbreak or continuation of previous (consider compliance with testing, IPC measures, vaccination coverage, visits out and admissions). If likely to be a continuation add an event on HPZone, if likely to be a new outbreak create a new situation on HPZone.

MINIMUM ACTIONS FOR ALL REPORTED CASES / SITUATIONS

1. Review the report, gather additional information from care home and carry out risk assessment.
 - Once notified of a suspected case the HPT should undertake a public health risk assessment to determine the next steps.
 - Atypical symptoms may be present in older people and those with multiple co-morbidities.
 - For outbreaks associated with atypical symptoms HPT should be consulted before proceeding to whole care home testing.
2. Gather relevant information and enter on HPZone:

- Layout of Home
 - Number of affected residents/number of contacts
 - Total number of current residents in the home
 - Number of affected staff/total staff
 - Number of confirmed symptomatic AND / OR asymptomatic case/s (residents and staff)
 - Infection control/outbreak control measures advised (verbal and via email)
 - Swabs taken Y/N + number + by who
 - Number of hospitalisations
 - Number of deaths
 - Home closed- yes/no
3. Note: for national surveillance and epidemiological analysis the metrics box is no longer required to be completed.
 4. Enter the CQC Registration Number into the outbreak number box on HPZone, this is found under key details and should be added in the format: "1-XXXXXXXXXX". If the caller does not know the CQC number, this can be found here:
<https://www.cqc.org.uk/about-us/transparency/using-cqc-data> (under 'Care directory with filters'). Location ID is the CQC number, the database can be filtered by care home, region and local authority. This is a large file and is updated monthly. Alternatively use the CQC 'find a care home pages' <https://www.cqc.org.uk/what-we-do/services-we-regulate/find-care-home> (enables identification of the CQC-ID which is contained in the URL for each location e.g. <https://www.cqc.org.uk/location/1-128976339>)
 5. Risk assess whether this is likely to be a flu and/or COVID-19 outbreak or whether another cause is equally as likely (e.g. norovirus if residents have D&V) - review by a senior member of the team is important as it may not be appropriate to proceed with whole home testing.
 6. Ensure the care home have access to infection control advice, PPE guidance, and risk reduction measures (e.g. social distancing, isolation and cohorting of symptomatic cases and contacts), as per national guidance:
(<https://www.gov.uk/government/collections/coronavirus-covid-19-social-care-guidance>)
 7. Advise that the care home manager escalates any operational issues in delivering services to the relevant commissioner (Clinical Commissioning Group / Local Authority) e.g. the need to close to further admission. Ensure the care home is aware of what local support is available via CCG/LA.
 8. Discuss minimising transfers. The decision to restrict admissions and transfers sits with the care home manager in discussion with their commissioners and will depend on the joint dynamic risk assessment.
 9. Discuss minimising community and other staff entry to home to essential care and work only. Consider whether aspects of care, for example a medicine review, may be done remotely to minimise visitors to the home.

10. If any residents/staff are hospitalised, then remind the care home manager to inform infection control at the receiving hospital and request swab if not already done for a respiratory screen and/or SARS-CoV-2 as appropriate.
11. In more complex situations HPTs, with the local authority public health team, will consider convening an outbreak control team (OCT) meeting to co-ordinate the outbreak response.
12. Ensure the care home is aware of what local support is available via CCG/LA.
13. Inform and update stakeholders in line with local agreements, e.g. Director of Public Health, Clinical Commissioning Group, and NHS England and Improvement about care home outbreaks in their area

The implementation of outbreak control measures should not wait for laboratory confirmation.

SPECIFIC ACTIONS FOR COVID-19 OUTBREAK

1. Advise that any resident with symptoms who test positive for SARS-CoV-2 should remain isolated for 14 days following their symptom onset. Residents who test positive for SARS-CoV-2 and who were asymptomatic at the time of test must self-isolate for 14 days from the date of the test.
2. Staff who test positive for SARS-CoV-2 should remain isolated for 10 days following their symptom onset or if they were asymptomatic at the time of the test must self-isolate for 10 days from the date of the test (or until they have received two negative lateral flow test results 24 hours apart from the sixth day of their isolation).

Exclusion from the workplace:

- Symptomatic staff should therefore be excluded from work for 10 days from onset of symptoms AND until symptom free and free from fever for two days without antipyretics (excluding mild, dry, post viral cough or anosmia which can persist for several weeks)
 - Staff who test positive for SARS-CoV-2 and who were asymptomatic at the time of the test must self-isolate for 10 days from the date of the test. If they remain well, they can return to work on day 11.
3. From 16th August 2021 Care home residents who are fully vaccinated will **not** need to self-isolate following contact with someone who has tested positive for COVID-19 provided they:
 - have received a negative PCR test
 - undertake daily LFD testing during their contact period (up to 10 days)

During this period, they should:

- avoid contact with other highly vulnerable residents in the care home
- continue to follow all outbreak measures in the event of an outbreak, even where they have tested negative

If they become symptomatic then usual testing and isolation protocols apply until their COVID-19 status is confirmed.

If symptoms or signs consistent with COVID-19 develop in residents in the 14-day period since last exposure, then testing for SARS-CoV-2 (along with any relevant testing for other potential diagnoses) should be performed.

4. Unvaccinated or partially vaccinated residents who are exposed to a confirmed COVID-19 case should be isolated or cohorted for 14 full days after their last exposure. If they are cohorted, this should only be with other residents who do not have COVID-19 symptoms but who have also been exposed to a confirmed COVID-19 case. This also applies to residents who have previously recovered from COVID-19.
5. From 16 August, staff members notified that they are a contact of a COVID-19 case are not required to self-isolate **if they are fully vaccinated**. They should inform their line manager or employer immediately if they are required to work in the 10 days following their last contact with a COVID-19 case.

The majority of fully vaccinated health and social care staff will be able to continue in their usual role. The following apply to all staff returning to work following this exemption:

- the staff member should not have any COVID-19 symptoms
- the staff member should not have any travel related isolation requirements
- the staff member should immediately arrange for a PCR test, either through their workplace arrangements or via the NHS Test and Trace service, and the result of this PCR test should be negative prior to returning to work
- following the negative PCR result, the staff member should undertake an LFD antigen test every day for the 10 days following their last contact with the case (even on days they are not at work)
- if a staff member has had a SARS-CoV-2 infection in the past 90 days, they should not have a PCR test and should only undertake daily LFD antigen tests for this purpose
- on days the staff member is working, the LFD antigen test should be taken before starting their shift, and the result should be negative
- the staff member should comply with all relevant infection control precautions and PPE should be worn properly throughout the day
- if the staff member works with patients or residents who are especially vulnerable to COVID-19 (as determined by the organisation), a risk assessment should be undertaken, and consideration given to redeployment during the 10 days following their last contact with the case.

6. If an unvaccinated or partially vaccinated staff member is notified as a contact of a COVID-19 case, by NHS Test and Trace or their workplace, they must self-isolate as advised unless they are exempt (because they are under 18, unable to be vaccinated due to medical reasons or are taking part or have taken part in a clinical trial for a COVID-19 vaccine).

If they are unvaccinated and are exempt from self-isolation they should not attend work, or should be redeployed for the period of time they would be required to self-isolate. If staff are to be redeployed, they should comply with the mitigations outlined above.

If they develop symptoms of COVID-19 during this period, they should self-isolate and follow the guidance.

7. If you suspect (or it is confirmed that) this is a COVID-19 outbreak, then HPTs may wish to consider sending an email with any outbreak support materials.
8. The care home may also distribute a letter to GPs with registered residents and relatives.
9. Residents who are on end of life care should be asked, where possible, if they would like to receive a visit from a loved one or a faith leader. Their family and those important to them should be informed about what is happening and offered the opportunity to visit, and supported to wear appropriate PPE and implement appropriate IPC precautions.
10. After a death, the infection control precautions described in this document continue to apply whilst a person who has died remains in the care home. This is due to the ongoing risk of transmission of infection via contact, although the risk is usually lower than from those living.

Contact tracing in care homes:

Contact tracing in care homes is managed as per the Test and Trace escalation criteria and follow up processes, in accordance with local health protection team arrangements.

Appropriate management and isolation advice should be given to all contacts identified. Current guidance is available here:

<https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings>

Contacts definition:

Resident contacts: Any resident that meets one of the following criteria:

- a. lives in the same unit or floor as a confirmed case (e.g. shares the same communal areas), unless the resident(s) (i.e. potential contacts) effectively isolate in their rooms throughout the infectious period of the case(s) (or vice versa);
- b. has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact;
- c. has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact;
- d. has spent more than 15 minutes within two metres of a confirmed case.

Staff contacts: Any staff member that has had the following contact while not wearing appropriate PPE or who has had a breach in their PPE:

- a. has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact;
- b. has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact;
- c. has spent more than 15 minutes within two metres of a confirmed case;
- d. has cleaned a personal or communal area of the home where a confirmed case has been located (note this only applies to the first time cleaning the personal or communal area);
- e. has been notified that they are a contact of a co-worker who has been confirmed as a COVID-19 case.
- f. Travelled in a small vehicle with a confirmed case or a large vehicle close to a confirmed case.

PPE and infection control guidance for relevant setting is available here:

- <https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-care-homes>
- <https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes>

Deaths:

For hospital deaths – there is no action needed by the HPT.

For deaths with suspected COVID-19 connected to care homes where there are no positive swabs and patients have many co-morbidities but had symptoms suspicious of COVID-19, the GP who certifies the death needs to decide whether they feel it is COVID-19. If they have concerns, they should discuss with the coroner.

Follow up:

Request care home to contact the HPT or local authority (depending on local arrangements) if significant increase in number of cases, hospitalisations, deaths, difficulty in implementing infection prevention and control measures, press interest or high anxiety levels in public or relatives.

Discharge of COVID-19 positive patients from hospital to a care home

Follow discharge and testing guidance here

- <https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes/coronavirus-covid-19-admission-and-care-of-people-in-care-homes>
- <https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings>

Visitors

During an outbreak all but essential visits to the care home should be stopped.

NB: For guidance on Covid vaccination in care homes with outbreaks see:

<https://www.england.nhs.uk/wp-content/uploads/sites/52/2020/12/C0993-Care-home-vaccination-guidance-31dec.pdf>

Further guidance on visits into and out of care homes is available here:

- <https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus>
- <https://www.gov.uk/government/publications/arrangements-for-visiting-out-of-the-care-home>

SPECIFIC ACTIONS FOR INFLUENZA AND OTHER ARI OUTBREAKS:

For detailed guidance on the management of influenza in care homes please refer to the national guidance: <https://www.gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes>

Key actions / messages are captured below.

1. Isolation periods

Isolation period for influenza and respiratory viruses other than SARS-CoV-2 (suspected or confirmed) should be for a minimum of 5 days after the onset of symptoms and until feeling well.

If COVID-19 or co-infection with COVID-19 is suspected, then isolation should be maintained in line with COVID-19 advice (as described above, see: Coronavirus (COVID-19): admission and care of people in care homes.

2. Close contacts of a resident with a respiratory virus, other than COVID-19, do not need to self-isolate. See sections above for guidance on self-isolation for COVID-19 contacts.
3. If staff members test negative for SARS-CoV-2 and have symptoms of, or are confirmed as having influenza, they should remain off work for a minimum of 5 days after the onset of symptoms and until feeling well. (A case-specific risk assessment may be necessary if, for example, the SARS-CoV-2 test was significantly delayed but the symptoms are highly compatible with COVID-19, and/or there is a COVID-19 outbreak in the care home where the staff member works.)
4. If possible, staff should work with either symptomatic patients only, or asymptomatic patients, but not both, to limit the risk of cross contamination of residents by staff members. The care home may consider using staff vaccinated against influenza, at least 14 days beforehand, to care for symptomatic patients. However, staff should always use PPE and adhere to infection control measures, regardless of vaccination status. Movement of staff between areas with and without symptomatic residents should be restricted as far as possible.
5. Ideally symptomatic residents should be cared for in single rooms or cohorted into separate floors or wings of the care home. If there is co-circulation of more than one respiratory virus (e.g. SARS-CoV-2 and Influenza), consider separate cohorting of residents with different viruses if possible. If this is not possible, symptomatic residents with compatible symptoms should be cared for in areas well away from residents without symptoms.
6. Visitor guidance for the prevention of introduction of COVID-19 to the home should be applied throughout the COVID-19 pandemic – see links to guidance in previous section.
7. Testing:
 - a. If COVID-19 outbreak suspected or confirmed, then proceed to whole home testing for SARS-CoV-2 – see COVID-19 guidance above
 - b. When national/local surveillance indicators suggest there is influenza circulation OR where influenza is clinically suspected, residents who have developed recent symptoms and/or those with symptoms most indicative of influenza should be tested for Influenza A and B, in addition to SARS-CoV-2, and also ideally for RSV, parainfluenza, human metapneumovirus, rhinovirus, adenovirus as above. For detailed guidance see seasonal influenza guidance and algorithm, as well as the local policy.
8. The care home may also distribute a letter to GPs with registered residents and relatives.
9. Influenza Antivirals & Vaccination
Detailed recommendations about the use of antiviral neuraminidase inhibitors (i.e. 'antivirals') can be found in the [PHE guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza](#) .
10. In keeping with current recommendations by NICE, PHE recommends the targeted prompt use of antivirals as follows:

- a. for treatment of uncomplicated influenza among specific at-risk groups
- b. treatment of complicated influenza regardless of underlying individual risk factors
- c. for influenza post-exposure prophylaxis among care home residents in at-risk groups in specific outbreak situations

11. Due to the potential limited effectiveness of vaccination in the elderly, antivirals should be offered to residents regardless of their influenza vaccination status.

12. For staff, only those in at-risk groups and who have not had an influenza vaccination this season (at least 14 days previously) should be offered antiviral prophylaxis.

NATIONAL GUIDANCE

General

NHS [National Infection Prevention and Control Manual](#)

COVID-19

- British Geriatrics Society guidance on COVID-19:
<https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes>
- Coronavirus (COVID-19): adult social care guidance
<https://www.gov.uk/government/collections/coronavirus-covid-19-social-care-guidance>
- Guidance on Admission and care of residents during COVID-19 incident in a care home:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878099/Admission_and_Care_of_Residents_during_COVID-19_Incident_in_a_Care_Home.pdf
- COVID-19: management of staff and exposed patients and residents in health and social care settings
<https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings>
- COVID-19: how to work safely in care homes:
<https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-care-homes>
- Infection prevention and control and personal protective equipment:
<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>
- PHE guidance: COVID-19: cleaning in non-healthcare settings:
<https://www.gov.uk/government/publications/covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings>
- DHSC guidance : Mental Capacity Act and Deprivation of Liberty Safeguard during Coronavirus: <https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-covid-19-pandemic-additional-guidance>
- COVID-19 situations: HPZone data entry guidance for situations:
<https://connect.phe.gov.uk/documents/preview/4277/HPZone-data-entry-guide-for-COVID-19-situations>

Guidance for stepdown of infection control precautions and discharging COVID-19 patients
<https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients>

Influenza

- National guidance for the treatment and prophylaxis of influenza is available from NICE [Amantadine, oseltamivir and zanamivir \(Relenza\) for the treatment of influenza](#) National Institute for Health and Clinical Excellence (NICE) technology appraisal 168, February 2009.
- [Oseltamivir, amantadine \(review\) and zanamivir for the prophylaxis of influenza](#) NICE technology appraisal 158, September 2008
- PHE guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza
<https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents>
- An evidence summary for professionals is available on <https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents> together with a letter for clinicians. This follows the 2014 Cochrane review that suggested that antivirals are not effective for influenza. The PHE view remains that there is, however, no evidence to support a change in practice from that recommended in the NICE guidance.
- Appendix 5 gives British Geriatric Society guidance on prescribing with **unknown renal function**.
- **Prevention and control of infection in care homes: an information resource** and
- **Prevention and control of infection in care homes: summary for staff**
- <https://www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published>
- **PHE guidelines on the management of outbreaks of influenza-like illness (ILI) in care homes:**
- <https://www.gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes>
- **Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings:**
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585584/RTI_infection_control_guidance.pdf

Record of updates / amendments to SOP

Date & Version	Update	Who by
Jan 2021	<ul style="list-style-type: none"> Update to testing Section to include introduction of LFD testing and guidance on testing within 90 days of a previous Covid-19 infection. SOP rewritten to include management if Acute Respiratory Infections and Covid-19, testing and treatment Appendix 1: FAQ on care home PCR testing removed 	Mike Gent, Kristina Poole, Fiona Neely
6.4.21	<ul style="list-style-type: none"> Section 2 f added under Testing in Care Homes section on the Evaluation of COVID-19 vaccine effectiveness in VOC / VUI outbreaks in care homes 	Mike Gent
06/05/21	<ul style="list-style-type: none"> Paragraph added at 3 “DECLARING THE END OF AN OUTBREAK” (page 3) in regard to outbreaks being over if 14 days, rather than 28 days, have elapsed since the onset of symptoms in the most recent case. Same section also added under RECORDING ON HPZONE → WHEN TO CLOSE A CARE HOME SITUATIONS ON HPZONE (page 10) Paragraphs f, g, h, i, j regarding VOC / VUI testing in care homes added under “TESTING FOR COVID-19” section (page 8) Removed Appendix 1: Advice for PHE Health Protection Teams, Care Home Managers and Clinicians if during whole care home routine testing a staff member or resident has an ‘unexpected positive’ PCR result for COVID-19 	Mike Gent, Will Morton
13.5.21	<p>Definition of a Covid-19 outbreak (page 3) changed from: An outbreak is defined as 2 or more confirmed cases of COVID-19 OR clinically suspected cases of COVID-19 among individuals (residents or staff) with onset dates within 14 days.</p> <p>To:</p> <p>At least one laboratory confirmed case of COVID-19 AND one or more cases which meet the clinical case definition of COVID-19 among individuals (residents or staff) with an epidemiological link to the care home and with onset dates within 14 days.</p>	Mike Gent
14/06/21	<p>Page 4: outbreak restrictions to remain in place until 28 since the most recent case for VOCs other than alpha or delta variants.</p> <p>Page 5: single cases of delta variant should trigger a single round of whole home testing by PCR (in addition to daily LFD staff testing). All SARS-CoV-2 positives to be managed as delta variant, unless proven otherwise by reflex assay or WGS.</p>	Mike Gent, Will Morton, Anand Fernandes

	<p>Page 8: single cases of delta variant should trigger a single round of whole home testing by PCR (in addition to daily LFD staff testing) but no longer trigger the implementation of outbreak restrictions. All SARS-CoV-2 positives to be managed as delta variant, unless proven otherwise by reflex assay or WGS.</p> <p>Page 8: outbreak restrictions to remain in place until 28 since the most recent case for VOCs other than alpha or delta variants.</p> <p>Page 9: HPTs are no longer required to report all delta VOC outbreaks to ASC but should report any significant delta VOC outbreaks (e.g.10 or more cases and/or outbreaks with significant hospital admissions/deaths).</p>	
1.7.21 V 4.05	<p>Due to a period of increased pressure on lab capacity for Pillar 2 PCR testing, single cases of delta variant should not trigger whole home PCR testing, only 7 day LFD testing in staff. This change will be kept under review.</p> <p>Text to reflect this change in testing inserted into pages 5 and 8</p>	Mike Gent Will Morton
06/09/21 V 4.06	<p>Updated section on Testing Care Homes on page 6 +7 regarding action following a single case in a staff member or resident.</p> <p>Updated section on Specific Actions for Covid-19 Outbreaks on pages 13 + 14 to reflect changes in self isolation of contacts from 19th August 2021.</p>	Mike Gent
04/10/21	<p>Updated section on Testing in Care homes p. 5-6 – testing in response to single cases and/or staff cases identified during daily LFD staff testing.</p> <p>Updated section on HPZone recording (p. 11).</p>	Fiona Neely Will Morton Mike Gent
06/01/22	<p>Updated section on VOCs and VUIs – omicron variant now managed as standard rather than high priority variant (p.9). Further amendments throughout SOP including omicron in the list of standard variants.</p> <p>Updated section on exclusion from workplace in line with change to self-isolation period for H&SC staff/LFD testing from day 6.</p>	Wil Morton