Public Health Scotland

COVID-19: information and guidance for social, community and residential care settings

(Including care homes for older people registered with the Care Inspectorate)

06 July 2022

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NHS National Services Scotland

Version 2.2

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Version history

An archive of all previously published versions of this guidance and supporting resources that relate to COVID-19 is available on the **PHS website**. This includes resources that have been retired from the website because they have been superseded or are no longer required.

Version	Date	Summary of changes
V2.2	06/07/2022	Key updates that are included throughout the guidance: • This guidance has been merged with the COVID-19: guidance for care home settings (for older adults). This means that all care homes (registered with the care inspectorate) are now included in the scope of this guidance and the standalone COVID-19: guidance for care homes (older adults) has been archived. New sections have been added to this guidance where specific advice is only applicable to older adult care homes. • Scope of the guidance expanded to included services who provide support to those experiencing homelessness. • References to the ARHAI Scotland Winter (21/22), Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum have been removed as the addendum will be withdrawn on 11 July 2022. References to the new ARHAI Scotland Community IPC COVID-19 Pandemic appendix have been added throughout this guidance for IPC advice. Key updates that are section specific: Section 3.3 Physical distancing: advice updated to align with the ARHAI Scotland Community IPC COVID-19 Pandemic appendix. Section 3.7 Advice for people at highest risk: section updated to reflect the end of the highest risk list on 31 May 2022. Section 6 Testing for COVID-19 infection: addition of three testing tables that contain testing advice for each of the following three groups: service users, staff and visitors. Where service user testing for admission purposes remains, LFD testing now indicated (previously PCR or LFD advised).

Version	Date	Summary of changes
		Section 7.2 Outbreak management in higher risk settings: advice separated in to three sub-sections that cover the initial assessment, testing during an outbreak, and outbreak management measures. Section 8.5 Service users who temporarily leave the residential setting: new sub-section added that contains admission advice for service users who attend a hospital appointment or have an overnight stay in hospital. Section 9.1.1 Community groups visiting residential settings: new sub-section added outlining the health protection principles for services who wish to reintroduce community groups into residential settings (including care homes).
V2.1	16/05/2022	Section 3.2.1 Routine asymptomatic testing recommendation no longer covers general population, only HSCW working in specific settings should undertake routine asymptomatic testing. Section 3.2.1 Asymptomatic LFD testing for some HSCWs reverted to twice weekly. Section 3.2 Update to LFD kit access advice Section 6.7 Asymptomatic LFD testing only advised before attendance at specific health and social care settings for general population (visitors). Updates to hyperlinks to other PHS guidance documents Removal of contact tracing information in line with Scottish Government provision Removal of asymptomatic testing for the general population (and service users) Addition of appendix 2- checklist for COVID-19 outbreaks

Contents

List of abbreviations

ABHR	Alcohol based hand rub
AGP	Aerosol generating procedure
ARHAI	Antimicrobial Resistance and Healthcare Associated Infection
BiPaP	Bi-level positive airway pressure
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CPAP	Continuous positive airway pressure
COVID-19	Coronavirus disease 19
ECDC	European Centre for Disease Control
FRSM	Fluid resistant surgical mask
HPT	Health protection team
HSCW	Health and social care worker
HSE	Health and Safety Executive
IMT	Incident management team
IPC	Infection prevention and control
IPCT	Infection prevention and control team
JCVI	Joint Committee for Vaccines and Immunisation
LFD	Lateral flow device - refers to test
MHRA	Medicines and Healthcare Products Regulatory Agency
NHS	National Health Service

NIPCM	National infection prevention and control manual
PCR	Polymerase chain reaction
PHS	Public Health Scotland
PPE	Personal protective equipment
RNA	Ribonucleic acid
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
SCRC	Social, community and residential care
SG	Scottish Government
TaP	Test and Protect
UKHSA	UK Health Security Agency (formerly Public Health England)

1. Scope of the guidance

This guidance is to support those working in social, community and residential care (SCRC) settings and users of their services about COVID-19. **This guidance now incorporates care homes for older people.**

Social, community and residential care settings covered by this guidance includes:

- Providing care to individuals in their own home
- Adult social care building based day services
- Community based settings for people with mental health needs
- Community based settings for people with a learning disability
- Community based settings for people who misuse substances
- Rehabilitation services
- Residential children's homes (including settings registered as care homes)
- Secure accommodation services for children and young people
- Residential settings for adults (including respite services for adults)
- Residential respite/short breaks services for children
- Care home services, registered with the care inspectorate (now including older adult care homes)
- Services helping those experiencing homelessness
- Sheltered housing
- Supported accommodation settings

This guidance, **COVID-19: guidance for social, community and residential care settings**, is now the advised guidance for adult and older adult care homes registered with

the Care Inspectorate (rather than **COVID-19: information and guidance for care home settings** that services had followed until June 2022 and is now withdrawn).

For Infection Prevention and Control guidance for SCRC Settings, see the **Community IPC COVID-19 pandemic appendix**, produced by ARHAI Scotland, our national partner organisation for **IPC**.

This guidance is based on what is currently known about COVID-19. Public Health Scotland will update this guidance as needed, and as additional information becomes available.

This guidance does not replace individual expert clinical judgment nor local response arrangements, but is designed to support the development of those arrangements and assist in that response, while maintaining a reasonable expectation that agreed health protection principles and national policy are supported and implemented to good effect in line with **The Public Health etc. (Scotland) Act 2008** including exercising their functions in a manner which encourages equal opportunities and in observance of equal opportunities requirements.

We would like to remind readers to regularly check the main **Scottish Government COVID-19 page** for updates on general mitigation measures and new response strategies.

Further PHS COVID-19 guidance for other settings is available on the **PHS website**.

Service providers are welcomed to share their feedback on this guidance - please contact **phs.hpscoronavirus@phs.scot**.

2. Introduction

The disease COVID-19 is caused by an RNA (ribonucleic acid) virus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The first cases in the UK were detected on 31 January 2020. COVID-19 was declared a pandemic by the World Health Organization on 12 March 2020.

Transmission of SARS-CoV-2 is thought to occur mainly through close contact with an infectious individual, mediated by respiratory particles. Transmission is most likely to happen where people are close to each other (usually within 2m).[1] Some environments facilitate transmission e.g. indoor, poorly ventilated and not regularly cleaned. The WHO recognise examples of long-range aerosol transmission as a potential route for exposure to SARS-CoV-2. However, the evidence in this area is currently limited and further research is required to examine the contribution of air-mediated transmission, acknowledging a spectrum of droplet sizes. The SARS-CoV-2 virus can survive on surfaces for periods ranging from a few hours to days.[2] However, the amount of viable virus declines over time and it may not always be present in sufficient quantities to cause infection, despite viral RNA persistence.

It is useful to note the cardinal symptoms of COVID-19 are:

- new, continuous cough,
- fever, or
- change in or absence of sense of smell or taste

(as outlined by **NHS inform**).

Symptoms of COVID-19 can vary in severity from having a fever, cough, headache, sore throat, altered sense or absence of taste or smell, diarrhoea, general weakness, fatigue and muscular pain to pneumonia, acute respiratory distress syndrome and other complications.[3] Mortality is an unfortunate potential outcome in those with severe disease. There is evidence of asymptomatic transmission of COVID-19.[4]

Older adults, very young people and people with underlying health conditions or who are immunocompromised may present with atypical, or non-specific, symptoms, which can

additionally include increased confusion, reduced appetite (and sometimes vomiting and diarrhoea), headache, shortness of breath, falls, dehydration and delirium or excessive sleepiness. Difficulty in breathing is an important symptom to be aware of in older adults and can present after the first week of illness.

The European Centre for Disease Prevention and Control (ECDC) states that the infectious period begins around two days before symptom onset to 10 days after, but people are most infectious during their symptomatic period, usually in the first 3 days.[5] WHO advises the average incubation period is between 5-6 days, however it can range from 1-14 days.[6]

After being infected with SARS-CoV-2, most people recover quickly, usually starting to feel better in a few days; unfortunately, some people take longer and symptoms can affect the whole body. SIGN has produced a **booklet** for anyone with ongoing signs and symptoms of COVID-19 and **NHS inform** provides a variety of useful information.

Inequalities in both risk and outcome of COVID-19 are described by age, sex, ethnicity and deprivation[7]. Older age remains one of the strongest risk factors for poor outcomes from COVID-19. People from minority ethnic groups and socioeconomically more deprived areas are more likely to experience harm from COVID-19. Those living in more deprived areas are more likely to be admitted to hospital with serious illness and have higher mortality rates. Additionally, the interventions designed to suppress viral transmission have an unequal impact across the population, with this differential impact most adversely affecting those in more deprived populations (e.g. overcrowded housing preventing adequate self-isolation from others, financial barriers to seeking a test or self-isolating, etc.). The **self-isolation support grant** remains available to help address this inequality, see also **COVID-19: HPT guidance** for testing criteria. It is important to be mindful of the challenges associated with inequalities in relation to COVID-19 and the individual's context should be considered during risk assessments.

PHS provides a **dashboard** with the latest available data including, but not limited to, the numbers of positive cases reported, trends and demographics, the number of vaccinations administered and percentage of Scotland's population who are vaccinated.

3. General prevention measures

This section outlines a range of measures that are recommended to reduce transmission of COVID-19. Advice on enhanced COVID-19 infection and prevention control measures for health and care settings can also be found in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**.

The COVID-19 pandemic is ongoing. Each social, community and residential care (SCRC) setting should regularly review the implementation of COVID-19 mitigation measures detailed in this section. SCRC settings must continue to follow robust mitigation measures to minimise transmission of COVID-19 (and other infections) as much as is feasible.

The advice included in section 3 applies to all SCRC settings captured in the scope of this guidance, which now includes older adult care homes.

3.1. Vaccination

Evidence for vaccination across adult age groups shows protection against symptomatic disease, infection (including in healthcare workers and in care home service users), hospitalisation due to severe illness and mortality, for all vaccines licensed for use in the UK. The observed reduction in both symptomatic and asymptomatic infections suggests that vaccination has the potential also to reduce transmission. A summary of the most recent data on real world effectiveness, schedule and other relevant information is available in the **COVID-19: the green book, chapter 14a.**

3.1.1. Vaccination recommendations

The Joint Committee for Vaccines and Immunisation (JCVI) provides details on the **groups that are to be prioritised for vaccination:**

- The JCVI recommends a booster COVID-19 vaccine for everyone 18 years and above. Care home service users and staff are strongly encouraged to accept booster vaccination.

- The JCVI have also recommended a spring booster vaccine for extremely high risk groups. This includes residents living in care homes for older adults - see **NHS inform**.

Vaccination of all staff is strongly recommended, including those who are pregnant, breastfeeding or planning a pregnancy, where the safety profile for COVID-19 vaccination remains good.

The excellent uptake of vaccination in staff and service users, particularly in care homes, has altered the COVID-19 mitigation measures (for both vaccinated and unvaccinated people) to be implemented in such settings. **Getting your COVID-19 vaccinations and boosters offers the best protection against the virus for you, your family and those you care for.**

3.1.2. **Vaccination status**

Vaccination status, if required in public health decision making, should be defined as:

- Fully vaccinated: An adult (as defined above, 18 years and 4 months or older) who has had three or more doses of MHRA approved vaccines; either through completing a two-dose course of approved vaccine and received a booster, or three doses of an approved vaccine (e.g. in the case of someone who is immunocompromised), at least 14 days ago, where day 1 is the day of the most recent vaccination.

- All other adults, including the partially vaccinated, are considered unvaccinated.

Where an individual has been fully vaccinated (as defined above) while participating in a formally approved COVID-19 vaccine clinical trial they should be treated as those who are fully vaccinated.

3.1.3. **Additional information**

Additional sources of information for the COVID-19 vaccination are available:

- Resources from Public Health Scotland are available to promote the COVID-19 immunisation programme to **frontline healthcare worker staff** and to **social care**

staff. **COVID-19 vaccination guidance: consent in care homes in Scotland (for care home managers)** and **COVID-19: guidance for Health Protection Teams (HPTs)**

- Workforce education materials are available on the **Turas Learn site**
- Leaflets explaining why the coronavirus (COVID-19) vaccine is being offered and how, when and where it will be given, are available on **NHS inform.** More information on the COVID-19 vaccine is available on **NHS inform** and a helpline for the public has been set up on 0800 030 8013

3.2. Contact tracing

Routine identification of contacts of COVID-19 cases is no longer undertaken.

Those with confirmed COVID-19 should tell everyone in their household that they are positive and follow the stay at home guidance on **NHS inform**. They should tell anyone they have had contact with in the 48 hours before they became symptomatic or before the date of their test if asymptomatic. Additionally, individuals with possible COVID-19 should tell people they were in contact with in the 48 hours before they became symptomatic that they are feeling unwell with respiratory symptoms. This ensures that contacts are vigilant of respiratory symptoms that may develop.

There is no formal definition of a contact. However, it should be noted that the risk of transmission for any respiratory illness, including COVID-19, increases as the duration of exposure increases. This places those individuals who have spent significant time with a case, such as household members and overnight contacts at highest risk of infection. The risk of transmission increases with duration of time spent with an individual and with proximity to the individual. The risk is also greater in indoor, crowded settings as opposed to outdoor activities.

See **section 4.1** and **section 5.2** for more information for service users and staff who are aware they have been in contact with a COVID-19 case.

3.3. Physical distancing

Physical distancing is no longer required for staff, service users or visitors. However, there should be an understanding among staff and visitors that the lack of physical distancing can increase the risk of viral transmission to the service user or to the visitor, depending on the circumstances. Indoor settings with poor ventilation can have a higher risk of transmission, as may situations where either person is not wearing a face covering or mask. Where services wish to continue physical distancing they may choose to do so, particularly in settings where staff remove their Type IIR Fluid Resistant Surgical Mask (FRSM) and a COVID-19 exposure event has the ability to result in high staff isolation numbers/significant service impact.

It is important to note that overcrowding in any area of a facility, including communal areas or visitor areas, increases transmission risk for respiratory viruses including SARS-CoV-2. It is important to remain mindful of the volume of people in a space at any one-time, taking account of staff, service users and visitors. Facilities should not return to pre-pandemic practices which facilitated overcrowding, and steps should be taken to prevent this.

Although there is no legal requirement to maintain physical distancing in social, community and residential settings, guidance on how measures can be maintained through e.g. hybrid working are available from the Scottish Government **guidance for safer workplaces and public settings**.

The HPT managing an outbreak in a SCRC setting may recommend a temporary reintroduction of physical distancing as an outbreak control measure.

3.4. Face coverings and masks

- The **WHO** recommend face coverings / face masks for use in the community as a measure in reducing transmission of COVID-19. Note that face coverings are not considered to be personal protective equipment (PPE).
    - It is important to note the difference between face masks and face coverings. Where Public Health Scotland guidance refers to face masks this means surgical or other medical grade masks, for example fluid resistant surgical masks (FRSM), that are used in certain health and social care situations. Face

coverings are made from cloth or other textiles that cover the mouth and nose, and through which you can breathe (e.g. a scarf).

- Face coverings / face masks should be worn in health and social care settings in line with the **Scottish Government guidance on the use of face coverings in social care settings including adult care homes** (for social care) and **guidance on the extended use of face masks and coverings in hospitals, primary care and wider community healthcare** (for healthcare). This sets out the guidance regarding face coverings and face masks for many groups and settings. Please note this guidance is currently under review.

- The use of face coverings / face masks by visitors, though no longer required under Scottish Government legislation, is still encouraged to help prevent spread of COVID-19 into and out of SCRC settings.

- Visitors to individuals living in older adult care homes (including community group visits) are currently still strongly advised to wear a face covering in communal spaces within the care home. They may choose not to wear a face covering in the resident's room if the resident is comfortable with this. Wearing a face covering in these communal settings minimises the risk of transmission to other residents who may be more vulnerable to COVID-19.

    - Transparent face masks may be provided to visitors to support communication between individuals with additional communication needs.

- Staff members who were exempt from the legal requirement to wear a face covering / face mask should discuss their exemption with their line manager and occupational health service to consider if patient, service user, professional or public-facing roles are appropriate in light of the potential risk to staff themselves or others. Exemption from wearing face covering / face mask will be part of any workplace risk assessment.

- In circumstances where a COVID-19 positive service user is receiving end of life care, visitors should be provided with FRSMs to mitigate against the risk of transmission of COVID-19 from the service user. They may remove their face mask

when in the room with the individual should they choose to, and with an awareness of the risk to themselves in doing so.

3.5. Hand, respiratory and environmental hygiene

- Follow hand hygiene and respiratory hygiene advice in the **NIPCM**.
- Ensure that workplaces/work areas are cleaned regularly in line with advice on safe management of the care environment in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**.
- Further advice is available from NHS inform at **Coronavirus (COVID-19): General advice.**

3.6. Ventilation

- Ensuring good ventilation in indoor spaces will help to reduce the risk of SARS-CoV-2 spreading.[10] The amount of fresh air entering a room should be maximised, wherever possible.
- Natural ventilation can be achieved by opening windows, vents and doors (excluding fire doors). Some buildings may have mechanical ventilation systems, these should maximise the amount of fresh air being introduced and minimise the recirculation of air in rooms and throughout buildings. However, it is important that the safety and thermal comfort of service users and service providers be maintained by ensuring adequate room temperatures.
- Health and Safety Executive (HSE) **ventilation in the workplace guidance** provides practical steps on improving ventilation. The UKHSA **COVID-19 ventilation of indoor spaces guidance** advises to keep room temperature to at least 18ºC as temperatures below this can affect health, especially in those who are 65 years or older, or have a long-term health condition.

3.6.1. **Advice for using fans in residential care settings and care homes**

If a service user is still feeling too warm after the heating has been turned off and windows opened, then a fan may be used in a service user's own private room. The fan must be clean, directed away from the door and well maintained. In an outbreak situation, or if the service user is on a respiratory pathway, fans are permitted in their own room but windows should remain open when in use.

Fans in communal areas of the residential setting (outside the service user's private room) should only be used following a thorough risk assessment and during exceptionally warm weather. Staff should turn off the heating and open windows and doors (if possible) to reduce the temperature before using a fan, as fan use should be as an exception and not routine. Fans should not be in use, in communal areas, where a setting has COVID-19 cases or an ongoing outbreak of COVID-19 or any other infectious pathogen. If additional measures are needed for temperature control during an outbreak, the service manager should complete a risk assessment with support for their local Health Protection Team. If the risk assessment results in use of fans, it is essential that fans are cleaned regularly (including the blades) and are not pointed directly at service users.

Please note this advice does not apply to individuals receiving care in their own home.

3.7. **Advice for people at highest risk**

Despite receiving vaccinations, some groups of people are at higher risk of severe illness if they catch COVID-19, including those with a weakened immune system. **Scottish Government provide advice for people who are immunosuppressed**.

Further information on COVID-19 and pregnancy can be found on **NHS inform** and the **Royal College of Obstetricians and Gynaecologists (RCOG) website**. Pregnant staff may also seek advice from their line manager or local OH service. COVID-19 vaccines are recommended in pregnancy.

4. Providing care for service users during COVID-19 pandemic

There are some parts of this section where advice varies between SCRC settings. Where setting specific advice varies from general SCRC guidance, this is noted.

Service providers should ensure vigilance among service users for **COVID-19 symptoms**, such as a new continuous cough, or fever, or loss of/change in sense of smell or taste, or other signs of illness. It is important to note that older adults may have atypical symptoms - see **section 2**.

As per local pathways, contact the GP for clinical advice on further management if a service user becomes unwell. If the person requires clinical assessment, seek advice on **NHS inform** and contact **NHS 111** via telephone, or online. Staff may need to call on behalf of the individual.

If urgent ambulance or hospital care is required, dial 999 and inform the call handler or operator that the unwell person may have COVID-19.

4.1. Service users with known contact with a COVID-19 case

Contact tracing will not be routinely undertaken in the SCRC settings covered by this guidance (see **section 3.2**).

Asymptomatic service users who are known to have been in contact with a COVID-19 case do not need to self-isolate. Asymptomatic testing of service users who have been in contact with a COVID-19 case is no longer indicated, unless advised by their clinician or HPT. Service users should follow the advice on **NHS inform** for those who are contacts.

Where a service user is known to have been in contact with a possible or confirmed case of COVID-19 or another respiratory illness, service managers should check that there is no one else with symptoms and should check that all **infection control measures** are in place.

4.2. Service users who are symptomatic or have confirmed COVID-19 infection

Advice for service users who have symptoms or have confirmed COVID-19 infection is provided in the **NHS inform stay at home advice**. It explains the symptoms of COVID-19, flu and other respiratory infections, how to help your symptoms, what to do if you have symptoms and have not taken a COVID-19 test, who is eligible for a COVID-19 test and what to do if you have taken a COVID-19 test and it is positive. It explains when to stay at home and how to reduce the risk of onward transmission to other people, in particular to those at higher risk of harm from COVID-19 infection.

Some service users may also be eligible for additional COVID-19 treatments, see **NHS inform**.

4.2.1. Additional advice for older adult care home service users

All symptomatic (**cardinal and other respiratory symptoms**) or COVID-19 diagnosed service users in the care home (older adults) should self-isolate immediately for a minimum of 5 days, counting day 1 as the day after symptom onset or the day after a positive test (whichever was earlier). Medical advice should be sought if clinically indicated.

Self-isolation can be discontinued after:

- 5 full days of isolation, and
- the service user has been without fever for 48 hrs (without use of medication such as paracetamol), and
- the service user is feeling better.

No further testing is required. Self-isolation may occasionally be extended if advised by the HPT.

Asymptomatic service users should not be tested (see **Table 1** for testing advice). If the local HPT exceptionally advises that an asymptomatic service user should be tested, then the advice for symptomatic service users applies if they test positive. If symptoms

develop during their self-isolation period, then the service user does not require to reset their self-isolation period or be re-tested. However support on risk assessment can be sought regarding the length of the self-isolation period. Self-isolation can be discontinued after 5 full days of isolation and if the service user has been without fever for 48 hrs (without use of medication such as paracetamol) and is well.

The reduction in previous self-isolation from 10 days to 5 days reflects the less severe presentation of COVID-19 in care home residents in recent months, and recognises the potential harms associated with prolonged isolation.

See **section 4.2.3** for managing self-isolation of service users in other SCRC settings.

4.2.1.1. Considerations for symptomatic PCR test negative service user in older adult care homes

In the event a symptomatic service user's test is PCR negative, consideration should be given to further clinical assessment of the symptoms or repeat testing in case this is a false negative result or was taken too early after symptom onset. Service users who are identified as possible cases can be released before their self-isolation period ends with a negative result if:

- The service user is well and has no fever for 48 hours, without using medication (such as paracetamol),
- the sampler was adequately trained and the sample was not deemed unsatisfactory,
- the service user is not completing a period of self-isolation following hospital discharge.

If respiratory symptoms lead to suspicion of an outbreak and COVID-19 testing is negative, other organisms may need to be considered and tested for. The local HPT can discuss this with their local laboratory service and provide advice.

4.2.2. **Additional advice for service users of residential SCRC settings**

All symptomatic or COVID-19 diagnosed service users should self-isolate immediately until they are absent from fever, without the use of medication such as paracetamol, and no longer feel unwell - see **NHS inform** for more information. Cough and loss of/ change in taste and smell may persist for several weeks and is not an indication of ongoing infection when other symptoms have resolved.

See **section 4.2.3** for managing self-isolation of service users in residential settings.

4.2.3. **Managing self-isolation of service users in care home or other residential settings**

The service user should be advised to remain in their single room, ideally with en-suite facilities. The door should be kept closed and specific staff should be assigned to provide care during their self-isolation. The service user should not use communal/shared spaces within the facility, where possible. See the **ARHAI Scotland Community IPC COVID-19 pandemic appendix** for more information on managing individual placement in self-contained residential settings.

If en-suite accommodation is not available, dedicated toilet facilities or a commode should be arranged for the service user. These should be decontaminated immediately following use as per guidance in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**, or cleaning arranged for a communal facility. Ensure that personal toiletries such as towels, toothbrushes and razors are dedicated for use by the symptomatic or COVID-19 diagnosed service user. Consider a rota for showering and bathing placing the symptomatic service user last.

Some residential care settings, including supported housing services, are managed as households with varying levels of support. If complete self-isolation is unmanageable , advice can be sought from the local HPT.

There may be circumstances where it may not be in the best interests of the service user to place them in an unsupervised or isolated areas due to distress, vulnerability or safety concerns. Further advice relating to the placement and management of individuals with

special requirements such as children, individuals with mental health conditions, dementia or learning difficulties, is available from the local HPT.

Meals can be provided for the individual to eat within their room. Using communal spaces is possible if risk assessed to be the most appropriate arrangement, especially in household-type services. All necessary care should be carried out within the service user's room.

Service users can be assisted by staff to take daily exercise outdoors during their self-isolation period, should service capacity allow for this to be done. This should be subject to local risk assessment to ensure appropriate infection control precautions are in place. Service users should not leave the grounds of the setting whilst self-isolating and contact with other service users and staff should be minimised as far as possible. It is advised that service users wear a FRSM during this activity. Where FRSM cannot be tolerated or worn, the risk assessment should take this into account. This advice on the allowance of daily exercise also applies during an outbreak where staffing capacity allows.

If a transfer from the facility to hospital is required, the ambulance service and ward staff should be informed in advance if the individual has respiratory symptoms or confirmed COVID-19 and of the requirement for self-isolation on arrival.

Guidance on discontinuing IPC precautions in community health and care settings for COVID-19 positive service users can be found in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix** and from the local HPT.

4.2.4. **Additional advice for care at home and supported housing settings**

All symptomatic or COVID-19 diagnosed service users should follow the **NHS inform stay at home guidance**. They should self-isolate immediately until they are absent from fever, without the use of medication (such as paracetamol), and no longer feel unwell. Cough and loss of/ change in taste and smell may persist for several weeks and is not an indication of ongoing infection when other symptoms have resolved. Service users living in shared housing should follow **NHS inform guidance on how to reduce the spread of infection in your household.**

Care at home and supported housing workers should report possible or confirmed cases of any respiratory illness to their managers. Providers should work with community partners and the person receiving care to review and assess the impact on their care needs. Care should not be discontinued if a service user has tested positive for COVID-19. For information on PPE use and additional IPC measures - see the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**.

There may be instances where a household or family member of a service user has symptoms or a diagnosis of COVID-19 (or another respiratory illness). In such circumstance, the symptomatic/diagnosed individual should be encouraged to remain in a separate area of the service user's home throughout the period of care-giving, in order to reduce the risk of transmission to staff. Opening windows to increase ventilation, as always, is a useful mitigation to prevent transmission. It is understood that there may be particular circumstances (due to distress of the service-user or issues of personal safety) where it is inappropriate for the household member to leave the service user. In such situations, a risk assessment should be undertaken by the service manager to minimise the risk of onward transmission. Where additional advice is needed, the local HPT should be contacted.

Staff should adhere to:

- **ARHAI Scotland Community IPC COVID-19 pandemic appendix**
- **COVID-19: use of face coverings in social care settings including adult care homes**

5. Measures specifically for staff

Ensure staff are enabled to follow key measures described in this guidance to prevent spread of COVID-19 infection. Consider the additional demands that will be placed on staffing requirements in the event of outbreaks and/ or staff absence from respiratory viruses and plan ahead (resilience planning) to support this.

Resilience planning should include the following:

- staff self-isolating as a case
    - Scottish Government **COVID-19: social care staff support fund guidance** aims to ensure social care workers do not experience financial hardship if they are ill or self-isolating due to COVID-19 and their employer terms and conditions mean a reduction in income.
- time required for staff testing
- resource to support service users and meet their caring needs when they are unwell or in self-isolation
- resource to support named visiting during outbreaks
- time and resource required to follow **IPC measures** (including **PPE** use, increased cleaning and **staff cohorting**), training updates and guidance review.

Further staff information:

- Workplaces and their staff should continue to ensure that the risk of infection, both within and outwith the workplace, continues to be risk assessed and that sufficient resilience is planned and in place. This is particularly important for small departments where resilience arrangements may be at moderate to high risk.
- Businesses and organisations should follow the advice in **COVID-19: safer businesses and workplaces** for enabling home working, hybrid working and safer office working.

5.1. Staff who have contact with a COVID-19 case at work

Care home and other SCRC staff will not be routinely contact traced by the local HPT. Staff who come into contact with a COVID-19 positive service user, another staff member or any individual with COVID-19 whilst at work are no longer automatically required to self-isolate. However, a risk assessment should be conducted and extra vigilance taken for the development of COVID-19 symptoms. The service manager should ascertain whether appropriate **infection prevention and control measures** are in place and were followed during that potential exposure and review such measures. The measures expected include practising good hand hygiene, not working with COVID-19 cardinal symptoms, and wearing relevant personal protective equipment (PPE) correctly. The service manager should check that staff had been using PPE correctly and following infection prevention and control measures, if the contact occurred at work, to identify any training needs.

All staff should be vigilant for COVID-19 symptoms at all times, but particularly during the incubation period following exposure (up to 14 days) to someone infectious.

For those who are eligible to test asymptomatically they should continue to asymptomatically test twice weekly and if they develop symptoms they must self-isolate and seek an LFD test

For those who are not eligible to test asymptomatically, if they develop symptoms follow the **'stay at home' guidance on NHS inform**.

5.2. Staff who are a contact of a COVID-19 case

Care home and other SCRC staff will not be routinely contact traced by the local HPT. However, staff are advised inform their manager if they are aware of being in contact with a COVID-19 case, for example in their household or an overnight stay.

If they are eligible for asymptomatic testing they should continue to test asymptomatically twice weekly and should discuss ways to minimise risk of onward transmission with their line manager as detailed in the **Director's Letter (DL) (2022) 12.** Symptom vigilance is important.

If they are not eligible for asymptomatic testing then they should follow the **guidance on NHS inform** that advises how to reduce risk to other people and also explains what to do if the individual develops symptoms.

Regardless of where contact with a COVID-19 case occurred, the service manager should risk assess the placement of staff if there are any extremely vulnerable individuals i.e. those who are severely immuno-suppressed, in the setting. Staff should also continue to be vigilant to the development of any symptoms. See **Director's Letter (DL) (2022) 12** for further information.

5.3. Staff who become symptomatic or have positive PCR or LFD test

Staff who are symptomatic should **not** attend work. If symptoms develop at work, they should put on a FRSM and return home immediately.

5.3.1. Staff who are symptomatic and are not eligible for a COVID-19 test

Anyone who has symptoms of a respiratory infection and a high temperature, or does not feel well enough to go to work, is advised to stay at home, alert their line manager and avoid contact with other people as set out in the **stay at home guidance**. It also provides advice on other actions to take outside of the work environment. On returning to work, speak with your line manager who will undertake a risk assessment and continue to comply with all relevant infection control precautions measures.

5.3.2. Staff who are symptomatic and are eligible for a COVID-19 test

Health and social care staff (including those working in older adult care homes) who work with patients and service users, that are eligible for symptomatic testing, are advised to follow the testing advice in **Table 2**.

The result of the test should be reported to their line manager. If the test result is negative, they can attend work if they are clinically well enough to do so and they do not have a high temperature. If the result is positive, see **section 5.3.3**.

5.3.3. **Staff with a positive PCR or LFD test result**

If the LFD/PCR result is positive, the staff member should stay at home, not attend work and avoid contact with other people for a minimum of 5 days after the day they took the test, whether symptomatic or asymptomatic.

Staff working with patients and service users in face-to-face settings can return to work when they have had 2 consecutive negative LFD test results (taken at least 24 hours apart). The first LFD test should only be taken 5 days after the day their symptoms started (or the day their first positive test was taken if they did not have symptoms); this is described as day 0.

Requirements for returning to work, including testing when indicated for certain groups of staff, are outlined in the **Director's Letter (2022) 12**.

If an asymptomatic LFD/PCR test positive staff member becomes symptomatic during their isolation period, they must remain isolated but do not require to reset their self-isolation period or be re-tested.

Return to work should be risk assessed by line manager if symptoms persist, as outlined in **Director's Letter (2022) 12**. If the staff member works with individuals whose immune system means that they are at higher risk of serious illness despite vaccination, a risk assessment should be undertaken before return, and consideration should be given to redeployment until 10 days after their symptoms started (or the day their first positive test was taken if they did not have symptoms).

Where a risk assessment is required before a HSCW can return to work, HPTs should have oversight of how these decisions are being made but do not need to individually undertake all risk assessments.

Household members of the case should follow the advice on **NHS inform**.

5.4. Visiting professionals and agency staff working in care homes or other residential settings

Professional visits should continue to be supported as these can be essential to wellbeing. It is important that visits by services / professionals are coordinated (e.g. planned in advance) with services to manage footfall and minimise burden and risks on the service user population.

Visiting clinical staff should be supported to attend in person for essential clinical assessments and treatment of service users where this is clinically indicated. Methods such as telephone and telemedicine remain useful and important ways to provide aspects of care. However for some service users, clinical care and assessment provided in person may be more appropriate. Care will be needs-led and wherever feasible, aim for a renewed focus on anticipatory, preventative and rehabilitative care for all service users.

All visiting staff are expected to follow the COVID-19 guidance and all control measures implemented in the facility, in particular, the IPC advice in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**. Testing guidance for professional visitors to care homes can be found in **section 6.3.1**.

Testing advice for new staff or agency staff starting work in the care home can be found in **section 6.2.1**. During an outbreak, the deployment of clinical staff from other care homes / residential settings or healthcare services to replace ill or self-isolating staff must be carefully considered, at the discretion of the local HPT managing the outbreak in collaboration with service provider management. Visits from non-clinical services may pause temporarily, unless deemed essential, on advice of the local HPT.

6. Testing for COVID-19 infection

There are currently various tests available for the detection of SARS-CoV-2 (virus that causes COVID-19 disease). More information on PCR test, LFD tests and POCT is available in the **COVID-19: guidance for HPTs**. This section focusses on the eligibility for COVID-19 testing.

Testing is not mandatory for individuals or staff and must be done with consent or provision made otherwise, for those without capacity. See **Adults with Incapacity (Scotland) Act 2000: principles** for more information.

In line with the Scottish Government's **Test and Protect transition plan**, the primary purpose of COVID-19 testing is changing from population wide testing to reduce transmission to targeted testing to support clinical care. Routine asymptomatic testing is therefore only recommended for specific groups and purposes.

Tests for those who are eligible remain available to order via the **online UK Gov booking portal**. More information on when tests are recommended and how to access them is available on **NHS inform** or the national helpline which can be reached by phoning 119.

Vaccination status does not change the relevance of such testing.

6.1. Testing recommendations for service users

Table 1. Overview of testing for service users in SCRC settings

Status	Symptomatic	Asymptomatic	Asymptomatic but known contact with a COVID-19 case
Older adult care home service users	PCR test.	No testing required.	No testing required.
Older adult care home service users - admission from hospital (**non-respiratory pathway**)	Not applicable as only asymptomatic service users are on the non-respiratory pathway.	One negative LFD result should be available preferably within 48 hours prior to discharge from hospital.	One negative LFD result should be available preferably within 48 hours prior to discharge from hospital.
Older adult care home service users - admission from hospital (**COVID-19 recovered**)	No testing required if the 10 day isolation period is completed in hospital. If not, one negative LFD test before discharge (preferably within 48 hours prior to discharge).	One negative LFD test before discharge (preferably within 48 hours prior to discharge) OR no testing required if 10 day isolation completed in hospital.	Not applicable as the service user is a recovered COVID-19 case.
Older adult care home service users - admission from the **community** (including from other care homes and hospices)	One negative LFD test (taken within 3 days prior to admission date). See section **8.2** and **8.4**.	One negative LFD test, taken within 3 days prior to their admission date (where testing is not possible before, testing on admission to the care home is acceptable). See section **8.2** and **8.4**.	One negative LFD test, taken within 3 days prior to their admission date (where testing is not possible before, testing on admission to the care home is acceptable). See section **8.2** and **8.4**.

Status	Symptomatic	Asymptomatic	Asymptomatic but known contact with a COVID-19 case
Service users in community and residential settings	No testing indicated - follow **stay at home advice** for the general population. Unless advised otherwise by HPT or clinician.	No testing required. Unless risk assessment by HPT or clinician advises otherwise.	No testing required. Unless risk assessment by HPT or clinician advises otherwise.
Service users in residential settings - admission from hospital (COVID-19 recovered)	No testing required. Unless risk assessment by HPT or clinician advises otherwise.	No testing required. Unless risk assessment by HPT or clinician advises otherwise.	Not applicable as the service user is a recovered COVID-19 case.
Service users in residential settings - admission from hospital (non-respiratory pathway)	Not applicable as only asymptomatic service users are on the non-respiratory pathway.	No testing required. Unless risk assessment by HPT or clinician advises otherwise.	No testing required. Unless risk assessment by HPT or clinician advises otherwise.
Service users in residential settings - admission from the community	No testing indicated - follow stay at home advice for the general population. Unless advised otherwise by HPT or clinician.	No testing required. Unless risk assessment by HPT or clinician advises otherwise.	No testing required. Unless risk assessment by HPT or clinician advises otherwise.

See **section 6.4.1** for testing considerations following recent COVID-19 infection.

Any testing on admission to care homes / residential settings should be undertaken with consent and not taken forward if the service user declines or is distressed. If transferring remains in the clinical interests of the service user, a risk assessment using respiratory screening questions can support this process and local HPTs can advise in complex situations. A service user may be discharged to the care home without a test result being available and following risk assessment, self-isolation may not need to be completed.

Please see the ARHAI Scotland **respiratory screening assessment** for further information.

If a COVID-19 recovered service user is being discharged from hospital to an older adult care home before their 10-day self-isolation period in hospital has ended, one negative LFD test is still advised as outlined above. This applies even if the service user is not required to self-isolate on admission to the care home.

See **section 4.2** for information on managing symptomatic or test positive service users.

6.2. Testing recommendations for staff

Table 2. Overview of testing for staff working in SCRC settings

Status	Symptomatic	Asymptomatic	Asymptomatic but known contact with a COVID-19 case
Staff working in care homes for older adults	Take one of the twice weekly LFD tests immediately (see advice in **Director's Letter DL (2022) 12**)	Twice weekly LFD testing and once weekly PCR test for **staff screening** purposes	Twice weekly LFD testing and once weekly PCR test for **staff screening** purposes - no additional testing required
SCRC staff included in the **social care and community based testing guidance**	Take one of the twice weekly LFD tests immediately (see advice in **Director's Letter DL (2022) 12**)	Twice weekly LFD testing	Twice weekly LFD testing - no additional testing required
All other SCRC staff not included in the **social care and community based testing guidance**	No testing indicated - follow **stay at home advice** for the general population	No testing indicated	No testing indicated

See **section 6.4.1** for testing considerations following recent COVID-19 infection.

NHS health workers who attend SCRC settings as part of their role can find further asymptomatic testing information on the Scottish Government website: **COVID-19: Staff testing in NHS Scotland**.

Further information for symptomatic staff or staff who have tested positive for COVID-19 is available in **section 5.3**.

6.2.1. New staff or agency staff working in SCRC settings (including care homes)

Any new or agency staff starting work in a SCRC setting must be screened for current symptoms consistent with COVID-19 infection and should follow the testing advice for staff working in that setting - see **Table 2**.

Any new or agency staff coming into an older adult care home must be screened for current symptoms consistent with COVID-19 infection and require a recent PCR negative test result, ideally before their planned start date and no longer than 7 days before, whether the care home is affected by an outbreak or not. Agency staff need to follow the same guidance as permanent staff for general infection and prevention control. Care homes should ensure that agency or new staff are included in their asymptomatic testing regimes whilst working in the care home.

If PCR testing of new staff (including agency staff) is not possible before their start date in the care home, the care home manager should risk assess this. The risk assessment should include the vaccination status of the worker (considering whether fully vaccinated or not), the presence of respiratory symptoms, negative LFD test before 72 hours of starting work (care home could facilitate this if difficulties accessing LFD tests), fully trained in the use of PPE and the urgency for the staff member to start (to ensure adequate staffing levels for maintaining safe operation of the care home). The HPT can be contacted for advice if required. New staff (including agency staff) should take a PCR test as soon as possible and apply all **IPC measures**.

If a prospective new staff member is symptomatic during pre-work screening or tests positive for SARS-CoV-2, they must not start work at any care home or SCRC setting and follow the advice in **section 5.3**.

The vaccination status of new or agency staff should be checked before starting work. Staff should be supported to become fully vaccinated as soon as possible, in order to protect service users.

6.3. Testing recommendations for visitors to the setting

Table 3. Overview of testing for friends and family visitors to SCRC settings

Status	Symptomatic	Asymptomatic	Asymptomatic but known contact with a COVID-19 case
Visitors to care homes for older adults	Visiting not advised - follow advice on **NHS inform** for general population with respiratory symptoms	LFD test before visiting the care home or twice weekly for those who visit more regularly	Visiting not recommended - see **section 9**
Visitors to SCRC settings, where staff are included in the **social care and community based testing guidance**	Visiting not advised - follow advice on **NHS inform** for general population with respiratory symptoms	LFD test before visiting the setting or twice weekly for those who visit more regularly	Visiting not recommended - see **section 9**
Visitors to all other SCRC settings	Visiting not advised - follow advice on **NHS inform** for general population with respiratory symptoms	No testing indicated	Visiting not recommended - see **section 9**

See **section 6.4.1** for testing considerations following recent COVID-19 infection.

It is acceptable for family and friends visiting care homes to test at home (or away from the care home) before visits, where testing is indicated. Information for visiting family and friends can be found on **NHS inform**.

Children aged 12 and over are recommended to undertake an LFD test before visiting, if visitor testing advised as per **Table 3**. As with any test, parental consent should be sought, though children's views must be considered. Children should not attend visiting if they are unwell.

Exceptions to testing and visiting advice can be made for end of life essential visits - more information on essential visiting is available in **section 9**.

6.3.1. Professional visitors to care homes

Regular testing of asymptomatic visiting staff is advised using **LFD tests**. Testing programmes for visiting professionals (health and social care professionals) are organised through their employers. Verbal confirmation of a negative LFD test within the last 72 hours from health and social care professionals who participates in such testing is acceptable. The absence of testing must not present a barrier to providing necessary clinical care in person - as long as appropriate **IPC measures** (including on PPE) are followed.

Other visiting staff, such as maintenance staff, private podiatrists, hairdressers, etc., who may not be offered testing through their employers are encouraged to undertake an LFD test at the care home. Some of these professionals may visit several care homes in a day or across several days, therefore it is recommended that they test twice weekly. They do not need to be tested in each care home they attend.

6.4. Additional information on testing

Symptomatic testing is only recommended for specific situations and groups. Further to the eligible groups outlined in the **Table 1** and **Table 2** of the guidance, symptomatic testing is also retained for:

- Those who are symptomatic and are eligible for new COVID-19 antivirals, monoclonal anti-body therapies and other treatments. Information about which patient groups are considered at high risk from COVID-19 and are eligible for treatments can be found on **NHS inform (COVID-19 Treatments).**

- People with respiratory symptoms who intend to apply for a self-isolation support grant.
- People participating in COVID-19 surveillance programmes.
- People advised to test either by a health professional; as part of an outbreak investigation; or in relation to investigation of a COVID-19 variant and mutation (VAM).

6.4.1. **Testing advice following confirmed COVID-19 infection in the past 90 days**

If staff or service users have had a diagnosis of COVID-19 either via positive LFD test or positive PCR test, they should not use LFD tests after the initial isolation period for 28 days from day 1 (day 1 is the date of cardinal symptom onset or date of positive test if asymptomatic or displaying other non-cardinal symptoms). Similarly, staff and service users should not use PCR tests for a period of 90 days following recent COVID-19 infection. This is to avoid an individual with a PCR positive result due to remnant RNA material from being interpreted as a new case (false positive).

Staff with a COVID-19 diagnosis (cases) who participate in asymptomatic testing should pause their twice weekly LFD asymptomatic testing for 28 days.

If new symptoms of COVID-19 develop in staff or service users during this 90-day period, the advice for symptomatic individuals should be followed (some groups may be eligible for testing).

Repeat PCR positive tests after 90 days should result in the usual public health action. Any queries in such matters should take a risk assessment approach and HPTs can be contacted for complex situations.

7. Outbreak management

A COVID-19 outbreak is defined as two **linked** cases of the disease over a 14-day period within a defined setting.

Management of COVID-19 outbreaks should follow existing, well-established principles and practice of outbreak management. This can be found in the **SHPN Management of Public Health Incidents: guidance on the roles and responsibilities of NHS led incident management teams**.

Proactive identification and reactive management of outbreaks by HPTs is not recommended in all settings. Instead, a risk-based approach is advised to ensure HPTs can focus their limited resources on the highest priority settings. This section outlines the approach to outbreak management in lower risk and higher risk settings.

Some SCRC settings are considered lower risk settings i.e. those in which there is relatively lower risk of direct health harm arising from infection i.e. predominantly younger or working-age population settings. Within lower risk settings there may be individuals with higher vulnerability. In the event of an outbreak in a setting they are regularly in, these individuals should follow the advice provided by their clinician.

Care homes for older adults are considered higher risk settings as the population is older and service users generally have more underlying health conditions putting them at greater risk of more severe illness, in comparison to younger people. In addition to older adult care homes, there may also be some SCRC settings that have older or clinically vulnerable people, and these may also be considered a higher risk setting in terms of outbreak management. If service providers require further advice, then the local HPT can be contacted.

In addition, there may be outbreaks that do not fall into either a higher or lower risk setting categories but do have the potential to severely disrupt health services or critical infrastructure. In these situations, a HPT may choose to take a closer management approach.

Often due to the size and nature of SCRC services, staffing shortages can quickly become an issue of concern during an outbreak and advance resilience plans should be formulated for such eventualities. Local Authority and Care Inspectorate input may be useful in finding

solutions based on a risk assessment approach led by the HPT. Such assessment will take into consideration the relatively lower vulnerability to COVID-19 of service users in many SCRC settings and balance this with the risk of suspending these important services and the wider harms this could pose.

Some settings may have obligations to report clusters or outbreaks to other agencies e.g. Care Inspectorate, environmental health departments or the Health and Safety Executive but this requirement does not necessarily mean HPT notification is required or recommended.

7.1. Outbreak management in lower risk settings

- There is no obligation for lower risk settings to report clusters of confirmed COVID-19 cases or unusually high levels of absence thought to be associated with COVID-19 (i.e. possible cases) to HPTs as it is expected that most of these situations will be managed via standard working practices in place in each setting for sickness and absence at work. However, if approached for advice HPTs should engage and support the setting to manage the outbreak proportionate to their assessment of the risk to public health. HPTs may make the decision to engage in the handling of any individual cases, clusters or outbreaks at their discretion.

- In response to an outbreak, service providers should undertake a rapid internal review of the setting's risk assessment and mitigation measures and consider any improvements made to their implementation as a priority.

- See the **ARHAI Scotland Community IPC COVID-19 pandemic appendix** for IPC advice. Particular issues can arise in services for children or those with learning disabilities where isolation and mask-wearing, the key mitigations, can be challenging to implement, especially when they create distress for the individual. The local HPT can be contacted in situations where applying the guidance can be difficult.

7.2. Outbreak management in higher risk settings

7.2.1. Initial assessment

In a higher risk setting if one confirmed service user case arises or two or more individuals develop symptoms of COVID-19 within 14 days in a facility, the service provider should:

- Alert the local HPT who will carry out a risk assessment and investigate whether an outbreak has occurred. The level of response to an outbreak from the HPT will be based on the HPT's risk assessment. A checklist is provided in **Appendix 2 - Checklist for COVID-19 outbreaks** to support this assessment.
- Service providers should undertake a rapid internal review of the setting's risk assessment and mitigation measures and consider any improvements made to their implementation as a priority.
    - See the **ARHAI Scotland Community IPC COVID-19 pandemic appendix** for IPC advice.
- Assessment of service user cases when considering any potential outbreak should also include service users who have either been transferred from the care home / residential setting to hospital or died within the same time period of 14 days.
- Symptoms and cases in staff must also be considered.
    - Service providers do not require to contact the HPT following a single confirmed staff case if there are no further staff or service users that are symptomatic or confirmed cases. Symptom vigilance in staff and service users and robust application of IPC measures should continue. Local policies can be implemented for notification of single staff cases in this situation.
    - When investigating COVID-19 transmission in a care home / residential setting and implementing mitigation measures, this should be decoupled from the identification of staff cases (particularly in light of current high community transmission) if no links are found.

    - Any care home / residential setting that has employed staff, including agency staff, linked with another facility where an outbreak has been declared, must also be risk assessed as part of the heath protection response.

- It is the role of the HPT to declare an outbreak, follow identification of two linked cases, at least one of which has been confirmed through testing. An Incident Management Team (IMT) may be convened and led by the HPT, or intensive support provided directly by the HPT.

- Where the setting has a COVID-19 workplace risk assessment or other outbreak management plan in place this should be reviewed by the HPT. These steps should be undertaken collaboratively with the setting and be used to develop an individualised action plan for outbreak management.

7.2.2. **Testing information**

Testing using PCR and/or LFD can be used to support an initial risk assessment when a COVID-19 case arises in a care home. It can be used as a diagnostic tool or as part of surveillance. **Asymptomatic service users who are well should not be tested.**

- A service user with fever and/or new respiratory symptoms should have a PCR sample submitted for SARS-CoV-2 and if indicated a wider respiratory panel of tests including for Influenza, in line with local diagnostic laboratory protocols.

- When a cluster of symptomatic cases arises, it is now acceptable practice to submit samples for up to five symptomatic service users to confirm the pathogen. Additional cases matching the outbreak case definition do not all need to be tested once the pathogen is identified.

    - There can still be a clinical need to test further cases, for example to confirm the diagnosis in individuals with other respiratory illnesses or to determine eligibility for some treatments.

- Testing arrangements during an outbreak is at the discretion of the local HPT with autonomy to deviate from the guidance according to local circumstances and risk assessment.

- Symptomatic service users should be cared for in self-isolation in line with advice provided in **section 4.2**.

When COVID-19 was an infection that led to significant morbidity and death in frail elderly populations, it was important to case find and isolate all cases. Now that service users and staff are much better protected through vaccination and robust infection control, and the virus has evolved to a generally milder form, mass testing can lead to case finding of asymptomatic or mildly symptomatic cases of limited consequence to others. **Service users who are asymptomatic and well should not be tested.** Testing asymptomatic residents can have unintended consequences such as prolonged periods of self-isolation.

Mass testing is now unlikely to be justifiable in most instances. Limited testing of a cluster of symptomatic service users is now considered more appropriate than undertaking mass testing in most circumstances.

- If whole home testing is, exceptionally, used, the local HPT determines whether to limit this to a section of the care home / residential setting and whether to use PCR or LFD tests (symptomatic service users should be tested for diagnostic purposes using PCR tests).

- If testing an asymptomatic service user is justifiable by the HPT (expected to occur only exceptionally), and they return a positive LFD result, no confirmatory PCR is required and they should be cared for in line with advice provided in **section 4.2**.

- If an asymptomatic service users returns a negative LFD test but then becomes symptomatic, they should self-isolate and have a PCR test.

Information on considerations for testing those with recent COVID-19 infection can be found in **section 6.3.1**.

7.2.3. **Outbreak management measures**

Local HPTs continue to lead on the management of outbreaks in care homes, according to their statutory duties under the Public Health Etc. (Scotland) Act 2008. The local HPT has a duty to support the care home in the management of the outbreak and make decisions on outbreak control using a risk assessment approach, according to the particular circumstances of the outbreak and the care home itself.

A number of outbreak management measures are available, as advised by the HPT. These include physical distancing, isolation of cases, appropriate PPE usage, enhanced cleaning, and pausing routine visiting. See the **ARHAI Scotland Community IPC COVID-19 pandemic appendix** for advice on these measures, including information on cohorting of service users and staff. The **COVID-19 care home outbreak checklist** can also be used as a supplementary tool when managing an outbreak in a care home setting. The HPT managing the outbreak may recommend a temporary reintroduction of physical distancing.

Sometimes it is possible to manage areas of a residential facility as separate unit/s, with no shared activities or staff. In such instances unaffected services can continue with normal life, albeit with increased vigilance for any contact links or symptoms in their service users or staff.

During an outbreak, movements of service users within the facility will be monitored and, in particular, self-isolation will be in place for service users who are symptomatic or confirmed COVID-19 cases. Service users who walk with purpose often need increased support during an outbreak.

Communal areas may need to be more closely supervised, namely to ensure service users who are symptomatic/confirmed cases do not mix with others. Communal areas should remain open for use by service users that are not identified as cases or symptomatic of COVID-19. This is the default position during an outbreak if it can be arranged by staff. However, if outbreak measures prove particularly challenging to implement or staffing capacity is low, communal areas may not be able to be used temporarily by service users who are not self-isolating, though they should be reopened as soon as practical.

See **section 9.3** for information on visiting arrangements during an outbreak.

Transfers of service users in and out of the setting during an outbreak must be risk assessed and considered carefully (e.g. service user's COVID-19 status, size of the outbreak, spread within the setting, which units are affected, physical layout of the building, vaccination status of the individual and coverage at the setting) with support of the local HPT managing the outbreak. Any receiving service (e.g. hospital ward or ambulance or back to the facility) must be advised of the IPC measures required for each

service user they support. Service user transfer across services may benefit from a multi-agency approach for particularly challenging service user movements, but this should not be an onerous process and can be a conversation between key services, when needed.

Non-residential services should consider pausing activity for a few days in discussion with their local HPT.

For the HPT to declare an outbreak over, there should be no new linked symptomatic or confirmed COVID-19 cases for a minimum period of at least 14 days from last possible exposure to a case, whether in a service user or staff. The HPT must also be satisfied that existing cases have been isolated/cohorted effectively and that guidance on IPC and other interventions is being applied appropriately. There should be sufficient staff to enable the setting to operate safely using PPE appropriately.

8. Admissions to and visits away from SCRC residential settings

The general advice included in this guidance, alongside the setting-specific advice provided in this section, should be followed in all residential facilities detailed within the **scope section**.

Prior to admission to the care home / residential setting, respiratory screening questions should always be undertaken with either the service user or their carer, as outlined in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix.**

Further information on individual placement/assessment of infection risk can be found in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**.

Residential facilities should also conduct a risk assessment for their facility to determine if there are service users who are at **highest risk** of severe illness and whether additional measures are needed to protect these individuals, should cases arise in the setting.

8.1. Admissions of service users to SCRC residential settings from hospital

Service users who are on the respiratory pathway (e.g., symptomatic or tested positive for COVID-19) do not require any further testing or self-isolation prior to admission to an SCRC setting if they have completed their testing and self-isolation in hospital (including adult and older adult care homes). If COVID-19 recovered service users are to be discharged before their self-isolation period in hospital has completed, they should follow the advice in **section 4.2.2** until they are absent from fever without the use of antipyretics and no longer feel unwell.

For asymptomatic service users on the non-respiratory pathway, no additional testing is required prior to admission to an SCRC setting, unless the setting provides care to **clinically vulnerable individuals** and at the instruction of the local HPT. In this case, a local risk assessment should be undertaken by the SCRC setting management in communication with the hospital team. Service managers undertaking such risk

assessment may wish to refer to the respiratory screening questions for SCRC settings contained within the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**.

For particularly complex admission cases, due to either the clinically vulnerability of the service user being admitted or existing service users within the setting, the local HPT can advise on whether admission screening would be suitable. This should not be required for every individual admission.

8.1.1. Admissions to older adult care homes from the non-respiratory pathway in hospital

Self-isolation is not required on admission to the care home for service users coming from the hospital non-respiratory pathway. These are service users who are not COVID-19 cases and have answered 'no' to the respiratory screening questions just before transfer to the care home.

A risk assessment using the respiratory screening questions prior to hospital discharge for service users with a non-COVID-19 diagnosis should be undertaken in the healthcare setting and agreed with the care home. Service users who are considered fit for discharge from hospital to the care home in such circumstances should always be strongly supported for return home, since returning to a homely environment, rather than remaining in a clinical setting, is important for their recovery and general wellbeing. On rare occasions, the risk assessment may determine the service user should self-isolate further upon return to the care home (e.g. if there are new symptoms). Identification as a contact by the Infection Prevention and Control Team (IPCT) during their hospital stay should not require further isolation in the care home upon transfer.

See **section 6.1** for testing guidance for admission purposes.

8.1.2. Admissions of COVID-19 recovered service users to older adult care homes from hospital

The self-isolation period in hospital is 10 days. COVID-19 recovered service users who have completed 10 days of isolation in hospital can be discharged to the care home (10 days after symptom onset or first positive test, if asymptomatic) without further testing or

isolation, providing the service user is clinically stable and fever free for 48 hours without using medication (such as paracetamol). This process uses a risk assessment approach and any decision should be made in collaboration between the healthcare setting and the receiving care home manager and is informed by responses to the **screening questions**. Discharging such service users from hospital based on clinical judgment and general risk assessment should always be strongly considered and usually supported, as service users returning to their homely environment, rather than remaining in a clinical setting, is encouraged for their recovery and general wellbeing.

This process for COVID-19 recovered patients who have completed 10 days of isolation in hospital applies to both returning and new service users being discharged from hospital into the care home.

8.1.2.1. Discharging before completion of the self-isolation period in hospital

If a service user has not completed their self-isolation period in hospital, then they can do so in the care home, and do not require to start a new period of isolation. They do not require further testing once this isolation period is completed.

The self-isolation period for hospital inpatients and care home service users now differs, as inpatients require a minimum of 10 days whereas service users self-isolating inside the care home require a minimum of 5 days. In both circumstances, inpatients and service users should also be fever free for 48 hours without the use of medication before self-isolation can end - this is in addition to completing the minimum self-isolation period.

From 1 May 2022, if the service user has completed a minimum of 5 days self-isolation whilst in hospital (counting day 1 as the day after the date of their positive test), they do not require to continue with the remaining 10 days of self-isolation (as applies to inpatients) on return to the care home. The self-isolation period for the care home now applies, as long as they remain well with no fever for 48 hours without using medication such as paracetamol. The self-isolation period for care homes is outlined in **section 4.2.1**.

See **section 6.1** for testing guidance for admission purposes.

8.2. New admissions from the community

Service users admitted from the community (including from other residential settings) should complete the respiratory screening questions as advised in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**. These will inform the risk assessment.

- If a new admission answers 'yes' to any of the respiratory screening questions, they should follow guidance in **section 4.2**. If they are symptomatic or a confirmed COVID-19 case, also see **section 4.2**.
    - Consideration should be given to whether delaying the admission is appropriate. If admission to the care home / residential setting is in the best interests of the service user's health and wellbeing then this should be supported. This is provided the care home / residential setting can isolate and care for the service user appropriately.
- If the service user is known to have recently been in contact with a COVID-19 case, see **section 4.1** for advice.
- See **section 6.1** for guidance on testing for admission purposes.

Where there is not an increased risk of infection, identified through completion of the respiratory screening questions, no self-isolation is required on admission. For older adult care homes, a decision on admission and any self-isolation requirements must involve the care home manager and may be subject to local processes as guided by the local Partnership oversight group. A clinical or Health Protection view may also be sought, on occasion, to support this process.

It is advised that any service user being admitted to a setting is fully vaccinated prior (currently 3 doses), in order to minimise the risk of transmission for themselves, staff and any vulnerable service users. Whilst this is advisable, particularly where admission is planned, it is recognised that this may not be possible due to instances of sudden need for admission or due to medical exemption. Vaccination is neither a requirement for admission nor grounds for delay of admission.

8.3. Children being moved between or to new care facilities

Children admitted from the community (including from other residential settings) should complete respiratory screening questions as advised in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**. A decision on whether it is appropriate for a child in this situation to be tested should be made locally based on the answers to the respiratory screening questions, advice contained within the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**, information on the context, clinical needs and urgency of the situation and appropriate risk assessment, where needed, by the social work professionals. Discussion with the local HPT is available, if needed. The decision to test and the results must not impact on the urgency of responding to the needs of the child and ensuring their safety and wellbeing. However, the placement should take account of the health protection and infection prevention control requirements of others in that setting, if the child has symptoms that could be COVID-19 or another respiratory infection.

For children living in residential SCRC settings or who use SCRC services, communication is key between service providers and the child and/or their guardian or carer. Effective communication and explanation of why decisions are being made and what to expect is an important aspect of promoting wellbeing and reducing distress.

8.4. Residential respite/short breaks services

Service users admitted from the community, for respite/short break, should complete the respiratory screening questions as advised in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix** and have one negative LFD test, ideally within twenty four hours before arrival. LFD testing can be undertaken on arrival if this is not possible.

If the individual answers 'yes' to any of the screening questions they should follow the advice in **section 4.2.**

If they answer 'no' to all the questions, self-isolation is not required.

Individual services must identify and set out the capacity for their setting. This should be considered through the risk assessment for the service, taking account of the full range of factors including, but not limited to, the size and layout of the setting, the clinical vulnerability of those attending the setting, vaccination uptake in staff and service users,

the staffing levels, arrangements for hand hygiene facilities and environmental cleaning and the ability to maintain physical distancing, if implemented by the setting. This may also include whether the respite area is part of, or separate from, a care home which may or may not provide care to clinically vulnerable individuals. Further information relating to IPC and communal areas can be found in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**.

The measures taken will need to be tailored to the specific residential/short break service and to the individual needs and considerations of those who use the service and of their careers. This will need regular review over the course of the pandemic. This assessment must be documented by the service.

Residential/short break services may wish to use some of the contents of this guidance in conjunction with their local protocols and arrangements. Other useful information can be found in PHS **COVID-19: information and guidance for workplace and community settings**.

The respite advice included in this guidance also applies to:

- Residential respite facilities for children (including those registered as care homes).
- Stand-alone residential respite facilities for adults and older people (settings registered as care homes).
- Respite-providing care homes for older people that are not considered stand-alone facilities.

If a facility does not fall into these categories or is unsure about which guidance applies, they can approach their Health and Social Care Partnership Oversight Group or local HPT who will advise based on the characteristics of the setting.

8.5. Service users who temporarily leave the residential setting or care home

8.5.1. Service users who temporarily leave the residential setting or care home to attend hospital appointments

Service users who are able to go out during the day, for example to attend a hospital appointment do not require the same measures upon return as a new service user admission.

Overnight admissions to hospital should be managed similarly upon their return back to the SCRC setting or older adult care home, provided the service user answers 'no' to the respiratory screening questions immediately prior to hospital discharge. Testing is unhelpful if the service user has remained asymptomatic, since at least 24-48 hours are needed for a result and the virus will not have had the time to establish itself if infection has occurred and is therefore not required.

8.5.2. Day visits away from all care homes and other residential settings

As communicated to the sector, it is the expectation for care homes to enable personal and social outings, and routine visiting, in the absence of an outbreak is encouraged. Information on the Scottish Government visiting policy is available on **Open with Care: supporting meaningful contact in adult care homes-principles**.

The **NHS inform** guidance on vaccination, hand and respiratory hygiene, use of face coverings and when to self-isolate should be followed. A brief risk assessment should assist in preparing for such excursions into the community to determine whether additional measures should be considered upon return (for example, if symptomatic while away from the setting).

Symptom vigilance amongst service users and their friends and family when planning outings away from the care home / residential setting is an important measure and the outing should exclude anyone with respiratory symptoms.

Visitors taking service users on outings away from the care home / residential setting are also reminded to follow the Scottish Government guidance on **staying safe and protecting others**. Service users and their visitors should be made aware of this risk during the planning of such outings, particularly when the course of vaccination has not yet been completed.

Staff may also take service users on visits outwith the care home / residential setting. Please note there is no requirement for service users or staff to change their clothes upon return. During shared vehicle journeys with service users, it is good infection control practice to increase ventilation by opening windows and using FRSMs for staff and face coverings for service users, if tolerated.

8.5.3. Overnight stays away from all care homes and other residential settings

Service users who are able to visit family or friends overnight can do so and it is recommended that Scottish Government **advice on staying safe and protecting others** is followed to more safely facilitate this. Symptom vigilance among service users and their family and friends is an important measure.

When a cluster or outbreak of cases arises within a residential service, visits elsewhere by service users can be arranged, for essential healthcare reasons (e.g. hospital attendance). In addition, a service user who is not identified as a case can also be supported in planning an outing using a risk assessment approach, providing the residential facility can accommodate preparation for such outings without adversely impacting on the management of the outbreak itself - see **section 9.3.1**.

If an outbreak develops in the residential facility whilst the service user is away, the service user can choose to remain away or return to the facility, recognising that it is their place of residence and home. The local HPT can advise on such decisions which need to be discussed and agreed between the service manager and the service user, and their family, in particular regarding restrictive conditions in the setting upon their return.

Where service providers are involved in facilitating outings, respiratory screening questions should be asked on their return, as advised in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix** and extra attention should be given to the

development of symptoms following return to the setting. Service users or their carers/relatives have a duty to report to setting staff any symptoms developed during the visit away or potential exposures to COVID-19 cases that have occurred whilst off-site.

9. Visiting arrangements in residential settings

The advice included in section 9 does not apply to people receiving care in their own home. The advice in section 9 applies to all other SCRC settings captured in the scope of this guidance, including older adult care homes.

9.1. Routine visiting

Visitors should not visit any care home / residential setting if they have symptoms of COVID-19, flu or other respiratory infection, or if they have tested positive for COVID-19, and should follow the stay at home guidance on NHS inform.

Visitors should be informed of, and adhere to, IPC measures that are in place.

There are no limits on length of visit or how often service users can receive visitors in the care home settings. There are no restrictions on group sizes, however overcrowding should be avoided. The service provider should consider the number of people that can use an area that allows individuals to have their own space. The assessment should consider the built environment of the care home / residential setting, including factors such as ventilation. Vaccination is encouraged for all visitors but is not obligatory.

The Scottish Government published **Open with Care: supporting meaningful contact in adult care homes – principles** on 1 June 2022. It is an update of the original Open with Care guidance published in February 2021. It details the expectation and principles for visiting in adult care homes (including older adult care homes). It also provides an overview of the current guidance.

Further information for visitors is available in this guidance:

- see **section 3.4** for advice on face mask and face covering use
- see **section 6.3** for information on visitor testing

9.1.1. **Community groups visiting residential settings**

Community group visits to residential settings / care homes (including older adult care homes) can begin to be re-introduced. Service providers may wish to invite community groups (including groups of children) into the residential setting / care home to engage with service users and enhance wellbeing.

If a setting is organising a visit by a community group, they should follow the below principles to reduce the risks to the service user population:

- Individuals in community groups should not attend if they are a COVID-19 case or a known contact of a case.
- Individuals in community groups should not attend the care home / residential setting if they have any COVID-19 symptoms or if they have any other symptoms of illness e.g. sickness or diarrhoea, respiratory symptoms, colds or rashes etc.
    - The service provider should ask those in the community group (including any children) the respiratory screening questions and about wider symptoms before any interaction with service users.
- See **Table 3** for advice on testing for all visitors.
- Overcrowding should be avoided. The service provider should consider the number of people that can use an area that allows individuals to have their own space.
- Outdoor visits from community groups should be encouraged where weather permits. Visits can occur inside the facility, provided overcrowding is avoided.
- Ventilation in the care home / residential setting should be maximised during indoor visits.
- When considering the frequency of community group visits, it should remain manageable for service providers.
- Service users who wish to participate in the group activity, but may feel anxious about the risks of COVID-19, should be offered a face mask and their own dedicated space if they wish.

- If a choir/singing group is performing, a 2 metre distance is advised between the choir and the service users while performing.

Visits from community groups should be postponed if there is an outbreak in the setting.

9.2. Visiting a service user who is symptomatic or COVID-19 diagnosed (when no outbreak has been declared)

If a service user has tested positive for COVID-19 or has **symptoms** consistent with COVID-19 infection, visiting can be supported, following a risk assessment involving the local HPT. Service users can receive one visitor per day in their private room during the stay at home period. The visitor must adhere to IPC measures and only enter the service user's private room, avoiding other areas of the setting, and minimising time spent passing through corridors as much as possible. Visitors should wear a FRSM at all times - see **NIPCM** for further information on PPE for visitors.

The visitor should not be symptomatic of COVID-19, or a confirmed case themselves, during the period they are visiting. They should avoid visiting the setting if they live with someone following the **stay at home guidance for people with respiratory symptoms**.

If an outbreak has been declared by the local HPT, then guidance in the **section 9.3** should be followed instead.

9.3. Visiting during an outbreak (named visitor initiative)

A framework is in place whereby settings can support service users to choose 'named visitors' who may visit them in their private room during a COVID-19 outbreak. Service users can now choose up to three named visitors, and one named visitor can visit them in their private room each day.

Visiting arrangements in care homes / residential settings during an outbreak, by default, is through the named visitor initiative. Service managers and HPTs must support and encourage this initiative for service users' general well-being. In some instances, the HPT may risk assess that it is necessary to pause this initiative during an outbreak if concerns are identified that could jeopardise effective outbreak management. If this occurs,

restrictions to the named visitor initiative should be in place for the shortest possible period and re-start as soon as possible. Essential visiting should continue to be supported regardless of outbreak status.

The outbreak management process is at the discretion of the local HPT, led by an appointed competent person under the **Public Health Etc. (Scotland) Act 2008**. Outbreak management in a care home / residential settings follows a dynamic risk assessment approach led by the Health Protection Team, often via the incident management team (IMT) whereby the situation is continuously assessed and the control measures reviewed.

It is important to note that enabling the opportunity for each service user to have named visitors during an outbreak in the care home / residential setting carries a degree of risk. Older adult care homes still remain vulnerable settings due to the nature of communal living and the susceptibility of the service user population to infectious disease. PPE is needed to protect the visitor. However, having a named person to visit during a COVID-19 outbreak can avoid service users experiencing prolonged periods of isolation from their loved ones and recognises the benefits to service users' health and wellbeing this brings.

The following points provide an outline for this initiative of the 'named visitor':

- care homes / residential settings should support service users to nominate up to three named visitors and keep an updated record of each service users named visitors. They should involve family members, friends and advocates in this task, as appropriate

- service users can have up to three named visitors but only one named visitor should visit each day. Visiting is restricted to the service user in their own room. Exceptionally, two named visitors can visit at one time if support is needed by one of them, e.g. an elderly spouse. Such exceptions remain at the discretion of the care home / residential setting and/or the HPT.

- in the event that none of the named visitors can visit (e.g. they are-self-isolating, on holiday, ill), the care home / residential setting should facilitate an alternative individual that can act as the named visitor. Frequent changes in named visitor are not workable for this initiative and now with the provision of three named visitors, this should occur less often.

- Visitor eligibility for a named visitor includes:
    - the named visitor is asymptomatic and not known to be COVID-19 positive.
    - the named visitor has not been identified as a case or known to be in contact with a COVID-19 case in the previous 14 days.
    - the named visitor is strongly encouraged to be **fully vaccinated**, defined as having received the full primary course and booster of an MHRA approved vaccination, with at least 14 days having elapsed since the final dose. Although vaccination is recommended it is not a requirement for visitors.
    - the named visitor is advised to undertake pre-visit LFD testing.
- named visitors can visit a COVID-19 positive service user who may require some comfort in what can be a stressful time. This would require the local HPT's involvement in risk assessing whether 'named person' visits to a positive case can continue, considering the service users' needs and the nature of the outbreak at that time.
    - if the service user they are visiting is diagnosed as a COVID-19 case, the named visitor must wear a FRSM mask (and other PPE if advised) and be supervised and supported by care home / residential setting staff on donning and doffing of the FRSM (and other PPE), and maintain optimal physical distancing (as advised in the **ARHAI Scotland Community IPC COVID-19 pandemic appendix**)
    - the named visitor is made aware and understands the risks to themselves in visiting during an outbreak. In particular, if the service user is found subsequently to be a COVID-19 case.
- named visitors may, with agreement of the service user (or representative) and the care home / residential setting staff, provide day to day basic care to support service users' health and wellbeing. This is complementary to the care from staff and might for example include encouragement to eat and drink.
    - as care homes / residential settings have a range of additional tasks to care for and protect all service users during an outbreak, relatives and care home /

residential setting staff are asked to work together to support named visitors on factors such as the time and length of visits.

- the local Health and Social Partnership Oversight Team working alongside the local HPT have a role in supporting care homes / residential settings to implement the approach to visiting and in monitoring implementation of the named visitor initiative.

9.3.1. **Outings from SCRC residential settings and care homes during an outbreak**

If there is an outbreak in a care home / residential setting, service users who are not identified as possible or confirmed cases of COVID-19 may leave the setting to go on outings. Such outings should be discussed and arranged with staff, in line with the service users care plan and the overall management of the outbreak. In these circumstances, service users, and their friends and family should be aware that staff resource will be prioritised on managing the outbreak and providing safe care, and this may mean care staff cannot accommodate outings for a temporary period of time.

Service users and their visitors may continue to use communal areas (although possible or confirmed cases should not) if the setting is not being managed as a household. This is to ensure that those individuals identified as, or working with, COVID-19 cases do not mix with individuals who are not cases of COVID-19.

9.3.2. **Essential visiting**

Regardless of outbreak status, efforts will continue to be made to enable visits of loved ones of a service user receiving end of life care. Other essential visits for consideration can include providing support to someone with a mental health issue, a learning disability or autism where not being present would cause the service user to be distressed.

Essential visits are generally not limited to one visitor, nor are they typically restricted in frequency and duration.

10. Death Certification during COVID-19 pandemic

Details on death certification during the COVID-19 pandemic are outlined in the Chief Medical Officer (CMO) letter dated 20 May 2020 **Updated Guidance to Medical Practitioners for Death Certification during the COVID-19 Pandemic**.

Appendices

Appendix 1 - Contact details for local Health Protection Teams

Up to date information on contact details for local Health Protection Teams is available **here**.

Appendix 2 - Checklist for COVID-19 outbreaks

Initial risk assessment

Following notification of an outbreak an initial risk assessment should be undertaken by the HPT. As far as is possible, this risk assessment should be undertaken in collaboration with the setting owner, such as a manager or owner of the setting where the outbreak has occurred. A standardised approach to risk assessment should be developed to assist with this. This approach should consider:

Severity

- Has anyone in the setting been reported as having been admitted to hospital, intensive care unit (ICU) or known to have died as a result of COVID-19 during this incident?
- Are the setting population particularly vulnerable e.g. unvaccinated adults, elderly, immunocompromised?

Spread

- HP Zone should be used to collate and review case and contact data.
- Produce a basic line-list summarising current known cases, contacts, onset dates, symptomatic / asymptomatic.
- Assess initial links between cases and the suspected attack rate within the setting.

Uncertainty

- Assess the potential for extensive spread, number of contacts / cases, closeness of contacts in the setting e.g. shared sleeping accommodation
- Reflect on the strength of collaboration: Is the setting experienced and engaged with the management of incidents such as this?
- Assess the potential for those in the setting to spread infection to other settings, including higher risk settings e.g. medical students.

Control measure

- Assess actions taken to date and number of cases and contacts already self-isolating or undertaking testing, interrogate compliance, infection control, handwashing, current physical distancing measures in place, setting layout, consider likely adherence to any potential additional measures.

Context

- Any communications already issued, any operational issues due to staffing anxieties or absence, anxiety or misinformation circulating in staff or others in setting; social media context; press interest; ages and cohorts affected.

Management

Following risk assessment, the HPT should consider the need for a PAG or IMT meeting in line with **Management of Public Health Incidents: Guidance on the roles and responsibilities of NHS led incident management teams.**

Where the HPT is managing multiple simultaneous situations, it is recognised that it may not be practicable or possible to convene an IMT for each one and that alternative management approaches are in place across HPTs.

Whether through an IMT or other approach, the HPT should work in partnership with key stakeholders including the setting owner in order to make recommendations on ongoing assessment and control of the incident. Where relevant, Environmental Health Officers (EHOs) or the Health and Safety Executive or Food Standards Scotland should be invited

to attend. PHS and Scottish Government (as observer) can also be invited to join IMTs for significant incidents.

A checklist for further investigation and control is provided below:

Updated assessment

- Maintenance and update of line list.
- Consideration of operational implications of the incident for the setting.

Investigations

- Linkages between cases: Consider hypothesis of transmission. Consider layout of setting and establish linkages between cases, both in setting and outside the setting e.g. social events.
- Testing (LFD or PCR, or combination) can be used to support an initial risk assessment when a COVID-19 case arises in a high risk setting. Repeated rounds of mass testing are unlikely to be justifiable for outbreak management purposes.
- Vaccination coverage: Assess coverage and consider approaches to maximise vaccination uptake in response to the incident. The Green Book advises that vaccination is not as yet used as a tool in managing outbreaks, where the risks and benefits of a vaccination session during an outbreak must be carefully considered, in particular the ability to vaccinate whilst maintaining IPC measures. The lack of an established evidence base on this means that the local HPT should undertake a risk assessment in order to determine the appropriate next steps in such situations.

Control Measures

- Review implementation of appropriate PHS guidance for the setting
- Cohorting of population / minimising contact between groups ('bubbling')
- Physical distancing: policy / guidance and adherence. Include discussion of car sharing, communal areas, changing rooms, breaks including smoking

- Reminder to population re symptom vigilance and following NHS Inform **Stay at Home advice**
- Personal Protective Equipment and face coverings: Availability, quality, compliance
- Personal hygiene: Hand and respiratory hygiene
- Environmental cleaning
- Ventilation

Communications and wellbeing

- Consider wellbeing and the impact of incident and any enhanced mitigations on those involved in or using the setting including financial impact on cases and contacts. Consider support required.
- Inform other stakeholders and widening participation as required.
- Assess the need for a proactive or reactive media statement.

Chairing of PAG/IMTs

- HPT to chair
- Consent for supportive recording, if useful for minute-taking
- If new attendees, explain PAG/IMT process briefly, acronyms
- Confidentiality reminder regarding reporting back organisationally generally and for personal identifiable information (PII)
- FOI reminder for documentation, etc.
- Declarations of potential conflicts of interest, e.g. private owners, service managers or otherwise connected to the situation (e.g. link to specific school, business, service)
- Review membership
- Review case definition

- If company or setting manager invited to provide an update or support risk assessment, this should be only to part of the PAG/IMT in order to enable PAG/IMT members to discuss final conclusions.

- Establish plans for next meeting

Conclusion

An outbreak investigation should be concluded when there have been no new cases for a minimum of 14 days from the last potential exposure to a confirmed case and no further follow-up actions are required to mitigate the potential for future outbreaks.

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