COVID-19: GUIDANCE FOR DOMICILIARY CARE PROVIDERS IN NORTHERN IRELAND

10 April 2020

Contents

COVID-19: Key messages for providers of domiciliary care in Northern Ireland

- **Co-ordination** between care providers, Trusts, informal carers and/or family members is critical to the success of the strategy for delaying and treating COVID-19.
- **Workforce:** providers, Trusts, informal carers and/or family members must plan in partnership, making the best use of all available assets to ensure continuous and effective support for residents in their own home, with up-to-date training or guidance provided as appropriate.
- **Access to Personal Protective Equipment (PPE):** independent providers must work with suppliers to secure an adequate supply of PPE but will be supported by Trusts where they are unable to source items.

Introduction

1. This guidance is aimed at HSC trusts and registered providers of care and support delivered to people in their own homes, including supported living arrangements. It also contains information relevant to informal carers and those in receipt of Direct Payments.

2. Provision of care and support in people's homes, whether in a supported living arrangement or otherwise, is largely a high priority service, in that most care and support cannot be deferred to another day without putting individuals at risk of harm.

Steps for HSC Trusts to support domiciliary care provision

3. HSC Trusts should:

    a. Collaborate with service providers, recognising the importance of sharing and prioritising resources during the forthcoming period.

b. Ensure their list of individuals in receipt of Trust commissioned / provided domiciliary care continues to be kept up to date including input from independent providers on the levels of informal support that could be made available to individuals. Independent domiciliary care providers will bring additional insight and knowledge which must continue to be drawn on.

c. Where possible, divide domiciliary care delivery into COVID-19 and non-COVID-19 teams. As far as possible COVID-19 teams should deal with people who are symptomatic.

d. Continue to work with independent providers to identify anyone who funds their own care and help them to establish the levels of informal support that could be made available. It may be helpful for independent providers to share information about the type and intensity of support they provide to help with planning, but they will want to satisfy themselves that it is lawful for them to share that information.

e. Where not already done, contact all clients receiving direct payments who may be employing their own carers, make them aware of this and other relevant guidance and ask them to make their carers aware.

f. Consider any information held on people being supported by informal carers and the impact that widespread illness or inability to care would have on demand for formal care packages. Take this into account in all planning. Where contacts are held for informal carers, make them aware of this and any other relevant guidance.

g. Trusts should review, update and prioritise their vulnerable client list (taking account of anyone receiving privately funded support and care).

h. Continue to discuss resource planning with all domiciliary care providers in the HSC Trust area. It is vital that planning involves all providers,

including those who may mainly or solely deliver services to people who fund their own care – and is not solely confined to Trust-commissioned services.

i. Make the best use of all of the assets available to the community. This will include the voluntary, community and social enterprise sectors as well as volunteers where it is safe to do so. Trusts should consider how they can use existing contracts with the voluntary, community and social enterprise sector to support work related to COVID-19, including supporting people in their own homes. Details of many community and voluntary organisations can be accessed through the Northern Ireland Council for Voluntary Action, who have a member directory on their website www.nicva.org/members.

j. In particular, Trusts should work with the scheme being run by Volunteer Now to consider whether any of those volunteers would be appropriate to support domiciliary care delivery.

k. Trusts will need to work with families and friends to ensure they understand that those deemed medically fit and waiting on a home care package may be discharged home to await elements of their care package. Additional family support may therefore be required until the home care package is finalised.

l. Trusts should work with in-house teams and independent providers to maximise the use of technology.

How should Trusts support the supply of PPE and other resources for domiciliary care provision?

4. Independent domiciliary care providers are responsible for sourcing their own PPE. However, in the event that they are unable to source the appropriate items HSC Trusts must work with independent providers to ensure they have the appropriate equipment available to them, and that the provision of PPE

reflects the guidance set out in this document. These measures must include ensuring providers are able to hold a buffer of stock, rather than only issuing PPE once individual cases are known or suspected. The HSCB will work with Trusts to ensure all Trusts work towards a consistent approach in the provision of PPE – including how the level of stock to be held by providers is judged. The Department and HSC are continuing to pursue all feasible PPE supply routes in order to ensure all providers will continue to be able to access the PPE they need.

5. In addition to the provision of PPE through Trusts we will seek to link providers of care with suppliers of PPE. Working with the Department of Finance's Central Procurement Directorate the RQIA has set up a system whereby registered providers will be notified of all offers of PPE assistance which are not of a suitable scale for the Business Services Organisation. These offers will then be shared by the RQIA with all registered providers so that they have the first chance to engage directly with suppliers to purchase. One hour later this information will be released the information to the wider procurement sector in the public sector.

6. Each Health and Social Care Trust must ensure that they maintain a single point of contact for their independent providers to liaise with on PPE issues. Trusts must ensure that their independent providers know who this is and that they have their contact details. These contacts are listed at Annex C. An out of hours contact must also be provided by the Trusts.

7. Where independent providers are unable to source appropriate PPE provision, Trusts must take into account these needs when seeking supplies from the Business Services Organisation. Trusts must therefore work with independent providers to understand requirements and prioritise stock across organisations, where there are any short term limitations on stock. Independent providers should not be charged for the provision of PPE from Trust stocks. The Department and HSCB will monitor the provision of PPE to the independent sector.

8. The same approach should also apply for clients who are employing their own carers through Direct Payments.

9. Trusts should also seek to provide PPE to informal carers, where it is required, recognising that failure to do so could create requirements for formal packages of care.

10. This approach to providing PPE is a time limited approach, related to COVID-19 only.

Steps for Independent Domiciliary Care Providers to maintain delivery of care

11. Independent domiciliary care providers are advised to:

    a. Review lists of clients (both Trust-commissioned and privately funded), and ensure they are up to date, including any information on the levels of informal support that could be made available to individuals. Consider how relevant information can be shared with the relevant Trust or voluntary organisations, if a legitimate request is received. Work with the relevant Trust or Trusts as they review, update and prioritise their Vulnerable Client List and support the development of any additional contingency plans.

    b. Work with HSC Trusts to establish plans for mutual aid, including the deployment of volunteers where that is safe to do so. Work with Trusts to consider what further role voluntary, community and social enterprise sectors could play.

    c. Keep business continuity plans under review, with a specific focus on the workforce. Continue to consider how they can increase capacity in the event of staff illness or absence

d. Providers should seek to secure, in so far as it is possible to do so, supplies of PPE and other critical resources, including food supplies where relevant, for as far in advance as possible. Providers will routinely be procuring personal protective equipment (PPE), though we recognise the challenges being faced at this time. Difficulties with levels of PPE or other essential provisions providers should be flagged with the Trust immediately.

e. Work with Trusts to consider how to use technology to best effect.

What if a care worker is concerned they have COVID-19?

12. If a member of staff is concerned they have COVID-19 they should follow guidance on the Public Health Agency website https://www.publichealth.hscni.net/news/covid-19-coronavirus#guidance-for-people-with-confirmed-or-possible-coronavirus .

13. If they are advised to self-isolate at home they should follow the PHA guidance on this available at https://www.publichealth.hscni.net/news/covid-19-coronavirus#advice-for-home-isolation.

14. If advised to self-isolate at home, they should not visit or care for individuals until safe to do so as per PHA guidance https://www.publichealth.hscni.net/news/covid-19-coronavirus#advice-for-home-isolation.

What is recommended for infection control and Personal Protective Equipment (PPE)?

15. Updated UK-wide guidance setting out the appropriate PPE equipment that should be used when dealing with COVID-19 has been issued. It is available at: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe. This guidance applies in Northern Ireland.

16. The guidance recognises that in contexts where COVID-19 is circulating in the community at high rates, health and social care workers may be subject to repeated risk of contact and droplet transmission during their daily work. It is also understood that in routine work there may be challenges in establishing whether patients and clients meet the case definition for COVID-19 prior to a face-to-face assessment or care episode.

17. It remains the case that if the individual receiving care and support has symptoms of COVID-19, then the risk of transmission should be minimised through safe working procedures. Care workers should use PPE for activities that bring them into close personal contact, such as washing and bathing, personal hygiene and contact with bodily fluids. Aprons, gloves and fluid repellent surgical masks should be used in these situations. PPE should be replaced when workers move between homes.

18. Where it is not known if the individual receiving care and support has symptoms of COVID-19 an initial risk assessment should, where possible, take place by phone, other remote triage, prior to entering the premises or at 2 metres social distance on entering. Where the care worker assesses that an individual is symptomatic and meets the case definition, appropriate PPE should be put on prior to providing care.

19. Where the potential risk to health and social care workers cannot be established prior to face-to-face assessment or delivery of care (within 2 metres), the recommendation is for health and social care workers in any setting to have access to and where required wear aprons, fluid repellent surgical mask, gloves and (if risk of splashing or there is direct face to face contact) eye protection.

20. Ultimately, where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection, as determined by the individual staff member for the

episode of care or single session. This should be informed by organisational-level risk assessments.

21. PPE should always be used in accordance with standard infection control precautions and requirements for hand hygiene. Hand hygiene should extend to include washing of exposed forearms. Staff should be provided with alcohol based hand rub and/or soap in case it is not available in the homes they travel to.

22. Different PPE is required where a patient is undergoing aerosol generating procedure (AGPs). See https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe for further details. Annex B lists these procedures.

23. A visual guide to PPE for both AGP and non-AGP patients can be found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878056/PHE_COVID-19_visual_guide_poster_PPE.pdf.

24. For delivery of care to any individual meeting criteria for 'shielding' (that is, those who are in a vulnerable group) in any setting, as a minimum, single use disposable plastic aprons, gloves and fluid resistant surgical mask must be worn for the protection of the patient. The same approach applies when delivering care to an individual in a home where someone else is in a vulnerable group and therefore shielding. The criteria for an individual to be classed as in a vulnerable group and subject to shielding in Northern Ireland are set out at Annex A. All individuals in this at risk group should have received a letter from their GP stating that is the case.

25. If an individual, or someone in their home, is not in one of the vulnerable groups defined at Annex A they may still be in a group at increased risk of severe illness from coronavirus. This should be taken into account when making any risk assessments. Those at increased risk are defined in social distancing guidance: https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-

distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults

26. A risk assessment is required for health and social care staff at high risk of complications from COVID-19, including pregnant staff. Employers should:
    - refer to the Government guidance on social distancing for vulnerable people; https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people
    - ensure that advice is available to all staff, including specific advice to those at risk from complications.

27. Bank and agency staff should follow the same deployment advice as permanent staff.

28. In the event of a breach in infection control procedures, staff should be reviewed by their occupational health service.

29. As part of their employer's duty of care, providers have a role to play in ensuring that staff understand and are adequately trained in safe systems of working, including donning and doffing of personal protective equipment. Domiciliary care workers will be used to routinely using PPE such as gloves and aprons when delivering care in people's homes (and should continue to do so).

30. All domiciliary care staff, volunteers and temporary staff, and drivers delivering meals, must receive training and/or guidance on:
    a. infection prevention and control, and
    b. the use of PPE equipment.

31. The Northern Ireland Social Care Council has published a free resource on its learning zone on infection control, hand hygiene and PPE: https://learningzone.niscc.info/learning-resources/96/supporting-good-infection-control.

32. The HSC Clinical Education Centre (CEC) also provides training, including on-line infection prevention and control programmes (these are available at www.hsclearning.com).

33. Posters available at: https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures should be made available to all frontline staff.

34. New PPE must be used for each episode of care. Provision of care can be dynamic, with different contexts sometimes encountered in a single care episode. Where workers judge that it is necessary to change PPE within a care episode, they should refer to government guidance https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe.

35. Doffing and donning new PPE should happen away from the client, as far as possible. If PPE requires changing then every effort should be made to ensure this is not done close to the patient but in appropriate locations for each activity (e.g. doffing in a “dirty” area and then when the worker has rendered themselves “clean” donning new PPE in a “clean” area).

36. It is essential that PPE is stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste within the room. This should be put aside for at least 72 hours before being put in the usual household waste bin.

37. If care workers undertake cleaning duties, then they should use usual household products, such as detergents and bleach as these will be very effective at getting rid of the virus on surfaces. Frequently touched surfaces should be cleaned regularly. Personal waste (for example, used tissues, continence pads and other items soiled with bodily fluids) and disposable cleaning cloths can be stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste within your own room. This should be put aside for at least 72

hours before being put in the usual household waste bin for disposal as normal.

38. If care workers support the individual with laundry, then they should not shake dirty laundry; this minimises the possibility of dispersing virus through the air. Wash items as appropriate, in accordance with the manufacturer's instructions. Dirty laundry that has been in contact with an ill person can be washed with other people's items. If the individual does not have a washing machine, wait a further 72 hours after the 7-day isolation period has ended; the laundry can then be taken to a public laundromat. Items heavily soiled with body fluids, for example, vomit or diahorrea, or items that cannot be washed, should be disposed of, with the owner's consent.

39. Where a resident has suspected or confirmed COVID-19, care workers should ensure that family members do not remove laundry for washing at their own home but that it is laundered onsite by staff in accordance with the guidelines above.

40. General interventions which may help to minimise the spread of infection include increased cleaning activity and keeping property properly ventilated by opening windows whenever safe and appropriate.

Have there been any changes to regulation and oversight?

41. RQIA will work with providers to support them to make risk-assessed and evidence-based decisions using their professional judgement and knowledge and understanding of the people they provide services to. This will include RQIA working with providers to come to solutions to issues that may be outwith the letter of standards or regulations but which provide safe, pragmatic remedies to issues that could never have been planned for on this scale.

42. NISCC have made clear that their fitness to practice process will focus on high risk concerns.

What support is there to maintain staffing levels?

43. As noted, Trusts should work closely with providers to identify and help address staffing pressures. This should include the use of volunteers, where this is appropriate.

44. Separate guidance has been published on revised vetting arrangements and is available at https://www.health-ni.gov.uk/publications/covid-19-pre-employment-vetting-guidance-employers-providing-health-and-social-care.

45. Care workers providing support in the community are able to access COVID-19 testing to help ensure they remain available for work. This includes domiciliary care staff, including those who are self-isolating due to a family member being symptomatic. It is important to note that using a negative test result to allow someone to return to work is not completely without risk and will need to be carefully considered. The Department will provide further advice on accessing tests separately.

46. Free travel is also available to those working as part of the health and social care system.

Will I be told if someone discharged from hospital has tested positive for COVID-19?

47. Trusts should ensure that where individuals who are discharged from hospital have tested positive for COVID-19 or are symptomatic and are in receipt of domiciliary care, that the domiciliary care provider is made aware of this, in line with any legislative requirements and guidance about sharing of data and personal information. A statement on information sharing is at Annex D.

What if someone has tested positive or has symptoms in the community? Can I share information with others?

48. Trusts and providers should consider the statement at Annex D and take any appropriate steps, in line with legislation and guidance, which maximise the safety of all staff and help to minimise transmission.

What financial support is available for domiciliary care providers?

49. Health and Social Care Trusts will support independent domiciliary care providers whose income reduces by greater than 20% below the past 3 month's average. Trusts will provide funding to 90% of the previous 3 month average to help to provide stability to the independent sector. We will work with providers to ensure the details of this how this mechanism will be applied are agreed.

50. In addition, we recognise that further action is likely to be needed to address the additional costs impacting on independent providers. We will therefore work with providers to identify any further financial support that may be necessary to address issues such as the costs of procuring PPE. Providers should maintain a record of additional costs.

51. Where a domiciliary care visit is not completed because a care worker is not let into the home independent providers will not be financially penalised for this either now or later. This will allow providers to ensure that care workers continue to obtain their wages commensurate with the Trust approved care plans which they are scheduled to deliver. Providers should not be penalised now or in the future where staff sickness or the need to self isolate impacts on their ability to deliver agreed packages.

52. However, providers must make every effort to explain to the client how appropriate infection control measures are being undertaken to keep them safe – and that they should therefore feel confident in continuing to receive domiciliary care.

53. Trusts should be seeking to maximise delivery of domiciliary care and to maintain maximum capacity for as long as possible. Collaboration with

independent providers is essential and should include the provision of some discretion to complete other tasks for people who do not wish to let providers into their homes but who still need support. More generally, Trusts should be looking to limit their monitoring and maximise the discretion and flexibility they give to their delivery partners during this period.

54. These financial measures will be time limited, to reflect the impact of COVID-19.

Where can I get help and support from?

55. Queries and contacts related to individual case management should continue to be directed to HSC Trusts.

56. The RQIA has set up a Service Support Team staffed by experienced inspectors who are nurses, social workers and pharmacists. The Service Support Team is intended to act as a first point of contact for other advice, help and support that is needed.

57. The Service Support Team can be contacted at https://rqiani.glideapp.io/ or through 02895 361111. All providers are strongly encouraged to access the web link regularly, even just to confirm that they have no issues.

Supported Living Accommodation

Off-site Visits by those resident in Supported Living Accommodation

58. We acknowledge the benefits of regular visits to family and friends, including overnight stays. Where a person usually pays a visit to a family member who has been advised to self-isolate, it will be necessary to cease visits to that family member's home during the period of self-isolation.

59. In circumstances where visits to family homes must cease, it is vital that staff in the supported living setting take all possible steps to support continued contact with family and friends through electronic means, such as e-mail, video-calls, and/or regular telephone calls.

60. Where there is an absolute necessity to do so, family or friends may wish to take individuals to live with them away from the supported accommodation setting for a period. This should be discussed by the person, their family/friends and the supported living staff and their preference facilitated as far as possible. Support staff will need to discuss the support regime with any proposed carers and the person to provide assurance that their needs are capable of being met without the supported living staff. Families and friends should provide advance warning to the supported living service where they wish to discuss this and recognise that there may need to be engagement with the Trust to ensure a properly informed decision can be made.

61. Where the person does not have capacity in relation to this decision, usual processes regarding best interests should apply. Providers should not permanently re-allocate these places, without agreement from the Trust and individual affected. Where an individual is in isolation appropriate arrangements to maintain that isolation (including when travelling) must be made if the individual is to leave their home in the supported living service.

Use of shared spaces

62. If someone is in isolation with suspected COVID-19, they must not visit shared spaces such as sitting areas /common rooms. Shared spaces should be regularly cleaned and well ventilated if possible. All other occupants of the supported accommodation should be advised to keep a distance of 2 metres from other people and where possible seating in communal areas should be spaced in a way to make this easier to comply with. Where communal

facilities remain in use strict hand hygiene and cleaning arrangements must be in place.

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Annex A

Criteria for shielding vulnerable people in Northern Ireland

All those in the most at risk criteria will have received a letter from their GP. Those most at risk are:

1. Solid organ transplant recipients
2. People with specific cancers
    - People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer
    - People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - People having immunotherapy or other continuing antibody treatments for cancer
    - People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
    - People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD
4. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell)
5. People on immunosuppression therapies sufficient to significantly increase risk of infection
6. People who are pregnant with significant heart disease, congenital or acquired
7. People with Motor Neurone Disease

In addition to these criteria, GPs may have written to some individuals they have identified as at particular risk because of a combination of factors.

Any changes or updates to this list will be put on the Departmental and PHA websites.

Annex B

Aerosol Generating Procedures (AGPs)

The following procedures are currently considered to be potentially infectious AGPs for COVID-19:

- intubation, extubation and related procedures, for example manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)
- tracheotomy or tracheostomy procedures (insertion or open suctioning or removal)
- bronchoscopy and upper ENT airway procedures that involve suctioning
- upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract
- surgery and post mortem procedures involving high-speed devices
- some dental procedures (for example, high-speed drilling)
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- induction of sputum (cough)
- high flow nasal oxygen (HFNO)

Annex C

Trust PPE Contacts for Independent Domiciliary Care Providers

Belfast Trust	Christine Wilkinson	Christine.Wilkinson@belfasttrust.hscni.net	0788 523 8390
Northern Trust	Breige Donaghy	Breige.donaghy@northerntrust.hscni.net	0788 001 5020
S. Eastern Trust	Julie Davidson	Julie.davidson@setrust.hscni.net/	0771 580 7230
Southern Trust	Jim Crozier	Jim.crozier@southerntrust.hscni.net	0782 521 5858
Western	Michelle Kelly	Michelle.kelly@westerntrust.hscni.net	0779 964 7012
	Sarah Davidson	Sarah.Davidson@westerntrust.hscni.net	0758 405 7170

Annex D

Information Sharing

Guidance on the disclosure of COVID-19 infection status provided by the Chair of the Privacy Advisory Committee

Introduction

COVID-19. The present COVID-19 pandemic presents a serious threat to life to all our citizens, particularly older people and people with a variety of health conditions. The current principal means of public protection is reduction of spread through reducing contact between individuals, particularly reducing contact with individuals known or suspected to be infected with the virus.

Patient confidentiality and information sharing. Trust is an essential part of the service user health care professional relationship and confidentiality is central to this. Those who have, or may have, COVID-19 infection might be concerned about their privacy. This guidance sets out how the principles of confidentiality apply when a health professional is considering disclosing information about the infection status of patients who have or are suspected of having COVID-19 infection.

Disclosure of COVID-19 infection status

As with all health care information you should make sure that information you have about a patient's infection status is at all times protected against improper disclosure. If you disclose information about a patient's infection status you must keep disclosures to the minimum necessary for the purpose.

Disclosing information on a patient's infection status to others involved in that patient's care is likely to be part of the usual sharing necessary to provide their care. On occasions it may not be, for example with an independent sector domiciliary worker. Nevertheless it is likely to be necessary to prevent or to reduce the exposure of others to risk of death or serious harm. While such limited sharing of information is a breach of that person's confidentiality, in the present exceptional circumstances there is an overriding public interest in protecting life. If the circumstances permit you should discuss the situation with your line manager or Personal Data Guardian.

You should inform your patient of the need for this very limited sharing of their health information to reduce the spread of infection, unless you consider it inappropriate or impracticable to do so.

Information Commissioner's Position

The Information Commissioner has provided assurance that she cannot envisage a situation where she would take action against a health and care professional clearly

trying to deliver care. You can read the statement from the Information Commissioner's Office, alongside their Q&A resource. Health and Social Care regulators across the UK have also published a joint statement.