Department of Health & Social Care

NHS

Discharge to Designated Settings / Care Homes –

Frequently Asked Questions

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Contents

Summary

These Frequently Asked Questions (FAQs) for care homes and hospitals relate to the guidance on Discharge into care homes: designated settings and accompanying Clarification note. They include question themes raised at a webinar by care homes and hospitals held on 21st January 2021.

1. Overarching

1.1 Please can you explain how this guidance aligns with the existing guidance that all admissions into care homes (from hospitals or the community) should be isolated for 14 days?

The existing guidance on Admission and care of residents in a care home during COVID-19 states that all admissions into care homes from hospital or the community should be isolated for 14 days unless they have already undergone 14 days of isolation. The current requirement outlined in Discharge into care homes: designated settings is that all people being discharged from hospitals into care homes must undergo and receive a COVID-19 PCR test result in the 48 hours prior to discharge with the exception of a subset*. All individuals who test positive should be discharged to a designated setting in the first instance to see out their isolation period. All individuals who test negative can be discharged to any care home where they should undergo 14 days of isolation as a precautionary measure.

*A subset of people identified in the guidance on Discharge into care homes: designated settings (and Clarification note) are exempt from testing prior to hospital discharge. These are people with a recent historical positive COVID-19 test result who are within 90 days of their initial illness onset or positive test date (see FAQ 5.1). These individuals must undergo a clinical assessment to determine their onward movement and isolation requirements. Where individuals have undergone their 14-day isolation period (in hospital, shared between a hospital and designated setting, or in a designated setting), meet the clinical improvement criteria for stopping isolation, have not developed any new COVID-19 symptoms, and have not had a new COVID-19 exposure, they do not need to undergo a period of further isolation following admission to a care home (from a hospital or designated setting). This is because they are no longer considered to pose an infection risk. However, a care home manager may choose to isolate them further at their discretion. Repeated periods of isolation could adversely impact on an individual's health and wellbeing.

1.2 If an individual undergoes and receives a negative COVID-19 test in the 48 hours prior to discharge but are known to have been exposed to COVID-19 while in hospital, should they be discharged to a designated setting or any care home?

As the patient has been exposed to a confirmed COVID-19 patient on the ward, the guidance on COVID-19: management of staff and exposed patients or residents in health and social care settings should be followed. This states that inpatients who are known to have been exposed to a confirmed COVID-19 patient while on the ward (an exposure similar to a household setting), should be isolated or cohorted (grouped together) with other similarly exposed patients who do not have COVID-19 symptoms, until 14 days after last exposure if they remain in hospital. If they are ready for discharge, provided they undergo and receive a negative COVID-19 test in the 48 hours prior to discharge, they can be discharged to any care home for 14 days of isolation as a precautionary measure as per the existing guidance on Admission and care of residents in a care home during COVID-19.

1.3 What can be done to improve the quality and timeliness of hospital discharge summary information?

Early dialogue should take place between hospital discharge or ward teams and care homes prior to discharge. The guidance on Discharge into care homes: designated settings makes it clear that everyone being discharged into a care home must have a time-stamped reported COVID-19 test result, and this must be communicated to the person themselves and the care home prior to the person being discharged from hospital. The care home's registered manager should assure themselves that all its admissions or readmissions are consistent with this requirement.

Some areas have trusted assessors based within hospital discharge teams who work with care homes and assess hospital inpatients on their behalf. They collate and feedback all information to ensure accurate information sharing and safe discharge. Further information about trusted assessment can be found in the LGA High Impact Change Model (see Change 6) and there is also a NHSE/I guide on Developing trusted assessment schemes: essential elements.

If a care home is concerned about the hospital discharge process and discharge summary information provided to them they should raise this with the hospital concerned in the first instance to provide an opportunity for improvement. If following this there are still problems, the care home should escalate to their CCG.

In relation to confirmed COVID-19 positive cases, no care home will be forced to admit an existing or new resident to the care home if they are unable to cope with the impact of the person's COVID-19 illness.

2. Hospital discharge (for those exempt from COVID-19 testing prior to discharge)

2.1 What exactly should be included in the hospital discharge summary information for those exempt from COVID-19 testing prior to discharge?

The hospital clinical team should provide detailed information about the clinical assessment and decision-making process for this subset of people in the discharge summary information provided to the care home or designated setting. This should include:

- Confirmation that the individual is clinically ready for discharge and has no underlying severe immunosuppression.
- Confirmation that the individual has received a positive PCR test for COVID-19 (including the time-stamped reported COVID-19 test result) and is within a period of 90 days from their initial illness onset or positive test date.
- Details of the individual's previous COVID-19 symptomology, including date of onset of symptoms and severity. Information about any persisting post-viral symptoms should also be recorded.
- Whether or not the person is considered infectious and therefore whether or not it is necessary to discharge them to a designated setting or any care home. This encompasses:
    - Whether or not the individual has completed their 14-day isolation period. This should reference the clinical improvement criteria which must be met in order to stop isolation.
    - Whether or not the individual has developed new COVID-19 symptoms.
    - Whether or not the individual has had a new COVID-19 exposure.

2.2 Who exactly in the hospital clinical team should undertake the clinical assessment for those exempt from COVID-19 testing prior to discharge and who should communicate this?

The hospital clinical team should provide detailed information about the clinical assessment and decision-making process for this subset of people in the discharge summary information provided to the care home or designated setting. The clinical assessment should be undertaken by the hospital clinical team led by a Responsible Consultant. Any member of the hospital discharge or ward team can communicate this information to the care home. Early dialogue should take place between the hospital and care home.

The care home's registered manager should review the discharge summary information, in conjunction with clinical support via the Enhanced Heath in Care Homes (EHCH) Service if required, to satisfy themselves that due process has been followed. If any information in the discharge summary information is missing or unclear, the care home manager should seek clarification from the hospital (the Responsible Consultant would be appropriate) before accepting a resident.

3. Designated settings

3.1 Why does an individual with a positive COVID-19 test in the 48 hours prior to discharge need to be discharged to a designated setting in the first instance if they are usually a resident in our care home, we are able to accept them and we are looking after other COVID-19 positive residents?

The default discharge arrangement for a COVID-19 infectious individual should always be to a designated setting, even if the originating non-designated care home is willing to receive the individual.

The guidance on Discharge into care homes: designated settings sets out exemptions on grounds of clinical or care needs (see Section 4), including consideration for individual assessments of need, preferences and risk. The individual, their family and any relevant advocates should be involved to ensure the most appropriate discharge arrangements and support plan are agreed.

3.2 How are designated settings supported to care for residents with COVID-19, including recognising and responding to deterioration?

A resident completing their isolation period in a designated setting must be monitored closely. This could be through pulse oximetry via the COVID Virtual Ward. If a resident becomes unwell or deteriorates whilst in a designated setting, support should be sought through the local Urgent Community Response (UCR) Team, local GP, NHS 111, or in line with actions set out in the person's Personalised Care and Support Plan (if available).

CCGs are responsible for ensuring the necessary clinical support is in place in designated settings. The guidance on Discharge into care homes: designated settings allows for local flexibility in how this is achieved. CCGs should work with local providers of designated settings and local acute, community health and primary care providers to agree the local model for this clinical support. This should build on existing support and structures, e.g. those established through the Enhanced Heath in Care Homes (EHCH) Service, recognising that additional support is required given the cohort of people being cared for. If a designated setting has concerns about the clinical support being provided to them they should raise this with their CCG.

The CQC inspect designated settings against their Infection Prevention and Control (IPC) in Care Homes Tool which includes prompts and good practice guidance on monitoring residents staff training. DHSC Regional Assurance Teams also proactively engage with designated settings to ensure staff have the training and support they need.

3.3 Is a clinical assessment required prior to transfer of a resident from a designated setting to a care home? If so, who should undertake this, what are the criteria and what information should be provided to the care home on transfer?

Early dialogue should take place between the designated setting and receiving care home, either by secure email or other agreed ways of working, to plan for transfer of the resident after completion of their 14-day isolation period.

A further COVID-19 test is not required prior to transfer given the test result could continue to be positive for a number of days or weeks after the person is no longer infectious. Instead a clinical assessment must take place prior to transfer to determine whether the person is still infectious. This clinical assessment must be undertaken by a registered clinician in line with the clinical improvement criteria set

out in Guidance for stepdown of infection control precautions and discharging COVID-19 patients.

CCGs are responsible for ensuring the necessary clinical support is in place for clinical assessments in designated settings which may be provided by registered clinicians from local acute, community health and/or primary care providers as locally agreed (see FAQ 3.2). If a designated setting has concerns about the clinical support being provided to them they should raise this with their CCG.

The manager of the designated setting should clearly communicate information regarding the person's COVID status and clinical assessment, as well as their original hospital discharge summary information to the manager of the receiving care home.

4. 14-day isolation period and preventing COVID-19 exposure

4.1 What is the evidence behind the 14-day isolation period as the timeframe within which a COVID-19 positive hospital inpatient or care home resident will clear their infection and no longer pose an infection risk to others?

It is recommended that all individuals who have been admitted to hospital with COVID-19 and all care home residents should be isolated for 14 days from their onset of symptoms or positive test result (if asymptomatic). This is on the advice of the UK Chief Medical Officers following a review of the evidence on incubation periods and disease progression.

In general, COVID-19 positive hospital inpatients will have more severe disease than those who can remain in the community. Therefore a 14-day isolation period is recommended for this group compared to the 10-day isolation period for people with milder disease managed in the community. A 14-day period of isolation is also recommended for residents in care homes as older care home residents are a particularly vulnerable group and their immune response may differ from younger, normally healthier individuals.

4.2 What are the clinical improvement criteria that hospitals and designated settings must use to determine whether isolation period of individual can be stopped after 14 days?

For suspected or confirmed COVID-19 individuals who require hospitalisation and those in designated settings, isolation and IPC measures should continue for 14 days and should only be lifted once the following clinical improvement criteria have been met as outlined in Guidance for stepdown of infection control precautions and discharging COVID-19 patients:

- Clinical improvement with at least some respiratory recovery.
- Absence of fever (> 37.8°C) for 48 hours without the use of medication.
- No underlying severe immunosuppression.

4.3 How can someone safely be isolated in hospital?

All hospitals should follow National Infection Prevention and Control (IPC) recommendations which outline treatment, care and support through three COVID-19 pathways. These pathways provide examples of how organisations may separate COVID-19 risks and are underpinned by patient/procedure risk assessment, appropriate testing regimes and epidemiological data. In essence, each organisation will keep separate those patients who are negative for COVID-19, those who have suspected COVID-19 (awaiting results) and those who are confirmed COVID-19 positive.

Standard Infection Prevention and Control Precautions (SICPs) must be used by all staff, in all care settings, at all times and for all patients/individuals, whether an infection is known or not, to ensure the safety of patients/individuals, staff and visitors. Additional Transmission Based Precautions (TBPs) will be necessary for patients/individuals with COVID-19. Patients who have symptoms or a history of contact/exposure with a case, should be prioritised for single room isolation OR cohorted (if an isolation room is unavailable) until their test results are known, e.g., use of screens or privacy curtains between bed spaces to minimise opportunities for close contact between patients/individuals. This should be locally risk assessed to ensure this does not compromise patient safety.

The IPC recommendations set out safe systems of working including administrative, environmental and engineering controls and interventions to reduce the risk of transmission of infection. These include cleaning and decontamination of the

environment and shared equipment, social/physical distancing, hand hygiene, use of Personal Protective Equipment (PPE) and ventilation.

4.4 Can you provide more detail about what is classed as a "new COVID-19 exposure" as referred to in the hospital clinical assessment?

A hospital COVID-19 exposure is classed as contact with a confirmed COVID-19 patient while on a ward as outlined in COVID-19: management of staff and exposed patients or residents in health and social care settings.

Hospital inpatients who are known to have been exposed to a confirmed COVID-19 patient while on the ward (an exposure similar to a household setting), should be isolated or cohorted (grouped together) with other similarly exposed patients who do not have COVID-19 symptoms, until 14 days after their last exposure if they remain in hospital (see FAQ 1.2).

4.5 What Infection Prevention and Control (IPC) measures should be taken during transportation of a person from a hospital or designated setting to a care home to prevent a COVID-19 exposure?

On hospital discharge, transfer of a person to a designated setting or care home should take place by the safest method possible to prevent onward transmission of COVID-19. Transport can be arranged via a variety of routes. The COVID-19 status and isolation needs of the person (or people if using shared transport) should be communicated to transport staff.

Standard Infection Prevention and Control Precautions (SICPs) must be used by all staff, in all care settings (including transportation between care settings), at all times for all patients/individuals. These are the basic IPC measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. These precautions include hand hygiene, respiratory and cough hygiene, use of Personal Protective Equipment (PPE), decontamination of the environment/equipment (transport vehicle) and maintaining social/physical distancing. For further information please see the National Infection Prevention and Control (IPC) recommendations.

If a person being transported is COVID-19 positive and within their 14-day isolation period then a number of precautions should be undertaken as outlined in Guidance for stepdown of infection control precautions and discharging COVID-19 patients. These include but are not limited to:

- The person should wear a surgical facemask for the duration of the journey, and be advised that this should be left on for the entire time if tolerated (not pulled up and down).
- The person should sit in the back of the vehicle with as much distance from the driver as possible (for example, the back row of a multiple passenger vehicle).
- Vehicle windows facing the outside environment should be (at least partially) open to facilitate a continuous flow of air.
- Vehicles should be cleaned appropriately at the end of the journey.

4.6 If an individual being discharged for 14 days of isolation may lack relevant mental capacity, is independently mobile and will not consent to isolating in a bedroom for 14 days, what should the care home or designated setting do?

Duties and powers under the Mental Capacity Act 2005 still apply during this period. If there is a reason to believe a person may lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before a decision about their discharge is made.

Where the person is assessed as lacking the relevant mental capacity and a decision about moving the person to a care home or designated setting needs to be made, there should be a 'best interest' decision made for their ongoing care in line with the usual processes. The decision maker must consider all the relevant circumstances, including the person's wishes, beliefs and values, the views of their family and what the person would have wanted if they had the capacity to make the decision themselves. They should make a record of their decision.

If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards (DoLS) in care homes and orders from the Court of Protection for community arrangements apply. Further information can be found in DHSC guidance on COVID-19: looking after people who lack mental capacity.

5. 90-day timeframe and testing

5.1 What is the reason behind the 90-day timeframe within which a person who has previously tested positive for COVID-19 does not need to be re-tested?

Individuals who have previously tested positive for COVID-19 are exempt from routine re-testing within a period of 90 days from their initial illness onset or positive test date, unless they develop new COVID-19 symptoms. This is because fragments of inactive virus can be detected by a PCR test in respiratory tract samples following an infection – long after a person has completed their isolation period and is no longer infectious. Re-testing should take place if a person in this category develops new symptoms consistent with COVID-19.

5.2 What is the difference between a PCR test and a Lateral Flow Device (LFD) COVID-19 test and which test should be used in which circumstances?

Polymerase Chain Reaction (PCR) COVID-19 tests are laboratory-based tests that detect the genetic material of the virus to indicate whether someone currently has a COVID-19 infection and might be infectious to others. They are the most reliable type of COVID-19 test however they are not perfect as they can detect inactive viral shedding long after a person is infectious (see FAQ 5.1). Samples need to be processed in laboratories and typically there will be an interval of over a day between taking a sample and the result being available. PCR tests are used for routine testing of hospital inpatients and care home residents.

Lateral Flow Device (LFD) COVID-19 tests for COVID-19 are point-of-care tests which detect proteins which belong to the virus. They are a fast and simple way to test people who do not have symptoms of COVID-19 (i.e. are asymptomatic), but who may still be spreading the virus. The tests are easy to use and give results in 30 minutes. They are not as reliable as PCR tests performed in a laboratory, especially when people have low levels of the virus (e.g. in the early or late stages of infection). Those who test positive via a LFD test must immediately self-isolate and have a confirmatory PCR test. LFD tests are used for routine testing of hospital and care home staff and visitors, with PCR tests also used to test hospital and care home staff.

For further information about COVID-19 testing in care homes, including testing schedules for staff and residents, please see Care Home COVID-19 Testing

Guidance. For further information about COVID-19 testing of care home visitors please see Care home LFD testing of visitors guidance.

6. Severe immunosuppression

6.1 What is meant by severe immunosuppression and why is this important?

Individuals with underlying immune problems may have issues clearing the virus that caused COVID-19 so extra precautions need to be taken with this group. If an individual is severely immunosuppressed – as defined in Guidance for stepdown of infection control precautions and discharging COVID-19 patients – testing is encouraged regardless of their time spent in isolation. For these individuals, Infection Prevention and Control (IPC) measures should be continued in hospital unless there has been virological evidence of clearance prior to discharge or a complete resolution of all symptoms. This reflects the complex health needs of such individuals and likelihood for prolonged shedding, with risk of spread in healthcare settings.

7. COVID-19 symptoms in care home residents

7.1 Can you provide more detail about what "new COVID-19 symptoms" look like, particularly for care home residents?

COVID-19 symptoms include a new continuous cough, high temperature and/or loss of, or change to, an individual's sense of smell or taste. People who usually reside in care homes (both older people and younger people living with a learning disability or autism) may not present with the typical symptoms of a cough or fever and may not be able to report loss of smell or taste. Therefore, it is important that this group are monitored in the hospital, designated setting or care home for softer signs of infection such as being short of breath, being not as alert, having a new onset of confusion, being off food and/or having reduced fluid intake, diarrhoea or vomiting. Further details are provided in Admission and care of residents in a care home during COVID-19.

It is important to distinguish new COVID-19 symptoms from residual symptoms that may remain after an active infection has resolved. A cough or a loss of, or change in, normal sense of smell or taste, may persist in some individuals who have

recovered from COVID-19 for several weeks, and these symptoms not considered an indication of ongoing infection when other symptoms have resolved.

8. New variant

8.1 What assurances can be given that this guidance is safe in light of the new UK variant of COVID-19 that is known to be more transmissible than the original variant?

It is known that the new UK variant of COVID-19 is more transmissible than the original variant and emerging evidence indicates it has higher mortality rate. However, to date there is no scientific evidence that the new variant causes an increased duration of infectiousness compared to the original variant so the precautions outlined in this guidance are considered appropriate. The increased transmissibility of the new variant highlights the importance of applying existing Infection Prevention and Control (IPC) measures with rigour.

9. Vaccinations

9.1 How should vaccinated care home residents be treated, compared to unvaccinated residents?

The national vaccination programme has now offered the COVID-19 vaccine to residents at every eligible care home with older residents across England. Vaccinated care home residents should be treated in the same way as unvaccinated residents. This is because no vaccine has ever been 100% effective and protection from the virus only starts approximately 7-10 days after vaccination and we are still learning about impacts on onward transmission. There is also a risk posed by the emergence and spread of new variants against which current vaccines may offer less protection. This approach will be kept under review, ensuring the UK is in the strongest position to protect people.

10. Outbreaks in care homes

10.1 What is the guidance on admissions to a care homes if that care home has an outbreak?

In the event of a suspected outbreak in a care home, the care home should contact their local Health Protection Team (HPT) at PHE as soon as possible. The HPT will conduct a risk assessment and if an outbreak is identified, they will arrange and provide testing for all staff and residents. The HPT may advise that restrictions are implemented for 28 days, e.g. they may advise closure of the care home to further admissions, recognising that this is usually the care home manager's decision in discussion with their commissioners. The local authority should be notified if restrictions are agreed.

10.2 If the 90-day re-testing rule remains in place, how does the new resident fit into care home testing schedules for care home residents?

The COVID-19 testing schedule for care home residents is a routine monthly Polymerase Chain Reaction (PCR) test, and where there is outbreak a PCR COVID-19 test on day 1 and again between days 4-7 of the outbreak. However, residents who have previously tested positive for COVID-19 are exempt from re-testing within a period of 90 days from their initial illness onset or positive test date, unless they develop new COVID-19 symptoms (see FAQ 5.1).

Currently Lateral Flow Device (LFD) COVID-19 tests are not used for care home residents. These types of tests are only used for care home staff and visitors as outlined in Care Home COVID-19 Testing Guidance and Care home LFD testing of visitors guidance.

11. Support for care homes

11.1 How are care homes being supported clinically to deliver this guidance?

Care homes (non-designated settings) receive clinical support from primary care and community health services under the Enhanced Heath in Care Homes (EHCH)

Service, which aligns every care home with a Primary Care Network (PCN), ensures a named Clinical Lead for each care home, and includes support from a Multi-Disciplinary Team (MDT) and a weekly home round.

Guidance for care homes on caring for residents depending on their COVID-19 status and particular needs is provided in Admission and care of residents in a care home during COVID-19.

If a care home is concerned about the clinical support being provided to them via the EHCH Service they should raise this with their PCN Clinical Lead. If they do not know who their PCN Clinical Lead is they should contact their CCG to find out.

For information about the clinical support provided to designated settings please see FAQ 3.2 and 3.3.