

How care homes managed **infection prevention and control** during the coronavirus pandemic 2020

November 2020

Contents

Foreword	3
Summary	5
Introduction	10
Purpose of this report	10
How we carried out this work.....	10
1. Are all types of visitors prevented from catching and spreading infection?	12
Context.....	12
Good practice.....	12
Impact on people.....	15
Winter planning	15
2. Are shielding and social distancing rules complied with?	17
Context.....	17
Good practice.....	17
Impact on people.....	19
Challenges for providers and low assurance	20
3. Are people admitted into the service safely?	21
Context.....	21
Good practice.....	21
Challenges for providers and low assurance	22
4. Does the service use PPE effectively to safeguard staff and people using services?	24
Context.....	24
Good practice.....	24
Impact on people.....	26
Challenges for providers and low assurance	27
5. Is there adequate access and take up of testing for staff and people using services?	29
Context.....	29
Good practice.....	29
Challenges for providers and low assurance	30
Winter planning	31
6. Do the layout of premises, use of space and hygiene practice promote safety?	32
Context.....	32
Good practice.....	32
Impact on people.....	33
Challenges for providers and low assurance	33
7. Do staff training, practices and deployment show the service can prevent and/or manage outbreaks?	34
Context.....	34
Good practice.....	34
Challenges for providers and low assurance	36
8. Is IPC policy up-to-date and implemented effectively to prevent and control infection?	38
Context.....	38
Challenges for providers and low assurance	39
Winter planning	40
Conclusion	42

Foreword

The coronavirus pandemic presented care homes with the massive challenge of keeping people safe, while supporting them to live fulfilling lives through person-centred care. Their response varied, as we will see through the analysis of our infection prevention and control (IPC) inspections that took place throughout August 2020. These inspections showed the level of professionalism and compassion shown by care homes and the wider health and care sector, which we highlight through examples of good practice in this report.

IPC is a constant requirement of care homes and is assessed as part of our key question, 'Is your service safe?'. Care homes have to demonstrate this well year in, year out, despite specific challenges that are not faced by all health and care settings. Care homes are not clinical environments; they are people's homes, and in many cases are converted from older residential properties. This means it can be difficult to adapt the layout to adopt a zoning approach, for example. People have their own bedrooms, with chosen decoration, ornaments, and soft furnishings. This means it is not easy to move people from room to room to facilitate cohorting of those with or without symptoms.

This report looks at the eight questions that we seek to assure ourselves about, to make sure that people receive appropriate and personalised care, while being protected through IPC against the spread of COVID-19. Each of these eight questions poses real challenges to care home providers, including how to manage safe admissions; how to shield people while minimising the impact of isolation; how to maximise the benefits of PPE and testing; how to make sure staff training and policies are up-to-date.

Most care providers that we have inspected have demonstrated that they have faced these challenges well. They have been supported by staff who have gone the extra mile to keep the people in their care healthy, stimulated, and as independent as possible, while keeping family members and carers informed and engaged.

As well as providers' experience of good practice and challenges, we also highlight the impact felt on people using services and their loved ones during the pandemic. The whole of society has struggled to come to terms with the changes needed to stem the spread of infection. This can be magnified for those who may not be able to fully understand why restrictions are necessary, why their routines and favourite places and pastimes are changed or put on hold, and why they are distanced from their friends and families.

Most of this report highlights good practice, but it also includes areas of concern. Where we have seen poor practice through these inspections, we have taken action to ensure providers act quickly to improve the quality of care they are delivering.

COVID-19 represents a clear challenge to care homes across the whole of the country. As stated in our State of Care report for this year, and updated in our November COVID-19 Insight report, we have not seen any clear relationship between care home ratings and the number of deaths due to COVID-19 in those homes. The quality of care does not on its own determine whether a care home experienced an outbreak, which is why the learning from IPC is important for all care homes, regardless of their track record.

There is a sector-wide desire to learn from experiences as well as to celebrate and share good practice. This report does not give all the answers, but we are sharing what we know and what people are telling us, to help support care homes to get into as good a position as possible to prepare for the winter and potential future waves of infection.

Kate Terroni

Chief Inspector of Adult Social Care

Summary

Effective infection prevention and control (IPC) is essential to protect people from acquiring COVID-19. Providers need to make sure they are taking action to minimise the risk of cross-infection.

During August 2020, we carried out a special programme of IPC inspections in 301 care homes selected as potential examples of where IPC was being done well. We have also reviewed IPC in 139 'risk-based' inspections between 1 August and 4 September, which were carried out in response to concerns about safety and quality. During these inspections, we reviewed how well staff and people living in care homes were protected by IPC measures, looking at assurance overall and across eight questions.

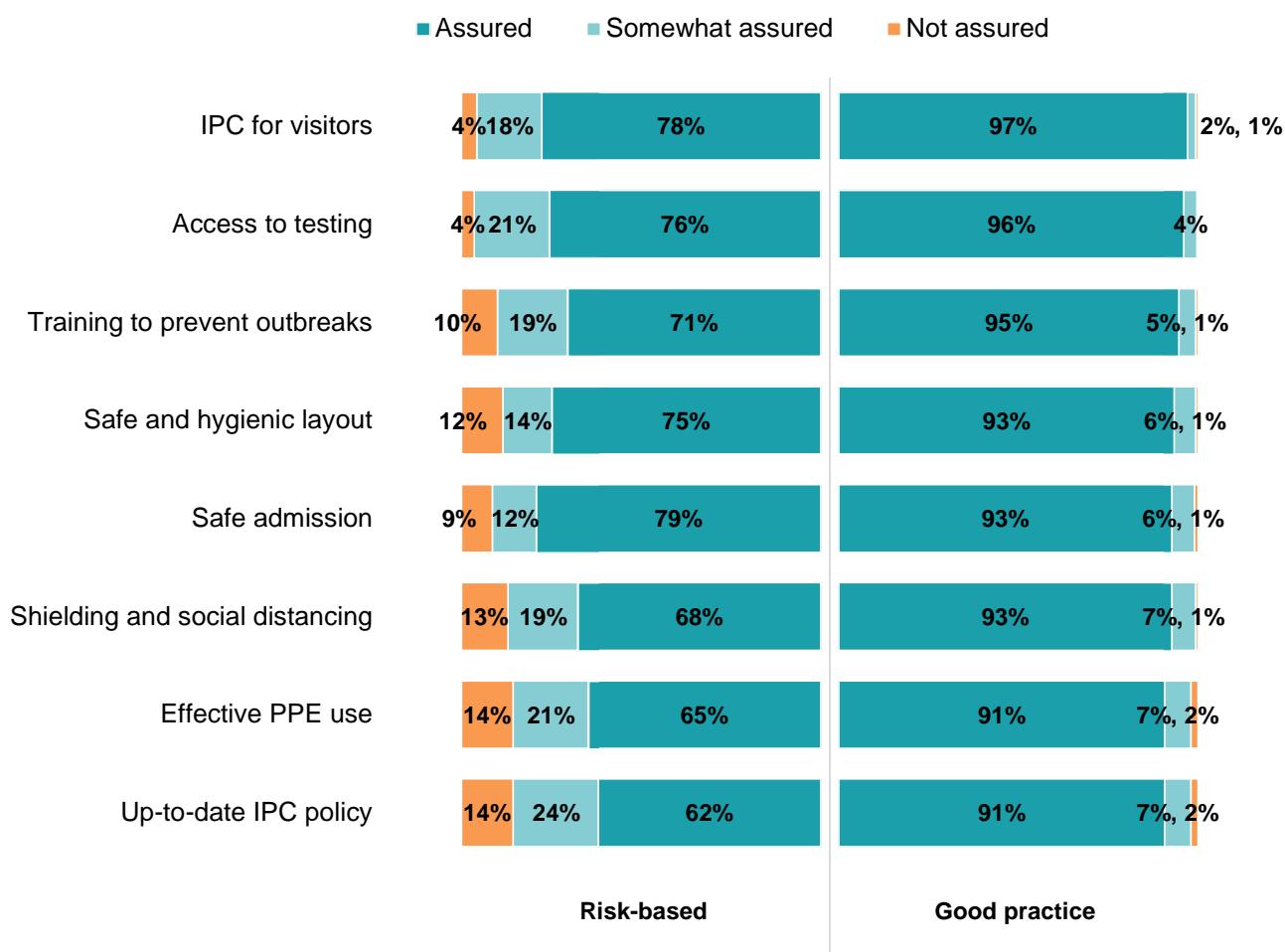
Across the 440 inspections, we found a high level of assurance in the eight questions (figure 1). At 288 of the 440 services visited (65%), inspectors were assured in all eight of the IPC questions.

Effective use of personal protective equipment (PPE) and having up-to-date policies in place were the two areas with the most gaps in assurance.

Wherever inspectors encountered poor practice, they escalated this at the time with the manager of the service and signposted to the available guidance. In a few cases an inspector returned to complete a comprehensive inspection or pursued regulatory action.

As would be expected, the care homes selected as potential good practice examples generally demonstrated higher levels of assurance across the eight questions than those where we carried out risk-based inspections.

Figure 1: Assurance against IPC themes for care homes inspected between 1 August and 4 September 2020 (440 care homes in sample)



Note: 'Good practice' care homes were those selected for potential good practice; 'Risk-based' care homes were inspected due to concerns about quality and safety

Access to visitors

IPC for visitors obtained the highest level of overall assurance (91%), with care homes working hard to comply with visitor guidance. Restrictions have come at a price, however, with many people using services feeling the impact of not seeing their families and carers in the way they are used to.

Good services had effective systems in place to ensure visiting could go ahead safely. They took a person-centred approach to individual situations to ensure people's needs were met. Garden visits were well supported and homes looked for methods to keep people in touch with loved ones and the community that did not rely on people meeting face-to-face.

Robust systems for screening and PPE for people entering the service were seen to be successful in preventing the spread of infection.

There were some challenges to ensuring social distancing during visits and some signage and screening procedures could have been improved.

There are considerations for all providers going forward on balancing visiting restrictions based on current, local advice, against the rights, health and wellbeing of people who use the service and the risk of harm from isolation.

Shielding and social distancing

Most services had suitable plans in place to care for people who are symptomatic or COVID-19 positive and protect others living in the care home in the event of an outbreak. Social distancing was promoted and maintained wherever possible.

Good services took a person-centred, risk-assessed approach, and took simple practical steps to support people where social distancing was a challenge (for example, when delivering personal care or supporting people living with dementia).

To mitigate the impact of isolation, good services provided meaningful activities and ensured people were included in the conversation about their isolation so they better understood it.

Good practice included supporting people to access the community safely as lockdown restrictions eased.

Where inspectors found gaps in assurance this most commonly related to services that had not considered social distancing in the layout of their services and where staff did not maintain this in their interactions with each other.

Safe admissions

Good services carried out effective admission assessments despite the challenges, considered mental capacity and took action to reduce the impact of isolation.

Services routinely tested and isolated new admissions to help prevent the spread of infection.

Gaps and challenges were reported where 14-day isolation on admission had not taken place.

While some services admitted new people after appropriate assessment, others made blanket decisions to refuse admissions. This had potential consequences, both in terms of financial viability and local capacity.

Effective use of PPE

Whether services used personal protective equipment (PPE) was the second lowest area of assurance.

Despite challenges at the beginning of the pandemic, the supply of PPE was seen to be working. Generally, inspectors were assured that staff understood the PPE guidelines and that safe procedures had been implemented.

Good examples of IPC using PPE began from the moment that staff arrived at work, where they would enter the separate donning/doffing area and remove the clothes that they travelled to work in to prevent contamination.

Staff wearing PPE could be difficult for people who use services. Good services engaged with people to provide reassurance, support and understanding. Risk assessments into the use of PPE were carried out as appropriate.

Good services promoted a culture of responsibility and engaged staff in the use of PPE, encouraged by 'champions'.

Where inspectors found gaps in assurance this related to a lack of compliance with guidance on donning and doffing of PPE, mask wearing and handwashing. Safe disposal of PPE was also an area of some concern.

Testing for staff and people who use the service

Good services had an enthusiastic, well-managed approach to testing and demonstrated going the extra mile to achieve this. Although they encouraged people who receive care to take tests, they respected their rights to refuse testing, and would risk assess them individually and consider capacity and best interest decisions.

Many providers saw routine and regular testing as vital, especially with the risk of asymptomatic spread.

Where inspectors found gaps in assurance this related to a small number of services that had made no effort to implement testing or they did not properly understand the expectations.

Although inspectors were assured that care homes were taking part in testing schemes and doing everything they could to apply guidance, this does not reflect the delays reported by providers in obtaining testing kits during August. This was deemed to be outside of the homes' control by inspectors but impacted on their ability to deliver testing at the required frequency.

Layout of space and hygiene practices

Though it has always been important for care homes to be clean and hygienic, the nature of the pandemic has put these practices under the spotlight.

Services were generally clean and hygienic. Some services had removed excess furniture, decluttered and made changes to flooring and furniture covers to facilitate easier cleaning.

Some services did not have good access to spare single-occupancy rooms or en-suite facilities. In these cases, managers had to make decisions on how to balance the pre-existing needs of people while also planning for possible outbreaks.

Services recognised the considerable impact of moving people from the room that they are used to, to another room for cohorting, isolation or shielding – particularly for those with dementia.

Staffing and staff training

Inspectors saw examples of very good staff practice across the services they visited. Staff demonstrated resilience to work under such uncertain circumstances and commitment to care for the people using services and their colleagues.

Most staff had received training and possessed good knowledge of infection prevention and control practice, and generally felt well supported.

Staff were often cohorted or assigned to areas to minimise movement and cross-infection. Reflecting the findings in a survey carried out between May and June 2020¹, a lot of services were not using any agency staff to limit the risk of cross-infection from other services.

IPC policy and contingency planning

IPC policy and contingency planning was one of the most variable areas, and where we saw the least assurance.

There were services that had reviewed and updated their policies and these were communicated well with staff. In contrast, there were IPC policies that had not been updated since the start of the pandemic and contained no reference or out-of-date guidance on COVID-19, which had the potential to be dangerous.

Some services have learned from the first wave of the pandemic and could give examples and reflect on things that did not go well and what actions were taken to change that. Services also asked for feedback from the people who live at the care home and their relatives to understand how they could improve.

¹ Office for National Statistics, [Impact of coronavirus in care homes in England: 26 May to 19 June 2020](#), July 2020

Introduction

Purpose of this report

In the September 2020 edition of our COVID-19 Insight report², we published analysis of infection prevention and control (IPC) in 59 high-risk inspections of care homes that took place during the first half of August 2020. This report follows this up in more detail, using a wider sample of care homes, and including more good practice.

We want to share what we have seen and what care home providers have told us has worked, and has caused them challenge through the pandemic. By sharing our findings of good practice and gaps in assurance, as well as highlighting the impact of the measures on people using services, we want to support providers to prepare for winter and beyond.

This report is structured around the eight key areas of IPC that we assessed during our inspections:

1. Are all types of visitors prevented from catching and spreading infection?
2. Are shielding and social distancing rules complied with?
3. Are people admitted into the service safely?
4. Does the service use PPE effectively to safeguard staff and people using services?
5. Is there adequate access and take up of testing for staff and people using services?
6. Do the layout of premises, use of space and hygiene practice promote safety?
7. Do staff training, practices and deployment show the service can prevent and/or manage outbreaks?
8. Is the IPC policy up-to-date and implemented effectively to prevent and control infection?

For each question, we focus on the good practice that we found with examples taken directly from inspectors' conversations with providers. We also draw attention to the impact of the pandemic on people using services, gaps in assurance, challenges for providers and learning for winter planning.

How we carried out this work

This report is based on analysis of findings from inspections carried out between 1 August and 4 September 2020 from:

² Care Quality Commission, [COVID-19 Insight: Issue 4](#), September 2020

- 139 high-risk inspections of care homes, which were carried out in response to concerns about safety and quality, or to feedback from staff or people using services and their families
- 301 IPC thematic inspections selected as potential good practice examples.

Inspectors judged the service as assured, somewhat assured or not assured across the eight questions. They used the 'somewhat assured' judgement where there were minor issues identified with the provider. For example, where we have not taken regulatory action but have shared information with the people running the service to help them improve their handling of IPC.

Wherever inspectors encountered poor practice, they escalated this at the time with the manager of the service and signposted to the available guidance. In a few cases an inspector returned to complete a comprehensive inspection or pursued regulatory action.

We also carried out a small number of interviews with care home leaders in early November to support our analysis.

Sample selection

The 301 good practice sites were distributed evenly across regions. They all had a service type of nursing care home or residential care home and included services for older people and working age adults. They included a mix of CQC ratings and care home sizes. The criteria for selection was:

- care homes that had not had an outbreak of COVID-19 despite high levels of the virus in the local authority area
- care homes that had had outbreaks but no deaths from the disease
- care homes that had had an outbreak but who appeared to have it under control.

Data sources used in these criteria were care homes death data, care home outbreak data from Public Health England (PHE) and the NHS Capacity Tracker and PHE's data on COVID-19 levels in local authority areas. Inspectors approved site selection or identified a substitution if they thought, using their local knowledge, that it was more appropriate.

Analytical approach

Analysts designed a coding framework around the questions and prompts which was further developed during analysis to best capture the emerging themes from the data. This was used to conduct a thematic analysis of the evidence collected on site. Comprehensive quality assurance was undertaken at each stage of the analysis.

Throughout the report, where we refer to 'good services' this relates to services that were demonstrating good practice in IPC when we inspected, as opposed to their CQC rating, or reason for selection.

1. Are all types of visitors prevented from catching and spreading infection?

Context

One of the key areas of risk in bringing coronavirus into care homes is through infected asymptomatic people entering premises and inadvertently spreading it directly to other people or through contaminating the environment. While this clearly applies to people working in the service, it also includes visitors – relatives and friends, other health and care professionals, and others who may need to visit people living in care homes or to carry out work or deliveries in maintaining the running of the business and service.

As we reported in our *State of care* report this year³, providers felt confused and overwhelmed at the high volume and frequency of changes to guidance from central authorities at the beginning of the pandemic. Care homes were given guidance on 22 July, just before our thematic review started. [Visiting care homes during coronavirus guidance](#) has since been updated and is potentially subject to change.

In our inspections, IPC for visitors obtained the highest level of overall assurance, with care homes selected for potential good practice being 97% assured and 2% somewhat assured, and care homes inspected due to concerns about quality and safety being 78% assured and 18% somewhat assured. All the services we visited had put new guidance in place for visitors to the care home in light of the pandemic.

The visits for this review took place in August, and it was clear from the evidence that different homes had different challenges depending on where they were and who they cared for.

Some of the services we visited were in local lockdown at the time of the inspection. Others were making plans to reduce restrictions and were making cautious arrangements for garden or indoor visiting and activities in the community. These geographical differences accounted for much of the variation seen in individual care homes' approaches to visiting.

Good practice

When visitors entered a care home there were screening procedures in place, such as a questionnaire or declaration and temperature checks. PPE was required and, in most cases, provided if the visitor did not have their own.

³ Care Quality Commission, [The state of health care and adult social care in England 2019/20](#), October 2020

Inspectors saw good signage at the entrance to care homes and reminders throughout the home. One inspector confirmed, “As a visitor entering the premises myself, I was given clear instructions about where to don/doff and dispose of PPE. Entering with a mask on, I was asked to wash my hands and put a fresh mask on. My temperature was taken and recorded in a log book.”

Inspectors noted lots of examples of good practice where modifications had been made or technology used to help IPC, including wash basins, hands-free bins, hand sanitiser, shoe mat sanitisers and contactless temperature checks.

“There was an automatic temperature device in the entrance that did a non-invasive scan.”

“A sensor alarm had been fitted outside to alert staff that a visitor is approaching the front door. This triggers an alarm inside, so that staff can answer the door without visitors having to touch or knock on it.”

“Small bags of PPE were prepared and put in the entrance lobby for when booked in visitors arrive. The bag is then used for PPE after the visit to dispose of in a bin as they leave. A new sink had been installed by the entrance so that all visitors and staff can wash their hands on arrival.”

It was most common for visits from family or friends to be supported in the garden. All visitors were required to wear a face covering and maintain a safe social distance. Contact with staff members was limited. There were many examples of gazebos, pods, shelters and Perspex screens being put in place.

“A visiting area had been devised where visitors accessed a sunroom at the back of the building instead of entering the service. Visitors were able to see the resident and speak with them via an intercom. The provider stated that this has helped people with dementia really see their relatives without a mask.”

Garden visits tended to be by appointment only, restricted to one visitor at a time and staggered to allow cleaning between visits. They were sometimes supervised at an appropriate distance by members of staff to ensure social distancing was maintained. Visitors did not usually have access to toilet facilities or refreshments and appointments were usually restricted to between 20 minutes and an hour.

Restrictions were difficult for some people and their families. In good services inspectors saw some person-centred examples of homes attempting to address this. This included:

- One person who was moved from an upstairs room to downstairs so family could come and see her at the window, as she was nursed in bed and unable to have a garden visit.
- A relative was given ‘carer status’ by the local council, which meant that they would visit the home for one hour daily to support their wife at mealtime. They self-isolated otherwise and were included in the home testing schedule.

“The manager explained to me that Alan’s wife has lived at the home for the last five years. They have no close family, just each other. Pre-Covid, Alan would visit the home every day from 9am until after 5pm to sit with his wife, watch TV, read the papers or books together.

When lock-down came the home were going to have to restrict Alan’s visiting to outside only. This would destroy both Alan and his wife, so they offered Alan the opportunity to move into the home into one of the spare rooms. Alan was over the moon and agreed.

They discussed that this would place some restrictions on his life and being able to come and go from the home, but he only ever came to the home or went to local shops for food, so moving into the home and getting his meals (and laundry) all done was not a worry to him.”

For the most part, care homes reported that families had been supportive and understanding of the visiting restrictions in place. Care homes had written to families to explain their visiting policy and it was this communication and regular updates that helped people understand and comply with the rules.

One care home provider told us that communication was absolutely key – particularly at the start of the pandemic. For the first month, they held a video call every day with staff and relatives so they could ask questions and input into updated policies. This was supported by another provider who told us “We’ve learned very quickly if you don’t give people information, they become anxious. If we have an outbreak, we pick up the phone to relatives. That way they are not hearing it in a newspaper. It has to come from within the home – someone who knows that family member.”

Inspectors spoke with some visitors who confirmed they understood the arrangements at the home and expressed that they were working well. There were good examples of individual risk assessments and care plans for how visiting could be best supported. Others were using apps to share updates and information about people’s loved ones.

“Relatives have been upset and emotional and have found it hard not visiting – [the provider] has been constantly discussing and explaining to them why. Informing people and relatives has been very important to develop their understanding around why rules are in place. They use two main means of communication – writing to them every week with updates about what’s going on, and a question and answer document to support staff to answer questions.”

All services were able to describe alternatives they had put in place to face-to-face visiting. This included using video calls to support virtual visiting or purchasing additional telephones. Some local authorities had provided care homes with tablets to help facilitate this. Again, this was particular to people’s preferences – one service described how video calls had proven unpopular and that most people preferred to use the telephone. Another care home provider told us that people’s ‘keeping in touch’ care plans detail their preferences – for example if one person likes to use video apps and another prefers more conventional means of communication.

“Provider said, ‘We created a WhatsApp group for each family and used it to share information with them, including photos of what people were doing. Families love it. They are encouraged to write letters and cards and send photos – we made a memory book to help manage levels of anxiety.’”

Impact on people

Despite many providers’ efforts to find alternatives for visiting, restrictions have come at a price for people using services and their families and carers.

During full lockdown, exceptions were made for people receiving end-of-life care and families were permitted more frequent visits at the person’s bedside. However, social distance had to be maintained and PPE had to be worn. One daughter described the pain of not being able to hold her mother’s hand, while also witnessing care staff perform the little things she would have loved to do herself for her mum.

There were a few examples of relatives who had been banned for failing to social distance, and people who used the service who had been made to isolate for 14 days because they had hugged a loved one. One instance of a family failing to respect social distancing guidance was taken to the court of protection.

Others found visiting, with all the restrictions it entailed, too distressing and some people and families had chosen not to visit as a result.

“One person’s family visited daily before – this has impacted on her mood. One family had to stop the video call as [the person] was distressed – couldn’t understand that she could not touch them.”

There are considerations for all providers going forward on balancing visiting restrictions based on current, local advice, against the rights, health and wellbeing of people who use the service and the risk of harm from isolation.

Winter planning

Good services were starting to plan for the winter when colder weather would make outdoor visiting more difficult, and were being responsive to local restrictions and advice from their local director of public health.

“The registered manager has an action plan in place for when the weather changes and how they are going to be able to accommodate visiting indoors. There is a plan to fit a large shed building to the patio door and make this area a visiting centre that will have plastic screening, rear access so visitors do not need to enter the home through the front entrance, hand washing facilities and heating.”

Other services were considering how visits may be safely conducted indoors (subject

to local and national restrictions) in people's bedrooms or 'visiting suites', specially adapted with Perspex screens. All these plans sought to make best use of the individual layouts, entrances and available space while minimising contact with the main body of the home. One care home, which could not be transformed internally for safe visiting, has worked with the community to build a 'visitors' pod'.

2. Are shielding and social distancing rules complied with?

Context

Zoning, cohorting and isolation are necessary approaches to take to minimise the spread of infection. The risk of not using these approaches, or not using them effectively, can result in rapid spread of infection in care homes.

Care homes need to be able to demonstrate their understanding of each of these approaches, and to know how and when to implement them to effectively prevent or manage outbreaks. They must do so in a way that promotes people's wellbeing and mitigates any anxiety and distress this may cause them, particularly those whose mental capacity may not give them a good understanding of the impact of the pandemic – such as people living with dementia.

Inspectors were assured that 93% of care homes selected for potential good practice were complying with shielding and social distancing rules, and somewhat assured for 7% (care homes inspected due to concerns about quality and safety 68% and 19% respectively).

Good practice

Even where services had not experienced any positive cases, staff were able to explain the procedures they would follow to safely accommodate people who develop symptoms. Most plans involved isolating people in single-occupancy rooms where these were available. People living in the care home could also be cohorted together and cared for within specific zones by the same staff.

“The [provider has] identified that the upstairs section of the house would be used for isolation purposes if they have a positive case. They would then have two members of staff working up there. There is a separate entrance to this area and there would be a staff room with toilet facilities for staff. They had procedures in place for how this would work including laundry, cleaning, medication, communication and disposal of cutlery and plates.”

To reduce the negative impact on wellbeing, we have seen some examples of services attempting to include people in discussions about their shielding or isolation arrangements where appropriate. The most common form of mitigation was providing more meaningful activities for people to offset new limitations on their daily routine.

“Staff had adapted people's meaningful activities where they could to offer people stability and comfort. For example, one person required structure and routine to enable them to feel settled. The person used to go bowling weekly, so staff set up skittles in the garden. This person also visited a pub for a lunch every week. To help them understand why this could not continue at the moment, staff took the person to the pub so they could see that it was closed and cooked his pub lunch for him back at the service to eat in the garden.”

“A person recently admitted to the home had to spend 14 days in isolation. Staff found out he was a keen cyclist. They have purchased a pedal exerciser and he is currently cycling from Bradford to Portsmouth. Staff have been talking to people about the challenge he set himself and this has helped him integrate into the service while in isolation.”

Most services were isolating people using services after hospital visits. The service in the following example reduced the need for people to attend hospital by carrying out as much of the hospital treatment within the care home.

“When people have to go to hospital for check-ups and then have to isolate for 14 days it can impact their mental health. For things like blood tests, the district nurses have agreed to come and do that, so they have not had to go to hospital.”

Inspectors observed that staff and people were adhering to social distancing guidelines at most services. Changes to seating arrangements in communal living areas were the most common way of maintaining safe distances between people.

Whereas this change could be unsettling for people living in care homes, this was reduced once restrictions began to ease and some services enabled people to spend time together in ‘bubbles’.

In addition to layout changes, some services limited the number of people using communal areas by staggering their use or delivering meals and activities across several rooms. Some services, like the example below, have made changes to their outdoor space to make them more accessible and appealing to people using the service.

“The home has re-landscaped the garden to make this an additional place for people to spend their time. There is a new patio, and new turf has been laid where we saw two people spending time socially distanced. In another area of the garden there is a vegetable patch to create different areas of the garden to appeal to different people's interests. This also encourages social distancing.”

Similar measures were in place to ensure safe distances between staff. Staff breaks were often staggered with limits on the number of people who could use staff rooms at any one time. Where staff rooms were deemed too small for social distancing, separate areas across the care home would be designated for staff breaks.

Due to the nature of some people's needs, staff were not always able to maintain a two-metre gap when communicating or delivering personal care. They would therefore wear full PPE, but some people struggled to communicate with staff when they were wearing masks. In this instance staff would move to a safe distance to talk without a mask before replacing it to provide the required support.

Services said that people with dementia found it particularly difficult to maintain social distancing and may walk about, which increases the chances of coming into contact with others and increase touch points. Staff would regularly remind them to maintain safe distances through constant verbal reinforcement, easy read information and signs.

“Signage is clear and brightly coloured to support those who may be living with dementia and reminded them of the need to socially distance.”

Inspectors also noted that people were encouraged to watch the news to learn more about the pandemic and the reasons for social distancing.

Impact on people

Shielding and isolation had considerable negative impact on people, which effected both their physical and mental health. We were told of examples of depression, anxiety, weight-loss, falls, confusion, and increased wandering. This had a greater impact on people whose wellbeing relied on routine and structure, or those whose rehabilitation had been affected.

“Manager said that the impact on people and staff of the pandemic and COVID has been huge. She said they went to hell and back, were scared, anxious and initially really struggling to keep up-to-date with the changes in guidance. Impact on people has been evident in weight loss for example. As people were isolated in their rooms, their mood became lower and they started to eat less.”

At some services it was not always easy for the people who used the service to adapt to layout changes. They enjoyed socialising and spending time with other people or had preferences for certain seats. In the example below, the service risk-assessed the impact of the rearranged layout to the wellbeing of people and subsequently decided to only use it if someone in the service tested positive for COVID-19.

“The service initially tried to socially distance residents in the lounge. However, they were very upset by this and kept trying to move chairs back. Some of them are hard of hearing so could not hear their friends. The impact on residents was quite high.”

“[Residents] weren't happy about changing the [dining] tables around. Could see weight loss, as socialisation is really important for eating and drinking.”

Challenges for providers and low assurance

We saw isolated instances of poor social distancing, with inspectors noting that services had made no attempt to encourage or facilitate it. There were also a few examples of staff not social distancing between each other while on breaks.

“We observed people using services sit in communal areas without social distancing and staff told us they did not socially distance or wear face masks when in the staff room.”

3. Are people admitted into the service safely?

Context

Early in the pandemic, in order to focus and adapt their service provision, hospitals continued to discharge people into the care of nursing and residential care homes. This continued as the pandemic progressed, with some patients being discharged quickly, when assessed as clinically ready, without a mandatory test for COVID-19.

Local health systems moved to ensure all patients had a test for COVID-19 before discharge so their COVID-19 status was clear. The government published its *Adult Social Care Action Plan*⁴ on 15 April, setting out that all individuals must be tested before discharge from hospital to a care home. Test results must now be received before discharge, and included in discharge documentation.

Inspectors looked at the admissions process in care homes to see how they were responding to ensure the process was safe for both the patient moving in and the people who lived there.

For safe admissions, inspectors were assured in 93% of care homes selected for potential good practice, and somewhat assured for 6% (care homes inspected due to concerns about quality and safety 79% and 12% respectively).

Good practice

There were many care homes that had no new admissions, in which case the manager was able to describe an admissions process, such as the one described below, or had a policy that was in line with the guidelines.

“The service undertook non-face-to-face assessments to try to triangulate evidence using video calls, talking to family and the hospital/social worker to get as much information as they could. The care home insisted the person had a negative swab as close to admission as possible with evidence of this.

The person was admitted to a room which had been prepared in advance, making sure their belongings and preferences were there. The person then isolated for two weeks in their room. For one lady who has deaf and had dementia the home provided one-to-one support to keep her mood up. Garden rooms are given to people that need to isolate as they give better air circulation.

⁴ Department of Health and Social Care, [Coronavirus \(COVID-19\): adult social care action plan](#), April 2020

Full PPE is used while the person is in isolation and there is a designated donning and doffing area. Electronic care plans and social isolation care plans were in place. The same crockery was used and laundry was kept for 72 hours.”

While some services cited challenges in carrying out effective admission assessments amid the pandemic, others sought alternative ways of doing this effectively. Virtual assessments were carried out over the phone and in one example a person was supported to have a pre-assessment in an outside area of the home in line with visiting guidance. This gave the person an opportunity to meet the manager and see where they were going to stay.

Care homes told inspectors about online tours via videocall for potential new admissions and their families, while others provided them with photographs of the bedrooms and communal areas. One manager had added a short welcoming video and tour to their website.

Whether the admission was from hospital or from the community, services were ensuring a COVID-19 test had been taken. On admission people were isolating in their room, or a designated area of the home, for 14 days and needed another negative test before integrating into the service.

Good services had considered the impact of the requirement to isolate on admission and took measures to reduce it. There were examples where services found out information about people’s likes and dislikes to make sure they had things in their room to occupy them, such as magazines, newspapers or e-books. One service allocated a staff member to assist people and reassure them, putting on music or doing activities so they settled in quicker.

“Frank was an Emergency Placement. He had to isolate for 14 days, which he was comfortable with as a private person. He was unable to join in group activities so we created a 14-day personalised activity plan with one-to-one activities. We were able to relieve the potential boredom of isolation and help him to settle in. Throughout this period, he was treated as if he had symptoms so appropriate PPE was worn.”

Another example was provided of an individual who was distressed by the move to the care home. They were given a garden room with direct access to the outside. This meant one family member was able to visit without having to enter the building. They maintained a safe social distance and wore appropriate PPE, but this helped the person settle in to their new home.

Challenges for providers and low assurance

Inspectors did find some gaps in assurance, most commonly relating to services that had not been aware of, or had not enforced, isolation for 14-days on admission. A few services were found not to be following their policy or found it difficult to isolate certain individuals.

Some homes also described the significant pressure they had faced at the beginning of the pandemic, prior to the national policy described above, to admit people. They

even gave examples where people had been sent from hospital without test results and without agreement where they had to send them back.

“The area manager told the local authority and clinical commissioning group at the beginning of the pandemic they would not admit people unless tested. They were told this was not possible. The area manager took this higher to insist, and testing throughout the area was brought in.”

Some services were keeping rooms vacant so that, should cohorting be required, they had extra rooms to allow for movement and zoning of people if there was an outbreak. There were, however, some services who had chosen not to accept new admissions due to the perceived risk to people already using the service. For a few this was in spite of the financial impact of operating below capacity.

“The provider had not accepted any new admissions since lockdown in a bid to reduce the risk of bringing the virus into the home. This had a considerable impact on the service’s finances. But they stated they had put the safety of residents first.”

While evidence was not found, this does give rise to concerns that certain people may not be able to access the care they need, as some services were saying they would not admit particular groups of people – for example, people who may struggle to isolate (such as people with dementia) or people requiring respite care.

There was some contrasting evidence that some services were finding it challenging to fill their beds as there was not the same demand from the community. This was also leading to financial pressures.

4. Does the service use PPE effectively to safeguard staff and people using services?

Context

This question looks at personal protective equipment (PPE) practice. PPE helps protect staff from being contaminated with coronavirus when delivering care. The question seeks to understand how well guidance is being followed. If procedures are not followed properly, risk of coronavirus contamination and transmission can increase dramatically.

The level of PPE used needs to be proportionate and correct for the various tasks care staff complete so, for example, varies for a person preparing food or delivering personal care. PPE needs to be worn correctly to be effective and this is something many care staff had less experience of prior to the pandemic. We wanted to see this had been addressed by appropriate training, signage and guidance.

We have reported on challenges for adult social care providers in sourcing PPE at the beginning of the pandemic, but the situation appears to have improved when inspections took place for this review.

Inspectors were 91% assured and 7% somewhat assured that PPE was used effectively in the care homes selected for potential good practice visited (care homes inspected due to concerns about quality and safety were 65% assured and 21% somewhat assured). This was one of the lowest levels of assurance seen across the eight questions overall.

Good practice

The safe practice that inspectors expected to see in relation to the use of PPE is highlighted in the example below.

“Use of PPE is in accordance with current government guidelines:

- Donning and doffing is done in staff room then separately in each room as per barrier nursing guidelines.
- Signage on donning/doffing PPE and handwashing is visible in all required areas, including for visitors.
- Staff were observed putting on/taking off PPE as per guidelines.
- Disposal of used PPE prevents cross-contamination. Sluice rooms for clinical waste bags – barrier nursing and clinical waste bags within each room.

- Staff do not wear the uniform while travelling to work. Their shoes are kept at the service. All staff supplied with extra uniform.
- Staff have received in-house enhanced IPC training and seen videos on PPE and donning and doffing.

The provider has considered the impact on residents of how PPE may cause fear and anxiety for residents, particularly those who have limited mental capacity and has mitigated these concerns. Residents are not alarmed and have been given the opportunity to wear the masks for themselves to help understanding and ease fears.”

Good services had ensured that staff understood the correct procedure for donning and doffing PPE by providing training during the COVID-19 pandemic. This was often followed with supervision and competency-based observations to maintain high standards.

“Staff are spot-checked for the correct application of PPE, IPC procedures and handwashing. Yellow card and red card system to ensure staff are following guidelines.”

“The home has developed a quality monitoring tool which is used by a manager to assess staff understanding and use of PPE. Monitoring is carried out with all staff at least weekly.”

“The service provided face coverings for all families of staff to use. This also acted as a reminder for everyone that COVID-19 and IPC is non-stop. It is something to consider when off-duty too. Staff owe it to everyone and themselves to follow the rules.”

Some services had IPC or PPE champions. They would be responsible for ensuring everyone within a care home was aware of the current PPE guidance as well as supporting staff with improving IPC practice. This support was provided through supervision, competency checks, organising training, and aids to help support people who lived in the care home.

“Two or three IPC leads in each service undertook further training to become part of the 'IPC Army'. They were given extra time to undertake additional IPC responsibilities such as PPE competency checks and assisting with more frequent audits.”

Services used their creativity to enhance people’s experiences and staff learning with the use of training and activities.

“The use of PPE has been included into activities and songs about hand sanitising and wearing masks to appease any anxieties people may have.”

“Allowing people to handle and explore masks assisted them to understand them. It lessened the anxiety of seeing staff wearing them and wearing a mask themselves when out in the community. People were observed to be very comfortable with staff wearing PPE equipment.”

“A COVID-19 quiz was introduced which tested staff knowledge and understanding of good PPE practice. This was strengthened by some games in team sessions; for example, who could don and doff PPE the fastest, which reinforced processes in a light hearted but effective way. All staff had a PPE competency check.”

The use of signs within a care home was also found to have a positive impact on the understanding of PPE usage by staff. These signs were often general and would describe the donning/doffing process or correct handwashing procedures.

“Prompts were seen on each person’s door for the level of PPE required before staff entered the room. For each person on the ground floor this was mask, gloves and apron.”

Some services described setting up PPE stations around the care home, which meant that staff could put on and take off PPE within the person’s room, away from the bed, to reduce the risk of cross-contamination. In one service an additional 38 PPE stations were installed.

“When people were barrier nursed, all equipment is available outside the person’s bedroom and a foot operated yellow bin is situated in each bedroom.”

“There were pre-prepared PPE outbreak packs, which housed all of the equipment needed, should someone test positive.”

Another service showed their consideration for staff wellbeing, while being aware of the risk of asymptomatic staff and the requirement for constant hygiene. The provider had bought a more expensive specialist foam hand sanitiser for staff who had eczema and sensitive skin to encourage regular use, as they were aware that painful skin may be a barrier to staff using it as frequently as necessary.

Impact on people

Although there is good practice in this area shown above, some people living in care homes found the widespread introduction of staff and visitors wearing PPE difficult. This was sometimes because they found it harder to communicate with them or

because they were fearful or anxious about the sight of PPE itself (for example people who are deaf, autistic people, people with dementia.)

“When Jean’s family came to the care home to visit, they wore masks. Jean was shocked and walked away. Jean experiences less anxiety now, and she uses a tablet and phone calls to stay in touch with her family and that helps.”

Challenges for providers and low assurance

Inspectors saw examples of staff who did not understand how to don and doff PPE correctly. This was due to a lack of specific PPE training or where senior staff were not aware of, or following, the correct donning and doffing guidance.

“A senior staff member was not familiar with the term donning and doffing, although we saw guidance about donning and doffing displayed near to the home entrance. This staff member told us they carried out competency checks regarding staff use of PPE. We found this same staff member failed to use their own PPE correctly and had not been given direction about what levels of PPE should be used and when.”

There were also examples where no specific area for donning and doffing had been identified, which led to more opportunities for cross-contamination.

Handwashing was an area of concern found by inspectors during the visits. It is an integral part of the [donning/doffing process](#) as well as general infection prevention and control throughout a care home.

Specific examples of concern were where staff were not washing hands (or wearing gloves) when providing support from one person to another, for instance when administering medicines and supporting people with food and drink, or when they were in contact with crockery, cutlery, and touching people.

There were many examples of masks not being worn correctly within care homes, which was seen across a wide range of staff types from management to staff carrying out personal care and kitchen staff. Sometimes staff were seen to not be wearing a mask at all, usually because they were unaware of the current guidelines.

Inspectors observed:

- touching of masks without the use of hand gel or handwashing (often staff were unaware of this behaviour)
- masks hanging from ears during breaks and re-used
- masks held down around chins and moved up and down the face, or wearing under noses
- the removal of masks when speaking to people who live in the home or the inspectors themselves then placing the same mask back on when closer than two metres apart.

Inspectors also observed instances where other PPE was not worn according to guidance, such as not wearing disposable aprons to serve lunch, cloth aprons left around the kitchen area after use, and not wearing gloves.

As for all the areas we reviewed during our inspections, wherever inspectors encountered poor practice, they escalated this at the time with the manager of the service and pursued regulatory action where required.

5. Is there adequate access and take up of testing for staff and people using services?

Context

Prompt and regular testing of staff and people using services is an important way of providing a care home with the information they need to be able to quickly respond and put in place additional IPC measures should anyone test positive.

At the point of the thematic inspections care homes were expected to take part in whole home testing of both staff and people.

The 'Challenges' section below highlights variation in testing availability and the difficulties some homes have had in delivering routine whole home testing. Despite these challenges, inspectors were mainly assured that services were doing everything they could at the time to test staff and people; they were 97% assured and 4% somewhat assured in care homes selected for potential good practice, and 76% assured and 21% somewhat assured in care homes inspected due to concerns about quality and safety.

Good practice

Inspectors visited some services that had been very active with testing and were seen to go the extra mile.

“Started regular testing as soon as it was available. Very enthusiastic about this; we have a spreadsheet tracker of everyone, weekly for staff and monthly for people using services. Took the view that if cases could be asymptomatic it was crucial to do regular testing. This approach appears to have been a key factor in reducing spread of the virus.”

“The home had turned the disused salon into a testing station for staff and people using services. Weekly testing for staff and monthly testing for people was in place. ‘As and when’ testing was in place if symptoms were observed. There was a weekly report from the provider showing every resident has been tested and this flagged if someone has been tested too early or too late, when their next test was due and what the result was.”

Most services were able to describe what would happen should a staff member or person who uses the service test positive for COVID-19.

A staff member who tested positive would:

- immediately isolate at home, and all contacts would be identified
- return a negative test before they could return to work
- carry out a risk assessment on return.

We were encouraged to see many services ensured staff were paid in full if they had to isolate, which meant staff had no disincentive to refuse testing.

When a person who uses the service tested positive:

- they would be subject to isolation protocols
- they would be cared for by a dedicated staff team with full PPE
- managers would alert Public Health England, the local authority, the person's family and GP
- the visitors policy would be tightened again, back to just essential healthcare workers and for people at the end of their life
- any shielding staff would stop working until it was safe to return or, if a larger service, would work elsewhere in the home.

Refusal to take a test was not seen to be a common problem, particularly among staff who were often keen to be tested and reassured that this was taking place. At most care homes, staff testing was a clear expectation and widely accepted.

However, for people using services, their right to refuse testing was respected and recorded. In most cases people were encouraged to have a test and staff described the different methods they would try to do this. This included simple things like trying again at another, more suitable time or using a familiar staff member. Others had used diagrams, easy read versions and videos to help people's understanding.

“The registered manager ensured people who use the service had access to the testing procedure in a format they understood. There was a video which staff supported people to watch so they knew what the test involved. One person wanted to do their own test and they were supported to do this independently with oversight from a health professional.”

There were people for whom it was not possible to test due to their behaviour or lack of capacity. In these cases best interest decisions and Mental Capacity Act considerations had taken place. Risks were mitigated by carrying out enhanced observations, and often reduced by the high levels of testing of everyone else at the service.

Challenges for providers and low assurance

For the few services where inspectors were not assured in this area, there had been no effort to obtain the required testing for staff members, or managers did not demonstrate clear understanding of current requirements for continual testing.

In terms of challenges, the biggest concern raised by providers in August was a shortage of testing kits. This was reported to be a national problem and was affecting

a considerable number of the locations we visited. Providers repeatedly told us about delays in receiving kits, problems with the courier service and many services had been affected by a batch of 'Radox' kits which were faulty and could not be used.

Testing availability varied, with some services reporting they had completed eight rounds of testing and others whose first testing kits had just arrived. One manager told us how they had requested 100 kits but received 350.

“There have been issues with the portal and with the procedures. These have not been the fault of the home. Initially the portal would not recognise their ID number. The local authority assisted them, and it then worked. This was their first batch of testing.

The second batch of testing: The test got picked up by the wrong courier. So, they were disposed of. Third round testing went well and all results were negative. The registered manager ordered again on 10 July and still haven't got them (13th August). They are frustrated as they know they are supposed to do it every month and the last lot received were in June. The manager has been following up and they are getting emails every day.”

“Due to the problem with accessing tests for the weekly staff testing the provider has paid privately to test all of the staff. The provider had written to staff explaining the importance of regular testing and thanked them for going through the uncomfortable experience.”

Winter planning

Many providers saw regular, efficient whole home testing as key to managing the pandemic going forward towards the winter. One care home group leader told us that knowing when people had the virus through early testing “makes a huge difference to managing the outbreak quickly”. Speaking in early November, she went on to say that “Testing in the last two or three weeks has been spot on – with results within 24 to 48 hours”.

Another leader speaking around the same time, however, said that staff testing needs to be more frequent and regular – “needs to be a couple of times a week at least”.

One provider described how they had identified people and staff who had been asymptomatic but tested positive, so testing was crucial to identify this and start the isolation protocol.

There was learning for one service where an asymptomatic member of kitchen staff was found to be positive. Since then kitchen staff do not enter the units, but leave food trolleys at the end of corridors in units for staff to collect.

6. Do the layout of premises, use of space and hygiene practice promote safety?

Context

A care home is both people's homes and a place of work. The provider therefore needs to ensure that the environment has necessary IPC measures in place to ensure people's safety while also provide a homely and therapeutic environment for them to live life as they normally would.

Good hygiene and well-thought out use of space are essential to IPC outcomes. Though it has always been important for care homes to be clean and hygienic, the nature of the pandemic has put these practices under the spotlight. Keeping people distanced within a building they share has proved to be challenging across all strands of society not least a shared home. Therefore, it is important that services make good use of the limited space.

Inspectors were assured that layout, use of space and hygiene practice was safe at 93% of care homes selected for potential good practice and somewhat assured at 6% (75% and 14% respectively for care homes inspected due to concerns about quality and safety).

Good practice

The importance of good IPC was highlighted in our discussion with a leader of a large care home operator, who said, "I know it sounds basic, but PPE, hand washing, and good IPC will keep the virus out of care homes."

Most services appeared clean with good levels of hygiene at the time of inspection. Some services had removed excess furniture, decluttered and made changes to flooring and furniture covers to facilitate easier cleaning.

They also noted where processes for the people's laundry followed good practice guidelines. There were designated areas for storing laundry and people's clothes were kept separate to prevent any cross-contamination.

Some services recruited additional housekeeping staff or added extra housekeeping hours to the rota to cover the extra cleaning needs. Some care staff, particularly night staff, were asked to pick up the additional cleaning duties at other services. Designated leads for cleaning and decontamination were in place at some care homes. Their duties included monitoring and/or auditing of cleaning processes and identifying training needs.

Impact on people

Services recognised the considerable impact of moving people from the room that they are used to, to another room for cohorting, isolation or shielding – particularly for those with dementia.

“Manager advised that if another resident tests positive they will try to move them to the empty bedrooms downstairs and make this the COVID-19 zone. Although he said that not all of the residents there would agree to their room being moved and if this was attempted it could be very distressing for them.”

Challenges for providers and low assurance

Whereas the majority of services were well-suited to the needs of isolating people and maintaining social distancing guidelines, a few services were not as spacious. Inspectors noted that staff were not able to keep at safe distances because of narrow corridors or smaller rooms. The challenge had been recognised by staff who would then wear PPE to mitigate the risk of spreading infection.

Some services did not have good access to spare single-occupancy rooms or en-suite facilities. In these cases, managers had to make decisions on how to balance the pre-existing needs of people while also planning for possible outbreaks.

7. Do staff training, practices and deployment show the service can prevent and/or manage outbreaks?

Context

Care home staff are essential to the services they work for and to the people who receive their care. However, they are as susceptible to catching COVID-19 as anyone else and, in some cases, at higher risk, such as those in Black, Asian and minority ethnic groups.

It is vital that staff have been trained appropriately and work in a way that protects themselves, the people receiving care and their colleagues. Inspectors were assured that staff training, practices and deployment at 95% of care homes selected for potential good practice would be adequate to prevent or manage outbreaks; 5% somewhat assured (71% and 19% respectively for care homes inspected due to concerns about quality and safety).

Staff at most services had received training on COVID-19 and infection prevention and control; 66% of care homes selected for potential good practice had delivered training in-house (50% for care homes inspected due to concerns about quality and safety) and 57% of potential good practice services had provided staff with training from external sources (54% for services inspected due to concerns). Training was often in the form of e-learning or guidance cascaded from managers.

Good practice

Inspectors observed examples of very good staff practice across the services they visited. Staff demonstrated resilience to work under such uncertain circumstances and commitment to care for the people using services and their colleagues.

“Staff showed dedication to the people they care for and contributed towards problem solving and potential staffing issues, volunteering themselves to care for those who were ill and considered the needs of their colleagues.”

Though most inspectors reported no significant changes to rotas, the shift patterns at some services were adjusted so that staff worked longer shifts but on fewer days to limit the number of changeovers and number of different people on the premises each day. Other services made changes to accommodate changes to personal situations in light of COVID-19 or to give staff time to recharge.

“Shift changes were made to help staff where their situation had changed due to Covid, such as childcare arrangements. This ensured staff were still able to work different times to fit in with other personal responsibilities.”

“Staff completed a staff skills checklist so that appropriate staff could be redeployed to another role within the home if necessary, for example, a carer who could also cook. Additional staff were medication trained and signed off as competent just prior to the lockdown. This allowed any staff sickness or shielding to be covered in-house.”

To minimise movement around the care home, staff were usually assigned to a specific floor or areas within services. This also applied to non-care staff such as housekeeping or dining room staff. Similarly, staff would be cohorted and assigned to COVID-19 positive or negative people in the event of an outbreak – subsequently limiting the number of contacts with covid-positive people and protecting others within the service.

Some staff were asked to not work at any other care homes or use public transport to travel to work to limit the risk of COVID-19 being brought into the service. A few services provided transport to staff who could not travel to work without public transport.

There were considerable changes to how handovers were carried out. Meetings would take place in larger rooms or outdoor spaces to facilitate social distancing between staff. Where social distancing was impractical, one member of staff would feed back to a member of the next staff team who would then cascade to the rest of the staff. In some cases, handovers were being carried out virtually to avoid any mixing of staff teams.

Reflecting the findings in a survey carried out between May and June 2020⁵, a lot of services were not using any agency staff to limit the risk of cross-infection from other services. Services would invest in recruitment, overstaff shifts, use bank staff or encourage substantive staff to pick up extra shifts to ensure suitable staffing levels and reduce the need for agency staff.

“Staff working at this service do not work in other services and have been picking up additional shifts to reduce the need for increased use of agency staff. Where agency staff have been required (to provide enhanced care for some people) this is sought from one agency only and the same staff are booked for consistency.”

“The home used the same agency staff to reduce risks, and they were provided with a full induction into the control measures in place, worked with other staff and had their practice observed so they could be coached if necessary.”

Managers commonly carried out return to work interviews to ensure that it was safe for staff to return after isolation. These interviews also provided an

⁵ Office for National Statistics, [Impact of coronavirus in care homes in England: 26 May to 19 June 2020](#), July 2020

opportunity to discuss adjustments, concerns and the ways that staff could be supported. Adjustments made for returning staff included phased returns or time given for catching up with guidance and procedures.

“One member of staff returning from shielding was very nervous about the risks so the manager supported him by assuring him that he did not physically need to attend staff meetings. Maintenance jobs could take place when people were away from their rooms, and he could concentrate on outdoor jobs while feeling this way. The manager also reassured him by showing him all the measures that were being taken to keep people safe.

Another member of the night staff who had returned from shielding was worried about wearing a mask all the time, as they suffer from asthma. The manager agreed that at night, when not supporting people, this person could take their mask off to relieve this anxiety and then replace it when entering people’s rooms or assisting people.”

Staff generally felt well supported and were able to communicate openly and transparently about their concerns. We have seen examples of managers demonstrating that they care about employee wellbeing. Services have used different methods to monitor wellbeing and offer help where needed.

“All staff can complete a ‘health reflection form’, a document produced by the company to gauge how staff feel about the emotional and physical impact so far. The outcome has been positive where younger staff have recognised the importance of supporting each other and coming to work.

It also highlighted where people recognised support was required, and the company provided it. For example, staff who would not speak out found a voice in the support mechanisms. Since a company-wide training schedule has recommenced, the company have a ‘be kind to yourself course’. This reflects on the positives that have related to the pandemic.”

Challenges for providers and low assurance

It would be quite feasible for a significant number of staff to develop symptoms and/or test positive for COVID-19 at the same time, as they tend to work quite closely with each other. Or as demonstrated in the example below, some staff may be related or live within the same community. This would leave a service considerably short-staffed.

“[Isolation of staff testing positive and those in contact with them] has been a challenge within the service as a lot of staff are friends, family members and live in a close community. This impacted on the amount of staff that subsequently had to isolate and has been a learning point for the service in terms of future recruitment planning.”

A chief executive of a care home group told us about the importance of recognising how staff have felt throughout the pandemic: “Underestimate morale at our peril – our staff and managers got incredibly de-motivated”. He went on to say that this was not helped by staff being “treated like gifted amateurs” by system partners, such as paramedics. Other challenges were IPC training being delivered to care home staff by people who do not have a good understanding of care, and the amount of guidance being seen as a barrier to managers.

As well as echoing the emotional strain on staff, this last point was also picked up by another care home leader who said, “The changes in guidance have been a huge issue – extraordinary – in one day there were three changes of guidance.” In response they use a full range of methods, such as social media and other digital systems to make sure that all roles get appropriate updates.

8. Is IPC policy up-to-date and implemented effectively to prevent and control infection?

Context

An IPC policy should encompass all the elements of our eight questions and the [H&SC Act IPC code of practice](#). Care home IPC policies may not have taken full account of all the topic areas before the pandemic, and there are omissions even in the code of practice (such as visiting rights) that could not have been foreseen. This is why it is so important that a care home's IPC policy has been updated since the pandemic began and is audited and updated on a regular basis to take account of new information and guidance that has come out steadily. If an IPC policy has not changed since the beginning of the pandemic, it is highly likely that it is no longer fit for purpose.

The coronavirus has impacted on almost every aspect of care home provision and the policy should cover contingency and business continuity planning to ensure the level of care provision, quality and safety can be sustained through this challenging period.

IPC policy and contingency planning was one of the most variable areas, and where the least assurance was obtained. Inspectors were assured in 91% of care homes selected for potential good practice, and somewhat assured for 7% (care homes inspected due to concerns about quality and safety 62% and 24% respectively).

Good practice

Inspectors found some positive examples of ensuring that policies were kept up-to-date. By creating a number of IPC documents that were easy to read and kept up-to-date, staff could be knowledgeable about procedures and safe practice. One provider supplied a frequently asked questions booklet, which not only detailed how to prevent the spread of the virus, but it also explained what staff should do if they felt unwell and key contact details for managers.

Where audits were being completed regularly, there was clear recording and thorough infection control auditing, with actions allocated to particular staff members, with a deadline for completion.

“The provider had created a number of IPC documents including procedural guides, visiting guidelines and COVID-19 guidance for staff. There was also a handbook for staff which was available in eight different languages and a competency assessment that was completed with all staff regarding hand hygiene and donning and doffing procedures.”

“Audits were carried out daily and included general IPC checks, compliance with guidance for any person suspected of having COVID-19, and staff knowledge about procedures and safe practice.”

We found good examples of services that had ensured that staff and the people within the care home were supported with active and thorough risk assessments. Some staff were treated compassionately and offered alternative working arrangements to reduce the level of risk, where appropriate.

“There are staff risk assessments which consider staff who are at a higher risk. For example, one member of staff has a diagnosis of inflammatory bowel disease and has consulted with her GP and fed information into a risk assessment to ensure that she is well supported, and risks are reduced.”

“People who live in the care home have all had their own risk assessment in terms of support needs and PPE requirements. They also have a daily care plan and risk assessment highlighting whether they have no symptoms but are shielding/isolating or whether they are symptomatic.”

Learning was also shared among different services, which helped to promote best practice and continued education among staff. It also acted as a reminder of any changes in government guidance so that everyone was compliant.

“The [provider] shared any best practice or learning that had been found in one of their homes, to ensure all homes were aware of any concerns or changes that had to be made. This included reminders about correct use of PPE for visitors where one home allowed a relative to visit with a face visor and not a mask. It also reminded managers to ensure contracted staff members were also not working in other care homes/settings part time or through agency work.”

Challenges for providers and low assurance

Inspectors were concerned when they viewed IPC policies that were out of date because they contained no reference to COVID-19 or where COVID-19 information was no longer accurate.

Sometimes this inaccurate information had the potential to be dangerous. For instance, in one service the IPC policy had not been updated since early in March 2020 and so it included information that was “out of date, such as COVID-19 cannot be spread if people are asymptomatic and masks do not need to be worn by staff”.

There was further evidence to show that some services had not considered the impact on individuals who may be disproportionately at risk of COVID-19 and had not taken action around this.

“Risk assessments not completed for staff in high-risk categories, such as those in Black, Asian and minority ethnic groups. The manager was unaware of her responsibility to do this.”

Inspectors found that some services did not have an effective contingency plan for their care home. Some did not reference a pandemic, and so did not address potential winter pressures or what to do in the case of a future COVID-19 outbreak.

“The business continuity plan does not include assessment of the number of staff who could keep the service running safely if there were widescale absences. It does not mention making sure there are adequate stocks of food, medicines, PPE, etc at all times and does not include any preparedness for the winter – eg, winter flu vaccination planning.”

Winter planning

Although contingency planning was one of the areas with least assurance, inspectors did see some good examples.

“The prevention and protection plan was updated in July. It was very detailed and shared among all the staff about what plans are in place for how to manage a possible second wave. It also includes an outbreak checklist, role specific responsibilities and top tips, a symptoms checker, a standard cleaning process, housekeeping and catering teams top tips, hand hygiene guidance, PPE guidance for cohorting and zones, and cohorting guidance in the care home.”

One large care home operator used existing plans for flu outbreaks to start building their contingency plan at the beginning of February before the pandemic really took hold. They are now trying to keep ahead of the virus by being aware of how it is changing, and how their strategies for managing it need to change.

We could see that some services have learned from the first wave of the COVID-19 pandemic earlier in the year and could give examples and reflect on things that did not go well and what actions were taken to change that and plan for further waves and the winter. Services also asked for feedback from the people who live at the care home and their relatives to understand how they could improve. One care home responded to feedback by creating a ‘buddy system’ that gives relatives of people who are new to the home the chance to talk to, and ask questions of, more established relatives.

“The service locked down on 13 March, in advance of government advice to do so. Families who were upset at a unilateral lock-down just before Mother’s Day have now told the registered manager they feel he took the right course of action. There is a high level of trust in the service, which

will make any additional measures (such as the local lockdown) easier to implement.”

Services were encouraging staff to have flu vaccinations by making arrangements with a local pharmacist to do these when it was convenient for individual staff members. Another service had promoted the flu vaccine using easy read leaflets and videos to support both the people who lived in the care home and staff members.

Services had kept areas of the care home clear so that they could be used if staff needed to sleep over, or in case live-in staff were needed for a period of time. There was evidence that services had also invested in training and had identified multi-skilled staff to ensure that the service ran smoothly if there were any absences.

“There are detailed contingency plans in place and recorded. This included details of staff who are able to undertake specific procedures; for wound dressings to payroll completion. The home operates on three separate floors, so staff considered at 'higher risk' could be supported to work in lower risk areas.”

Conclusion

Good infection prevention and control is the backbone of care homes' fight to protect people using services and staff from the threat of COVID-19. In our State of care report this year, we said that issues with IPC were the most common feedback that we received to our Give Feedback on Care service during the first few months of the pandemic.

As we have seen through the practice and examples in this report, care home providers, managers and staff have, by and large, responded well to the need to make IPC an even bigger priority.

Over six months on, and IPC is as important as ever. This is why we have committed to complete a further 500 stand-alone IPC care home inspections by the end of November. These will include services where we expect to see good IPC practice, so we can continue to learn and share what works well as the situation develops, but we will also take action in services that are not adapting well to the pandemic.

As we said at the beginning of this report, we are focusing on sharing what we have seen and heard from providers about the successes and challenges in using IPC as tool to combat COVID-19 – not only in preventing an outbreak but, when it does occur, getting through an outbreak quickly. As we gather more data on IPC practice, we want to analyse the difference that good practice makes in dealing with outbreaks.

We acknowledge that there is still a lot that we do not know about the virus, and that there is no single solution – each care home has to create a plan for each person living there, that can adapt to local guidelines and restrictions.

The pandemic has put a huge demand on care home providers, managers and, particularly, individual staff. We are encouraged to see some of the support for staff that good providers have facilitated. This support has to extend to all providers, so that their staff feel valued at this time when their contribution is so important and their dedication so appreciated.

As care homes face winter, it is vital that providers alongside local and national partners, including ourselves, work together to share learning, data and information to keep people and staff safe while giving them the best possible care and support.

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