Department of Health and Social Care

Rheynn Slaynt as Kiarail y Theay

Integrated Covid-19 Community Care Response

Care Home Assessment & Rapid Response Team (CHARTT)

Operational Review: July 13th 2020

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Introduction

The Isle of Man Government's priority throughout the Severe Acute Respiratory Coronavirus-19 (Covid-19) outbreak has been to protect the health of the Island's community and help everyone to stay safe. From the outset, individuals that fell into the clinically vulnerable and clinically extremely vulnerable groups were asked to stay at home as much as possible and to avoid any face-to-face contact. People falling into the vulnerable group include those aged 70 or older (regardless of medical conditions) and those under 70 with an underlying health condition (i.e. anyone instructed to get a flu jab as an adult each year on medical grounds).

The estimated percentage of the population aged over 65 years on the Island has risen in early 2020 to 21.62%[1] with the care home sector caring for around 10% of Isle of Man residents who are over 70.

The recent Covid-19 outbreak therefore posed a particular threat to care homes not only due to the above vulnerability but also because of the often large numbers of residents cared for within the same building by a small team of registered nurses or care/ support workers. In addition, the design or age of the care home building often makes it difficult for staff to maintain the same level of infection control precautions as in a clinical setting like a hospital, mainly due to the lack of en-suite bathroom facilities, smaller bedrooms, shared bathrooms and dining rooms, and tight corridors, therefore extra vigilance was required to avoid potential transmission of Covid-19 between residents.

As part of their outbreak response the DHSC committed to supporting care homes across the Isle of Man and to keeping our most vulnerable sector of society safe from the Covid-19 virus.

Isle of Man Covid-19 Context

On 16th March 2020, the Council of Ministers made a specific policy decision to move away from the Public Health England approach to Covid-19 and take a more robust stance to reduce the reproduction rate of the virus in the Isle of Man. In order to achieve certain elements of the new plan, the Queens representative on Island, the Lieutenant Governor declared a State of Emergency. This allowed the Council of Ministers to put emergency measures in place to tackle the threat of coronavirus to the Isle of Man.

The intent of the Council of Ministers was to flatten the rate of reproduction in order to protect the Island's health services. Reducing the rate of transmission reduces the number of people who are ill at any point in time which in turn reduces the demand on health and care capacity, particularly intensive care beds, to ensure they are available for those who need them. From this date, it was mandatory for all people arriving in the Isle of Man to self-isolate for two weeks. The Island's biggest event, the Isle of Man TT, was cancelled. Community testing was increased, including the creation of a new, dedicated drive through testing centre. The Island tested far more people per head of the population than the UK.

The Government's strategy[2] focussed on four main aims:

1. Preservation of life

[1] https://iompopulationatlas.paulcraine.im/
[2] https://covid19.gov.im/

2. Maintain critical national infrastructure
3. Maintain public safety and confidence
4. Support a controlled return to normality balancing social, economic & health impacts

These four aims were underpinned by a strategy of continued community testing supported by contact tracing. Hospital ICU capacity was increased from 6 to 16 beds, with two being held available for non-COVID-19 cases.

On 26th March 2020, the Government introduced the first phase of its three phase approach **'Stay at Home'** which provided a framework for further measures to be put in place to protect the community:

- Borders were closed to all inbound movement with certain exemptions for critical workers
- New and more stringent measures on daily life were introduced, requiring everyone to stay home, except for very specific reasons, with a dedicated police team being established to enforce this
- Many businesses were closed
- The very vulnerable were told to stay home for at least 12 weeks
- Schools were closed, with exceptions for vulnerable children and those of key workers
- Community testing continued at an increased rate, supported by robust contact tracing
- On-Island testing capacity and capability was being developed

In response to the evidence on low case numbers, on the 23rd April 2020 the Government moved to the second phase of its approach **'Stay Safe'** which provided a framework to enable:

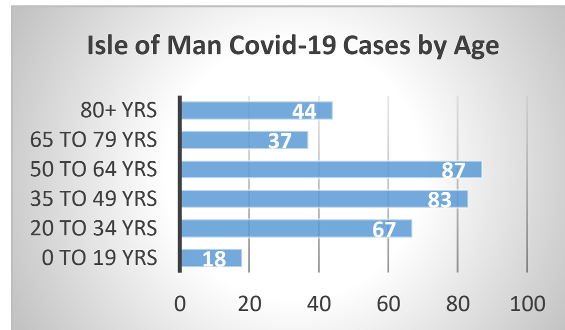
- health system readiness by maintaining suppression measures to avoid exponential growth of the virus,
- to respond to social pressures by staying safe and healthy,
- easing of economic pressures by facilitating a return to work where it was safe to do so.

Finally on the 15th of June when the Island reached day 26 of no new cases the third phase of the approach **'Stay Responsible'** was released by the Government. This framework provides an ongoing guide to remaining vigilant and prepared to react quickly if there is an increase in Covid-19 cases again.

Isle of Man Covid-19 Data[3]

[3] https://covid19.gov.im/about-coronavirus/open-data-downloads/

Confirmed cases	Hospital admissions
336	0
Total tests	Concluded tests
6022	5994
Awaiting results	Awaiting tests
28	0
Number of deaths	Total active cases (community and hospital)
24	0
Number of deaths in hospital	Number of deaths in the community
6	18



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Integrated Community Care Covid-19 Response

The community arm of the Manx Health and Social care system, including the private and third sector organisations contracted to provide direct care, created an operational coordination group 'Community Operational Bronze' to discuss key issues, challenges and ideas and collectively agree a way forward to present upwards to the clinical and governmental groups to approve. This group enabled a vision for the community care Covid-19 response to slowly form around real-time learning and feedback into the following areas:

Testing – Community swabbing team

Testing is undertaken by the mobile coronavirus testing unit. The unit, set up to take samples from members of the public to test for coronavirus operates during a two hour window from 10am to midday seven days a week.

In addition a drive-through hub for community testing opened at the Grandstand on 20 March and is designed to streamline the task of sample-taking in one location.

Staff test people referred to them on the day by clinicians at the COVID 111 helpline who have assessed their symptoms.

Contact Tracing

Under the oversight of Public Health and Environmental Health teams with strong collaboration from Government Technology Service, real time contact tracing was established from the first confirmed person with Covid-19.

The system grew from an initial Health Protection model on paper, to a large database integrated with information from the 111 call centre.

All people receiving a positive test result were contacted rapidly to gain details of their condition, timelines, travel and close contacts. All positive cases remained in isolation at home or in the hospital until the end of 14 days or negative test result. Investigation teams contacted all known contacts to decide level of infection risk from the known case. All high risk contacts then received a daily monitoring call for 14 days or until symptoms has ceased.

As the number of cases grew, the database enabled clearer monitoring of outbreaks and cross tracking of cases. The database also enabled the team to work remotely from home during the

height of the outbreak, using Microsoft Teams as a tool to ensure members of the team were connected at all times

The contact tracing team was an integrated model of staff from across government, many of whom were shielding and unable to provide their normal frontline roles. Public Health, Environmental Health, GTS, Health Visitors, Social Workers, sports centre staff and many more joined during the journey.

Community Covid-19 bed facility

A number of community, bank and retired nursing staff revived a mothballed rehabilitation ward within the wider hospital grounds to create two wards specifically aimed at caring for people with Covid-19. The 50 bedded Covid-19 unit also included step up and step down support for people recovering and discharged from the main hospital.

A Standard Operating Procedure was approved which allowed the facility to admit people directly from care homes or their own home. This facilitated rapid admissions and care by GPs and care managers when people needed more care than their home allowed.

Sadly one of the main drivers for this being established was an outbreak in a care home where 50 residents tested positive, 20 of whom died from Covid-19. Residents were able to be moved into a safer clinical area, where staff from consultants to housekeepers rolled up their sleeves and provided person centred care at a difficult time.

Covid-19 Home Assessment and Treatment Team (CHATT)

The CHATT was established on the 27th April 2020 to work alongside GPs and other community professionals to provide home based care to people who have tested positive for Covid–19 (or highly suspicious thereof) and require some level of health and care support but not to the extent that an acute hospital bed is required. The team was assembled to divert demand away from the acute hospital, in order to protect capacity for those who were severely unwell requiring specialist intervention.

At that point “the curve” prediction was that there would potentially be up to 3,000 people requiring care and support. This figure was gauged by comparing the demographics of the Island population to other parts of the world, and using the Rockwood Frailty Scoring system to work out how many of the people affected would not be suitable for admission to ITU. For these individuals their underlying condition, ventilation and more aggressive treatments delivered within an Intensive Care setting would likely to be futile and therefore be more suitable to be cared for at home.

Care Home Assessment and Rapid Response Team (CHARRT)

The Care Home Assessment and Rapid Response Team was created to provide proactive support to both DHSC, private and third sector owned care homes. The support was given through a series of assessment and discussions, infection control visits, and medical reviews. Additional support to care homes was provided through a rapid response team in the event of a resident or service user contracting covid-19.

The visits by the team assessed the resilience of the care home in the context of the COVID-19 outbreak and to provide any required support for IPC and for decision making. As the assessments

are specific to the Covid-19 outbreak they fell out of the usual framework of Registration and Inspection.

Prior to the professionals visiting the homes, Care Home Managers or the person with delegated responsibility was contacted to provide information including a completed infection control audit, and any COVID Related policies procedures and action plans the home had developed.

The CHARRT team was made up of Multidisciplinary group comprising Senior Nursing staff (Dementia specialist, Mental Health, Learning Disabilities, and Public Health) Infection Control Practitioners, Hospital Consultants (Gerontologists), GPs, and supported by Admin Officer to help coordinate all the visits and documents.

The CHARRT team met weekly to share updates from the weeks' visits, discuss challenges and find a collective solution and to plan the week ahead. Microsoft TEAMS was used to facilitate both the weekly meetings and central storage and updating of CHARRT documentations and those shared by the care homes.

Care Home Context on the Island

In total there are 26 Residential and Care Homes along with 16 Sheltered Housing complexes for older people. In addition there are 30 community care homes for young adults (28 for people with Learning Disabilities, 1 for people with Mental Health needs, and 1 for people with physical disabilities). Domiciliary care and care services at home, with access to day services, normally provides across island support assisting many people to stay cared for in their own homes.

As mentioned above there was early acknowledgment that Covid-19 in a Care Home would be difficult to manage due to the physical nature of many of the homes, and also the vulnerability level of the residents or service users. News and reports of outbreaks in care home environments from Spain, the USA and UK showed trends of high numbers of deaths in similar homes. As a precaution the DHSC took an early decision to close all homes to non-essential visitors from mid-March.

The DHSC was able to establish a central PPE procurement and stock system for all the islands care settings. This enabled care homes to access adequate quantities of fluid repellent masks, gloves and aprons from early on and adhere to PPE guidelines from Public Health. https://www.gov.im/media/1369213/010-covid-19-guidance-for-home-care-provision.pdf Care homes were also advised to cohort staff into teams and to reduce or stop use of bank staff unless they only worked in that one care home setting. All respite and emergency care placements were suspended, with the majority of domiciliary care being contracted to a third sector organisation. This allowed day centre staff to be redeployed into residential homes.

As the swabbing and testing capacity expanded on island, priority was given to testing of residents and service users in care homes to reduce waiting time for results. In June this was expanded to access to rapid testing once it was available on island, giving a result turn-around time of 1 hour. At the same time DHSC also prioritised testing of all Health care workers and care home staff on the island, and enabled them to be swabbed twice in order to return to work before 14 days if they received two negative results and were healthy again.

The final very key decision was to support all residents and service users being discharged back to a home from hospital to have received 2 negative swab results, one being in 24 hours of discharge.

CHARRT Team and Process

As outlined above, the CHARRT team was created to provide proactive support to both DHSC, private and third sector owned care homes. The support was given through a series of assessment and discussions, infection control visits, and medical reviews. Additional support to care homes was provided through a rapid response team in the event of a resident or service user contracting covid-19. See annex 1 and 2 for details.

CHARRT: Covid-19 Resilience Assessment Process

Individual care home visits were undertaken by each of the professional groups separately in order to reduce the burden of a large group requiring access to the Care Home Manager and decrease footfall within the home. Where possible the visits avoid contact with residents or service users to reduce further any risk of infection. Often the senior nurse and medical reviews were off site, or in the gardens. The process of visits is outlined below:

1. Visit and discussion with Senior Nurses – combination including Dementia, LD and MH – on care home contingency plans, details of home and environment, summary of resident or service user needs and dependencies, discussion on normal care and activities and impact reducing this is having on residents, discussion on wellbeing of staff and staffing needs, finally discussion on resilience and contact with families.

2. Medical review of most complex residents or service users with consultant and GP based on specifically developed Covid-19 care plan document.

3. Onsite visit by Infection Control Nurse providing practical advice.

4. Follow up visit by integrated care team member for ongoing support on recommendations.

Any immediate risks (be it general care or Covid-19 readiness related) highlighted during the visit were flagged to the Registered Manager at the end of each visit, with immediate action requested.

Care Home Managers and staff were encouraged to complete a COVID specific care plan for each of their Residents which will identify their individual needs should they contact the virus. During the medical reviews the consultant and GP discussed the most complex residents to agree an action plan for the GP, the care home Manager or person with delegated authority. Plans should then be discussed with the residents and their next of kin if appropriate. Up to date advanced care planning, including end of life and DNACPR discussions are encouraged.

The CHARRT matrix focused on Covid-19 resilience on the following areas:

- Staffing – sickness rates/resident dependency. Is there a rotation system in place to prevent transmission of virus from the community into the home via staff movement? Wellbeing?
- Training – has infection control/PPE training etc been rolled out? Are there training records in place?
- Stores and supplies – are there adequate supplies of PPE and other clinical consumables?
- Infection control audit, including cleaning products, schedules, PPE stations, handwashing etc.
- Environment – does the environment support good care and infection control practices?

- Clinical engagement – does the local GP practice have sufficient capacity and resources to support the care home with onsite or telemedicine visits as required during the current situation?
- Policies & Procedures – are there Covid-19 specific policies, procedures and other documentation in place to support provision of safe care
- Direct clinical review of a sample of residents
- Wellbeing of residents and service users during lockdown, including supporting contact with families
- Resilience planning to re-establish normal activities and visiting

The CHARRT assessment matrix was used to guide questions and conversations during each visit, and split by the above areas. A 'red, amber, green' (RAG) rating was then given for each assessed item with any recommendation or action to be followed up either by the Home or by the CHARRT team. These recommendations and actions formed the basis for ongoing monitoring visits by a member of the integrated care team who was supporting the CHARRT process, or CHARRT team member who made the recommendation.

The results of the assessment matrix were shared back with the Manager of the Care Home so that action plans could be followed up. As the sections of the team sometimes had a number of days (or weeks) between visits, the assessment matrix are best shared after the initial senior nurse visit and then updated later with additional feedback. Managers were given opportunity to review the matrix summary to make corrections and edits to ensure information was captured correctly.

CHARRT: Rapid Response Support

In the presence of a confirmed or suspected COVID-19 outbreak the CHARRT team will facilitate an urgent visit to the home to review the resident and support the staff, referencing the previous visit and documentation. Additional assessment at this stage will focus on reducing the risk of further nosocomial infection, ensuring staffing levels remain acceptable and safe, confirming adequate PPE supplies and adherence to PPE guidance.

The response will depend on whether this is a confirmed outbreak (one or more positive cases) or whether it is suspected (2 or more clinically suspected cases in 24 hours awaiting swab results).

- In the case of a suspected outbreak, a small team attends within 24 hours. This team makes a rapid assessment of the 'state of play' in the care home and the outcome will either be a further assessment by the full team or 'standing down' the assessment pending swab results. GPs are involved in all such visits.
- In the case of confirmed COVID-19 positive swabs from one or more resident in the previous 24 hours the same initial CHARRT visit focuses on preventing further transmission. This includes decision making about the location of care for the person with COVID-19 and a review of the ability of the home to support the resident or service user to isolate. There will be a subsequent visit the following day by a wider team to support decisions around the location of care, the care of other residents and service users, and the need for/ or access to further PPE and staff.

CHARRT team will help the manager coordinate with the Contact tracing and outbreak response team to ensure completion of the contract tracing information sheet on all residents or service users and staff, support the swabbing of all residents or service users and staff within 24 hours, and support the manager as results come back in relation to any further positive cases and how that

impacts staffing and care in the home. Contact tracing will continue to monitor residents and staff as required helping to track dates required for isolation based on presentation of symptoms.

CHARRT team will continue to provide supportive visits and calls throughout the isolation period as required, particularly to monitor infection control measures and adherence.

The CHARRT team also enable a link for the Care Home particularly for Residential and Community LD homes who do not have registered nurses on their staffing, with the CHATT team (see above). This link will enable additional support for people who have tested positive to be cared for in their own rooms where possible and when their wishes have indicated this. The CHATT team will also provide mentoring for support workers who have familiarity with the service users to provide the care themselves and ease levels of anxiety that might otherwise complicate their isolation.

At the end of the isolation period required by the residents or service users of the home, the CHARRT team, home manager and service lead will meet to review the resident(s) who had contracted covid-19 and their current medical condition, and well-being of staff, to jointly agree if the home can step down and return to normal again. In the event this is agreed the Infection control team will arrange to visit and support any required deep cleaning and easing of PPE guidelines, and waste disposal.

CHARRT Monitoring and Actions

The CHARRT team assessment matrix provides a summary record of the visits, RAG rating and recommendations or actions to be followed up through monitoring visits. It also helps identify in advance the level of response should an outbreak of two or more positive Covid-19 diagnoses or highly suspicious of Covid-19 cases be reported in a care home, either through the GP and 111 call centre or through admission via Nobles.

Following the review of a care home and RAG rating by area, an overall RAG rating was given to each home to show this ongoing level of support that would be needed in the event of a resident or service user contracting Covid-19. Homes on either a Red or Amber rating were discussed in the weekly CHARRT team meeting along with any outstanding visits, or recommendations.

Whilst some Homes were able to change RAG scores by completing actions, a key learning for the CHARRT team was that due to the nature of particular residents in their care, or the physical infrastructure of the home being older, they will remain on an amber rating and require additional support in the event of a covid-19 case. For example:

- Older homes with tight corridors, chair lifts in old town houses, and many bedrooms with shared bathrooms will always struggle with caring for residents isolated in their rooms for 2 weeks.
- Residents or service users with complex and often challenging behaviour would be difficult to isolate in their rooms without relying on heavy sedation or physical restraint. In these situations individualised care will be required which may require moving the person either to Nobles in the case of dementia or to emergency single use respite for people with learning disabilities.

CHARRT Outcomes

Over the time period a total of 25 of the 26 nursing and residential homes, 16 sheltered housing complexes, 28 community learning disabilities homes, 1 supported living complex for people with mental health needs, 1 supported living complex for people with physical disabilities were assessed and supported by the team. Prior to the CHARRT team being established one nursing home had an outbreak of Covid-19 within the residents and staff, and subsequently closed so this was not included.

1 community LD home had a Covid-19 case which was supported by infection control and contained really well. No subsequent infections noted.

1 dementia unit for challenging behaviours had a Covid-19 case, support by whole Rapid Response Team. Well contained. No subsequent infections. Resident moved to Covid ward due to difficulties in isolation.

No further cases to date in any of the remaining homes, however several homes provided with remote support during swabbing of residents and whilst waiting for results.

Managers and Service leads supported to develop risk assessments and plans around resilience as restrictions ease.

Advanced care planning training provided in response to CHARRT medical reviews by Hospice team, including specific ones focused on learning disabilities.

CHARRT Summary and Next Steps

During the process the CHARRT team learnt a number of key lessons that will improve the design of the response if needed in the coming months. It has also established a baseline of information on which to build future support for care homes when the Isle of Man contracts another case of Covid-19 in the coming months. Finally it has helped provide a bases of information to service leads and operational management to reflect on in terms of resilience of care homes for easing of restrictions and in responding to any future increase in Covid-19 cases on the island.

Below are a list of lessons learnt, best practices, feedback from home managers, and recommendations. What is key to remember that each home is unique in its environment, staffing team and most of all combination of residents and service users. All the managers involved in the CHARRT process are to be hugely congratulated and thanked for their hard effort and dedication at keeping their staff and residents or service users safe throughout a difficult period.

Our CHARRT team recommendation is that guidelines for homes are based around the different groups of needs and recognise the younger adults with learning difficulties need support with life skills and social distancing, but frailer older people in nursing homes need support through physical shielding.

As there remains a supportive role for the CHARRT team for Care Home managers over the coming roles around resilience and the easing of border controls, the team have created a CHARRT Covid-19 Response Plan. The plan aims to outline the engagement and activity required by the CHARRT team against the Government Covid-19 Phases 'Stay Responsible, Stay Safe, Stay Home'. Please find the document in Annex 1.

Lessons Learnt

a) Breaking CHARRT team into small focused activities: Initial contact, Senior Nurses, IPC, Medics, Monitoring/ follow up.
b) The access to resources across the various areas including clinical waste, obtaining cleaning equipment etc can be challenging.
c) Coordinating Consultants and GPs challenging at times, good to have an expanded number of consultants on board at start.
d) Acknowledging some challenges are wider or longer term than Covid-19: e.g Wifi, Podiatry, Best Interest, Advanced Care Planning, EOL conversations.
e) Grouping LD service users together for medical reviews worked better than individual homes due to smaller numbers.
f) MH and LD senior nursing support proved very useful. Long term practices for shared care need improving generally.
g) Rapid response element of team essential to provide additional support within 24 hrs for home with complex behaviour residents.
h) Medical reviews for residential and nursing homes work best with drafted covid-19 care plans, managers, senior care staff and GP with close relationship with home.
i) Learning on having team reviews of homes rating amber with medics, infection control, and senior nurses.
j) Including drug reviews in medical reviews.
k) More support needed for the homes to complete the IPC audit tool
l) CHARRT team need to differentiate clearly between ‘advice’ and “instruction’ as some care homes mistook advice for instructions and made decisions based on what they think we “told them to do”.
m) Homes attached to one or two GP practices had less variation in care, and were easier for Managers to seek support when needed.
n) Clear IPC/PPE guidelines helped avoid the confusion at the commencement of the outbreak.

Best Practices

I. Flash Cards for communicating whilst wearing masks
II. Special events for Staff to say thank you – cupcakes – radio shout outs – hand cream – bring and share lunches
III. Risk assessments for individual staff with underlying health issues to enable them to work safely/ return to work after shielding
IV. Ice-cream van coming for staff and residents
V. Ballroom dancing chair based exercises
VI. Using visors rather than goggles for residents who rely more on facial expressions
VII. Supporting residents and service users to access the garden as regularly as possible during lockdown
VIII. Mixing day service staff into homes helped expand range of ideas and activities
IX. Weekly review of contingency plans and risks
X. Monthly review of dependency levels for residents
XI. Reducing the frequency of staff changes, and the number of daily activities had beneficial impact on service users with LD with noticeable reduction in challenging behaviours and anxiety behaviours.

XII. Taking temperatures of residents BD and Staff arriving on shift.
XIII. Portable Hand wash sinks.
XIV. Early detection and isolation of symptomatic residents.
XV. Testing of all hospital discharges back to homes and sheltered housing helps reduce need for further isolation.
XVI. Administrator / coordinator role helped ensure smooth communications, tracking of documents and filing. TEAMS software supported remote working and document sharing.
XVII. Care home company wellbeing app.
XVIII. Cohorting staff into teams during shift patterns reduced contact and interaction between staff, and supported contact tracing processes.
XIX. Day centre staff or administrative staff calling service users weekly or daily as they preferred to maintain social contact with those isolated in their own homes or without close family residing in care homes.
XX. Regular briefings with residents and service users with capacity to keep them updated, discuss Government News briefings and respond to questions.

Feedback from Managers of Homes

Share a report back with Homes

Develop an FAQ

"It was a very scary time for everyone and we asked ourselves so many times were we doing everything we could to prevent Covid entering the home, it was nice to have you all behind us and indeed ready to help".

Recommendations

<u>Home Level</u>

1. Recommendation for someone known to service users or residents with complex behavioural needs, and nurses in nursing homes to undertake the swabbing when required.
2. Due to resident complex behaviours some homes will always need additional support with any cases due to challenge of isolation.
3. Older homes do not benefit from good en-suite bathrooms and often have small corridors so will always need additional support with cases.
4. All homes should have good Wi-Fi access to allow residents and services users to have video call/ face time with both medical professionals and families.
5. Ensure risk assessments by activity and individual in relation to ongoing resilience to covid-19 and resuming normal daily lives of residents and service users.
6. A number of homes were in the middle of renovation or repair work which was halted during the lockdown. Whilst this helped reduce external visitors to the home it left some difficult environments for safe infection control.
7. Include Nicotine patches or replacement therapy available for residents or service users who are smokers and may need to isolate.

Higher level

8. Design lockdown restrictions by type of community or residential home: fitter young adults with LD and MH need support maintaining social distancing but do not require the same medical shielding as Residents with advanced frailty.
9. CHAT type team to support residential and LD community homes in event of covid-19 to provide medical mentoring for non-clinical staff and support advance care plans.
10. Covid-19 respite facility available for either those who really wouldn't self-isolate and be complex, or ones who need protection.
11. Agreement to manage LD houses as 'family homes', to ensure care and reduce over-sedation/ reliance on sedation for management.
12. Encourage creation of a forum for managers (Matrons) of residential and nursing homes.
13. The creation of specific IPC training for care homes to support consistency as this appears to be accessed from a variety of sources at present. Accompanied with creation of IPC practitioner forum for sharing ideas and support.
14. Provision of respite stopped during covid-19, this needs to be supported to continue safely particularly for people with LD or to provide additional home support for older people in the future in the event of further restrictions.
15. Rapid testing for residents of homes and sheltered housing / supported living complexes to confirm or rule out covid-19 infection is enormously helpful.
16. Ensure continued follow up by GPs following medical review, including finalising all covid-19 care plans for less complex residents.
17. Advanced care planning in some older person's homes and for people with physical and learning disabilities should always be in place and regularly updated. Older people homes focused on DNACPR rather than advanced care and end of life plans, this needs to be part of daily living planning.
18. A review of Covid-19 care plans with managers of homes and GPs would ensure plans are updated as part of the seasonal flu preparations.
19. To work closely with the care homes to ensure that working towards best IPC practice can be obtained in a safe manner taking into account the infrastructure, needs of residents/ service users and other required resources.

Annex 1: CHARRT Covid-19 Response Plan

Response Level	CHARRT Status	CHARRT Activities
Level 1 Stay Responsible	Standby	• Partially resourced team (reduced time commitment) • Support for off-island compassionate visits to residents in end stage EOL in care homes. • Support to Care Homes and Services for Resilience Planning and Preparation in the event of renewed transmission on island – as requested • Infection control oversight with ongoing training on PPE and IPC • Review event with Care Homes • Finalise report and documentation • Monitor progress towards achieving CHARRT recommendations • Review of Covid-19 care plans for complex residents and service users as part of seasonal flu preparedness • Support Advanced Care Planning training for Care Homes and encourage all residents and service users to have one in place • Monthly team meetings
Level 2 Stay Safe	Active	• Partially Resourced Team enabling 7 day a week cover for rapid response • Support to mangers for restricting non-essential visitors and activating covid-19 contingency plans • Provide calls or visits to all care homes by senior nurses and by infection control team – review and update overall RAG score to ensure correct level of support to home in the event of a contracted case of Covid-19 • Support to ensure adequate PPE stocks • Ensure active swabbing and result system in place to coordinate with rapid response team • Provide regular and clear information to managers and service leads on changes to guidelines, DHSC response and Government regulations • Encourage wellbeing for staff in all homes • Support care homes to meet wellbeing needs of residents and service users given changing situation • Meet with service leads and managers of third sector organisations, including sheltered housing and domiciliary care • Weekly team meetings
Level 3 Stay at Home	Alert	• Fully resourced team with 7 day a week cover for rapid response – depending on outbreak additional team members required • As above for Level 2 with increased frequency of contact with care home managers

Annex 2: Care Home Resilience Assessment Process

1) Initial contact and risk score undertaken with Home: Adrian Tomkinson
2) Manager of Home receives email request for documents from Registration & Inspection Unit and Julie Lister
3) Documents return by Manager of Home and uploaded to Team folder by Julie Lister
   a) Infection Protection and Control Audit completed by home and shared prior to visit by infection control nurses.
4) Manager of Home shares availability for visits with Julie Lister
   a) First: Senior Registered Nurse visit arranged with Home to give overview of process, discuss key things to prepare for other visits, and review resident 'care' element of Covid-19 preparedness. EMI units or homes with residents with Mental Health issues to be joined by Mark Butler. Learning Disabilities facilities to be joined by Gary Daly.
   b) Second: Infection control nurses visit as IPC audit, review of training and supplies is a priority.
   c) Third: Consultant and GP visit to review selection of residents' medical notes, advanced care plans, EOL and DNACPR. In addition normal / business as usual health needs should be reviewed. Medics to use Care home care planning process tool as basis of reviewing each resident.
      Also to review any residents of concern to manager/ Registered Nurses, and those on Non-invasive ventilation.
      NB: Senior Registered Nurse team or external issues from DHSC may identify higher priority for medical visit.
5) All: provide feedback summary through Team folder or to Julie Lister to upload.
6) All: provide feedback on relevant and urgent issues with the home, and oversee any urgent actions assigned to them e.g. share relevant documents or provide training.
7) Collated feedback shared with Home manager.
8) Ongoing support visits to each home from Adrian Tomkinson to follow up actions.
   a) In addition follow up visits where appropriate from one of the Senior Nurses or Infection control nurses as required.
9) All: Team meeting each Friday to discuss key issues arising, areas of concern and plan for following week.
10) All: continue to provide support for their recommendations
11) GP to ensure residents are reviewed as planned

Annex 2: Learning Disabilities Home Resilience Assessment Process

1) Initial contact with Manager of Services: Andrea Whitaker, and Heads of Praxis and Autism Initiative.
2) Manager forwards assessment tools and documents to individual residential home for senior staff/ manager to complete
3) Documents are return and uploaded to Team folder by Julie Lister
   a. Infection Protection and Control Audit completed by home and shared prior to visit by infection control nurses.

4) Manager of Home shares availability for meetings, calls or visits with Julie Lister
    a. First: Senior Registered Nurse joined by Gary Daly meeting arranged with Home manager to give overview of process, discuss key things to prepare for other visits, and review resident 'care' element of Covid-19 preparedness.
    b. Second: Infection control nurses visit as IPC audit, review of training and supplies is a priority. This is the only team to go into the home.
    c. Third: Medical review by Consultant and trainee GP, with Senior Nurses to review selection of resident's medical notes, advanced care plans, and EOL for services users over the age of 65yrs. In addition, normal / business as usual health needs should be reviewed. Medics to use Care home care planning process tool as basis of reviewing each resident.
        i. Any service user on Non-invasive ventilation should be reviewed.
5) All: provide feedback summary through Team folder or to Julie Lister to upload.
6) All: provide feedback on relevant and urgent issues with the service manager and with the home, and oversee any urgent actions assigned to them e.g. share relevant documents or provide training.
7) Collated feedback shared with service manager.
8) All: Team meeting each Friday to discuss key issues arising, areas of concern and plan for following week.
9) Manager of Home contacted by Gary Daly to monitor progress on recommendations and actions.
10) All: continue to provide support for their recommendations