

Infection Control for Shared Accommodation

1. Contacts

Michael Linnell is the single point of contact for Manchester and he can be contacted at: michael.linnell17@icloud.com

Public Health England Greater Manchester Health Protection Team at Public Health England: **0344 225 0562 (Option 3)**.

Admission/General Site Administration

As there is no national guidance on shared accommodation, Public Health England recommends the use of pre-admission checks and/or testing (when available) and providing temporary non-shared for COVID +ve or symptomatic.

All suspected/confirmed cases should be isolated in temporary non-shared accommodations room with their own bathroom for 14 days from onset of symptoms unless they require high intensity/critical care in a hospital.

In line with current national recommendations, you may wish to consider asking residents to wear cloth face coverings in communal areas – but social distancing should still apply and please note that there is insufficient evidence as to their efficacy at preventing COVID spread at this time.

A lower limit on the max. number of occupants staying in the shelter at any one time is recommended to facilitate social distancing

- As many service user/1:1 interactions to take place over the phone as possible
- Separately risk assess any staff and service users for vulnerabilities which mean they should be more stringent with social distancing and/or avoiding front line work etc.

Source: Public Health England NW – Infection Control Team and Clinical Homeless Sector Plan (Note: this could not be approved by PHE but was agreed to be published by Pathway Healthcare for Homeless)

2. Infection Control Lead

Each site should have a person who is designated as an Infection Control contact

- The contact is responsible for current infection prevention and control policies and procedures and that these are readily available and appropriate to the site and understood by all members of staff. The lead is responsible for:
 - Recording and reporting symptomatic guests and arranging for isolation/transport
 - Recording information on incidents/challenges and training/education of staff where needed.

- Ensuring 100% staff adherence rate with up-to-date infection prevention and control policies
- Nominating a COVID-19 co-ordinator per shift
- Deliver/reinforce staff and guest education on hand and respiratory hygiene
- Ensure adequate supplies – hygiene, tissues, soap, paper towels, cleaning materials
- Ensure adequate PPE is available – disposable gloves, aprons, fluid repellent
- face masks and eye protection
- Coordinating testing for staff/guests
- The Infection Control Lead should have access to advice on infection prevention and control from a suitably qualified individual. Queries can be submitted to:
 - Public Health England North West: ICC.Northwest@phe.gov.uk or Darryl.Quantz@nhs.net

Source: Adapted from Care Home IC Guidance and discussed with PHE to confirm applicability.

3. Social/Physical Distancing

The primary approach to infection control is social distancing. Staff should follow DH guidance:

- All persons should remain at least 2 metres (3 steps) apart at all times.
- The importance of social distancing should be explained, explored and emphasised to all individuals upon check in and repeated as often as necessary.
- Staff should model safe distancing for residents at all times.
- Adjustment on how people move around buildings and use the space within in should be made to ensure safe distancing is possible at all times. This is supported by use of floor marking to indicate safe distances.

4. Symptom Identification/Outbreak Reporting

Residents should be asked to self-report on a daily basis (or twice daily is possible) regarding any new symptoms of Covid-19:

- **a new, continuous cough** – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)
- **a high temperature** – this means you feel hot to touch on your chest or back (you do not need to measure your temperature)

Please note that Public Health England have advised that not all cases of COVID-19 will display pyrexia (raised body temperature), especially those with other health

conditions. It is a very non-specific symptom, and those with pyrexia could just as easily have a UTI as COVID-19. Taking temperatures (unless it is self-administered), is likely to increase the exposure of staff to infection rather than improve detection of cases. Therefore regular temperature monitoring is not recommended. However, where individual guests are self-reporting feeling hot, they could be supported to use the Tempa Dot ([Instruction Video](#)).

Whenever possible, symptom monitoring should be supported by health care staff (through regular interactions) or on-site visits from St John's Ambulance.

Any suspected symptoms of Covid-19 should be reported via 111 immediately and advice followed. If the individual is advised to self-isolate, this should be reported to the Central Allocation Team immediately for advice on appropriate accommodation and self-isolation support measures.

If 2 or more cases are suspected in one site, please contact the Public Health England Greater Manchester Health Protection Team at Public Health England: **0344 225 0562 (Option 3)**. They will be able to provide tailored advice specific to the situation.

Source: Consultation with Public Health England NW Health Protection Team

5. Personal Protective Equipment (PPE)

PHE NW has recommended following the PPE guidance available for Community and Other Settings ([Table 2](#) or [Table 4](#)) and highlights the definition of 'direct patient care' in these settings defined as:

Patient contact is now defined as being within 2 metres (rather than within 1 metre) of a patient, which is more precautionary and is consistent with the distancing recommendations used elsewhere.

Although it is not anticipated that staff onsite are providing direct care, the experience has been that social distancing is not possible and staff are working with a population with high needs in many cases. Further, sites have not been cohorted (to date) to Covid-19 symptomatic sites, so the approach should be to consider that all sites could have possible cases. As well, emerging evidence is showing that spread is also through asymptomatic cases so this is in line with this evidence.

Given these circumstances, the most applicable guidance in [Table 2](#) would be the scenario of "working in reception/communal area with possible or confirmed case(s) and unable to maintain 2 metres social distance" which recommends the use of Fluid-resistant (Type IIR) surgical mask for a sessional use. A session is defined as:

A single session refers to a period of time where a worker is undertaking duties in a specific care setting/exposure environment. A session ends

when the worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.

For any direct patient care within 2 metres, gloves and aprons will be made available to workers to use. These should be changed frequently to avoid spreading infection from person to person.

General Principles

- Staff should be trained on donning and doffing PPE. PHE has recommended the following [training video](#). A visual guide is also [available](#).
- Staff should know what PPE they should wear for each setting and context
- Staff should have access to the PPE that protects them for the appropriate setting and context
- Hand hygiene should be practiced and extended to exposed forearms, after removing any element of PPE

6. Cleaning

General Principles

- The virus can survive on environmental surfaces – the amount of surviving virus reduces dramatically after 72 hours, but may last up to 9 days on hard surfaces
- The virus is easily inactivated on surfaces using bleach containing solutions (where appropriate) and standard detergents
- The virus is easily inactivated on hands by washing with soap, water and drying, or by using alcohol-based hand gels
- Frequent cleaning of touch sites, door handles, switches, hand rails etc. use of communal areas should be avoided as much as possible

Responsibility

- Whilst hotel cleaning is contracted, workers might wish to regularly disinfect their own work stations and equipment.
- Cleaning is being contracted out but should still follow standards for [non-health care settings](#). Individual rooms should be thoroughly cleaned between residents following non healthcare cleaning guidance - including the use of broad spectrum disinfectant ie 1000ppm chlorine.
- PHE advises that guests be supported to clean their own during their stay and therefore staff only need to clean rooms when they are vacated (which would reduce the usage of PPE)
- All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately, wearing PPE.
- Clean spillages using a product which combines detergent and disinfectant (and ensure it is effective against both bacteria and viruses). Always follow the manufacturer's instructions. Use disposable paper towels or cloths to clean up

blood and body fluid spills, and dispose of after use. A spillage kit should be available for bodily fluids like blood, vomit and urine.

7. Sharps Waste/Disposal

- Use a sharps bin to dispose of used needles or sharps.
- For sharps managements and waste the situation is straightforward for those hotels located in Trafford and Bury with GMMH both issuing injecting equipment and responsible for waste collection.
- Further guidance is available [here](#).

8. New Residents

- Normal care/social distancing would be applicable for *any new resident* unless people are symptomatic (which would be triaged as per the accommodation protocols developed (e.g., separate hotel, health care setting if needed, etc).

Source: Admission and Care of Residents guidance and consultation with PHE NW.