COVID-19: Key messages for providers of supported living services in Northern Ireland

- **Rights-Based Approach:** The operationalisation of this guidance must respect the human rights of clients, families/carers and staff and decision making should be balanced, proportionate and equitable.
- **Household Bubbles:** Households should be clearly identified and defined to effectively manage risk and to inform decision making. A household is a reflection of interactions, behaviours and contacts of individuals within that household, not the number of clients.
- **Risk assessment, reduction and local implementation:** Providers should make decisions based on risk assessments, individual circumstances and their own operating model. Decisions should be made in collaboration with delivery partners, services users and families/carers.
- **Collaboration** between all providers, the NI Housing Executive (NIHE), Health and Social Care (HSC) Trusts, Landlords and the Public Health Agency is critical to maintaining supported living services, making best use of all available assets and minimising the impact of COVID-19 on clients and staff.
- **Shared direction, diverse approaches:** HSC Trusts and providers should refer to existing guidance to ensure the safety of clients, maintain service delivery and respond to emerging needs. HSC Trusts and providers should adopt diverse approaches to reflect the wide range of households, services and clients.

Introduction

1. This guidance is aimed at HSC Trusts, the NIHE and independent providers of supported living services and should be considered alongside guidance for Nursing & Residential Care Home and Domiciliary Care providers. This guidance might also be a useful resource for the wider supported housing sector, such as retirement or sheltered accommodation.
2. Separate guidance is available for 16-21 Supported Accommodation and Homeless Providers in Northern Ireland.
3. Supported living provides extra housing support and/or an element of care to meet the support needs of individuals and help them lead as independent a life as possible. Settings may be shared between several people and have

communal space or consist of separate units of self-contained accommodation – with or without communal space – but which may be located in shared buildings such as a block of flats and/or on shared grounds. Settings that primarily deliver HSC services are regulated by the Regulation and Quality Improvement Authority (RQIA).

4. Supported living services are delivered in people's homes, involving tenure rights – renting or ownership – with associated occupancy rights that should be respected. However, it may also be a staff workplace and include a range of communal areas and shared facilities, therefore it is important to consider risk to the client, others they live with and staff/contractors involved in delivering services.

5. Provision of care and support in supported living settings is a high priority service, in that most care and support cannot be deferred to another day without putting individuals at risk of harm. It is therefore vital that these services are maintained. Additionally, supported living placements are facilitated by a number of in-reach services to support assessment, familiarisation and transition – these services should be maintained and underpinned by inter-agency collaboration.

6. Some people being supported may lack capacity to understand and make decisions based on advice about the COVID-19 pandemic. Concerted efforts must be made to communicate information with people in a way that they are most likely to be able to understand and that any decisions made about people who lack capacity must be taken in their best interests. Such decisions should include consideration of the wishes and feelings of the person where it is possible to ascertain these and the wishes and feelings of families/carers where appropriate.

Definitions and key principles

Household Bubble

7. For the purpose of this guidance and to assist with the implementation of public health advice and guidance in respect of infection prevention and control, the following applies:

    - A household bubble is defined as an individual or group of people who mix together in communal areas on a regular basis without the need to social distance. Households are not defined by numbers but by behaviours. A household is a reflection of interactions, behaviours and contacts of individuals within that household. Households should be clearly identified and defined to effectively manage risk and to inform decision making;

- There can be multiple households within a setting (for example, a block of flats on shared grounds). Within a supported living setting, individualised units with or without communal facilities should be considered as individual households;

- In the context of visiting other households, an individual can be identified as being part of up to two households. Further guidance on visiting is available at Regional Principles for Visiting in Care Settings in Northern Ireland and COVID-19 regulations and localised restrictions apply; and

- Increasing the number of households that individuals are part of increases the potential risk of COVID-19 transmission to everyone in those households. This increase in risk should be balanced against all other benefits and risks to aid decision making.

Risk assessment, reduction and local implementation

8. Certain factors have been associated with individuals being more at risk to infection or adverse outcomes from COVID-19. Definitions of clinically vulnerable and clinically extremely vulnerable are available athttps://www.nidirect.gov.uk/articles/coronavirus-covid-19-definitions-clinically-extremely-vulnerable-and-vulnerable and guidance for such individuals is available at https://www.nidirect.gov.uk/articles/coronavirus-covid-19-guidance-clinically-extremely-vulnerable-and-vulnerable-people. However, strict infection prevention and control measures have a significant impact on a person's life, relationships and overall wellbeing. A risk based approach enables providers to identify, assess and reduce risk to inform decision making according to individual circumstances and their own operating model. An individualised and positive risk based approach should be adopted, aligned to the Ethical Advice & Support Framework.

9. Decisions should be made in collaboration with the client, where possible, their family member or close friend where appropriate, people from their household, and guidance and input from other relevant professionals and organisations if/as required. Risk assessment may have different outcomes for each setting or individual, reflecting the operational context and assessed need of the client.

10. Risk should be considered in the broadest sense, recognising vulnerability to COVID-19 as well as the impact of restrictions on health and wellbeing. When considering risk, the needs of four distinct groups need to be considered, with the needs of the individual central to all decision making. The four groups are:

    - The client;

- Peers/friends who also reside in the household;
- Family members/close friends of the client;
- Staff involved in the care/support of clients in the household.

For HSC Trusts (As Commissioners)

11. As a starting point, HSC Trusts should refer to guidance for Domiciliary Care and Nursing and Residential Care Homes in Northern Ireland. However, It is important to apply the key principles outlined above to make decisions on how this guidance is implemented, recognising the need for diverse approaches to produce shared outcomes. Also supported living settings can vary by funding arrangement, delivery model and client profile, therefore the following points of clarification apply:

Access to Personal Protective Equipment

12. The NIHE will source and deliver PPE for supported living services which are solely funded by Supporting People and jointly funded with HSC. This includes ensuring that providers are able to hold a buffer of stock and prioritising stock across organisations, where there are any short term limitations on stock. The NIHE should continue to ensure all providers have a named point of contact with whom to discuss PPE provision. Providers should not be charged for the provision of PPE from NIHE stocks.

13. Supported living providers in receipt of HSC funding (solely funded schemes) should work with suppliers to secure an adequate supply of PPE, but will be supported by Trusts where they are unable to source items.

14. Trust support should ensure that providers are able to hold a buffer of stock, and provision of PPE is in line with advice provided for domiciliary care or nursing home providers. HSC Trusts must work with providers to understand PPE requirements and prioritise stock across organisations, where there are any short term limitations on stock. HSC Trusts should continue to ensure all providers have a named point of contact with whom to discuss PPE provision. Providers should not be charged for the provision of PPE from HSC Trust stocks. The HSCB will work with HSC Trusts to ensure all Trusts work towards a consistent approach in the provision of PPE – including how the level of stock to be held by providers is judged.

Testing

15. Routine asymptomatic testing is being implemented for supported living staff and access to training materials will be provided. Any positive cases should be reported to the Health Protection Duty Room at the PHA on 0300 555 0119 for a risk assessment to determine further action, including consideration of whole facility testing.

16. Testing of asymptomatic staff will be undertaken through the National Testing Programme managed by the Department of Health and Social Care (DHSC), England. DHSC will provide all supported living providers in Northern Ireland with a unique organisational identity code by email to enable providers to order test kits.

New or returning clients to the setting

17. Trusts must ensure that all individuals discharged from hospital into shared supported living setting are tested for COVID-19. Supported living providers should ensure that support plans are in place to maintain a supportive and planned transfer informed by discussion with the person being discharged, and where appropriate their family and care providers.
18. Where the provider has the resources to isolate an individual, they should accept new or returning clients while test results are awaited. All new clients in supported living settings should be treated as if they were COVID-19 positive until a 14 day period has passed, even where they have tested negative for COVID-19.

19. An exception to this process is for individuals who have previously tested positive for COVID-19 and are within 90 days of their initial illness onset or positive test date. If these individuals have already completed their 14-day isolation period from onset of symptoms or positive test result (if asymptomatic) and have no new COVID-19 symptoms or exposure, they are not considered to pose an infection risk. Public Health England guidance outlines relevant considerations to facilitate discharge and share the isolation the 14 day isolation period across the clinical and care setting – this is fully applicable to supported living settings in Northern Ireland. Note that if an individual develops new COVID-19 symptoms and tests positive within a 90 day period from last positive test, they would be deemed a new infectious case.

20. The Department recognises that there are challenges to maintaining isolation in small domestic shared households and clients with distressed behaviours may require additional support. Risk assessment and mitigation should consider the use of temporary accommodation, stepdown facilities or enhanced infection control measures in the household. This should take into account the views of other clients on the risk of sharing their household with a person being discharged whose COVID-19 status is unknown and may need to consider if any change in the living arrangement is needed.

Financial support

21. Trusts should collaborate with independent sector partners to consider how contracted activities could be repurposed in response to needs emerging from COVID-19 and reduced HSC provision.

22. In response to COVID-19 cost pressures faced by supported living providers, The Departments of Health and for Communities secured additional funding, administrated by the NI Housing Executive for 20/21. Additional funding has been secured for the current financial year and this arrangement will be reviewed on a quarterly basis.

For Supported Living Providers (HSC Trusts and Independent Sector)

23. The Department recognises that providers have continued to support vulnerable people throughout the COVID-19 pandemic, adapting services to adhere to public health guidance, responding to new and emerging needs, and have been impacted by additional financial pressures.

24. As a starting point, providers should reference guidance for Domiciliary Care and Residential and Nursing Homes in Northern Ireland. It is important to apply the key principles outlined above to make decisions on how this guidance is implemented, recognising the need for diverse approaches to produce shared outcomes. Also supported living settings can vary by funding arrangement, delivery model and client profile. Therefore, the following points of clarification apply:

Testing

25. COVID-19 testing is available to all supported living (inclusive of sheltered accommodation) clients if they display symptoms.

26. Staff testing within supported living environments will help protect residents and staff, and is an important part of the national effort to tackle coronavirus. Further information for providers can be found on the PHA website.

Keeping clients safe and monitoring symptoms

27. Infection prevention and control measures should be deployed to reduce the risk of COVID-19 transmission between households and informed by risk based assessment. It is important to identify household bubbles as it may not be practical nor desirable to restrict clients to their rooms, maintain social distancing or strictly limit the use of communal facilities.

28. As far as possible, providers should seek to limit turnover in staff they use and seek to limit the number of staff moving between households. As far as possible, staff should work in groups who are limited to particular groups of clients and/or parts of the setting. The Department recognises that this is not always possible as providers may employ staff that work for a number of agencies, therefore risk assessment should identify any mitigations.

29. Recognising that supported living services are delivered in people's homes, providers should adopt a rights-based approach in deploying infection prevention and control measures. Supported living clients ultimately have responsibility to adhere to public health advice, guidance and regulations and should be supported to do so. Providers should raise awareness and educate clients on the importance of social distancing, hygiene, face coverings and local/regional regulations.

Symptomatic clients

30. Any client presenting with symptoms of COVID-19 should be advised to organise a test via -https://www.publichealth.hscni.net/covid-19-coronavirus/testing-and-tracing-covid-19/testing-covid-19 and be supported to self-isolate pending the result, in line with guidance available at https://www.nidirect.gov.uk/articles/coronavirus-covid-19-staying-home-and-self-isolation.

31. This should be in in a single room with an en suite bathroom, where possible. If a separate bathroom is not available, consideration should be given to drawing up a rota for washing or bathing, with the person who is unwell using the facilities last before thoroughly cleaning the bathroom themselves (if they are able or it is appropriate, otherwise the provider should arrange appropriate cleaning). Where the supported living environment is cleaned by the tenant, advice and guidance should be offered.

32. Every effort should be made to ameliorate the impact of an isolation period with consideration given to the provision of entertainment, exercise, suitable activity and alternative forms of contacts with others including virtual methods.

33. The client should not have access to shared living, dining and kitchen spaces. If there are any communal areas in the setting which cannot be avoided, then people who are symptomatic or have tested positive for COVID-19 should not make use of communal areas at the same time as others and these areas should be cleaned after use.

34. There may be instances where a symptomatic individual will not follow guidance and advice and not self-isolate, presenting an ongoing risk of transmission to others. In this situation, it is vital to try and ascertain their concerns and, where possible, to reassure and make appropriate arrangements to overcome these barriers. These concerns may include

access to food, washing and toileting facilities or medications, lack of understanding or support, or a lack of comprehension as to the implications. Every effort should be made to alleviate these concerns and provide support. If individuals refuse to self-isolate, staff should report this to the Trust and NIHE (where appropriate) and seek their support and guidance.

35. COVID-19 cases and outbreaks should be reported via established communication channels, including the Health Protection Duty Room at the PHA on 0300 555 0119 to assist with risk assessment and consider testing requirements. Staff in close contact with someone that has tested positive for COVID-19, should self-isolate in line with https://www.nidirect.gov.uk/articles/coronavirus-covid-19-testing-and-contact-tracing.The PHA risk assessment will help to determine if any clients or staff meet the criteria of a close contact and should therefore self-isolate. It will also determine whether whole facility testing of all staff and clients is required. Cases (staff and residents) should also be encouraged to engage with the PHA Contact Tracing service
- https://www.publichealth.hscni.net/covid-19-coronavirus/testing-and-tracing-covid-19/contact-tracing

36. A close contact is defined as per NI Direct at https://www.nidirect.gov.uk/articles/coronavirus-covid-19-self-isolating#toc-2 as:

    - anyone who lives in the same household as someone with COVID-19 symptoms or who has tested positive for COVID-19

    OR

    - anyone who has had any of the following types of contact with someone who has tested positive for COVID-19 with a PCR test:
        - face-to-face contact including being coughed on or having a face-to-face conversation within one metre
        - skin-to-skin physical contact for any length of time
        - been within one metre for one minute or longer without face-to-face contact
        - sexual contacts
        - been within two metres of someone for more than 15 minutes (either as a one-off contact, or added up together over one day)
        - travelled in the same vehicle or a plane

    These definitions apply to supported living clients and community contacts, as well as staff. If other supported living clients within the setting meet any of the above criteria, they should self-isolate for 10 days from date of last contact with the positive individual.

Restrictions on Visitors

37. People in supported living settings live in their own homes and should be treated as such. This means they, and their visitors, need to follow the same national restrictions as other members of the public.

38. Providers should seek to support and facilitate visiting opportunities wherever it is safe to do so. They should develop policies for visits into and out of the setting that are based on risk assessment and reduction, and include the individual needs of the clients living in the household. As outlined in paragraphs 8-10, risk assessment should be informed and guided by the views of affected parties.

39. The specific circumstances of the setting, and the people who live there will largely define the range of visiting that is possible – both into and out of the setting, for example:
    - Those living in individualised housing units may be able to host visitors or leave the setting freely with little support needed from the provider;
    - For shared settings with limited or no communal areas, enhanced cleaning may be required or visiting in may be limited to the client's room/housing unit or a public space near the setting; and
    - Clients may present with significantly differing needs and clinical vulnerabilities, requiring individualised visiting policies and/or decisions.

40. Providers should consult Visiting with Care – A Pathway as a starting point to develop a visitation framework and risk mitigations. The Department recognises that some measures are not appropriate or practical for supported living settings, as above the range of visiting is dependent on the operational context and clients living in the household.

41. Where appropriate, providers are directed to facilitate care partner arrangements, aligned to the Regional Principles for Visiting in Care Settings in Northern Ireland.

42. Children will be encouraged to visit and the responsibility will rest with the adult for supervision to ensure they adhere to all IPC measures as appropriate. Any child visiting will be included in total number of visitors for the arranged visit.

43. Previously established Shared Care arrangements should resume, inclusive of overnight stays, dependent on the output of risk assessment. To enable overnight stays, a plan should be developed that outlines what to do if the person or someone in either the setting or family household becomes symptomatic. This plan should consider immediate actions to be taken and should include useful telephone numbers for those to be contacted for advice both in hours and out of hours. This should always include public health advice.

44. Dependent on dynamic risk assessment, the client may not need to self-isolate for 14 days upon return to the setting. Anyone showing or experiencing the symptoms of COVID-19 or defined as a close contact should follow public health advice, they should be supported to self-isolate immediately (if this is feasible), testing should be arranged and the person should not visit any other household.

45. Providers should consider enhanced cleaning and limiting the use of communal facilities to minimise the spread of infection during this time. As above, supported living clients ultimately have responsibility to adhere to self-isolation requirements and providers should raise awareness and educate on measures taken to reduce the transmission of COVID-19.

46. Testing of symptomatic clients and staff in the setting should continue throughout this period.