Disability Services
Community Operations
Health Service Executive
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Interim Rights-based Guidance on implementing Infection Prevention Control Measures and mitigating risk in Disability Services

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Please be aware that within the changing nature of the epidemic clinical guidance regarding management may change quite quickly. Keep updated and please refer to the following websites regularly for updates: www.hse.ie/coronavirus and www.hpsc.ie

All HSE Guidance and Resources for Disability Services are available on

https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/partner-resources/

Actions for Healthcare Workers

Implement Standard Precautions for infection prevention and control with all people you support at all times:

- Hand hygiene
- Respiratory hygiene and cough etiquette
- Environmental hygiene

Promote respiratory hygiene and cough etiquette which involves:

- Covering mouth and nose with a tissue when coughing and sneezing or coughing into the crook of an elbow
- Discarding used tissue into a waste bin
- Cleaning hands

Maintain a physical distance of at least 1 metre (3 feet) but ideally 2 metres from individual with respiratory symptoms (where possible)

Avoid touching your face

Clean you hands regularly as per WHO 5 moments

Cleaning and disinfection is also very important

Use a facemask in addition to Standard Precautions when working within 2 metres of a service user, regardless of COVID-19 status.

Use Contact and Droplet Precautions (use of PPE) in addition to Standard Precautions when working within 1 metre of person who is confirmed/suspected COVID 19. PPE use:

- Mask
- Gloves
- Eye protection (if risk of contamination to eyes from splashing of blood, body fluids, excretions or secretions including respiratory secretions)
- Plastic disposable apron (if risk of blood or body fluid splashing on HCW's clothes)

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1.0 Background and Context

In Ireland there are currently over 8300 (as per the national service plan) people with disabilities living in 1302 HIQA registered designated centres. In keeping with the "Transforming Lives" policy, most of these people now live in decongregated settings in the community. These range from community houses, to single apartments and a few campus-based bungalows and shared accommodation. Providers of Disability Services have made huge strides in the last few years in "de-medicalising" the services and ensuring that people with disabilities are integrated into their communities and live a meaningful life and one that is of their choosing. It is critical that these gains in changing the culture and environment for people with disabilities are not lost in the current COVID-19 pandemic.

The fear of an outbreak of a transmissible infection including the current global pandemic of COVID-19 in a service has the potential to make the services more risk adverse, which could have the knock-on effect of restricting the rights of people with disabilities and even treating people with disabilities differently to members of the general public, which must be avoided where at all possible. There is no such thing as "zero risk" in these settings, or any other environment, but there is a need to balance the risks associated with COVID-19 and the rights of people with disabilities. Each situation must be individually assessed in order to mitigate the risks and ensure the rights of people with disabilities are respected in a balanced, pragmatic and proportionate way. Both the HSE (as provider and funder) and HIQA (as regulator) support the argument that service users rights should not to be unreasonably restricted. This should give services support to proceed with a positive approach to assessing and managing risk in a practical and proportionate way. This is important because the uncertainty and fear that are inevitable in a pandemic can result in escalating preoccupation with risk avoidance measures that restrict the lives of service users with little or no meaningful reduction in risk of infection of either service users or staff.

Much of the guidance for Residential Care Facilities (HPSC 2020 – RCF 19/06/2020 and Visiting 05/06/2020) to date has understandably been focussed on large congregated settings such as nursing homes. These facilities include large number of residents often with relatively high dependency and vulnerability related to advanced age and underlying medical conditions. As such the guidance for these settings is not in all respects applicable to the situation of a large proportion of disability residential services which are small community based houses and homes.

At present 21% of disability residential centres have 10 or more people living in them however many of the people living in them are living with smaller groups (HIQA designated centres)

within the campus. In these settings, depending again on the individualised risk assessments, the number of people living in each unit and those people's underlying medical conditions, it may be appropriate to use the *Interim Public Health and Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units*. In these settings, staff do not work between units/ houses on the campus therefore mitigating the risk of transfer of the virus.

However, the arrangements for the vast majority of disability services which are small community based houses need to be tailored to their circumstances and not simply adopting the universal application of measures which may be more suitable for larger congregated settings.

Note that people diagnosed with COVID-19 are considered infectious for other people for 14 days from the day their symptoms started. If they have no symptoms they are considered infectious for 14 days after the day the swab was taken. At the end of the 14 day period provided they have had no temperature for the last 5 or those 14 days they are no longer considered infectious and any COVID-19 specific infection control precautions should stop. They should not have another test at that time.

2.0 Impact of COVID-19 in residential centres for people with disabilities

Small community based houses are similar to family units, i.e. there are a small number of residents and a limited number of staff. As of June 23rd 490 people living or working in HIQA registered designated centres have been laboratory confirmed positive COVD-19. Approximately 56% of those affected were staff and 44% were residents. Sadly, to date 13 people with disabilities have died as a result of COVID-19 – this equates to 0.17% of individuals with disability residing in a designated centre.

In all, 106 residential services experienced outbreaks. 77% of these outbreaks have now been declared closed. The average number of persons (staff and residents) symptomatic per outbreak was 6 (compared to around 20 per nursing home outbreak) reflecting the typically smaller scale of most disability residential services. 85% of all residential services for individuals with disability did not experience any outbreak.

Those living in residential disability care are a significantly younger population than those living in nursing homes. In general the nursing home population are older. Over half of those living in nursing homes are aged 85 or over. However the vast majority (7, 200 or around 87%) of the disability residential population are under the age of 65. Approximately 6,000

(72%) of those living in residential disability centres are under the age of 60, with a further 1,200 or so aged 60-64 (15%). While the severity of COVID-19 shows a very marked age gradient, the other critical marker for COVID-19 is the presence of underlying medical conditions. Underlying medical conditions are less common in the disability residential population compared to the older person's residential services.

3.0 General Measures to mitigate risk of COVID-19

There are many resources on the **www.hpsc.ie** website as well as the HSE Disability Services website - **https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/partner-resources/** to support staff in teaching and emphasising the importance of educating and informing people with disabilities regarding COVID-19 and the measures which they can take to decrease the risk of transmission of the virus. There are Easy Read tools, and tools in other accessible formats on hand washing, respiratory etiquette and desensitisation programmes for people with disabilities to help them tolerate testing, face coverings etc.

The key overarching elements of managing the risk of infection are

1. Processes to identify people (service users and staff) with communicable infection (including COVID-19) before they access services/attend work or as soon as possible after they access services/attend work
2. Processes to minimize the risk of spread of infection from people (service users and staff) who access services/attend for work with unrecognized infection (Standard Precautions)
3. Early detection of spread of infection in the service and immediate response to limit harm

Therefore consideration around the following is important:

- Entry and arrival at work protocol (check for symptoms and temperature check)
- Shifts are controlled with staff working with the same staff to the greatest degree practical.
- Ensuring that staff support the same residents consistently to the greatest degree practical – where possible staff do not work between houses or agencies (where staff must work between houses, small consistent teams with Infection Prevention and Control (IPC) protocols in place should be used)
- Availability of sinks, hand sanitisers and training on hand hygiene
- Regular thorough cleaning of contact surfaces.
- Disinfection is generally not required unless there is a specific reason (for example someone has a communicable infection or there is a spill of blood or body fluids)

- Respiratory etiquette
- Social distancing where practical and appropriate to the needs of the service user
- PPE use where appropriate (including staff training and PPE supply by organisations)
  Interim Public Health and Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units.

The following recommendations are relevant to the use or surgical masks or cloth face coverings:

NPHET recommendation for **Surgical masks to** be worn as follows

- Surgical face masks should be worn by healthcare workers when they are providing care to people and are within 2m of a person, regardless of the COVID-19 status of the person
- **Surgical masks** should be worn by all healthcare workers for all encounters, of 15 minutes or more, with other healthcare workers in the workplace where a distance of 2m cannot be maintained

NPHET have also recommended the use of cloth-face coverings in indoor public spaces where a distance of 2m cannot be maintained including situations such as public transport and retail outlets.

IMPORTANT NOTE: Please note that the NPHET recommendations are respectively relevant to **healthcare settings** or to **public spaces**. The guidance is **not** directly applicable to residential disability services because these are social care settings rather than healthcare settings and they are **not** public spaces.

Residents should not be asked to wear a mask or face covering in the residence unless they have symptoms of infection. In indoor public spaces (for example public transport and retail outlets) where distance cannot be maintained, use of a cloth face covering or mask consistent with the recommendation is appropriate if the person can tolerate the mask. Likewise wearing of masks by visiting family members or friends is not always appropriate particularly if they are in a room with only the resident.

Staff should use compassion and good sense in relation to their use of masks in the social care setting considering their assessment of risk to themselves and the needs of the resident. Wearing of face masks by staff may result in difficulty with communication, anxiety or distress

to some the people with disabilities who are being supported. In these instances (as described in the scenarios below) a sensible approach should be taken in managing low risk situations. In some cases use of a clear visor is a practical alternative to mask use and as the entire face is visible this may cause less difficulty with communication.

The framework for decision making in Appendix I may help staff in supporting people with disabilities to make sensible decisions about their safety and the service user's autonomy, "nothing about me without me" and where appropriate encouraging engagement with other service users, advocates, GP, families and friends. Autonomy is the ability of an individual to direct how he or she lives on a day-to-day basis according to personal values, beliefs and preferences. In health and social care, this involves the person using our services making informed decisions about the support that he or she receives (HIQA 2016).

4.0 Scenarios

4.1 General situations

4.1.1 An individual with a disability was walking in town with his support worker and walked up to relatives on the street then shook hands and hugged them. The support worker reminded the person with a disability and relatives to move to a safe distance. The relatives were not displaying any obvious symptoms of infection. The support worker offered hand sanitiser to the individual and the relatives and then cleaned their own hands with hand sanitiser. Keeping a safe distance the individual with disability continued to talk to their relatives for a short while. The support worker reminded the individual with disability and relatives to take leave of each other without further hand shake or hugs.

Advice –

This support worker dealt with a very low risk incident in a practical and sensible manner. It is appropriate to record the incident but no further action is required.

4.1.2 People with disabilities are looking forward to going out to restaurants and pubs for a meal and a few drinks. What precautions should staff take when supporting people to do this?

Advice-

An individualised risk assessment (see Appendix A) should be carried out and public health guidance in relation to, where relevant, those with underlying conditions and in relation to indoor gatherings should be considered. The person and/or where appropriate their family/advocate should be advised of these and the public health restrictions that are in place for these venues. Individuals should be supported to make an informed decision as to what precautions they need to take when partaking in these activities and also on return to the service they are living in, such as hand hygiene and cleaning of their wheelchair where appropriate etc.

4.2 Visiting

4.2.1 A mother was visiting her daughter in a residential service. The service user became very distressed when her mother puts on a face mask as requested. The service user begins to injure herself and her mother.

Advice –

Assuming the mother and daughter have no symptoms of infection and no fever, it would be preferable that she should not have been asked to wear a mask if there was any reason/experience that should lead staff to anticipate that her daughter was likely to react in this way. The mother could have been advised to avoid physical contact if this is practical, to maintain a distance if this is practical, and to clean her hands before and after the visit. If the mother is very vulnerable and wishes to do so she could be offered a face visor if that is likely to create less distress. If a face visor or mask is used by a visitor or staff member caring for a person who had difficulty accepting the use of PPE, it may help to relieve anxiety if the visitor/staff member enters the space, and after greeting at a safe distance, puts on the mask of visor while in sight of the person and explain what is happening.

Support can also be provided to support the individual to recognise and become comfortable with a family member wearing a mask, using video technology or photographs.

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4.2.2 A person with a disability is living in a single occupancy house. The individual does not leave the property and four staff work closely with her. Parents are currently visiting with interaction through a window. Can her parent(s) visit their daughter in the house or garden? The daughter cannot tolerate either wearing a mask herself or her parents wearing a mask as she needs to see their full face.

Advice –

In the context of the general advice on visiting (symptoms and temperature check) this is a low risk situation. If the resident and her family have been given information on the risk and wish to proceed with the visit it is appropriate to respect their choice. The visitors should be been advised to avoid physical contact if this is practical, to maintain a distance if this is practical and to clean their hands before and after the visit. If the visitor is very vulnerable and wishes to do so, he/she could be offered a face visor if that is likely to create less distress.

4.2.3 Four people with disabilities share a house in a community setting. None of the people living in the home have underlying medical conditions and none have symptoms of or are known to be infected with COVID-19 or are COVID-19 Contacts. The RCF Visiting Guidance (HPSC 2020) may restrict visiting to two named visitors, with each of those visitors allowed a maximum of one visit per week, and only one person allowed to visit at one time (note this guidance is currently under review). However, a person with a disability may want to meet more than two family members, or friends per week. Note - An independent advocate or visiting therapist are service providers, not visitors in the usual sense, and their access to their client should be facilitated with appropriate IPC precautions.

Advice –

Social contact and interaction is important for everyone. The decision on the number, frequency and duration of visitors for people with disabilities living in a home such as this should be the same as for the general public living at home; otherwise the rights of the person with a disability are being infringed upon. Other than a requirement for visitors to declare that they have no symptoms and not temperature, the guidance about visits to home gatherings for the general public should be utilised. The visit

should if possible be in a room with the person being visited and interaction between the visitor and other residents should observe social distancing requirements.

4.2.4 A woman with a disability living in a disability service is unable to use the facilities in her hairdresser's salon due to the types of sinks used in the salon. Pre-COVID her hairdresser came to her house. Is this possible again?

Advice –

Yes if she follows requirements that generally apply to visitors/service providers before and during the visit and complies with guidance for resumption of service by hairdressers and barbers to the greatest extent possible. If at all practical the hairdresser should provide the service to the resident in a room separate from other residents.

This same advice should apply to chiropody, physiotherapy, masseuse etc.

4.3 Respite

4.3.1 An adult with a disability who is living at home is going into Respite Services for the weekend. Is there a need to self-isolate either before entering or during the Respite Stay?

Advice –

Seek assurances that neither the person with a disability nor other members of their household had any exposure to or symptoms of COVID-19 for the previous 14 days. Following confirmation, the following protocol should be used before admitting an individual into Respite Services for people with disabilities.

a. An individual (or where appropriate a person known to them on their behalf) who is going into respite should complete a declaration form that they have not had a temperature or been in close contact with a person who was known to be COVID-19 positive for the previous 14 days. In the case of a child entering Respite, this could be completed by the parent(s).
b. The individual's temperature should be taken prior to admission to Respite (a fever is 38 degrees Celsius or above) – if the individual has a temperature they should be advised to self-isolate as per HPSC guidelines.

c. Subject to the above there is no requirement for any specific restrictions on the person during the period of respite beyond the general requirements for good infection prevention and control practice that apply in all settings. The person may participate in communal and community activities subject to their remaining will with ongoing monitoring for symptoms of infection or fever.
d. When the person is ready to returns home the symptom an temperature check should be performed. If this is not remarkable and everyone else in the facility is free of symptoms of infection there is no need for the person to self-isolate when they go home.

4.3.2 A person with a disability, who normally lives in supported housing with one other person with a disability, has lived at her family home during the lockdown. Does this person need to isolate for 14 days before moving back into her supported living accommodation?

Advice –

No. An individual (or where appropriate a person known to them on their behalf) who is going from her family home back to supported living in this scenario should complete a declaration form that they have not had a temperature or been in close contact with a person who was known to be COVID-19 positive for the previous 14 days. The individual's temperature should be taken prior to her returning to the supported living accommodation (a fever is 38 degrees Celsius or above) – if the individual has a temperature they should be advised to consult with their GP and self-isolate as per HPSC guidelines**.**

4.3.3 A person with a physical disability, living at home with her partner is coming to a residential disability service for 21 nights respite whilst their own home is being renovated to provide her with more accessible accommodation. This service has 12 permanent residential beds and two respite beds. Does this person need to be tested for COVID-19 before admission and do they need to be isolated from the other residents in the service?

Advice

Yes. In this situation the person is living at home and is moving in a scheduled way into the a congregated setting with a relatively large group of people. The guidance for admission to a residential setting should apply to minimise risk to other residents (see RCF guidance document).

4.4 Day Services

4.4.1 Day services will be combined indoor/outdoor arrangements with staff meeting people in their local community to spend time in local parks etc. Are all of the staff expected to take their own temperature as part of the service?

Advice –
Yes it is recommended that Day Service staff self-monitor for symptoms including a temperature of 38 degrees Celsius or higher. If staff do not need to come to centre before starting work (for example if they would normally go directly to the park) they may record their own temperature before leaving home.

4.5 Outreach Support Services

4.5.1 Staff that are providing PA supports, home support or other outreach services may be working with more than one person with a disability or visiting other facilities in one day. Is this considered "working across agencies" and therefore contravening the guidance on staff working in one location?

Advice -

No. Further guidance for health and social care workers visiting people in their homes in the community, which includes guidance on risk assessment and planning pre-visit, actions during the visit, and at the conclusion of the visit; this is available on the HPSC website https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/healthandsocialcareworkers/

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5.0 Summary

This document aims to support all staff when making complex decisions during the COVID-19 pandemic. As such, it applies to the work practices of frontline staff, clinical staff and management teams at all levels in disability services. All services are provided in the context of and in line with the UN Convention on the Rights of Persons with Disabilities (2006), the principles of the Assisted Decision Making (Capacity) (ADM) Act (2015) and all other Irish national legislation, including the recently enacted emergency legislation relating to the COVID-19 Public Health Crisis (2020). **The HSE presumes that all adults have the capacity to make their own decisions unless the contrary is shown.** All individuals are supported to take an active role in their emotional wellbeing, their physical health and in making choices about things important to them and for them. The COVID-19 pandemic has rapidly brought us to a place where difficult decisions need to be made and significant changes are happening within service users' everyday lives. The current public health crisis requires a new way of thinking, so that we act in ways that are **both** person-centred **and** in the best health and welfare interests of society and the population as a whole. Balancing individual and public health needs and interests in the context of a pandemic can involve making difficult decisions around such aspects of our services as the provision of supports/interventions, supporting service users to comply with public health guidance, provision of supports, allocation of resources/interventions, balancing individual rights and public health responsibilities and restrictive practices.

If a restrictive practice is to be implemented, this should only occur in line with the service's policy on the promotion and protection of human rights. It should always be transparent and notified to HIQA as required in keeping with a pragmatic and proportionate approach as we adhere to public health guidelines. It is important that staff have a process that informs the decisions that are taken, within which service user's will and preferences can be considered in line with Public Health policy and relevant legislation. The advice in the attached framework is based on the Department of Health's Ethical Framework for Decision-Making in a Pandemic (2020). (See Appendix I)

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APPENDIX I

A Framework for Staff for Decision Making during COVID-19

A: The Decision ***(reasonableness, openness, transparency)***
1. What decision(s) need(s) to be made? 2. Why do we need to make this decision? 3. Who needs to be involved in making this decision? 4. What options are there (including not acting)? 5. Consider the risks and benefits of all options.
B. Involvement of the Person in the Decision Making Process ***(inclusiveness, person-centredness, consent)***
1. Have you established what the person's will and preference are in this situation? 2. What steps need to be taken to support the person to engage in the decision making process? 3. Has the person been provided with appropriate information about the situation, in a way they can understand? 4. Nominate a support person for the service user, agreed in advance with an alternative. 5. Support person explains decision(s) and options to the service user. 6. Presume person has capacity to make their own decisions unless/until the contrary is shown.
C. Make a Decision
1. Does the proposed measure *minimise harm* (to the person and/or others)? 2. Is the proposed measure *proportionate* (to the benefits of doing it and the risks of not doing it)? 3. Is it *fair and reasonable*? (Does it treat the person as equal to all others and is it based on best available evidence and sound clinical judgement?) 4. Are we fulfilling our *duty to provide care* (to the person, staff and others)? 5. Is the decision making process *open and transparent*? 6. Have all key stakeholders been included in the decision making process? 7. Consider whether consultation with the SMH Ethical Advisory Committee is required (i.e. Is the decision complex? Are there varying views? Are there consent issues?)
D. Make a Plan to Review/Revise the Decision ***(responsiveness, accountability)***
1. Is the decision making responsive? (How will it be revisited as the situation changes? How will complaints/appeals be managed?)
2. What are the systems of accountability? (Who is responsible for the decision? Who has oversight? 3. How has all of this recorded in the person's file? (rationale for decision and the process)

APPENDIX II

References

1. Department of Health (2020). Ethical Framework for Decision-Making in a Pandemic.
2. Government of Ireland (2020). Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act.
3. Government of Ireland (2015). Assisted Decision Making (Capacity) Act.
4. United Nations General Assembly (2006). Convention on the Rights of Persons with Disabilities.
5. Government of Ireland (2015). Assisted Decision Making (Capacity) Act.
6. HPSC (2020). Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities (V5.2 19/06/2020)
7. HPSC (2020). COVID -19 Guidance on visitations to Residential Care Facilities (V1.0 04/06/2020)
8. (HIQA 2016) Supporting people's autonomy, a guidance document.

APPENDIX III

Acknowledgements

Thank you to St. Michael's House for the use of their Decision-Making Framework. Special thanks to Professor Martin Cormican, HSE Clinical Lead and Mary McKenna, Infection Prevention and Control Nursing Lead from HSE Antimicrobial Resistance and Infection Control (AMRIC) Team who supported the development and agreed the final version of this guidance.