Northern Ireland Assembly

Research and Information Service Briefing Paper

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COVID-19 and Care Homes – an International Perspective

Amended to include further analysis into discharge policy/ practice and public versus private care home settings

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This briefing paper has been prepared, primarily to assist the Committee in preparing a short, focused review of COVID-19 in relation to care homes, with a view to the Committee producing recommendations to help prevent/ mitigate a second surge in that sector.

As a starting point for the Committee's consideration, this briefing paper will look particularly at performance within Northern Ireland and measures implemented to date, with additional reference to wider international work in this regard and some particular examples of good practice in selected international countries.

Contents

1. Context

There have been almost 440 deaths to date in Northern Ireland (NI) of vulnerable elderly care home residents after contracting coronavirus. They make up almost half all coronavirus-related fatalities that have occurred locally.

The latest figures, published on 9 October by NISRA, stated that the total number of COVID-19 related deaths was 906 (including those registered up to and including 7 October).

Place of death	Number	Percentage
Hospital	488	53.9%
Care Homes	**356**	**39.3%**
Hospices	8	0.9%
Residential addresses/ other locations	54	6.0%

The 364 deaths which occurred in care homes and hospices involved 85 separate establishments (out of a total 483 homes across NI, providing in excess of 16 000 beds).

Further analysis, which includes deaths of care home residents in hospital shows that, of the **437 deaths of care home residents** involving COVID-19 in the year to date to 2 October 2020, 81.5% (356) occurred in a care home, with the remaining 81 occurring in hospital. **On this basis, deaths of care home residents account for 48.2% of all COVID-19 related deaths**.

People who reside in care homes are vulnerable due to their health status and the fact that they live in close proximity to others. The impact of COVID-19 on care home residents has varied internationally, with some countries reporting no deaths (or infections) in care homes, such as Hong Kong, Jordan and Malta, and two countries (Canada and Slovenia) reporting that over 80% of COVID-19 deaths were of care home residents. With the caveat that the definitions used vary, on average the share of all COVID-19 deaths that were care home residents is 40.5% (based on 26 countries)[1]. This brings NI figures in slightly (0.3%) above average.

The following timeline highlights the measures and actions taken by the government to support care homes since the onset of the pandemic:

27 April	Health Minister Robin Swann announced £6.5m in additional funding for NI's care homes[2]. He also confirmed a further expansion of testing and the publication of updated guidance for care homes[3], aimed at strengthening infection prevention and control and protecting residents. Under the support package, homes received or were to receive a payment of £10k, £15k or £20k, depending on their size.

[1] Comas-Herrera A, Zalakaín J, Litwin C, Hsu AT, Lemmon E, Henderson D and Fernández J-L (2020) Mortality associated with COVID -19 outbreaks in care homes: early international evidence. Article in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 26 June 2020.

[2] https://www.health-ni.gov.uk/news/minister-announces-support-measures-care-homes

[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/COVID-19%20%20GUIDANCE%20FOR%20NURSING%20AND%20RESIDENTIAL%20CARE%20HOMES%20IN%20NORTHERN%20IRELAND%20%28JULY%202020%29.pdf

13 May[4]	The Minister detailed the following key areas in relation to protecting care home residents: ▪ Significant expansion of testing for care home residents and staff; ▪ Intensive support for care homes, including strengthening by Trusts of hospital-to-community outreach teams; and ▪ Investment and reform in social care.
2 June[5]	A press statement of 2 June announced an £11.7m package of support for care homes including: ▪ Funding for sick pay for staff; ▪ Enhanced cleaning regimes; ▪ Provision of new equipment; and ▪ Tablet devices for care homes.
17 June[6]	The Minister announced plans for a new framework for nursing, medical and multidisciplinary 'in-reach' into care homes, co-designed between the Chief Nursing Officer, in partnership with the care home sector for the provision of clinical care.
22 June[7]	The RQIA – NI's health and social care regulator – was directed by the Department in March to reduce the frequency of its statutory inspection activity and cease its non-statutory inspection activity and review programme. This direction was rescinded on 22 June.
24 June[8]	The Health Minister announced that the Department is taking forward a Rapid Learning Initiative[9] into the transmission of COVID-19 into and within Care Homes to identify learning to date in advance of a predicted second surge of the virus.
30 June[10]	The Health Minister announced revised guidance that recognises the right of people to visit their loved ones in hospitals and care homes, while balancing the ongoing risk from COVID-19. Specifically, In COVID-19 free care homes one person is permitted access to visit at any one time and if necessary a second person if required will be accommodated where possible, as long as this can be carried out safely and under the usual social distancing requirements. All visitors are required to wear a face covering.
28 July[11]	The Health Minister announced a rolling programme of COVID-19 testing in NI's care homes from 3 August. This will involve regular testing for all residents (monthly) and staff (fortnightly) in homes which do not have a confirmed outbreak of the virus. Testing continues to be prioritised for care homes with an outbreak.

[4] https://www.health-ni.gov.uk/news/minister-underlines-extensive-programme-support-care-homes
[5] https://www.health-ni.gov.uk/news/minister-announces-ps117m-care-home-support-package
[6] https://www.health-ni.gov.uk/news/new-framework-planned-nursing-and-medical-input-care-homes
[7] https://www.health-ni.gov.uk/news/department-lifts-rqia-covid-19-restrictions
[8] https://www.health-ni.gov.uk/news/work-underway-learn-care-home-covid-19-experiences
[9] https://www.health-ni.gov.uk/rapid-learning-initiative
[10] https://www.health-ni.gov.uk/news/swann-announces-changes-visiting-guidance
[11] https://www.health-ni.gov.uk/news/rolling-testing-programme-care-homes

2. Discharge from hospitals to care homes

From 17 April 2020 a protocol requiring all patients to be tested 48 hours before discharge to care homes was brought into effect in NI. Prior to this date (between 1 March and 15 April), due to a limited number of available tests, Trusts tested only a proportion of patients. Specifically, the Northern Health and Social Care Trust tested about one in six, with the Southern and South Eastern Trusts testing about one in five[12].

Following receipt of a letter from the Permanent Secretary on 25 April (as reported in the media[13]), Trusts were required to continue to discharge 'COVID-positive' patients from hospitals to care homes, provided isolation was possible in the care home, with Trusts responsible for identifying alternative accommodation for those patients where isolation could not be provided.

An initial review of the literature reveals a range of good practice from other countries relating to this issue (a more in-depth analysis of discharge policies and practice is included at Annex A):

- Assessment of 'isolation facilities'- one study[14] into international examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings highlighted that such homes have not been designed to be isolation facilities and vary in their layout and facilities. Therefore, they require technical support in assessing the feasibility of effective isolation within their current buildings. If more isolation spaces are required than can be provided, contingency plans should be put in place, such as using adapted hotels or other accommodation. For example, (i) the Republic of Ireland worked with hotels to accommodate people being discharged from hospitals back to long-term care facilities in order to ensure that facilities were prepared and patients were found to be COVID-negative; and (ii) Homes in Israel have been required to establish COVID care units and in the Czech Republic, long-term care facilities have been required to reserve 10% of their capacity to accommodate suspected or infected cases[15].
- Step-down centres - many countries[16] have taken measures to limit direct hospital discharges to care homes, sometimes using "step-down" quarantine centres before people are admitted into a care home. There is increasing recognition of the danger of discharging people directly from hospital into care homes without ideally two negative tests within 24 hours (due to the risk of false negative tests), even in the case of people who were not originally hospitalized for COVID-19. Ideally, all new residents into care homes should be isolated and tested. Freezing of admissions - other countries[17] banned new admissions to care homes, for example, Austria, Germany (where exemption was only possible if the institution could ensure a two-week quarantine of the new resident - those discharged from hospitals were sent to rehabilitation-hospitals). Italy froze admissions where isolation was not possible or in the absence of a negative test. The government in Jordan successfully implemented a number of very specific measures to prevent/ minimise the spread of COVID-19 within its care centres. Most notably, no admissions to any residential facility from either hospital or the community was permitted from the onset of the pandemic.

[12] Belfast Telegraph, 4 August 2020, Jessica Black. 'Returning Covid-19 patients to care homes slammed'. https://www.belfasttelegraph.co.uk/news/health/coronavirus/returning-covid-19-patients-to-care-homes-slammed-39420855.html
[13] Irish News, 11 June 2020, Seanín Graham, 'Hospitals were told to admit Covid-19 cases to care homes'
[14] Comas-Herrera A, Ashcroft E and Lorenz-Dant K. (2020) International examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 11 May 2020.
[15] Curry N, Langins M (2020): what measures have been take to protect care homes during the Covid-19 crisis, 8 June 2020. https://analysis.covid19healthsystem.org/index.php/2020/06/08/what-measures-have-been-taken-to-protect-care-homes-during-the-covid-19-crisis/
[16] As 14 above.
[17] As 14 and 16 above.

Despite a population of 10,215,074[18], as of 26 July, there were only 1,146 COVID-19 cases in Jordan with 11 deaths recorded[19]. Significantly, there have been no cases of COVID-19 infection affecting either long-term care users or staff in any residential care facilities in Jordan[20].

- Minimum quarantine requirements - in Germany, the Robert Koch Institute (RKI)[21] recommends patients discharged from hospitals into a care home can only be released from isolation in the care home after at least 14 days following hospital discharge and if the patient has been free of COVID-19 related symptoms for at least 48 hours. Similarly, China[22] requires a 14-day quarantine before admission or return to care homes for all residents, care workers and other staff. Brazil's[23] approach recommends discharge from hospital to a care home only after testing positive for an immunity cure test, or 14 days after being hospitalised and having no other symptoms for 72 hours. In Hong Kong[24] in order to stop the spread from hospitals into nursing homes, any confirmed cases were quarantined for up to three months. In the words of Professor Terry Lum:

"Protecting the elderly from the virus is protecting the healthcare system, which protects everyone".

3. Testing in care homes

On 27 April, Health Minister Robin Swann announced that part of £6.5m in additional funding for NI's care homes[25] would be committed to the expansion of testing and the publication of updated guidance for care homes[26], aimed at strengthening infection prevention and control and protecting residents. He stated:

"Testing will now be carried out on all staff and all residents in care homes when a home is identified to the Health Protection team in PHA as having a potential outbreak or cluster of infections. The previous approach was to test staff and residents displaying symptoms."

By 13 May, a further increase to the testing programme for care home residents and staff was announced[27], including the use of mobile testing units being provided by the NI Ambulance Service and a deployment of 40 nurses from the HSC to support testing in care homes. Homes were also asked to check staff and residents twice a day for symptoms, including temperature, although it is recognised that presentation may be atypical in older people.

[18] Elaboration of data by United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2019 Revision. (Medium-fertility variant), 14 August 2020. https://www.worldometers.info/world-population/malta-population/

[19] https://petra.gov.jo/

[20] Black J (2020) Jordan*: Managing COVID-19 and protecting care homes* available at LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 26 July 2020.

[21] Lorenz-Dant, K. (2020) Germany and the COVID-19 long-term care situation. Country report in LTCcovid.org, International Long Term Care Policy Network, CPEC-LSE, 23 April 2020.

[22] Shi C, Hu B, Feng M and Wong G (2020) Report from Mainland China: Policies to Support LongTerm Care During the COVID-19 Outbreak. Country report in LTCcovid.org, International LongTerm Care Policy Network, CPEC-LSE, 18th April 2020.

[23] Da Mata F and Oliveira D (2020) COVID-19 and Long-Term Care in Brazil: Impact, Measures and Lessons Learned. Country report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 6 May 2020.

[24] Wong K, Lum T, Wong G (2020) Report from Hong Kong: Long-Term Care Responses to COVID19 by Increased Use of Information and Communication Technology. LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE

[25] https://www.health-ni.gov.uk/news/minister-announces-support-measures-care-homes

[26] https://www.health-ni.gov.uk/sites/default/files/publications/health/COVID-19%20%20GUIDANCE%20FOR%20NURSING%20AND%20RESIDENTIAL%20CARE%20HOMES%20IN%20NORTHERN%20IRELAND%20%28JULY%202020%29.pdf

[27] https://www.health-ni.gov.uk/news/minister-underlines-extensive-programme-support-care-homes

On July 28, more than five months after the first positive test for COVID-19 in NI, a rolling test programme started in care homes with staff being tested fortnightly and residents, monthly.

An initial literature review of lessons learned and guidance relating to this issue highlighted:

- New surveillance study, England[28] - this will offer 100 care homes repeat COVID-19 testing. The study aims to offer a detailed picture of the COVID-19 infection rate in care homes, with approximately 10,000 people across 100 facilities receiving repeat testing to help understand more about how the novel coronavirus spreads in these settings and enable quick responses to control the infection if outbreaks occur.

  The study intends to provide insights into the rate of infection in care home staff and residents, and add to existing knowledge about the risk factors regarding how the virus affects individuals differently.

  The study will also investigate the proportion of infected patients who have an antibody response to the virus (blood antibody testing began on 11 June). Results from the study will help to inform government strategy regarding the ongoing response to managing the pandemic, including lockdown and social distancing measures. Professor Martin Green OBE, Chief Executive, Care England:

  "The government's study will help us understand the way in which this virus operates thus enabling us to be better prepared today, tomorrow and in the future."

- Syndromic surveillance - according to the European Centre for Disease Prevention and Control[29] the key to preventing and controlling outbreaks of COVID-19 is systematic monitoring of all residents and staff at a Long-term Care Facilities (LTCFs). It states that residents should be monitored for symptoms by measuring temperature, oxygen saturation, and respiratory rate at least once a day, or once every shift to identify cases as early as possible and initiate testing. The Centre suggests this 'syndromic surveillance' should be recorded daily on patient records noting: whether a resident has received a COVID-19 test; has been isolated due to COVID-compatible symptoms; and/ or required any other non-standard infection prevention and control (IPC) measures. Responsibility for this active monitoring must sit with an appointed, named staff member.

- Testing programmes[30] - these have been expanded in care homes as the pandemic has spread. The initial focused approach of only testing those patients with symptoms (or, in the case of France only those with symptoms and underlying conditions) has now evolved through the knowledge that COVID-19 can be spread while a person is asymptomatic.

  - Denmark[31] began testing all care home residents, regardless of symptoms from 27 April, whilst Spain and Switzerland require post-mortem testing whether COVID-19 is suspected or not. In addition to patients the testing of staff has evolved. For example, the Czech Republic[32] and Denmark[33] have stressed the need for repeat testing for asymptomatic staff, or those with a negative test, being retested at regular intervals (7 – 14 days).

[28] https://www.healtheuropa.eu/uk-study-will-involve-repeat-covid-19-testing-in-uk-care-homes/100979/. 26 June 2020.
[29] European Centre for Disease Prevention and Control. Surveillance of COVID-19 in long-term care facilities in the EU/EEA, 19 May 2020. Stockholm: ECDC; 2020.
[30] Curry N, Langins M (2020): what measures have been take to protect care homes during the Covid-19 crisis, 8 June 2020. **https://analysis.covid19healthsystem.org/index.php/2020/06/08/what-measures-have-been-taken-to-protect-care-homes-during-the-covid-19-crisis/**
[31] https://www.covid19healthsystem.org/countries/denmark/livinghit.aspx?Section=1.5%20Testing&Type=Section
[32] https://www.covid19healthsystem.org/countries/czechrepublic/livinghit.aspx?Section=1.5%20Testing&Type=Section
[33] As 31 above.

- In the Republic of Ireland[34] the National Public Health Emergency Team requires that all staff have their temperature measured twice a day.
- In China[35], staff and residents in care homes are required to have their health status checked every day, and sent to the hospital if symptoms noted whilst in Germany, RKI recommends at least daily documentation of clinical symptoms among residents and staff including fever, coughing, shortness of breath, sore throats and sniffing.
- In Malta[36] swabbing and contact tracing within the 3 testing hubs on the Island were key towards controlling the pandemic and swabbing of health care professionals was mandatory prior to assuming duties within the residential care facilities.

- Staff measure to reduce risk of infection - many countries have introduced measures[37] to reduce the risk of staff bringing in infections include ensuring that staff only work in one home (ideally also one section of the care home), ensuring that staff have sick pay so they do not feel compelled to work while unwell, offering alternative accommodation to staff (particularly important where staff live in high-density accommodation). In some cases, staff have moved into the care home, typically voluntarily.
  - Canada restricted healthcare workers to employment at a single home and restricted movement between hospitals and care homes.
  - Republic of Ireland recommended that staff should be discouraged from working in different homes with consideration also being given to providing separate accommodation for some nursing home staff.
  - Israel prohibited staff members from working in more than one institution. Furthermore, staff work in two 12-hour shifts; each staff member works at the same department, treating the same patients; employee teams do not meet but communicate by phone; residents are separated to groups of up to 10.
  - In Jordan[38] staff at care centres worked in three distinct teams with each team spending a full week working and living in the centre. The three teams then alternated week about with each also then having two weeks off from work.
- Strict infection control measures - despite sharing a border with China, Hong Kong has recorded zero deaths in care homes from COVID-19 by employing strict infection control measures. As reported in the media[39] Professor Terry Lum, the head of social care policy at Hong Kong University, told the UK parliament's health and social care select committee that Hong Kong treated the outbreak like Severe Acute Respiratory Syndrome (SARS), the viral disease that caused an epidemic in Asia in 2003, which saved lives. Professor Lum stated:

> *"Most important is stopping the transmission from hospital to nursing home. We do a very good job on isolation. Once we have any person infected we isolate them in hospital for three months and at the same time we isolate all the close contact people in a separate quarantine centre for 14 days for observation. They do tests regularly in that 14 days to make sure they don't have the virus. We use a supercomputer to trace the close contacts of people being infected particularly for cluster outbreaks."*

[34] Comas-Herrera A, Ashcroft E and Lorenz-Dant K. (2020) International examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 11 May 2020.
[35] As 34 above.
[36] Elaboration of data by United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2019 Revision. (Medium-fertility variant), 13 August 2020. https://www.worldometers.info/world-population/malta-population/
[37] As 34 above.
[38] Scarpetta S, Colombo F, De Bienassis K and Llena-Nozal A (2020) Workforce and Safety in Long-Term Care during the COVID-19 pandemic. Oecd.org/coronavirus. 22 June 2020.
[39] The Guardian, 19 May 2020, Robert Booth, MPs hear why Hong Kong had no Covid-19 care home deaths. https://www.theguardian.com/world/2020/may/19/mps-hear-why-hong-kong-had-no-covid-19-care-home-deaths

Importantly, he added that all nursing homes had a trained infection controller who underwent emergency drills, simulating an infection outbreak, four times a year the result being that infection control becomes “a well-worn practice”.

4. Funding and increased costs for care homes

On 27 April[40] the NI Health Minister announced a £6.5 million package of support for care homes to help with additional staff and cleaning costs.

More recently (2 June)[41], the Minister announced, a further £11.7 million package, which included funding for sick pay for staff. The Minister stated this would enable homes to pay staff 80% of their salary when on sick leave for COVID-19 related reasons. It was also to provide support with cleaning costs and the provision of specialist equipment.

A significant issues remains, however, in that homes will, for the foreseeable future, require much higher than normal volumes of PPE and costs have reportedly spiralled by thousands of per cent[42].

An initial literature review of lessons learned from other countries relating to this issue highlighted:

- Increased financial support - in recognition that care homes are facing increased costs (e.g. from extra PPE, staff sickness, and a reduction in new residents), financial support has been given in some countries[43].
    - In the Republic of Ireland, a temporary COVID-19 Financial Support Scheme was introduced by the government to support care homes. The scheme is aimed at providing immediate temporary assistance payment to support private and voluntary nursing homes to take measures to further mitigate against a COVID-19 outbreak (an analysis of private versus public care home settings is provided at Annex B). Funding is based on the number of Nursing Home Support Scheme residents. When a nursing home has incurred significant further costs or undertaken necessary enhanced actions arising directly from COVID-19 outbreak, a nursing home can submit a separate business case for enhanced funding.
    - In England and Sweden[44], money was given to local authorities to allocate at their discretion. In England, that has led to concerns that the homes, and other care providers, have received no direct financial support. Germany has sought to compensate providers for low occupancy in some facilities but extra costs of PPE and so on are largely covered by long-term care insurance.
    - Several OECD countries[45] have increased funding for long-term care (LTC) to face the increased costs caused by the pandemic response. For example, Germany has issued financial support for LTC to increase minimum wages in the sector, promote bonuses for workers and facilitate the distribution of personal protective equipment.

[40] https://www.health-ni.gov.uk/news/minister-announces-support-measures-care-homes
[41] https://www.health-ni.gov.uk/news/minister-announces-ps117m-care-home-support-package
[42] http://www.irishnews.com/news/northernirelandnews/2020/06/19/news/ppe-shortages-will-increase-dental-treatment-by-6-000-when-surgeries-reopen-1978964/
[43] Curry N, Langins M (2020): what measures have been take to protect care homes during the Covid-19 crisis, 8 June 2020. **https://analysis.covid19healthsystem.org/index.php/2020/06/08/what-measures-have-been-taken-to-protect-care-homes-during-the-covid-19-crisis/**
[44] https://www.covid19healthsystem.org/countries/sweden/livinghit.aspx?Section=4.1%20Health%20financing&Type=Section
[45] Scarpetta S, Colombo F, De Bienassis K and Llena-Nozal A (2020) Workforce and Safety in Long-Term Care during the COVID-19 pandemic. Oecd.org/coronavirus. 22 June 2020.

France has also announced support in the form of bonuses for workers and sharing additional costs for institutions.

- Based on the lessons learned from SARS and immediately after the COVID-19 outbreak in mainland China in late January, 74.5% of adults in Hong Kong used face masks to protect themselves. That number rapidly increased to 97.5% by mid-February [46]. Masks and other protective equipment were also an essential part of the care homes' defensive strategy[47]. To cope with the additional resources needed in long-term care facilities during the COVID-19 outbreak, the Social Welfare Department in Hong Kong provided financial support for NGO service providers to procure sanitary and personal protective equipment and to hire additional temporary staff for extra cleaning and hygiene practice[48]. Although the city's mask supplies quickly began running low, most nursing homes kept one to three months' supply of protective equipment. In addition, various community charities donated thousands of masks to care homes which ensured they did not run out before the government began distributing 2 million masks to care homes a month from April onwards.

- Centralised procurement of PPE - almost all countries have experienced shortages in PPE for their long-term care facilities, or difficulties in procurement (e.g. Belgium, Finland, Germany, Republic of Ireland, Malta, the United Kingdom)[49]. Several countries have reported managing this challenge by centralising procurement of PPE for regions (e.g. the Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Malta). In Malta[50] the procurement of PPE, medical equipment and all the requirements related to the pandemic response took place through a single centre to ensure adequate planning for critical resources and accountability of utilisation. Others (Estonia, Italy) have emphasized the need to streamline procurement for all private and public long-term care facilities with the procurement for health services.

5. Rapid Learning Initiative

The Department of Health (DoH) is taking forward a Rapid Learning Initiative[51] into the transmission of COVID-19 into and within Care Homes to identify learning to date in advance of a predicted second surge of the virus.

The Rapid Learning Initiative is being taken forward by a Task and Finish Group[52] which is chaired by the Deputy Chief Nursing Officer (reporting to the Chief Nursing Officer) and includes representation from the independent care home sector, the Health and Social Care system and the Royal College of Nursing.

Four Subgroups have been established to consider the following in care homes:

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[46] Cowling et al., 2020 Cowling, B. J. , Ali, S. T. , Ng, T. W. Y. , Tsang, T. K. , Li, J. C. M. , Fong, M. W. , Liao, Q. , Kwan, M. Y. , Lee, S. L. , Chiu, S. S. , Wu, J. T. , Wu, P. , & Leung, G. M. (2020, April 17). Impact assessment of non-pharmaceutical interventions against Coronavirus disease 2019 and influenza in Hong Kong: An observational study. *The Lancet Public Health*, 5(5), e279–e288. https://doi.org/10.1016/S2468-2667(20)30090-6 [Crossref], [PubMed], [Web of Science ®], [Google Scholar].

[47] The Independent, 27 May 2020, Laurel Chor, 'How Hong Kong avoided a single coronavirus death in care homes'. https://www.independent.co.uk/news/world/asia/hong-kong-coronavirus-care-home-death-toll-china-wuhan-covid-19-a9532506.html

[48] Wong et al., 2020 Wong, K. , Lum, T. , & Wong, G. (2020, April 27). *The COVID-19 long-term care situation in Hong Kong: Impact and measures*. International Long-Term Care Policy. https://ltccovid.org/wp-content/uploads/2020/04/Hong-Kong-COVID-19-Long-term-Care-situation-27-April-2020-1.pdf [Google Scholar].

[49] Curry N, Langins M (2020): what measures have been take to protect care homes during the Covid-19 crisis, 8 June 2020. **https://analysis.covid19healthsystem.org/index.php/2020/06/08/what-measures-have-been-taken-to-protect-care-homes-during-the-covid-19-crisis/**

[50] Fenech MA, Vella M and Calleja N (2020) *The COVID-19 Long-Term Care situation in Malta and Gozo*. LTCcovid, International Long-Term Care Policy Network, CPEC-LSE, 6 June 2020.

[51] https://www.health-ni.gov.uk/rapid-learning-initiative

[52] https://www.health-ni.gov.uk/sites/default/files/publications/health/task-and-finish-tor.pdf

- The experience of residents, their families and staff in care homes;
- Symptom monitoring and intervention and care planning;
- Infection Prevention Control; and
- Physical distancing of residents.

Reports were due to be issued to the Chief Nursing Officer by 17 July. RaISe has contacted the Department for an updated position on each and is awaiting a response.

Internationally[53], a number of countries have encountered problems in coordinating an effective response to COVID-19 for care homes and have created National Taskforces to bring together different government departments and levels and representatives from relevant bodies, including relevant expertise.

For example, in Austria a Coronavirus taskforce was established at the Ministry of Social Affairs, Health, Care and Consumer Protection, including Ministerial staff and a wide range of consultants from various health professions and representing relevant stakeholders, but no representative for long-term care with the exception of a representative of the Red Cross. Notably, crisis groups were also established by the regional governments that are actually responsible for LTC. The interest and umbrella organisations of care homes have also provided guidelines.

The Israeli government have appointed a similar national-level team - the "Mothers and Fathers Shield", to manage the COVID-19 outbreaks in the LTCFs.

6. Staffing levels

Staffing shortages were raised with the Committee (and acknowledged by the Department[54]) as early as 19 March as stated by the chief Social Worker:

"Care homes and domiciliary care providers are likely to face challenging staff shortages which we will work with them to address. Ongoing family support will be crucial as we coordinate staff resources and look to deploy volunteers, where it is safe and effective to do so."

Staff were redeployed from Trusts into care homes during the peak of the pandemic. And on 17 June[55], the Minister announced plans for a new framework for nursing, medical and multidisciplinary in-reach into care homes being led by the Chief Nursing Officer.

An initial review of lessons learned from other countries relating to this issue highlighted:

- Increase supply of staff - while some countries reported providing additional training for staff (e.g. Belgium and France), the focus of most workforce strategies was to increase the supply of staff (Belgium, Canada, Germany, Republic of Ireland, Israel, Switzerland)[56]. Iceland[57] took special measures to quarantine all long-term care staff in affected facilities and bring in replacement staff from other areas of the country. Several

[53] Comas-Herrera A, Ashcroft E and Lorenz-Dant K. (2020) International examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 11 May 2020.

[54] Social care will play vital role during severe Covid-19 challenges, Sean Holland, 18 March

[55] https://www.health-ni.gov.uk/news/new-framework-planned-nursing-and-medical-input-care-homes

[56] Curry N, Langins M (2020): what measures have been take to protect care homes during the Covid-19 crisis, 8 June 2020. **https://analysis.covid19healthsystem.org/index.php/2020/06/08/what-measures-have-been-taken-to-protect-care-homes-during-the-covid-19-crisis/**

[57] https://www.covid19healthsystem.org/countries/iceland/livinghit.aspx?Section=3.3%20Maintaining%20essential%20services&Type=Section

countries (e.g. Austria, Germany, Iceland, Switzerland) have deployed armed forces to provide anything from care to delivering meals to testing or procuring equipment.

- Increased recruitment and retention - in the face of pre-existing and widespread staff shortages, some countries have made efforts to boost staffing levels through recruitment and retention. England launched a recruitment campaign to attract newcomers and return former staff to the sector; France has brought in auxiliary staff and volunteers; Israel is deploying student nurses and unemployed doctors in homes; Norway banned health and care staff from leaving the country; and Germany has offered staff a bonus.
- Training and guidance - there are key specific characteristics of COVID-19 (such as asymptomatic transmission) that mean that guidance documents and training on infection control that had been developed for influenza or norovirus are not suitable[58]. It is very important that guidance is reviewed and updated regularly to incorporate emerging evidence on COVID-19 and that staff are trained accordingly. For example, in Israel the national project team issued a presentation with directives regarding the training of the LTC institution staff. The training includes: expanded rules of conduct for each sector of workers entering the institution during their stay and departure; outbreak prevention such as the use of antiseptics and PPE and identifying disease symptoms.
- Continuity of care - as outbreaks among care home residents will also result in a relatively high proportion of staff becoming ill or needing to self-isolate, there is a risk that some homes may be too short-staffed. Rapid response teams can be deployed to support care homes in that situation to ensure guarantee continuity of care. In Australia the government has employed a healthcare delivery provider to provide rapid response teams to residential care, deploying to facilities with COVID cases. In Israel a Ministry of Health 'Arrow team' is ready to replace the staff of affected LTCF for 7 to 14 days.
- Regulations - some countries opted to recruit additional staff/ loosen staff regulations. For example:
  - Australia recruited recent graduates and health students and allowed the number of working hours a week by international students to be temporarily lifted to 40 hours a week to fill shortages in residential care.
  - Austria allowed individuals with limited or no qualifications to provide basic care and suspended the mandatory registration of nurses, in addition to increasing workforce capacity from retired care professionals and those with formal training but working in another sector.
  - The UK government aimed to attract 20,000 people into social care through a national recruitment campaign and target returners and new starters. Previously registered social workers were temporarily re-registered and they can work (opt-out basis) if their name is on the list. Occupational therapists could temporarily re-register and nurses were deployed to support social care. People received online training and access to job opportunities through an online platform and key parts of the Care Certificate were available free of charge. The government enabled furloughed workers from other sectors to undertake paid employment in social care.
  - Germany allowed care homes to deviate from rules and operational frameworks around staffing levels.
  - The Dutch Youth and Health Care Inspectorate allowed nursing home managers to recruit personnel beyond their traditional pool of employees, allowing them to hire personnel such as medical students.

[58] Comas-Herrera A, Ashcroft E and Lorenz-Dant K. (2020) International examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 11 May 2020.

- The Spanish governments have new legal powers to recruit additional staff by temporarily suspending the accreditation requirements.

7. Staff pay and conditions

On 13 May[59], the Minister announced new measures to protect care home residents. One of the three commitments was on investment and reform in social care with additional support for staff an immediate priority. He stated:

"I am therefore proposing to move ahead with reform and investment plans, subject to the necessary financial support being provided by the Executive. As an early priority, I want to see training and terms and conditions for care home staff being standardised and improved…that means a decent wage, access to some form of sick pay, a career pathway and training to do the job safely and well."

The funding announcement on Press statement of 2 June[60] did provide for sick pay in current circumstances, though it is not clear when/ if this will be mainstreamed into terms and conditions.

An initial review of lessons learned from other countries relating to this issue highlighted:

- Investment in workforce and infrastructure - the OECD[61] recognised that, looking forward, more investment in LTC workforce and infrastructure are required. Better jobs will mean better quality of care, reductions in the high staff turnover and improved care delivery. Increasing entry wages and offering opportunities for career progression helps motivation to stay in the sector.
  - France, for example, has announced a bonus for care workers during the COVID-19 crisis. Beyond wages, Norway and the Netherlands are promoting a healthier work environment through better prevention of workplace accidents and illness, which in turn can reduce absenteeism and turnover.
  - Safety standards should also be developed, properly measured and enforced to ensure that minimum standards are met, such as staff ratios and qualifications, infrastructure, and better living environments. For example, Denmark, Finland, Norway, Portugal, and Sweden, for instance, have national indicators to monitor quality and safety of LTC residents.
- Increased wages and bonus payments - many countries have increased pay and provided additional benefits to care staff, in recognition of the additional stress, workload and risk they are facing during COVID-19[62].
  - In England £1.6 billion was provided to local authorities to be used to backfill shifts, while also aiming to maintain the income for those that cannot work due to public health advice or distancing measures.
  - The German government has announced an increase in care workers' wages. Some regions (Bavaria and Schleswig-Holstein) announced one-off bonus payments for staff working during the COVID-19 pandemic.
- Other benefits - in some countries staff have been offered free accommodation and priority for shopping and other services. Where many members of staff are not able to work due to

[59] https://www.health-ni.gov.uk/news/minister-underlines-extensive-programme-support-care-homes
[60] https://www.health-ni.gov.uk/news/minister-announces-ps117m-care-home-support-package
[61] Scarpetta S, Colombo F, De Bienassis K and Llena-Nozal A (2020) Workforce and Safety in Long-Term Care during the COVID-19 pandemic. Oecd.org/coronavirus. 22 June 2020.
[62] Comas-Herrera A, Ashcroft E and Lorenz-Dant K. (2020) International examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 11 May 2020.

illness or need to self-isolate, additional staff may reduce the stress experienced by those who remain. A number of countries are providing psychological support for the trauma and grief experienced by many care home staff.

8. Visitors

Article 8 of the European Convention on Human Rights (ECHR) asserts that blanket visiting bans are contrary to the rights of both patients and their families and that failure to adopt an individualised approach to the safety of visits will breach the Article 8 rights of both the patients and their families[63].

Despite this, "COVID-19: Guidance for nursing and residential care homes in NI"[64] was issued to care homes on 17 March and an updated version issued on 26 April which detailed further information for the care home sector regarding visiting restrictions and included advice about visiting at end of life[65]. These were followed by "COVID-19: Regional Principles for Visiting in Care Settings in NI on 30 June"[66].

While there has been media coverage of initiatives to allow drive-by and outdoor visits, there is growing concern about the impact on residents of not seeing family and friends, in terms of physical and mental wellbeing.

The Department's additional funding allocation (2 June; £11.7m) makes reference to the purchase of tablets to allow video calls between residents and families.

An initial review of lessons learned from other countries relating to this issue highlighted:

- Banning visits - one of the key approaches to reducing the risk of community infection across the countries looked at was to ban visits to care homes, other than essential ones or those in exceptional circumstances (e.g. at the end of life)[67]. The timing of implementation varied between countries from early March through to early April.
- Structured and monitored contact - for some countries it became clear that physical distancing for people in long-term care facilities could be detrimental to their wellbeing and therefore guidance and rules have since been amended to allow some contact with families and friends:
  - In Australia visitors were limited to two people a day, to be held in private rooms. There were a number of exceptions including: no children under 16; no one who had travelled overseas within 14 days; no one who had been in contact with a confirmed case of COVID-19 in the last 14 days; and no one with fever or respiratory symptoms.
  - In Austria[68], single visitors can make appointments preferably to meet in an area outside the home and a mask (with mouth-nose protection) is obligatory.
  - In France[69], visits to relatives in nursing homes have been allowed again since 20th April, albeit under stringent conditions.

[63] https://www.echr.coe.int/Documents/Guide_Art_8_ENG.pdf
[64] https://www.health-ni.gov.uk/publications/covid-19-guidance-nursing-and-residential-care-homesnorthern-ireland
[65] https://www.health-ni.gov.uk/sites/default/files/publications/health/covid-visiting-guidance.pdf
[66] As 65 above.
[67] Curry N, Langins M (2020): what measures have been take to protect care homes during the Covid-19 crisis, 8 June 2020. **https://analysis.covid19healthsystem.org/index.php/2020/06/08/what-measures-have-been-taken-to-protect-care-homes-during-the-covid-19-crisis/**
[68] https://www.covid19healthsystem.org/countries/austria/livinghit.aspx?Section=3.3%20Maintaining%20essential%20services&Type=Section
[69] https://www.covid19healthsystem.org/countries/france/livinghit.aspx?Section=1.2%20Physical%20distancing&Type=Section

- In Germany and the Netherlands[70], care homes have created ways for residents to see and speak with relatives by using virus-proof containers, garden sheds, telephone boxes or other solutions.

- Virtual visits through the use of technology - there are many examples of the use of technology to facilitate virtual contact with families, although there is also evidence that not all care homes have access to the internet or the devices to facilitate this[71]. There have been many examples in the press of window visits and entertainment being delivered from the windows, and of innovative ideas for activities that are compatible with physical distancing. For example, in Hong Kong all face-to-face visits by outsiders including family members and volunteers were suspended. Instead, remote meetings via information technology channels (e.g., Zoom and Face Time) have been organised in some care homes to maintain residents' social connections virtually[72].

9. Regulation: RQIA role, inspections and risk factors for COVID-19

The Department directed[73] the Regulation and Quality Improvement Authority (RQIA) to cease its non-statutory inspection activity and review programme in order to reduce the risk of spreading the disease and to permit it to take on more of an advisory and support role. Feedback from the Independent Health and Care Providers (IHCP) indicated that providers had found the support and advice role helpful.[74]

Care homes were issued with guidance[75] that where a resident has been identified with symptoms of COVID-19, the care home management should then notify the Public Health Agency (PHA) duty room where a clinical risk assessment will be undertaken by the PHA duty officer with the care home manager (and if required, GPs). The PHA duty officer will advise the care home of what further appropriate action to take.

On 14 May[76], RQIA advised that they had continued to inspect where issues were raised with them or where, through their advice and support role, they became concerned with 22 on-site inspections and 13 remote assessments having taken place between April and May (as compared with 148 during the same period in 2019).

Importantly, RQIA also advised that while 90% of homes experiencing an outbreak had not been subject to enforcement action in the preceding three years, a number of shared characteristics were identified among homes where there was an outbreak of COVID-10. These include:

"Larger homes (40+ registered places); homes run by larger providers; homes located in urban areas; services with more than two manager changes over the past year; and services registered within past 10 years"

[70] As 67 above.

[71] Comas-Herrera A, Ashcroft E and Lorenz-Dant K. (2020) International examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 11 May 2020.

[72] Terry Lum, Cheng Shi, Gloria Wong & Kayla Wong (2020) COVID-19 and Long-Term Care Policy for Older People in Hong Kong, Journal of Aging & Social Policy, 32:4-5, 373-379, DOI: 10.1080/08959420.2020.1773192. 31 May 2020.

[73] http://data.niassembly.gov.uk/HansardXml/committee-22304.pdf

[74] http://aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?&AgendaId=22354&eveID=11873

[75] https://www.health-ni.gov.uk/sites/default/files/publications/health/COVID-19%20%20GUIDANCE%20FOR%20NURSING%20AND%20RESIDENTIAL%20CARE%20HOMES%20IN%20NORTHERN%20IRELAND%20%28JULY%202020%29.pdf

[76] As 73 above.

The Department announced on 22 June that it has now rescinded its request to the RQIA to suspend routine inspections.

An initial literature review of lessons learned and guidance relating to this issue highlighted:

- England, Scotland and Wales - in the week before the UK formally went into lockdown on 23 March, the official regulatory agencies for care and support services in England, Scotland and Wales each announced the suspension of routine inspections. With that suspension, each of the regulators dispensed with the core means by which they could examine what goes on in care homes. The legal function of inspection is to establish whether the provision of care meets basic standards of safety and quality, which are set out in law and cover matters such as sufficient staff numbers, safe care practices, provision of adequate food and hydration. Without routine inspection, there has been no mechanism for systematic examination of the care being provided during the pandemic, nor the impact of COVID-19 in care settings.[77] Furthermore, with friends and family excluded from visiting relatives in care homes, the suspension of inspection has hidden care practices from view and made care homes invisible to scrutiny.
- Republic of Ireland - nursing homes are required to notify the Chief Inspector of Social Services in the Health Information and Quality Authority (HIQA) - the authority with responsibility for inspecting nursing homes of any outbreak of COVID-19 as a notifiable disease, and soon after the first case of COVID-19, HIQA reminded nursing homes of this requirement[78]. HIQA initially continued to carry out inspections in nursing homes but with changes to its inspection process[79]. This decision was later changed with all routine inspections of nursing homes cancelled until further notice on 12 March[80].
- South Korea - while containing the spread of COVID-19 at the population level quite successfully with low-level approaches, the South Korean government took more aggressive approaches to contain the spread in LTC institutions and social-welfare facilities when collective infections occurred in a few long-term care hospitals (LTCHs) and other care settings, including instituting nationwide monitoring and inspections of LTCHs in the two regions with high numbers of confirmed cases. Along with such strict measures, additional preventive and supportive measures for LTC institutions were also established, such as temporary reimbursement packages, masks for care workers supplied at a relatively low cost, provision of guidelines, etc. No massive infections in LTCHs or LTC facilities have been reported under the series of measures implemented.[81]

10. Day Centres and Respite Services

Day care centres and respite services closed in March in NI as the health service planned to deal with COVID-19. This created concerns about isolation and mental wellbeing for service users and pressure on families caring for relatives. In the words of Lesley-Anne Newton, the Director of ARC, a support organisation for care providers in the learning disability sector:

"Capacity gaps in services places a huge responsibility on families and the charitable sector to bridge the gap".

To prevent the spread of COVID-19 into long-term care facilities, Hong Kong's Social Welfare Department issued the first operation guideline[82] to NGO care providers as early as January 28, including that all day care centers for older people would suspend their services to reduce

[77] https://blogs.lse.ac.uk/politicsandpolicy/care-home-inspections-covid19/
[78] https://ltccovid.org/2020/04/03/a-short-preliminary-report-on-nursing-homes-and-covid-19-measures-introduced-in-ireland/
[79] https://www.hiqa.ie/hiqa-news-updates/regulatory-response-hiqa-and-chief-inspector-social-services-covid-19
[80] https://www.hiqa.ie/hiqa-news-updates/regulatory-response-hiqa-and-chief-inspector-social-services-covid-19-2
[81] Kim, H (2020) The impact of COVID-19 on long-term care in South Korea and measures to address it. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 27 April 2020.
[82] Terry Lum, Cheng Shi, Gloria Wong & Kayla Wong (2020) COVID-19 and Long-Term Care Policy for Older People in Hong Kong, Journal of Aging & Social Policy, 32:4-5, 373-379, DOI: 10.1080/08959420.2020.1773192. 31 May 2020

the risk of infection arising from the gathering of people, but unlike other countries, centers would remain open at limited capacity to serve those who do not have anyone at home to care for them during the day time.

As reported in the media[83] many day care centres for people with learning disabilities began reopening in mid-July at 10% capacity, with NI HSC Trusts putting plans in place for a phased return of services (although it is unlikely they will return to pre-pandemic levels before the autumn). For example, the Western Trust's reopening plans include increasing capacity to 50% by September, while the Belfast Trust is planning a phased reopening for the most vulnerable. According to a DoH spokesperson:

"The recovery process will be informed by workforce readiness, population need, public health guidance, risk assessment and impacts on other parts of the HSC system. The next stage will see all trusts develop detailed service-specific action plans, which will look at staffing levels, the ability of centres to implement social distancing and other issues such as infection rates."

The National Institute for Health Research (NIHR) recently published 'Helping adult day centres to unlock lockdown"[84] which states:

"The COVID-19, or Coronavirus, pandemic and the lockdown of society from March 2020 were unprecedented. Most day centres closed to regular users. There is strong evidence that attending a day centre brings quality of life and so, despite risks, enabling people to have the choice of going to a day centre is something worthwhile."

11. Discussion

As highlighted throughout this paper, there are a number of areas of good practice, which had they been adopted by DoH NI, could have made a real difference to the impact of COVID-19 on its care homes. Nevertheless, there are important lessons to learn, and actions that must be taken sooner rather than later, in the event of a second surge:

- Implement a regime of strict discharge policies including: appropriate facilities for isolation; contingencies where such facilities are unavailable; and minimum quarantine requirements (in terms of isolation period).
- Implement a surveillance study of repeat testing within care homes with immediate effect to inform the government's ongoing response to manage the pandemic.
- Prohibit/ restrict the movement of staff between care homes.
- Appoint trained infection controllers within care homes.
- Ensure adequate financial support is available to care homes to cover staff sickness/ shortages, PPE etc.
- Centralise and streamline the procurement of PPE for all care homes and health services.
- Ensure lessons from the Rapid Learning Initiative are adopted and implemented in the short-term.
- Invest in workforce and infrastructure by increasing staff recruitment, retention, training, guidance, pay, safety and psychological support.

[83] BBC News NI, Maria McCann, 17 July 2020, Coronavirus: Many day care centres reopening at 10% capacity https://www.bbc.co.uk/news/world-53436908

[84] https://www.kcl.ac.uk/scwru/res/arc-sl/info/part-1-helping-adult-day-centres-to-unlock-lockdown-july2020.pdf

- Continue to enhance technological facilities at care homes to support greater levels of virtual visiting.
- Implement and maintain a robust and ongoing inspection regime in every care home.

To reiterate the words words of Professor Terry Lum:

"Protecting the elderly from the virus is protecting the healthcare system, which protects everyone".

Annex A - Discharge Policies and Practice

This annex provides a more detailed look at discharge policy from hospitals to care homes, with a focus on the impact of domestic and international approaches to discharge including the potential benefits of step-down facilities.

Minimum Quarantine Requirements

Most countries are very prescriptive in relation to the minimum quarantine requirements for residents discharged from hospital back into the care home setting. The following case studies highlight the different approaches applied across, and even within countries.

Hong Kong

Despite sharing a border with China, Hong Kong has recorded zero deaths in care homes from COVID-19 by employing strict infection control measures. According to Professor Terry Lum, the head of social care policy at Hong Kong University:

> *"Most important is stopping the transmission from hospital to nursing home. We do a very good job on isolation. Once we have any person infected we isolate them in hospital for three months and at the same time we isolate all the close contact people in a separate quarantine centre for 14 days for observation. They do tests regularly in that 14 days to make sure they don't have the virus. We use a supercomputer to trace the close contacts of people being infected particularly for cluster outbreaks."*

Importantly, he added that all nursing homes had a trained infection controller who underwent emergency drills, simulating an infection outbreak, four times a year the result being that infection control becomes "a well-worn practice".

Germany

In Germany, the authority for hospital discharges to care homes lies with the 16 federal states and a number of different approaches have been adopted.

- In Lower Saxony, people requiring care in an institutional care setting following discharge from hospital are being sent to one of around 80 rehabilitation hospitals where they will be receiving short-term care[85].
- In North-Rhine Westphalia, hospitals must test patients at the point of discharge. The receiving care home must be informed in writing about possible signs of infection. These tests should be marked so that they can be prioritised. Receiving institutions are required to have prepared specific areas of the care home for isolation and quarantine. Patients discharged from hospital into care homes should be placed in isolation or quarantine for 14 days. The care staff looking after people in the designated isolation area will also have access to prioritised tests[86].
- In Berlin, regular testing of patients being discharged from hospitals into care or nursing homes is not mandatory, due to the limited capacity[87].

[85] Niedersächsisches Ministerium für Soziales Gesundheit und Gleichstellung. Entlastung für die Krankenhäuser: Reha-Kliniken in Niedersachsen bieten Kurzzeitpflege an [Internet]. 2020 [cited 2020 Apr 8]. Available from: https://www.ms.niedersachsen.de/startseite/service_kontakt/presseinformationen/entlastung-fur-die-krankenhauser-reha-kliniken-in-niedersachsen-bieten-kurzzeitpflege-an-187154.html

[86] Ministerium für Arbeit Gesundheit und Soziales des Landes Nordrhein-Westfalen. Coronavirus: Neue Rechtsverordnung regelt Neu- und Wiederaufnahme in Pflegeheimen [Internet]. Pressemitteilungen. 2020 [cited 2020 Apr 7]. Available from: https://www.mags.nrw/pressemitteilung/coronavirus-rechtsverordnung-regelt-neu-und-wiederaufnahme-vollstationaeren

[87] Senatsverwaltung für Gesundheit Plfege und Gleichstellung. Coronavirus (SARS-Covid-19): Antworten auf häufig gestellte Fragen [Internet]. 2020 [cited 2020 Apr 7]. Available from: https://www.berlin.de/sen/pflege/pflege-und-rehabilitation/coronavirus/faq/

Discharge criteria developed by the Robert Koch Institute

In addition to the regulations of individual states, the Robert Koch Institute (in co-ordination with the working group for infection protection of the highest federal health authorities) has developed criteria for the discharge from hospital following COVID-19 infection into different care settings, including into nursing home care.

Following this guidance:

- Patients discharged from hospital into residential care settings are required to spend at least 14 days in isolation.
- After this time, patients can only be released from isolation if they have not displayed any COVID-19 related symptoms for at least 48 hours.
- The decision to release a patient from isolation within the care or nursing home can only to be made following a medical consultation.
- Patients discharged from hospital are not required to enter a 14-day quarantine if they have not shown any COVID-19 related symptoms for at least 48 hours and had 2 negative polymerase chain reaction (PCR) tests[88].
- If care and nursing homes do not have the capacity to enable care in isolation this kind of care can be provided in rehabilitation hospitals[89].

Isolation Facilities

Where a care home has identified a positive case of COVID-19 or has a resident with suspected COVID-19, the general approach has been to try to isolate and quarantine the affected person. This also applies to residents recovering from COVID-19 who have been discharged from hospital. For example, in England, where a home is unable to implement effective quarantine or cohorting, it has been the local authority's responsibility to find suitable alternative accommodation and to move the affected person. Similarly, Ireland has also worked with hotels to accommodate people being discharged from hospitals back to long-term care facilities so as to ensure that facilities are prepared and patients are found to be COVID-negative.

There are growing numbers of examples of hotels and other accommodation that would otherwise be unused being adapted as quarantine centres to mitigate pressures on hospitals and care homes[90].

Spain

There are a growing number of hotels being used as discharge facilities in Spain. A recent report[91] suggests that 2,500 hotel places have been made available for this purpose in Barcelona. According to media reports:

[88] Robert Koch Institut. COVID-19: Kriterien zur Entlassung aus dem Krankenhaus bzw. aus der häuslichen Isolierung [Internet]. 2020 [cited 2020 Apr 7]. Available from: https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Entlassmanagement.html

[89] Robert Koch Institut. Prävention und Management von COVID-19 in Alten- und Pflegeeinrichtungen und Einrichtungen für Menschen mit Beeinträchtigungen Empfehlungen für Alten- und Pflegeeinrichtungen und Einrichtungen für Menschen mit Beeinträchtigungen sowie für den öffentlichen [Internet]. 2020. Available from: https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Alten_Pflegeeinrichtung_Empfehlung.pdf?__blob=publicationFile

[90] Comas-Herrera, A, 6 April 2020, 'Examples and guidance on use of hotels and other accommodation to reduce pressure on care homes and hospitals during COVID-19'

[91] As 90 above.

- The army and fire services have been deployed to prepare the hotels;
- Once ready, the running of the hotel is taken over by the local hospital for which the hotel becomes a satellite facility for discharge of patients who are still symptomatic;
- A multidisciplinary team from the hospital and sometimes with the local primary care centre provides care.
- Hotel staff are involved (following training);
- Examples of infection control measures:
  - Separate lifts for personnel and patients;
  - Staff delivering food to outside the door and patients being asked to count to 5 before opening the door; and
  - No visitors allowed but are able to deliver care packages.

Whilst the use of hotels was intended only in emergency situations, there are reports of 50 residents being moved in Andalucía and 160 in Catalonia.

United States

In the United States, the Centres for Disease Control and Prevention of the United States (CDC) have issued guidance for two types of sites[92]:

- **Isolation Sites**

  Temporary housing for people with COVID-19 who do not need medical attention but who cannot stay at home (for example due to having high risk family members). It could also apply to facilities for people who have been exposed to COVID-19 and do not have symptoms. This type of quarantine centre has already been in use since the beginning of the outbreak as isolation facilities for people who had travelled from areas with high levels of infection.

- **Alternative Care Sites**

  Provide medical care to convalescing cases of COVID-19 after hospital discharge and provide care for other medical conditions in this population. These type of facilities could also be used to house residents of care homes that are experiencing COVID-19 outbreaks.

Step-Down Facilities

There is increasing recognition of the danger of discharging people directly from hospital into care homes without ideally two negative tests within 24 hours (due to the risk of false negative tests), even in the case of people who were not originally hospitalised for COVID-19. Ideally, all new residents into care homes should be isolated and tested. As a result, many countries[93] have taken measures to limit direct hospital discharges to care homes, sometimes using "step-down" quarantine centres before people are admitted into a care home.

These facilities are intended for patients recovering from COVID-19 who no longer need to be in a critical care environment but cannot yet return home. They are more flexible than hospitals equipped to provide critical care, and they avoid some of the main challenges associated with

[92] Comas-Herrera, A, 6 April 2020, 'Examples and guidance on use of hotels and other accommodation to reduce pressure on care homes and hospitals during COVID-19'.
[93] As 92 above

ICU field hospitals (e.g., high-risk transfers, greater staff needs). Crucially, they help address discharge bottlenecks, freeing up space in existing hospitals.

Dragon's Heart Hospital in Cardiff, Wales

This temporary hospital located at the Millennium Stadium in Cardiff, was designed and made operational in under two weeks in March 2020[94]. It was the first COVID-19 hospital set up in Wales. It opened on the 13th April 2020 with 300 beds[95] and space to expand to up to 2,000,[96] which would make it the largest hospital in Wales, and the second largest in the United Kingdom.[97]

The primary focus was on patients coming to the end of their illness and those recovering to return home, allowing more capacity to become available within intensive care wards elsewhere for critical patients.[98]

NHS Nightingale Hospital North West in Manchester, England

This was the third of the temporary NHS Nightingale Hospitals set up by NHS England in 2020 to help to deal with the COVID-19 pandemic. The hospital was constructed inside the Manchester Central Convention Complex[99] and opened on 13 April 2020.[100]

As of 4 May, a small number of patients had been treated at the hospital. Despite patient numbers remaining far below capacity, the hospital was not placed on standby like other Nightingale temporary hospitals in England, instead serving as a step-down facility for rehabilitation rather than an intensive care unit for patients requiring mechanical ventilation.[101]

Whiteabbey Hospital in County Antrim, Northern Ireland

On 2 September 2020, Health Minister Robin Swann announced a plan for a second Nightingale facility in Northern Ireland as part of a surge plan setting out our preparations for the next peak of infections.

It will be a step down facility, located in Whiteabbey Hospital, Co Antrim, and will include 100 regional intermediate care beds, which will be operational by this winter in order to increase bed capacity, help aid the flow of patients from ICU and acute care and relieve wider pressures.

Social Isolation Units, Turkey

In Turkey, nursing home residents discharged from hospitals are not immediately admitted to nursing homes. Those who have family members, stay with their families in accordance

[94] https://www.walesonline.co.uk/sport/rugby/rugby-news/giant-tents-built-inside-principality-18081445
[95] https://www.wales247.co.uk/dragons-heart-hospital-opens-with-300-beds-as-pictures-of-first-wards-emerge/
[96] https://www.bbc.co.uk/sport/rugby-union/52024970
[97] https://www.bbc.co.uk/news/uk-wales-52228321
[98] As 97 above
[99] https://www.manchestereveningnews.co.uk/news/greater-manchester-news/gallery/huge-new-hospital-manchester-city-18083385
[100] https://twitter.com/MichaelMcCourt1/status/1249597933294583810
[101] https://www.manchestereveningnews.co.uk/news/greater-manchester-news/nightingale-north-west-isnt-being-18198193

with the social isolation guidelines. Residents who cannot go to their extended family homes are admitted to 'social isolation units'[102].

These are units established to support residential care during the pandemic. Depending on the infrastructure availability, either newly built nursing homes without residents or care and rehabilitation centres were transformed into social isolation units.

The social isolation facilities have their own staff whose spend their entire shifts at these facilities and are free of charge to all nursing home residents irrespective of their income.

Summary

There are a wide range of options available for dealing with the discharge of patients recovering from COVID-19 back into care homes:

- Isolate patients for a minimum of 14 days prior to discharge.
- On discharge from hospital into residential care settings require residents to spend at least 14 days in quarantine or isolation.
- After this time, patients can only be released from isolation if they have not displayed any COVID-19 related symptoms for at least 48 hours.
- Care homes are required to have prepared specific areas of the care home for isolation and quarantine.
- If care homes do not have the capacity to enable care in isolation, this kind of care can be provided in rehabilitation hospitals/ centres; hotels; alternative care sites; social isolation units; and step-down facilities.
- Using the above types of facilities, which are more flexible that hospitals equipped to provide critical care, helps address discharge bottlenecks, aids the flow of patients from ICU and frees up space in existing hospitals.
- Depending on the infrastructure availability, these facilities could be:
  - Newly built nursing homes without residents;
  - Converted/ adapted wings of existing hospital structures; or
  - Unused Nightingale hospitals.

[102] Akkan B and Canbazer C (2020) The Long-Term Care response to COVID-19 in Turkey. LTCcovid, International Long-Term Care Policy Network, CPEC-LSE, 10 June 2020.

Annex B – Public versus Private Care Homes

This annex provides both domestic and international evidence in respect of infection rates and death rates in public versus private care home settings.

Northern Ireland

As at 30 April 2020[103], there were 483 registered care homes in NI of which 435 (90%) are independently owned and operated and 48 (10%) are publicly owned and operated. The total number of registered beds is 16,095.

	Nursing Homes	Residential Homes	Total	%
Independent	243	192	435	**90%**
Statutory	5	43	48	**10%**
Total	248	235	483	100%

As at 7 October 2020 there have been 255 total acute respiratory outbreaks. Of these, 212 have been closed; 34 are confirmed and 9 are suspected.

There is no evidence available at this time to indicate whether infection/ death rates were more significant in either a public or private care setting in Northern Ireland.

Scotland

As reported in the press in Scotland[104], as of June 2020, nearly 70% of private care homes had suspected coronavirus cases, with only 38% in the voluntary and not for profit establishments. This has led to calls for public ownership of care homes being made, with a growing number of politicians believing a national care service, along the lines of the NHS, is overdue.

As stated by a member of the Scottish National Party:

"This pandemic has shone a light on serious concerns about some private care homes and while I would not want to tar all private providers with the same brush, profiteering at the expense of care cannot be tolerated."

A GMB trade union (which represents care workers) representative said of the figures:

"How could government ignore the fact that workers in the public sector had their jobs, pay and conditions secure from the outset but workers in the private sector did not? Ministers knew that private care workers would be left destitute on statutory sick pay if they fell ill or had to isolate."

Ireland

In Ireland, as is the case in most countries, there are a mix of nursing homes – some private or for profit, some voluntary and some Health Service Executive (HSE) run. Approximately four out of every five of Ireland's 500 nursing homes are privately run.

In April[105], the Taoiseach, Leo Varadkar, said all nursing homes were facing challenges responding to COVID-19, regardless of their ownership. He stated:

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[103] http://www.hscboard.hscni.net/coronavirus/covid-19-care-homes/#care-homes-faq-13

[104] Daily Record, 03 June 2020, Paul Hutcheon, 'Coronavirus infection rates higher in private care homes than not-for-profit facilities: https://www.dailyrecord.co.uk/news/politics/coronavirus-rates-higher-private-care-22126986

[105] Belfast Telegraph, 16 April 2020, Aine McMahon, 'Varadkar: No evidence of more Covid-19-related deaths in private nursing homes: https://www.belfasttelegraph.co.uk/news/republic-of-ireland/varadkar-no-evidence-of-more-covid-19-related-deaths-in-private-nursing-homes-39133831.html

"I have yet to see any evidence that indicates that the number of cases or proportion of cases in private nursing homes versus public is higher or vice versa or the number of deaths is higher in private homes compared to public ones."

Victoria, Australia

According to a press article[106] in Victoria, Australia, the Victorian Government runs 10 per cent of aged care beds, with the bulk of aged care provided by not-for-profits (including private companies, church organisations and Aboriginal health groups).

Given that the majority of residences are not state-owned/ run it is unsurprising that the overwhelming majority of infections have been in private and not-for-profit aged care homes, not public facilities.

Specifically:

- There are 800 aged care facilities in Victoria, comprising 56,000 beds;
- 622 (78%) of the facilities are privately run and not-for-profits (regulated by the Commonwealth) and 178 (22%) are run by the Victorian Government (which constitutes only 10% of all aged care beds);
- The vast majority of aged care facilities in metropolitan Melbourne are run by the private and non-profit sector, whereas most of the state's aged care homes are in regional areas (where the private providers will not go). This correlates with COVID-19 cases, where circa 95% are centred in the city;
- In Victoria, state-run facilities have mandated nurse-staffing ratios. In high-care residential aged care wards, there needs to be one nurse to seven residents and one nurse in charge for the morning shift, and one nurse to eight residents in the afternoons with one nurse in charge. On night shift, it's one nurse to every 15 residents;
- Privately run centres do not have to abide by the same ratios, but the chief executive of COTA Australia (a peak advocacy body for older Australians) warned that staffing levels did not always guarantee better quality of care;
- There are also fewer casual staff hired in government-run centres.

USA

Despite the coronavirus pandemic posing a serious threat to the US long-term care industry, research[107] supports the idea that some homes are doing better than others at protecting residents and staff from COVID-19. Specifically, according to the research, three factors are likely to play the biggest role in determining how well a nursing home responds to a disease outbreak:

- Whether it operates for profit;
- The degree of government regulation; and
- The quality of management.

Most of the 15,000 nursing homes that currently operate in the US are for-profit facilities backed by private investors, and a small share are operated by non-profits or government.

[106] https://www.abc.net.au/news/2020-08-01/why-more-covid-19-cases-in-private-aged-care-than-public-sector/12503212

[107] 'Why some nursing homes are better than others at protecting residents and staff from COVID-19', 10 June 2020; Amirkhanyan, A, McCrea A, Meier, Kenneth J.

The research suggests that for-profit homes, which are motivated to keep costs low and profits high, tend to be understaffed and, on average, provide lower-quality care compared with public and non-profit homes. In contrast, non-profit and public homes tend to put higher emphasis on patient-centred care and reinvest their profits into better physical spaces, equipment and responsiveness to clients' needs. The research backs this up showing that government inspection of for-profit homes found 9 violations in an average regulatory inspection cycle, compared with 6.4 at non-profit homes and 6.8 at government homes (these trends have largely remained constant during the past two decades). This is further supported by data examined on COVID-19 cases in nursing homes, which reflects more COVID-19 cases per capita in for-profit than non-profit or public homes.

Federal and state government regulation aimed at protecting residents is another critical factor that influences nursing homes' ability to combat infection. All nursing homes in America that accept Medicare or Medicaid must comply with federal regulations, while states are able to set their own rules for all facilities in addition to the federal minimums. A closer look at the variation among states offers strong evidence that more stringent regulation leads to better care quality.

One key problem is that many state regulations emphasize staffing levels, rather than staffing mix, which means there is little incentive for homes to hire more skilled and expensive personnel. While federal rules issued in 2016 would have strengthened staffing requirements, including one that required homes to have an infection specialist on staff, they have yet to take effect.

Canada

In Canada, the difference in cases at private compared to public long-term facilities is striking. According to a story in the Toronto Star,[108] for-profit nursing homes had four times as many COVID-19 deaths as city-run homes. Furthermore, residents of for-profit nursing homes in Ontario are far more likely to be infected and die than those who live in non-profit and municipally run homes.

Such statistics have some calling for an end to privately-owned long-term care facilities, including the federal New Democratic Party leader who wants to establish a universal framework for seniors' care[109].

"I think we need to end them, I think there's no question about it given the results we're seeing, the evidence we're seeing that some of the worst conditions that seniors are in and some of the highest deaths have happened in the for-profit long-term care homes. Profit should not be the motive when it comes to how we care for our seniors."

The following case study, however, highlights that the difference is not necessarily about private versus not-for-profit.

Case Study: Arnprior Regional Health (ARH), which includes the public-run Grove Nursing Home

According to the president and CEO of ARH: "the problem private facilities face is they do not have access to specialised resources."

Namely, these two professionals:

- Infection prevention control officer; and

[108] The Star, 'For-profit nursing homes have four times as many COVID-19 deaths as city-run homes', 08 May 2020, Chown Oved ,M, Kennedy B, Wallace K and Tubb E.

[109] https://www.insideottawavalley.com/news-story/9992157-the-two-reasons-covid-19-hit-private-care-homes-harder/

- Occupational health and safety officer.

Given that Arnprior and District Memorial Hospital fell under ARH, the CEO was able to send those two officers from the hospital to the nursing home early on in the pandemic and, in his opinion, that made all the difference.

"When this is all over and they do a look-back, I think it is safe to say that is one of the areas they are going to look at."

He predicts provincial governments will conclude that all facilities, public and private, will need to have access to those two officers and that there is room for a hybrid solution, that would see public professionals working part of their time at privately owned long-term care facilities.

A new study[110] looking at COVID-19 cases and deaths in long-term care homes in Canada has reinforced earlier analysis showing that for-profit homes were more likely to have wider and more deadly outbreaks than non-profit or municipal homes[111].

The researchers found that while the profit status of a home was not significantly tied to the likeliness of a COVID-19 outbreak occurring, for-profit homes were associated with a much higher rate of cases and deaths compared to non-profit homes when an outbreak occurred, with twice the number of cases (a 196% increase) and almost twice the number of deaths (a 178% increase).

According to the media, for-profit homes account for less than 60 per cent of long-term care homes in Ontario, but account for 16 of the 20 worst outbreaks.

Importantly, the study isolated certain factors that made some homes more likely to have higher rates of cases and deaths when an outbreak occurred:

- Broadly speaking, for-profit homes with older design standards dating to the 1970s and chain ownership had much higher rates of disease and death. Twelve of the 15 homes with the most extensive outbreaks were for-profit homes that fell into this category, as were seven of the 10 homes with the most deaths.
- Buildings constructed based on Ontario's standards set out in 1972 tend to have smaller rooms housing up to four residents, more shared washrooms and centralised and crowded common spaces, which could result in increased spreading of COVID-19.

However, there are other factors related to for-profit status that likely increased these homes' chances of being hit with more cases and deaths. According to a sociology professor at York University who has been researching long-term care in Canada for more than 20 years, staffing is the single biggest issue leading to bigger outbreaks in for-profit homes. Armstrong said though advocates call for at least 4.1 hours of direct nursing care per resident daily, in Ontario for-profit homes it's usually less than three, compared to around 3.5 for municipal homes.

A spokesperson for the Ontario Long-Term Care Association said according to their organization's analysis, a number of factors including beds per room, geographic location and the "staffing situation" contributed to the extent of an outbreak within any given long-term care home.

"In particular, data points to the age of buildings and the number of beds per room as major factors ... Nearly half of Ontario's long-term care homes are older, and infection control, cohorting, and isolation are more challenging in these sites."

[110] CMAJ 2020. doi: 10.1503/cmaj.201197; early-released July 22, 2020
[111] The Star, 23 July 2020, 'For-profit nursing homes have four times as many COVID-19 deaths as city-run homes', Saba, R.

Summary

On the whole, domestic and international evidence would suggest that independent/ for-profit care homes are susceptible to higher infection rates and deaths than their statutory/ government-funded counterparts. However, there are a number of factors which influence this:

- Statistically, the majority of care homes in most countries are owned and run by the independent/ for-profit sector, therefore it is unsurprising that the overwhelming majority of infections have been in this sector, not public facilities.
- Generally, the majority of care facilities in metropolitan areas are run by the independent/ for-profit sector, whereas most government facilities are in regional areas (where the private providers will not go). This correlates with COVID-19 cases, where the majority are centred in cities.
- Government run facilities often have mandated nurse-staffing ratios, whereas privately run centres do not have to abide by the same ratios. Furthermore, even where independent facilities must adhere to government/ federal/ state regulations, these tend to focus on staffing levels rather than staffing mix, providing little incentive for homes to hire more skilled and expensive personnel.
- Private facilities do not have access to specialised resources, such as an infection prevention control officer and an occupational health and safety officer, as is the case with their statutory counterparts.

All of the above evidence has led to calls for public ownership of care homes being made in the UK, with a growing number of politicians believing a national care service, along the lines of the NHS, is overdue.