19 October 2020

Mr Colm Gildernew MLA
Chairperson, Committee for Health
Room 410
Parliament Buildings
Stormont
Belfast, BT4 3XX

Dear Mr Gildernew

RE: COVID-19 and Care Homes

Thank you for inviting me to contribute to the inquiry into the impact of COVID-19 on care homes. I wish to share my recommendations with the committee from the perspective of being the CEO of the NI Hospice, a registered nurse with 25 years' experience, of which over 20 of these have been working in palliative care. I also started my career as a staff nurse in a care home, so have some understanding of this sector.

As I share my response with you, I am mindful of colleagues working across the entire mixed health economy including my own organisation, who are already impacted by the second surge of COVID-19 both in their professional and personal lives. Recognition of all staff who have served keeps morale strong and sends a clear message how the system values each sector and the role they play in the fight against COVID-19.

During the first surge, my organisation like many care homes treated and supported local people who tested positive and who sadly deteriorated and died. Many of these people had underlying life limiting conditions and multi comorbidities resulting in them being high risk of mortality. The need to ensure robust infection prevention and management strategies became paramount at a local level, however, so too was the importance of applying the principles of palliative care to citizens living in care homes.

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I trust this response gives the Health Committee some helpful recommendations of practice which have served the Hospice care services well. I would also like to commend the NI Hospice team for their diligence and dedication in the service of others.

Yours sincerely

Heather Weir
Chief Executive Officer

Northern Ireland Hospice response
Inquiry into the impact of COVID-19 on care homes

As requested, I have outlined my response to cover the steps we took at the NI Hospice which have served us well with regards to :-

1. Minimising infections in care settings.
2. Caring for those infected in care settings.
3. Prioritising care and wellbeing of all residents.
4. Supporting the wellbeing of staff.

1. Minimising infections in care settings

1.1. NI Hospice similar to care homes strive to have homely environments, there is however a fine balance between needing to demonstrate safe sterile environments in which clinical care can be delivered to high hygiene standards, whilst also creating person centred space which reflects the residents preferences.

1.2. All care homes are expected under the RQIA minimum standards to have systems and processes in place to ensure the highest standards of hygiene, including the hygiene considerations of staff who deliver care including support staff. At the NI Hospice we refer to Gov.uk IPC guidance publications that are endorsed by PHA, the Regional Infection Prevention and Control Manual and audits aligned to the Belfast and Northern HSC Trusts. In addition to these standards, during the pandemic, we have intensified our internal auditing of infection prevention practise to twice weekly, sharing results immediately with staff so practice can be improved as necessary.

1.3. Other measures we have taken to protect our 'bubble' which may be helpful to adopt in care homes, include increasing the hours of our housekeeping team to increase the cleaning schedules in all areas including staff communal areas, multi occupancy offices and staff changing facilities. We have also replaced the traditional Hospice uniform with all staff now wearing scrubs, which are laundered in house so we can be sure they are washed at the correct temperature. All our front-line staff are also expected to shower on the premises prior to leaving the building. We provide towels and uniforms. Staff are expected to sanitise their own footwear, pens, access control swipes and we have provided alcohol wipes for staff to clean their workstations, door handles, telephones etc. We have reviewed how staff engage with each other and have reallocated office and clinical spaces to minimise physical contact. Daily handovers are conducted using socially distanced principles' and staff wear face

masks. To date these measures have protected our patients, staff, volunteers and the public.

1.4. Fundamental to internal infection control measures is how homes and staff support visitors to maintain the hygiene standards required. Communication both verbally, formally and digitally, with patients and family's needs to be continuous with staff supporting visitors to adhere to wearing the necessary PPE, as well as hand hygiene. At Hospice we have considered how to limit visiting yet show compassion for patients approaching the end of life. We have recently worked with the Department of Health Deputy CNO to influence the regional guidance, suggesting that patients and families determine and agree which two people should be allowed to visit for 1 hour maximum, with one at a time. We have explained to families that when clinical staff are working with patients, we respectfully ask them to leave. We have also been fortunate that our environment of care allows external access to each patient room, thereby allowing us to protect the internal clinical areas to our care staff.

1.5. Regarding proactive infection surveillance, on a daily basis we initiated daily temperature checks with all patients. This was helpful in proactively monitoring our patient population for symptoms of COVID-19 and resulted in infection prevention precautions being introduced much quicker in terms of barrier nursing whilst we waited for other pathology results to be reported on.

1.6. In terms of screening for COVID-19 in those being admitted and discharged, we asked the referring unit to undertake COVID testing prior to admission. As this was not always completed, we took the decision to swab all patients on admission to the Hospice and prior to discharge to nursing homes or transfer to another care setting, ensuring infection control procedures were in place whilst we awaited the results.

2. Caring for those infected in care homes.

As previously stated, we cared for COVID-19 positive patients in the Hospice during the first surge. This was extremely challenging for patients, families and staff.

Key changes we introduced to protect the patients, visitors and staff included:-

2.1. **Creating a secure cohort of 4 beds for COVID +ve patients**. We did this by installing a seal in our corridor, securing an area called the 'Red Zone'. Staff working in this zone, worked 12 hr shifts, with regular breaks being taken within the zone. Staff also adhered to the same PPE and infection protection guidance as that of the acute sector.

2.2. **Strict clinical procedures for Aerosol Generating Procedures (AGPs)**. This was the highest risk for our staff. We followed the clinical guidance from the Belfast Trust,

with who we have excellent clinical partnerships. Staff worked in pairs to assist with 'doning and doffing' PPE, following standards for clinical waste management.

2.3. **Continuous communication and shared decision making with patients and families.** This approach is a fundamental principle of delivering palliative care and essential in supporting patients to make informed choices around DNACPR and who they want with them in their last hours of life. Due to the guidance requiring visitors to self-isolate after being with their COVID positive relative, one of the most difficult conversations our team had to have with families was the consequence of visiting versus attending their loved ones funeral. Essentially families had to choose what was more important to them, this was heart-breaking for all concerned. However, by retaining regular daily communication and supporting the use of video calls, encouraging communication when the patient was lucid helped manage associated anxiety and sense of distance created by the pandemic.

2.4. **Continuous holistic assessment and symptom management.**

2.4.1. Of equal importance in a care home setting is ensuring both medical and nursing staff are continually assessing the resident using a holistic approach. This was difficult in a nursing home environment given GPs increased telephone consultation and had a physical presence in the COVID centres.

2.4.2. Clinically we observed patients with COVID-19 deteriorate quickly, managing symptoms of respiratory distress, pain as well as the emotional and psychological pain was one of the key goals of end of life care, promoting comfort and reducing anxiety. During the pandemic, NI Hospice medical consultants conducted virtual video teaching on symptom management for GPs caring for COVID-19 patients in the community. This was highly evaluated.

2.4.3. Much has been spoken and written about the impact of not being allowed to be present during the final days and hours of life of a loved one. Having access to social workers and the pastoral care team helps to support the anticipatory grief of families and enhances emotional, spiritual and psychological care. How care homes drawn in the multi professional expertise should be reviewed with the goal of increasing multi-disciplinary approaches to planning, implementing and evaluating the goals of care.

3. **Prioritising care and wellbeing of all residents.**

3.1. During the first surge of the pandemic, Hospices like care homes, continued to support local people who still needed access to great care to support them to live well to the end of their life.

3.2. Delivering care in a cohorted environment for all patients was underpinned by two fundamental principles. First do everything to make people feel safe and second, treat people as individual's delivering person centred holistic care.

3.3. The management and clinical team meet frequently collaborating and making decisions on how best to deliver high quality care in a safe environment. We depended on our multi professional staff to be at their best for every situation. This was challenging at times as the level of distress for all concerned was elevated throughout the pandemic, with new government guidance being announced late in the working day. This resulted in staff working longer hours to make the necessary changes including preparation of communications with the public and keeping all staff updated on the changes.

3.4. In addition, to essential holistic care, extra therapeutic activities had to be risk assessed to determine if on balance it was safe to continue or withdraw temporarily. Clinical staff went above and beyond to ensure patients felt engaged to prevent the feeling of isolation.

4. Supporting the wellbeing of staff

4.1. At the NI Hospice we have always had a culture of supporting our staff well-being and personal resilience given the abnormal high levels of exposure to death and the emotional impact of supporting others through grief and loss. This has been a fundamental consideration of the management team throughout the pandemic, as we ask our staff to go above and beyond, facing uncertainty both in terms of exposure to COVID-19 patients in work and the choices they make in their personal lives to protect others including their own families.

4.2. Similar to patient surveillance, we created a process for staff reporting in with symptoms, this was centrally held by our People Team who escalated incidence to the leadership team on a daily basis. For staff experiencing symptoms and/or self-isolating, we proactively kept in touch with them, offering help with food essentials and alleviating concerns.

4.3. In terms of communication with staff and volunteers we took a blended approach to this using live zoom calls with the CEO, CEO recorded messages, backed up by FAQs, flowcharts of the different scenarios for staff to follow dependent upon the presentation of symptoms, and weekly clinical leads meetings , where staff concerns were invited. We are fortunate that the charity developed a staff App and uses SMS messages to interact with staff. We increasingly used WhatsApp for group chats as appropriate and updated our public messages directly with patients, families and the public via our website and telephone.

4.4. We developed a Hybrid Working Policy to ensure our staff working remotely didn't feel isolated, we introduced flexible working especially for staff with young children at home. We invested in the procurement of new laptops with webcams and boosted broadband for remote workers.

4.5. Our clinicians created the 'Wobble Wall', which was a space for staff to write down their feelings and talk about them, if they wished. As well as peer to peer staff support, we offered staff free meals, drinks and random acts of kindness. More recently the leadership engaged with staff to discuss what would help recognise their efforts and promote their resilience. The collective view was the level of exhaustion faced by staff, so we have given staff up to two days pro rata additional well-being leave to take as they begin to feel tired. We encourage staff to use their annual leave recognising most need a break between 8 -10 weeks of continuous working.

4.6. In terms of emotional and psychological support, we have ongoing confidential talking therapy and counselling service through a partnership with INSPIRE. Staff have also been encouraged to take part in quizzes, cocktail hour (Fridays) and we have created the 'Good Craic Club' where staff can join virtual events to just see each other, laugh and support each other. The management team have also ensured they retain their resilience by moving from monthly meetings to weekly catch-ups, recognising when they need to take breaks and keep well.

5. Concluding Remarks

5.1. In concluding, the cost of COVID-19 both in terms of economic impact on our unforeseen expenditure, which is currently around £200K purely for COVID related costs, together with the human impact of the pandemic and loss of fundraising has tested the resilience of the charity as a whole.

5.2. Strategically we have developed contingency plans, to as far as practicably possible, sustain care services and which include taking difficult decisions such as initiating the redundancy process for non-clinical staff. We welcomed the first quarter government funding package; however we now face significant decreases in donations, reduced footfall in our retail shops and staff experiencing symptoms of exhaustion across the charity.

5.3. Clinically we have experienced a 20% increase in referrals to all Hospice services since April 2020 and have initiated waiting list management protocols. Our statutory funding remains unfairly balanced and a recent 4% increase in the contract value failing to address the continued flawed government funding of Hospices. If the Hospice is to continue to deliver its vital services and care on behalf of the NHS, it must be funded 50% of what it costs the charity to deliver services, as opposed to the

flawed funding methodology applied by the HSCB without any clear rationale or accepted Hospice care benchmark. Essentially, the Hospice should not be expected to absorb the cost of care and the increase in demand from charitable resources to plug the gap created by HSCB Commissioning and accounting methods. I would respectfully ask the Health Committee to escalate this untenable situation, using its influence to seek urgent resolution.