Belfast Health and Social Care Trust

Covid-19 and Care Homes

Committee for Health

19th October 2020

1. Discharge from hospitals to care homes

Testing prior to discharge/ Isolation facilities in care homes/step down facilities

In line with the regional guidelines, the BHSCT implemented the testing requirements from April 2020 which required patients to be tested 48 hours before discharge to a Care Home. This forms part of the Trust's Discharge Hub and Care Homes pre-admission risk assessment and actions required on admitting a resident. Whilst mitigating the risk of spread of Covid-19, this requirement has had an impact on the timeliness of the discharge pathways, due to the reluctance of some Care Homes to accept residents back in a range of different scenarios.

A number of Covid-19 pathways are required to support more timely discharge :

- Covid-19+ patients who are within the self-isolation period
- Covid-19+ patients whose Care Home is a 'Green' home, ie no residents or staff with Covid-19
- Covid-19- patients whose Care Home has an outbreak
- Patients who have been exposed to Covid-19 during their inpatient admission

Increasing numbers of Care Homes are expressing a reluctance to take residents back who fit these categories. Whilst the Trust had a step down /step up facility in place at the Ramada Hotel during the first surge, staffed by redeployed staff, it is proving difficult to replicate this again due to the challenges with securing a workforce.

There is also the impact on residents when returning to their Care Home after a 14-day isolation period in hospital that they are isolated again for a further 14 days within the Care Home, usually in their own bedroom. This prolonged isolation has obvious detrimental impacts on the resident and their families.

Care Home environments that are restructured to have specific isolation areas, that include a bathroom, lounge and dining area, instead of a single bedroom, enable a more positive experience for the residents, better social interactions and for those residents who are mobile, the benefit of more space.

The Trust has experienced significant increase in requests for 1:1 staffing to support the isolation of residents during the 14-day isolation period, particularly in dementia facilities where the resident does not have the capacity to understand the risks associated with being non-compliant with self-isolation.

There is a need for staffing in Care Homes to be enhanced to a higher staff to resident ratio to meet this need and ensure the dependency levels and acuity of residents can be met with the required staffing levels and skill mix.

2. Access to PPE

The Trust has supplied significant quantities of PPE to all Care Homes and domiciliary care providers in the locality from March 2020 and continues to do so at no cost to the providers as per the regional guidance. This is supplied and delivered to all providers on a weekly basis. The majority of providers continue to report issues with their own suppliers and high costs so continue to request from the Trust.

The Trust established a dedicated team to oversee the ordering and distribution of PPE, establishing a single point to contact for receipt of requests and queries from Care Homes who require PPE. This was extremely challenging at the start of the pandemic due to supply issues, but an effective system has been put in place over the last 6 months with weekly reporting to the Department of Health on the number of items of PPE being provided. This service has also been effective in ensuring providers are kept updated and supported with changes in PPE requirements when new guidance is issued. Having this single point of provision has assisted in ensuring supplies are secured and issued appropriately. It has required the Trust to secure /repurpose an appropriate venue to work out of given the large quantities of PPE stored and transported and a dedicated re-deployed staff resource to oversee this.

The Trust is aware of the financial grants awarded to providers that was to assist in the escalation of costs. Ideally, providers should be assisted to secure their own PPE supplies directly from suppliers as was historically the case so this requirement does not remain indefinitely with the Trust

PPE	**Quantity Issued to Date**
Masks	3,627,692
FFP3	8,582
Goggles	17,300
Visors	758,437
Gloves	6,785,350
Aprons	2,792,454
Hand Sanitisers (5l)	8
Hand Sanitisers (500ml)	1,003
Hand Sanitisers (200ml)	447
Hand Sanitisers (100ml)	693
Gowns	7,797
Sleeves	6,300
Caps	5,680
TOTAL	**14,011,743**

3. Testing in Care Homes

During the first surge, all testing of symptomatic staff and resident in the 88 Care Home facilities in the Belfast Trust locality were tested by the Trust's Care Home Nurse Support Team (CHNST). This is a team of 6.4 wte nurses which was enhanced by redeployed Trust staff and NIAS personnel to act as the single point of contact and who coordinated and facilitated testing and follow up support and monitoring.

- The Trust supported the introduction of the rolling programme in care homes with training and practical help for homes to undertake their own testing.
- The Trust provides testing of symptomatic residents and staff.
- The Trust provides testing for all outbreaks in care homes.

From 24 April 2020, in line with the Regional Testing Protocol, outbreak testing has been facilitated by the Trust. At the point of outbreak, at Day 4-7 and at Day 28, all residents and staff are tested. A dedicated testing centre with redeployed staff is in place over 7 days which interfaces with the CHNST and responds to jointly support each Care Home outbreak testing requirements.

The testing and enhanced clinical monitoring resource is not funded and continues to be provided at risk to ensure effective outbreak management and supports are in place at a local level. The Trust has significant staffing and capacity issues in delivering this in the absence of a long term funding stream.

Testing results are communicated within 24 hours with the Occupational Health Department providing support as follows.

Occupational Health Results Line and Advice and Wellness Lines

The Occupational Health service provides Covid-19 swab results and fitness for work advice to all staff tested. In addition to this, the service identifies any positive cases and provides welfare calls to staff, providing support and guidance related to health and wellbeing and return to work advice. The service also provides access to an Advice Line which aims to support staff and managers who have concerns or queries around any matters related to Covid-19.

The service operates 7 days per week. Weekly reporting data is produced on the numbers of staff testing positive/negative and their fitness for work as well as the number of advice and wellness call received and provided through the service.

In the event of an outbreak in a Care Home, the CHNST and Infection Prevention and Control (IPC) Team provide a risk based support response. There is an increased frequency of outbreaks being declared by the Public Health Agency as the national testing programme is identifying increasing numbers of asymptomatic staff and residents. This has increased demands on the Trust to respond to outbreaks over a 7-day period, and the CHNST has since been extended to 7 days to meet this demand.

The level of anxiety that still exists in the Care Home sector when an outbreak is declared is significant and does require onsite support to assist in facilitating all required actions. Onsite support has proved effective, evidenced by independent sector providers expressing the huge benefit of this approach in assisting them at times of crisis. Despite all the preparedness, the real experience of an actual outbreak and heightened anxieties and fear this brings requires the provision of support and assurance from experienced staff who have been responding to outbreaks from the start of the pandemic. Care Homes have benefited from the dissemination of shared learning and knowledge through this approach.

The National Testing Programme undertaken by Care Home staff fortnightly and monthly has proved challenging. Care Home management teams report the testing is labour and time intensive. The Trust has trained Care Home staff in the swabbing technique, which is a skill which must be maintained in order to prevent it not being carried out effectively resulting in inconclusive results and need for repeat testing.

Furthermore, there can be delays in results being received from the national testing programme which can limit the benefit of testing as staff are on occasion having a further test before they receive their previous test result.

Whilst the level of frequent testing for residents and staff provide assurances and acts as a measure of early intervention when Covid-19 is identified, it is often described as intrusive for residents and staff who can be tested a minimum of 3 times in a 4-week period if their Care Home is in outbreak.

Significant training has been and continues to be provided by Trust staff on symptom monitoring and in recognising a deteriorating resident. There has been focused training within residential homes by the CHNST and Acute Care At Home Team (ACAHT) - as there are no registered nurses employed within these environments, this creates an enhanced risk of the deteriorating patient not being recognised. This training resource continues to be provided on an ongoing basis to both nursing and residential homes. Although the training is offered to all across the locality, there is considerable variability in independent sector providers accessing the training. The Trust suggests consideration should be given to determining this training as core/mandatory.

4. Funding and increased costs for care homes

Since March 2020, during the Covid-19 period of first surge the HSC wished to ensure that its independent sector partners in Care Homes were supported financially to manage the cost pressures which they faced as a result of Covid-19. Regionally, a grant was paid to 370 Independent Sector Care Homes on 15 May 2020 totalling £5.4m from the Minister's April announcement of £6.5m - the BHSCT element was £1m. Regionally, a balance of £1.1m has not yet been issued and is being discussed with HSCB and DOH.

This grant was to support Care Homes to manage any Covid-19 specific cost pressures – it was issued in bands (see table below), dependent on the number of beds in each facility. Governance arrangements have been on a 'light touch' basis with a monitoring return to the HSC to advise how the Care Home applied the grant. From a review of the returns there has been a wide variety of application, e.g. staffing support, loss of income, accountancy support ref the Government's Coronavirus Job Retention Scheme, PPE and essential equipment.

Beds in Home	Grant Award
0-30	£10k
31-50	£15k
>50	£20k

In addition, a mainly claims based process for Care Homes within a financial envelope of £11.7m was announced by the Minister in June 2020. This financial package covered 3 key areas:

1) To assist Care Homes to pay their employees at 80% of their pre-Covid-19 average salary if they had to shield, isolate or were ill as a result of Covid-19. The period of claim confirmed by DOH was from June to August 2020.

2) To support Care Homes to increase their level of environmental cleaning hours from June to August 2020 as set by the PHA.
3) To support Care Homes to purchase additional essential equipment (Pulse Oximeters, Thermometers, Blood Pressure Monitors and Tablets/Communication devices), the volume of each was informed by a survey completed by the PHA in May 2020.

In addition to the claims element, Trusts have separately ordered defibrillator's for Care Homes which did not currently have one, as well as purchasing an additional stock of syringe drivers to support Care Homes when required. This has cost circa £0.7m.

The current level of reimbursement is set out below for BHSCT and the Region.

As of 02/10/2020	**BHSCT £'000**	**Regional Total £'000**
Value of essential equipment reimbursed (£)	31	389
Value of 80% sickness reimbursed (£)	15	57
Value of additional cleaning reimbursed (£)	130	807
TOTAL PAID ON CLAIMS TO DATE (£)	**176**	**1,253**

A number of Care Homes have not made any claim and at the end of August 2020, all were again invited to claim with local support offered to assist. At the time of writing there are 29 Care Homes who have not claimed for any element of this support package from BHSCT and 5 for which no evidence of the additional costs has been provided to allow reimbursement to be made by BHSCT. Regionally all Trusts are writing to these Care Homes again in October 2020 offering further support and encouragement to partake in these claims.

'Guidance for Nursing and Residential Care Homes in NI' issued on 17 March 2020 was supported by the application of the temporary cash Payments on Account (POA) to ensure that Care Homes were supported to maintain financial resilience during Covid-19 disruption.

There were 2 key elements to this:

1) The guidance indicated in section 4f – '*Planning will also need to take account of the financial resilience of care home providers. Where, as a result of the Covid-19 outbreak a nursing or residential care home's income reduces by greater than 20% below the past 3 months' average then Trusts should block purchase 80% of the vacated beds at the regional tariff. The Trust should then fill these beds as required over the next three months. If beds are still vacant at the end of that period a further review would be undertaken by the Trust working with the Health and Social Care Board*.'
2) In a regionally agreed letter issued by Trusts to all Care Homes on 7 April 2020, it was advised that during the period of the pandemic, an interim cash POA would be issued to Care Homes. This would bring the value of payments made to each Care Home to a minimum of 90% of the pre- Covid-19 average payment, adjusted for 2020/21 price uplifts. This would be achieved by 'topping up' any payment for actual value of the monthly payment below 90%. If a Care Home's value of payment remained above 90% they did not receive any POA /cash contingency.

Putting this interim measure in place in April 2020 provided a supported, consistent cash flow for Care Homes until the collation, validation and processing of the conditions set out in s4f could be actioned and for all monthly activity from April to be processed by Trusts, as payments for placements are generally in arrears. The expectation was that the impact of Covid-19 may have increased processing time. The total amount of interim cash Payments on Account paid from April to September 2020 to Care Homes by the Trust has been £1.1m.

Regionally Trusts have developed and agreed a methodology for the retrospective review of activity with the HSCB and the Department of Health. All Care Homes will be provided with individual details on any adjustments required which may be an additional payment or retraction; the process commences in October relating to April's activity and will continue while the contingency arrangements are in place, or changed by the DOH.

There are 2 caveats :

1) There could be a delay with September information reporting – so further hours may be added later;
2) The total hours and therefore costs include a mix of additional hours and costs [included in Covid-19 Monitoring returns as additional costs] and hours and costs of staff resourced by the Trust already but working normal hours in Care home instead [not included as a cost in Covid-19 Monitoring returns].

This excludes other support to Care Homes in general from the Trust such as senior management, professional advice, designated leads, link workers and the Care Homes Response Team.

It is recognised that the Covid-19 pandemic has placed additional workforce and resource pressures on both the Trust and Care Homes. The additional Trust staffing resource has included the mutual aid provision of nursing and care staff, and Infection Prevention and Control staff to Care Homes during an outbreak. In addition, additional workforce pressures have been placed on the Care Home Nursing Support team, Acute Care at Home and secondary care to provide intensive clinical support during an outbreak which these services have not been resourced to provide. The mutual aid package to Care Homes has enabled homes to close to admissions during periods of outbreak while maintain financial stability but has resulted in less usable beds and subsequently the finance sustainability of individual care homes.

It was also very evident during the first surge that Care Homes were challenged in providing and using technology to support virtual training, visiting and to enhance communication with families. This has been a significant theme in complaints escalated to the Trust. Difficulties of families getting in contact with homes, no ability for virtual visits, limited ability at times for providers to use standard platforms such as Zoom and Microsoft teams to provide consistent forums for communication and accessing training was a consistent theme.

5. Staffing issues and Staffing Levels

Covid-19 brought into sharp focus the challenges the Care Home sector faces with the availability of nurse staffing, the high acuity and complexity of patients cared for in the Homes and the limited MDT support available. Homes were heavily reliant on

agency provision to support their staffing complement, a situation which was already the case prior to the pandemic. The limitations of the staffing resource was further impacted by the need for enhanced levels of supervision for assisting in social distancing and isolation of residents, particularly in dementia facilities. The speed at which many homes went into crisis, the absence of robust business continuity plans and the high level of dependency on mutual aid staffing support from the Trust highlighted the fragility of the independent care home sector.

The challenge for Care Homes of covering shifts and minimising staff movement was significant. A number of providers attempted to block book the same agency staff in an effort to minimise staff movement. The Trust is aware that other jurisdictions implemented an arrangement to permit homes to secure block agency staff, limiting their use to one home but protecting their income so that they didn't have to seek additional shifts, this could be implemented in Northern Ireland

The Covid-19 pandemic has highlighted the need to consider the Care Home sector as an area of specialist practice with a specific career pathway, qualifications and training and Terms and Conditions reflecting this. There is a need for further definition and enhancement of management and leadership roles and structure that provides visible leadership over 7 days. Enhanced responsibilities such as those for Adult Safeguarding, Infection Prevention and Control, dementia champion and tissue viability are examples of essential roles to ensure the safe and effective delivery of care. Staff therefore require a level of training that reflects the responsibility and expertise of these roles.

5.1 Cleaning

Sufficient levels of cleaning staff should be employed to ensure required cleaning tasks and frequencies are completed with capacity to maintain activity during periods of leave, with contingency plans in the case of an outbreak. Supervision of cleaning staff largely sits with the Care Home Manager who may not have the required training and knowledge to support the cleaning staff and this may not be their main focus during an outbreak.

During the first surge, Trust Patient Client and Support Services staff were deployed to work within 5 Care Homes to support cleaning requirements. To date, there have been 865 total hours of direct intervention.

A review of cleaning equipment and materials would be useful to determine a standardised approach and level of equipment in Homes, while being mindful of the different environments across Care Homes.

5.2 Infection Prevention and Control

The Trust used a range of senior staff to provide dedicated Infection Prevention and Control nurses to support Care Homes in the Belfast locality. Homes experiencing an outbreak of Covid-19 are prioritised for onsite visits and continued virtual support to assist with timely management of outbreaks. The expertise of these staff was an invaluable source of advice and support to Care Homes.

5.3 Care Review and Support Team

The Care Review and Support Team (CREST) aligned key workers to each Care Home and family and continued with virtual reviews and enhanced communication with each home and families during the period of lockdown. The Trust's Senior Manager Lead for Care Homes is in place to coordinate all Trust supports in line with DOH and HSCB directives. These are small teams working in enhanced roles and hours to provide onsite and virtual supports as detailed previously. On-call senior managers are also in place for Care Homes due to the level of response and support required at weekends.

During the first surge, and prior to the Trust having a dedicated team of staff to deploy to Care Homes, staff were secured through the Trust's Nursing Bank and through agencies. This equated to the following hours comprising Band 5 nurses, Band 3 and Band 2 Care Assistants :

- April - 348 hours cost of £17,982
- May - 310.5 hours cost of £7,492
- September - 169 hours at a cost of £3,651

In total, the Trust has provided staffing support to 15 Care Homes. The first requirement was for Care Homes to have considered their own contingency arrangements in respect of seeking agency cover or staff from other local providers. However, Care Homes were often unable to source alternative staffing and given the immediate nature of the surge the Trust attempted where possible to provide staff. The Trust found this challenging given the demands across all Trust services at the time.

Between 24 April and 3 July 2020, the following staff were redeployed to support 10 Care Homes. This team was stood down in early July 2020 as staff returned to their own areas as services were reinstated.

	No of Hours	Hourly Rate	Cost
B3	4868.25	£15.25	£74,240.81
B5	1038.50	£19.96	£20,728.46
B7	1971.00	£30.70	£60,509.70
B8A	462.00	£34.30	£15,846.60
Agency	365.75		£14,061.87
			£185,387.44

In the latter half of September and the beginning of October 2020, three Care Homes in the Belfast locality have requested nursing and care assistant supports as their staffing has been depleted. The Trust does not currently have a dedicated staff team for this due to the significant amount of rebuilding of services that has taken place. Staff have been provided where they can through the Nurse Bank and agency. A number of options are being explored to re-establish a dedicated staff resource for this purpose including workforce appeal, staff redeployment and through block

booking agency staff, however, this is proving very challenging. This is presently on the Trust's risk register.

6. Staff Pay and Conditions

A key risk during the first wave of the pandemic, prior to the financial aid package being implemented, was symptomatic staff refusing to be tested or returning to work while symptomatic, as they were not paid for Covid-19 related absence.

Existing staff pay and conditions in the Care Home sector is a significant factor in the ability of Homes to achieve a sustainable skilled workforce – it undoubtedly impacts on recruitment and retention. This is an area that requires much needed reform to ensure staffing requirements, qualifications, training and development opportunities and equitable pay and conditions are in line with the public sector. There is a need for the Care Home sector to be recognised as a unique area of practice with terms and conditions set to reflect this.

7. Visitors

Care homes have been supported in a number of approaches by the Trust in relation to securing meaningful visiting arrangements. However, throughout the Covid-19 pandemic, the issue of visiting has remained a challenging and contentious issue that has been a factor in many complaints by families to the Trust. There is growing evidence of the impact of restricted visiting and lack of social and physical contact having a detrimental impact on mental health and emotional well-being of residents.

The regional principles for visiting are subject to individual Care Home interpretation which has led to inconsistent practice across the sector - some care providers have been restrictive in visiting practices and adopted a very limited approach in facilitating virtual, on site and indoor visiting. It is hoped that the new guidance of Care Partners will address this, although the initial feedback from Care Homes is that they remain concerned it will result in increased footfall and spread of infection. Providers receiving more detailed guidance on how to facilitate a care partnership approach would be beneficial. Balancing the rights of the residents and family with minimising the risk of transmission, compliance with IPC measures while maintaining a homely environment has been extremely challenging for Homes. Smaller facilities, greater space, higher staffed, dedicated individual visiting areas, ability of families to be trained and receive training in IPC/ PPE would enable more frequent visiting. The ability of the Care Home sector to achieve all of this within existing facilities and with their existing workforce remains a challenge.

During the March to June 2020 period, with the resultant access to funds to support Care Homes to secure technical solutions, the Trust has been proactive in engaging with those Homes who have not made use of this resource and provided staff with ipads to support virtual visits with residents and families. Likewise, during periods of outbreak, Trust staff have facilitated virtual contact between family members and residents and the CREST team provide daily updates on residents' health and wellbeing.

More latterly, the Trust, on receipt of the revised visiting principles on 24 September 2020, consulted with all Care Homes in the Belfast locality to provide a view of the implementation of the Care Partner principles. Based on the outcomes the Trust is committed to working with the Care Home sector to ensure family and resident

engagement is maximised in a meaningful way, subject to the Covid-19 status at any point in time.

8. Regulation : RQIA role, inspections & risk factors including public versus private ownership

The Trust continues to engage with all partners in the delivery of care within Care Homes. Ongoing surveillance is supported by the Care Homes uploading data onto the RQIA website, which in turn is shared and considered daily in the form of a dashboard.

It is the view of the Trust that there was a detrimental impact of the standing down of RQIA routine inspections and statutory care reviews. The absence of on-site visits from Trust staff and RQIA created difficulties in maintaining oversight of the Homes and also in the early identification of risk. Across the Trust's locality, this has been evidenced by the increase in the number of homes of concern identified through the commissioned service governance escalation framework, complaints and SAIs. The requirement for Care Homes to reduce footfalls for all routine visits including Trust staff visits resulted in a number of Care Homes refusing any on-site visits.

During further Covid-19 surges, there is a need to further consider how to best balance the risk of infection transmission with the need to ensure that the safety and quality of care to residents is not compromised. The Trust would be keen to maintain staff visiting Homes in line with its governance arrangements, for RQIA enhanced inspections to continue and for timely communication with the Trust as to outcomes of the inspections. The Trust would welcome clear, more defined roles and responsibilities of RQIA and Trust roles in this area.

Statutory Homes operated within the same guidance and restrictions as independent sector providers. The main difference was that the Trust was able to maintain oversight of the quality of care and governance arrangements within the HSC Care Homes and these Homes had a readily available resource in relation to infection prevention and control and other training.

9. Medical Care within Care Homes and Advance Care Planning

Medical care within care homes is substantially provided through the GMS contract with GPs providing medical cover. During periods of outbreaks the Trust has taken the lead in providing enhanced clinical support through the Trust's model of Care, Review and Support Team, (CReST), Care Home Nursing Support Team (CHNST) and the Commissioned Services Governance team. This proved invaluable and effective in its provision of timely clinical assessment of residents, communication with families and the provision of clinical and educational support to nursing home staff and management during the first surge. In addition, they coordinated the mutual aid support to nursing homes.

This Trust team provided the front line enhanced Covid-19 support to the Care Home sector through a single point of access, the provision of clinical assessment and treatment, the testing of staff and residents, infection prevention and control assessment, PPE provision and through education and training on Covid-19 related issues. The Trust enhanced the Care Home Nurse Support Team (CHNST) with additional MDT and medical support over 7 days to provide high quality, evidence

based MDT response to the needs of residents presenting as Covid-19 positive. In addition they provided advice, support and training to improve the knowledge, skills and capacity of the Care Home nursing teams in caring for older people with complex and frequently changing needs, including palliative and end of life care.

Activity of the Care Home Nursing Support Team March-July 2020:

- Training
    - 24 Training sessions via Echo
- Nos of resident reviews in Outbreak Homes via telephone call
    - Approx 10,449
        - 366 positive cases-average 9 calls per case
        - 2,236 negative cases-average 3.2 calls per case
- Delivery of weekly virtual call with all Care Homes
    - 1,008 calls to 72 Care Homes over 14 weeks
- Record of clinical visits to residents
    - 90 visits to Care Homes
        - 46 testing demonstrations on residents and teaching procedure
        - Remaining visits to review residents' clinical needs in Homes with outbreaks. During these visits a range of 5-20 residents would have been reviewed

The CHNST provided the single point of contact for Care Homes that triggered a range of supports and in reach into Care Homes including the Acute Care at Home Team, Infection Prevention and Control, and respiratory team. The main challenge for Care Homes was in proactive advance care planning and the coordination of GP input. Multiple GPs aligned to single Care Homes was challenging for Care Home staff as accessing multiple practices by telephone was time consuming and staff where often faced with difficulties securing a range of onsite visits.

The Community Dietetics and Speech and Language Therapy services continued to provide a service to Care Homes by telephone. In addition, the Speech and Language Therapy and Dietetics professions across Northern Ireland provided regionally agreed, evidenced based information for staff working in Care Home settings managing residents with Covid-19, as it has been well established that these residents may present with nutrition, eating, drinking, swallowing and communication difficulties exacerbated or caused by the virus. This professional guidance contained strategic information and a single point of contact for Care Home staff to access support for further advice and specialist assessment.

Primary Care remained the primary decision maker in terms of assessing and meeting the health care needs of residents, including advanced care planning, in co-operation with the residents, family and Care Home staff. The CHNST included palliative nursing staff who supported Care Homes with these discussions and provided support to those at end of life.

11. Preparedness within the HSC and in Care Homes: pre covid baselines and future requirements

Prior to the pandemic, the Trust had aligned CREST key workers to all Care Homes and this service provided a direct line of communication and access to support to residents, care homes and families, including bereavement support and psychological

supports with onwards referral to Trust services for follow up. Daily Care Home huddles led by the Divisional Care Home Lead with all Trust support teams were effective in reviewing the status of Care Homes and providing direct support, including deploying Trust staff to Care Homes as required.

In future surges, it will be essential to sustain a multi-faceted model that provides an overall support network to Care Homes via a single point of contact. It will also be important to consider how an MDT model can prevent decompensation and deterioration in residents during periods of isolation and what support can be offered to residents during the recovery phase of their illness. In the long term this enhanced MDT support could help prevent admissions to hospital and promote more effective end of life care of residents within the care home environment.

12. Coordination and communication between DOH, Trusts and Care Homes

As noted above, the Trust had already established a link worker for each Care Home, to provide a direct line of communication and access to support. There were challenges for the Trust in meeting the needs of all Care Homes given the range of needs presented, the emergency nature of some of these, and the considerable challenges the Trust was dealing with in relation to its own workforce. The majority of other organisations involved largely provided a consultative role.

More consultation around key decisions involving the sector and timely communication with appropriate lead in times for implementation would be welcome. During the first surge, a number of policy decisions and guidance documents were communicated at short notice which while understandable given the pace of change and learning in the first surge, presented challenges to both Care Homes and Trusts to operationally respond in an effective way, particularly in those areas which required a workforce. Communication of key changes requiring urgent action across the sector should be avoided at the end of the week, as implementation then falls to the reduced staffing complement at weekends.

13. Standards in place for Infection Prevention and Control

Learning from the first surge indicates a high level of support and development in the area of infection prevention and control across the sector is required. Experience has indicated that Care Homes were not always familiar with best practice IPC measures or had considered IPC measures, PPE station locations, waste management, zoning etc. in their planning. The need for greater numbers of domestic staff enhanced cleaning schedules and contingencies for when cleaning staff were impacted with Covid-19 absence proved highly challenging. Whilst the Trust at times was directed to provide cleaning support when required, there remains a need for Care Homes to be self-sufficient in this area as with the number of Care Homes across localities, it will not always be possible for Trusts to resource the extent of the support required, particular as rates of transmission escalate.

Visits to Care Homes from the IPC team highlighted the following learning during the first surge.

- Care Homes are multi occupancy dwellings where care involves ‘toileting’ practices that are associated with a risk of environmental contamination. The vast

majority of Care Homes did not have access to an automated washer for bedpan or commode receptacle decontamination. Infection Prevention and Control Nursing observations noted that existing washing practices for commode pans and bedpans were ineffective at properly decontaminating these items and did not render them safe for reuse. Effective decontamination of these reusable items is essential to contain transmission of this virus. Current regulations do not require Care Homes to have automated bed ban washers installed - this should be given consideration as a mechanism to reduce this risk.

- A number of Care Homes did not have access to industrial style automated washing machines that can carry out a wash cycle option for appropriate laundry disinfection in wash cycles at 40^{0}C or lower when thermal disinfection in prohibited for certain types of clothing. Existing guidance for healthcare laundry services, HTM 01-04 (DoH 2016), requires that where thermal disinfection cannot be achieved an alternative chemical disinfection option should be in place. There is no regulatory requirement for the Care Home sector to follow this guidance.

- Care Homes would benefit from a formal recommendation of a standardised design for enclosed PPE stations e.g. a range of photographs of appropriate PPE station designs that could inform Care Home sector staff on how to lay out PPE appropriately with a visual aide.

- It was noted during Infection Prevention and Control Nurse visits to Care Homes that several Homes used vinyl gloves for the provision of personal care to residents. The tensile standard in vinyl gloves is not adequate for care that involves healthcare workers dealing with body fluids. Nitrile or neoprene glove should be used for care of this nature. While this was addressed, a formal recommendation from the regulator would embedded best practice in relation to the quality of gloves provided for care staff in Care Homes.

- Every Care Homes should have an IPC Link staff member(s). This person(s) should have local responsibility for the dissemination of IPC guidance and training within the Care Home. They will need regular support from the PHA to ensure that each Care Home IPC link person has attained an agreed appropriate level of education and skills to discharge this role appropriately relevant to their Care Home's needs.

Committee for Health

Dr Cathy Jack
Chief Executive
Belfast HSCT

By email: angela.muldoon@belfasttrust.hscni.net

Our Ref: C221/20

23 September 2020

Dear Dr Jack

COVID-19 and Care Homes

The Committee for Health is conducting an inquiry into the impact of COVID-19 on Care Homes and is seeking the views of your organisation with a view to developing recommendations aimed at mitigating and managing a second surge in infections.

The Committee has gathered evidence from a wide range of stakeholders on this matter since March, which has informed the enclosed terms of reference and identified the following areas for particular consideration:

- Discharge from hospitals to care homes;
- Access to PPE;
- Testing in care homes;
- Funding and increased costs for care homes;
- Staffing issues & levels;
- Staff pay and conditions;
- Visitors;
- Regulation: RQIA role, inspections & risk factors including public versus private ownership;
- Medical care within care homes and advance care planning; and
- Preparedness within the HSC and in care homes.

The Committee feels it has a good sense of the problems experienced but is keen to develop constructive recommendations that will inform decision-making in coming months.

I would therefore be grateful if your evidence could focus on the steps required to minimise infections in care homes and care for those infected, while prioritising the care and wellbeing of all residents in the broadest sense as well as the wellbeing of staff. It would be very helpful if you could use the above headings to structure your response, subject to any additional suggestions you wish to make.

The above headings are supplemented overleaf by a list of sub-topics designed to illustrate, in a non-exhaustive way, the type of information that would be useful. Appendix 2 sets out the Committee's terms of reference.

I would grateful for your reply by 19 October in order to maximise the usefulness and timeliness of the Committee's report.

Yours sincerely,

Colm Gildernew MLA
Chairperson
Committee for Health

Enc.

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Appendix 1

Further information on topics of interest

- **Discharge from hospitals to care homes**
  - Testing prior to & post discharge
  - Isolation within care homes
  - Step-down facilities

- **Access to PPE**
  - Costs
  - Security of supply
  - Procurement: central v individual

- **Testing in care homes**
  - Effective frequency and management
  - Symptom monitoring
  - Personnel
  - Consent issues

- **Funding and increased costs for care homes**
  - Cleaning
  - Other infection control measures
  - Technology

- **Staffing issues & levels**
  - Additional staffing requirements;
  - Recruitment, regulation
  - Staff movement, shifts, roles
  - Training & guidance

- **Staff pay and conditions**
  - Sick pay
  - Environment including staff changing facilities
  - Other support

- **Visitors**
  - Virtual visiting
  - Socially distanced visiting
  - Wellbeing

- **Regulation**
  - RQIA role including inspections & advice
  - risk factors
  - HSC-run versus privately-run homes: impact/outcomes comparison

- **Medical care within care homes**
  - In-reach teams / support from Trusts & GPs
  - advance care planning

- **Preparedness within the HSC and in care homes: pre-COVID baselines and future requirements**
  - DoH consideration of care homes within pandemic plans
  - Coordination & communication between DoH, Trusts & care homes
  - Care homes:
    - standards in place for infection control
    - staff training including infection control, dealing with infectious disease outbreak
    - PPE stocks typically in place and usual levels of need /cost

Appendix 2

Aim of Inquiry

The aim of the Committee's inquiry is to produce recommendations to mitigate and manage the impact of a potential second surge of coronavirus on care homes.

Terms of Reference

The Committee will:

- Identify the key issues impacting care homes as a result of the COVID-19 pandemic;
- Identify domestic and international examples of best practice in arrangements to protect and care for residents of care homes during the pandemic; and
- Report to the Assembly on its findings and recommendations by **13 November 2020.**

Committee for Health
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