Northern Ireland Assembly Committee for Health

Inquiry into the impact of Covid-19 on care homes

Submission from the Royal College of Nursing

Introduction

1 The Royal College of Nursing [RCN] is a trade union and professional organisation representing registered nurses, nursing assistants and nursing students in all practice settings across Northern Ireland. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policy.

2 The RCN welcomes the opportunity to submit written evidence to help inform the Committee's inquiry into the impact of Covid-19 on nursing and residential care homes in Northern Ireland with a view to developing recommendations aimed at mitigating and managing a second surge in infections.

3 As requested by the Committee, we have sought through this submission to focus upon the steps required to minimise infections in care homes and deliver care to those infected, while prioritising the care and well-being of patients/residents, in addition to promoting the health and well-being of staff. Our submission is structured and themed on this basis and in accordance with the issues set out in appendix 1 to the Committee's letter of invitation. It also seeks to reinforce the point that the phrase "care homes" should more appropriately refer to "nursing and residential care homes", and that people who live in nursing homes are not simply residents; they have health care needs and are, therefore, by definition patients too.

Discharge from hospitals to care homes

4 In relation to the testing of patients prior to and following discharge from hospitals to care homes, the RCN would expect all patients discharged from hospital to have received a confirmed negative Covid-19 test and been the subject of a completed dynamic risk assessment prior to admission to a care home. It is extremely difficult to isolate patients within a care home because the environment and design will generally not facilitate this. It would also prove extremely challenging to isolate a patient with cognitive impairment in their own room. Furthermore, care homes would not have access to the additional staffing resources that would be required to facilitate the one-to-one care provision that are generally required to manage isolation. The issue of deprivation of liberty safeguards also needs to be considered in this respect. Patients cannot be isolated in a restricted area or locked unit without a deprivation of liberty assessment having been completed. The same challenges would apply in relation to step-down facilities.

Access to PPE

5 The care home regional tariff and contractual arrangements with HSC trusts would previously neither have enabled nor required care homes to purchase visors, masks or gowns. However, care homes must now provide nitrile gloves for all clinical procedures at approximately five times the cost of vinyl gloves. The regional tariff should therefore be upgraded to reflect this increased cost burden for care homes. HSC trusts must be required to maintain the security of PPE supply to the care homes within their jurisdiction in order to ensure that there are no delays or interruptions in distribution. The RCN believes that a central procurement process would be more beneficial than a series of individual ones. This would help ensure that care homes would be in a stronger bargaining position and thereby prevent individual homes being obliged to compete against one another for PPE resources.

Testing in care homes

6 RCN members in Northern Ireland report that, currently, care homes are testing staff every two weeks. If the result has not been returned within seven days, care homes have been instructed to re-test the employee. This testing regime was announced without any prior engagement with the sector. Care homes often have minimal staffing levels and the testing regime, which is highly labour-intensive, has therefore proved to be a significant challenge. It presents, furthermore, an additional layer of administration for a sector that was already struggling to match demand with available resources and could prove to be a distraction from the provision of safe and effective care to patients/residents.

7 The current testing regime is therefore widely viewed within the sector as unsustainable. There have been no additional resources or funding to facilitate testing and no opportunity for the sector to prepare for the implementation of the testing regime. The RCN recommends the provision of additional funding for care homes in order to recruit the staff required to facilitate and support the administration and management of staff and patient testing. With respect to symptom monitoring, staff report twice daily the temperature checks of all staff and patients. Staff are also required to monitor twice daily the SAO2 (oxygen saturation) levels of patients. Older people are often not presenting with classic Covid-19 symptoms. Therefore, public health guidance for care homes requires the monitoring of temperature and oxygen saturation levels twice daily in order to detect non-symptomatic patients at an earlier stage than would be the case with four-weekly testing. This has created another labour-intensive burden for care homes. RCN members are also reporting that some patients with cognitive impairment will not consent to routine swabbing. Testing cannot proceed without the informed consent of the patient/resident.

Funding and increased costs for care homes

8 RCN members working within the independent sector report difficulties in obtaining the funding required for additional cleaning. They have also reported that the administration/audit process needed to secure this resource is so time-consuming that it has proved to be a deterrent to accessing the funding. RCN members also report that they have been unable to access all of the funding allocated to each home, due to the rigid criteria and tight timeframe. RCN members have highlighted the enhanced cleaning regimes required to facilitate visiting. Care homes have incurred increased costs in order to facilitate the creation of "visiting pods" and finance the construction work required to build external doors into visiting rooms, for example. Additional equipment has been required, such as single-use slings for hoists. During a Covid-19 outbreak, care homes also experience additional waste disposal charges. Some RCN members have reported difficulty with improving the intranet infrastructure and connectivity in care homes in order to facilitate virtual visiting. Previously, care homes would typically have internet access in the manager's office and reception but not necessarily throughout the home. This has also generated a significant cost implication for the sector.

Staffing issues and levels

9 The RCN identified significant staffing shortages within nursing and residential care homes in Northern Ireland in our 2015 report Care in Crisis. The position has further deteriorated during the last five years. Care homes generally have minimal staffing levels and no pool of staff to call upon in order to address shortages. The independent sector generally experiences difficulties in recruitment as it is largely incapable of competing with the terms and conditions of employment offered by HSC trusts. There is currently no dependency tool or agreed staffing ratio that would enable the sector to determine the staffing levels that are required to deliver safe and effective care. Phase eight of the Department of Health's Delivering Care normative staffing framework, relating

to nursing homes, was due to be completed in March 2020. In January 2020, however, the Public Health Agency held a meeting with independent sector representatives and informed them that it would, instead, be introducing the Telford model in March 2020. This is simply a mechanism for converting shift-level staffing plans into a calculation of the number of staff that are required to fill the daily staffing rota, making allowances for annual leave and sickness absence. The RCN has previously stated its concerns about the introduction of the Telford model without an associated dependency tool and its belief that the Telford model does nothing to secure or promote safe staffing. It fails to address the question of how evidence-based decision making around staffing requirements can be supported, which is what providers require and expect.

10 The RCN would agree that each care home should have its core staff in each facility. However, the sector is now entering the "second wave" of Covid-19 with a depleted workforce. There is, accordingly, an imperative upon the respective HSC trust to have robust systems in place to support the care homes within its jurisdiction in terms of staffing. Furthermore, the enhanced testing regime has meant that many staff are now self-isolating, creating even more intensive workforce pressures.

11 RCN members have been reporting that care homes which are already experiencing a Covid-19 outbreak during the current "second wave" are only just now starting to receive any staffing support from the respective HSC trust. One of the clear lessons of the "first wave" is that nursing and residential care homes simply will not be able to function without staffing support from the respective HSC trust. This message needs continually to be reinforced.

12 Given these challenges, the Committee may wish to consider the case for the establishment of a regional independent sector collective bargaining arrangement that would help set a regional standard for pay, terms and conditions. The implications of leaving the European Union will create further staffing pressures upon the sector. The RCN also believes that it is essential to develop a career progression pathway for care home staff that embraces the same levels of access to training and professional development as are

available to colleagues working within the HSC. Finally, patients/resident in nursing homes have increased levels of acuity. This necessitates a review of the skill mix in homes and particularly the ration of registered nurses to nursing assistants or health care assistants. This is currently estimated at 35:65, which is almost the exact converse of the skill mix within the HSC.

Staff pay and conditions

13 The RCN believes that all care home staff should receive full pay for any Covid-19 related absences. We also believe that, ideally, there should be changing and showering facilities for all staff in all homes. However, we acknowledge that this would present significant logistical and financial challenges. An alternative suggestion, therefore, would be to provide all staff with scrubs. Care home staff do not generally have the same levels of access to occupational health services as is the case for HSC trust staff. They require additional emotional support and accessing to counselling services to enable them to maintain their mental health and well-being during these challenging times.

Visitors

14 As referenced at paragraph 7 above, virtual visiting has created a significant administrative and practical burden for the sector. Care homes are required to organise the virtual visiting sessions themselves and then a staff member is required to remain with the patient/resident, as most are unable to utilise the equipment independently. Again, the introduction of virtual visiting was introduced without any prior engagement with the sector. It was announced via social media and then care homes were left to meet the requirement, resulting in a breakdown in communication with relatives and the creation of largely unmet expectations. This significantly damaged relationships between relatives and care homes. The obligation to conduct visiting in line with social distancing requirements has required homes to provide facilities such as visiting pods and

implement other logistical adaptions. This, again, requires additional funding, resources and staffing. Currently, in most care homes, activity therapists are organising the visiting, which inevitably impacts upon the availability of these staff to lead activities for the patients/residents.

15 Facilitating visiting will inevitably become more difficult with the current increase in community transmission and the number of recorded Covid-19 cases. It is important, therefore, to question the impact of visiting at a time when care homes are attempting to reduce footfall in order to minimise transmission and the prevalence of consequent Covid-19 outbreaks.

16 The RCN is particularly concerned about the Department of Health's care partners initiative. We would question the need for such an initiative if the relevant HSC trust is providing support to the care homes. It appears to be an attempt to compensate in some manner for staffing shortages through the deployment of relatives. These care partners will increase footfall into the care homes at a time of enhanced Covid-19 community transmission. The Health and Social Care Board has produced a video stating that care homes should facilitate one visitor per week for one hour, in addition to the care partner being split between two other relatives over the week. This is simply not viable.

17 RCN members are also concerned about the fact that care partners will not have received appropriate training or been subject to Access NI checks in order to ensure the safeguarding of patients/relatives. As noted at paragraph six above, staff are already struggling to deliver the current testing regime and do not have the capacity to test care partners too. Equally, there are no agreed criteria to define who would be suitable as a care partner. Such an initiative must be based upon a clear standardised policy and associated guidance for staff in order to provide an assurance of the robustness and practicality of the initiative. The well-being of patients/relatives and their families is vital, but measures to address this must, equally, be viable and appropriately resourced.

Regulation

18 The Regulation and Quality Improvement Authority [RQIA] should continue to regulate and inspect nursing and residential care homes. RCN members reported receiving invaluable support from the RQIA during the early stages of the pandemic and a similar level of support will inevitably be required in the weeks and months ahead. This, in turn, requires the RQIA to be able to operate autonomously. Given the role of the Department of Health in reducing the frequency of inspections and "repurposing" the work of the RQIA at an early stage of the Covid-19 pandemic, the capacity of the organisation to function autonomously in the interests of service users is now unclear. The majority of care homes in Northern Ireland are privately run. Any comparison between HSC and private homes would need to consider the respective running costs of each type of facility. Certainly, however, the current funding model for care homes needs urgently to be reviewed and the sector also requires an evidence-based dependency tool and robust staffing ratio to facilitate the delivery of safe and effective care.

Medical care within care homes

19 In relation to in-reach teams and support from HSC trusts and GPs, existing patterns of multidisciplinary support for care homes must continue. The in-reach teams must be enabled and supported to build upon the partnerships forged during the "first wave". This process should embrace the provision of training and staffing. GPs must have systematic access to patients/relatives in order to ensure that they receive the required medical care. However, RCN members are currently reporting that many HSC trust in-reach teams have been stood down and that the trusts therefore currently lack the capacity to continue to provide support to care homes. This is a matter of great concern.

20 Advance care planning was previously completed by a medical professional. Responsibility has now been allocated to the care home, but staff require additional training and medical input in order to undertake this role. RCN

members are still reporting that some GPs are not participating in DNACPR decisions. This has resulted in patients' wishes not being reflected in their advance care planning. GPs should be required to participate in DNACPR decisions alongside the patient/relative and the care home. This requirement should be defined and reinforced through a clear regional policy.

Preparedness within the HSC and in care homes: pre-Covid baselines and future requirements

21 In order to enable the nursing and residential care home sector to survive and flourish beyond the pandemic, the Department of Health must place care homes at the centre of its planning. The sector is currently experiencing severe staffing shortages, high levels of vacant beds, escalating levels of expenditure, low levels of engagement, unrealistic and unachievable public expectations, and a huge increase in workload, such as through the testing and visiting regimes described previously. As the Minister has acknowledged, the sector was experiencing profound difficulties prior to the pandemic and these have now compounded. Recently, the Health and Social Care Board requested that care homes "co-produce a communication strategy with residents and relatives to ensure all official information and guidance is cascaded directly to the residents and relatives".' As the Department of Health Rapid Learning Initiative identified, care homes should not have additional administrative requirements imposed upon them in this way. The RCN questions why it is perceived to be the responsibility of care homes to disseminate official guidance to relatives. The RCN believes that there should be one central resource responsible for communicating all information to care homes. The same central resource should also be responsible for gathering relevant data and information for the Department of Health, HSC trusts and the Public Health Agency.

22 The RCN advocates that the Public Health Agency should be responsible for developing guidance for care homes in relation to infection control and environmental zoning. This must be done in partnership with the sector. Care

homes should continue to have access to online infection prevention and control training at no additional cost. Each care home should have a named infection prevention and control link nurse designated to provide support and advice. As noted at paragraph 5 above, HSC trusts must continue to ensure that care homes have sufficient supplies of PPE, and be accountable for this.

Concluding comments

23 The RCN remains profoundly concerned about the sustainability and viability of the independent nursing and residential care home sector in Northern Ireland as we encounter the "second wave" of the Covid-19 pandemic. Some homes are reporting reduced occupancy and the reluctance of some families to admit a relative to a particular care home because of concerns over visiting access and susceptibility to Covid-19. The Rapid Learning Initiative identified that care homes are experiencing an ever-increasing workload. The issues arising from this have not been resolved. Indeed, the new monthly audit required by the Health and Social Care Board (Northern Ireland Covid-19 Regional Action Plan for the Care Home Sector) has, as noted above (see paragraph 21 above), has simply exacerbated existing pressures generated by increased costs and administrative responsibilities, and a lack of support or engagement.

24 On 13 May 2020, the Minister for Health stated: "The social care sector has been struggling for years and as a whole is not fit for purpose. The structural reasons for this are well documented and are no fault of staff. Reforming social care remains one of the most difficult long-term challenges facing modern day Government. It is beyond doubt that the sector needs much greater resilience. This is essential given the threat that will be posed by Covid-19 in the months and potentially years ahead. 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. We will have to ensure that the return on this investment will be to the benefit of staff

and residents, not the profit margins for operators. That means a decent wage, access to some form of sick pay, a career pathway and training to do the job safely and well. I accept that many providers already provide this. In the future, we must ensure that all do." The RCN welcomed this honest appraisal of the challenges confronting the nursing and residential care home sector in Northern Ireland. However, five months later, it is not clear what progress has been made by the Department of Health in addressing these broader issues. Moreover, at the time of submitting this written evidence, the largest nursing and residential care home provider in Northern Ireland has just entered administration, citing Covid-19-related occupancy levels and staff self-isolation requirements as decisive factors in this development. The RCN recommends that the Committee should request, as a matter of some urgency, a progress report from the Minister in relation to these wider matters.

25 The RCN hopes that the commentary above is helpful to the Committee in respect of its inquiry and that it will contribute to the development of helpful recommendations to mitigate and manage the impact of the "second wave" of Covid-19 on nursing and residential care homes in Northern Ireland.

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