

Rapid Review for Care Homes in Relation to Covid-19 in Wales

July - September 2020

By Professor John Bolton

Commissioned by Welsh Government

Spriggs Tanya
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Executive Summary and Key Recommendations

After a bumpy and in some places fragmented start the health and care sectors have worked very hard with care homes to reduce the spread of the virus in Wales. Overall, care home providers have appreciated the help and assistance offered to them. In particular there was consistent praise for support offered by Care Inspectorate Wales (CIW) in providing regulatory flexibility to help care homes ensure the well-being of all residents.

Prior to the final publication of this paper seminars have been run across the country to reflect on the best practice lessons that have been learned for both Local Authorities and Health Boards in order to assist them in preparing for any future wave of the virus and to assist in planning for the coming winter. The recommendations of the report have been fully explored and discussed and now have been converted into action plans by these regional partnerships. These action plans have been scrutinised and all of them were found to be complete and had considered the recommendations for Health and Care Partnerships that are made in this report.

This report has a strong emphasis on the need for co-production between the public sector and the independent and public-run care homes. The report tries to highlight where best practice has worked for both providers of care and public sector organisations, in the hope that partners across the public and independent sectors will be encouraged to continue to share learning and best practice in the future.

The following key messages came from this study:

- **Health and Care need to work in partnership with care home managers in order to ensure that:**
- **Every care home has an effective Infection Control Plan that is put into place;**
- **Every care home has an effective plan for business continuity that includes ensuring that there are staff available to meet residents' needs;**
- **Every care home should be supported to ensure there are meaningful and helpful day to day activities for residents and that the wellbeing of both staff and residents are taken into account in all the decisions that are**

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made. This must include help offered to ensure that residents can remain in touch with relatives and friends;

- Every care home has the right protective equipment;**
- Every care home has access to tests for residents and staff to know who may have the virus;**
- Every care home has good access to primary health services including GPs.**

The report includes sections summarizing the methodology used to produce this report, the context for care homes, the initial impact of the virus and the response, the best practices that were found in helping care homes to address the pandemic and the final section draws together a set of considerations that health and social care partners could use to assist them in completing their action plans for the winter. There are some appendices referred to in the document.

1 Introduction

This “rapid” review was commissioned by the Welsh Government in order to ensure that the lessons from best practice are learned and shared by Local Authorities and Health Boards who were involved in working with care homes during the initial period of the Covid-19 pandemic in the spring and summer of 2020. The work for the review has included reading some research studies, reading many submitted reports by Health and Social Care leaders from Wales and a series of interviews with stakeholders including a number of Care Home managers and owners.

Contacts were made with all 22 Local Authorities, 9 Health Boards (of which all the relevant eight Boards responded), Care Inspectorate Wales, The Older People’s Commissioner for Wales, The Children’s Commissioner for Wales, The Equality and Human Rights Commissioner for Wales, Care Forum Wales, Social Care Wales and Public Health Wales (all of whom responded). There were also additional interviews with 15 care home owners, General Practitioners and Environmental Health Officers. Interviews were conducted using Microsoft Teams (the majority), Skype or Google Meet. On average there were four people who joined each interview. For example, a Local Authority might involve any combination of the Director, an Assistant Director, a Senior Commissioning Officer, Contracting Officers an Environmental Health officer, a Public Protection Officer, a Health and Safety Manager or a Senior Social Worker. In total over forty interviews were conducted.

After an initial report was drawn up and shared a series of seminars were held in order to ensure that the messages from best practice were discussed and understood by Local Authority and Health Board partners in each region. This final report has been

produced following those seminars and scrutiny of the resulting action plans from each of the regions.

For a number of reasons it was not possible to arrange any meetings with people who had used care home services during this period. There was good information from people with experience of services and carers shared from the Older People's Commissioner and from Care Inspectorate for Wales. The interviews took place in July 2020 and the seminars in August 2020.

The review has mostly focused on the issues that have impacted on older people during the pandemic. There are a few references to younger adults living in care homes though they broadly seem to have been protected from the virus. The Children's Commissioner was contacted to hear her views and to capture key messages from her.

From the outset, the virus presented a real challenge to the owners, managers and staff working in care homes. Some staff were unable to work as they were required to stay shielded (either to protect themselves or people with whom they lived), or they had to keep socially isolated for an initial period. Those who went into work faced unknown conditions, a potentially deadly virus and often limited (or even none) personal protective equipment (PPE). They were, not surprisingly, highly anxious, very concerned both on behalf of the people for whom they cared and for themselves and their families. Despite this they rose to this challenge and gave a massive service to support a range of highly vulnerable people who lived in care homes. This report starts by recognising the selfless service and the highly professional commitment that these staff, managers and owners provided in the most challenging of circumstances. In addition, many staff in the public sector worked incredibly hard for long hours to offer the support and guidance to assist care homes in best managing the virus.

Through this report I offer my personal condolences to those who lost loved ones in care homes from Covid-19. It had been a difficult time not only for staff but also for relatives and friends of those who died in care homes sometimes without any opportunity for people to say their "good-byes" or for people to have a full funeral in the way in which they would have been able to do prior to the virus hitting the care home sector. I can at least assure those relatives that during this study I found care home owners, managers and health and care staff who were working diligently and professionally to try and reduce the impact of the virus into care homes. There were some problems of coordination and of understanding the nature of the virus in the early stages but once these were ironed out the sector has worked hard to reduce the risks.

Throughout this paper reference is made to "care homes". This includes all residential homes and nursing homes that offer care on a permanent or temporary basis to adults of any age.

Even after six months of the virus spreading across the United Kingdom it is clear that scientists are still learning more about the virus, its nature and behaviour and the way in which it spreads. Much that was not known in the early days has only been discovered as the work to protect people continues. This has of course had an impact on the frustration and sometimes confusion in the care sector about what has to be done. Much of what people shared in this review has been developed over time. A lot of what we now know to be good practice was much less known at the start. The material shared in this report has mostly come from the participants themselves. This demonstrates the strong commitment and resolve of all partners to look to protect care homes particularly if a second wave of the virus hits communities which is what many experts predict will happen.

2 Background: Care Homes in Wales

There are 1294 Care Homes in Wales caring for 26,681 people of all ages. These are made up of 217 Children's Homes (with capacity for 927 children), 814 homes for adults and older people (13357 people) and 263 Nursing Homes (12397 people). The majority of places for older people in care homes in Wales are funded by Local Government or the NHS. There is variation in this by local authority area. In Monmouthshire, Denbighshire and Wrexham for example the majority of beds are occupied by self-funders. In Neath Port Talbot, Gwynedd, Rhondda Cynon Taf and Ceredigion the vast majority are funded by the Local Authority/ NHS¹.

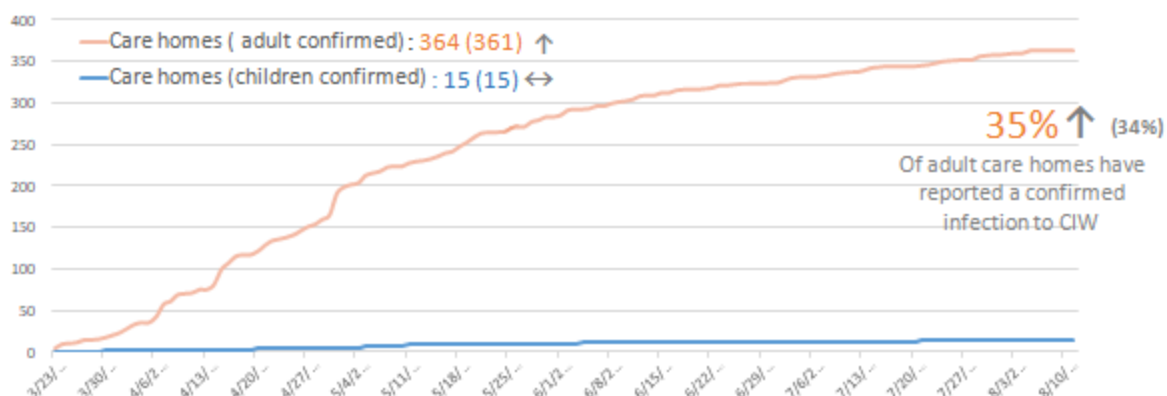
The majority (75%) of care homes for older people in Wales are owned by a single owner or an owner who has less than five homes. A much smaller percentage of homes are owned by larger group providers (8%) or by local authorities (17%)². 29% of care homes in Wales for older people are run by organisations based in England. Care homes can expect to function with occupancy of between 85%-90%. There are parts of Wales where care homes did not reach these levels before the pandemic. This was already presenting a problem for the sustainability of the sector which of course is further challenged by the lower occupancies now being seen as a result of Covid-19.

¹ Study undertaken by Institute of Public Care in 2015 – [The Care Home market in Wales: Mapping the sector](#) IPC (2015).

² Information from CIW Annual Report (2018-19) and Study undertaken by Institute of Public Care in 2015 – The Care Home market in Wales: Mapping the sector IPC (2015).

Care Homes – Infection (Cumulative)

Care Homes that have reported one or more confirmed cases of Covid-19 since 16 March 2020



↑↓↔ denotes change from previous week (previous week's data)

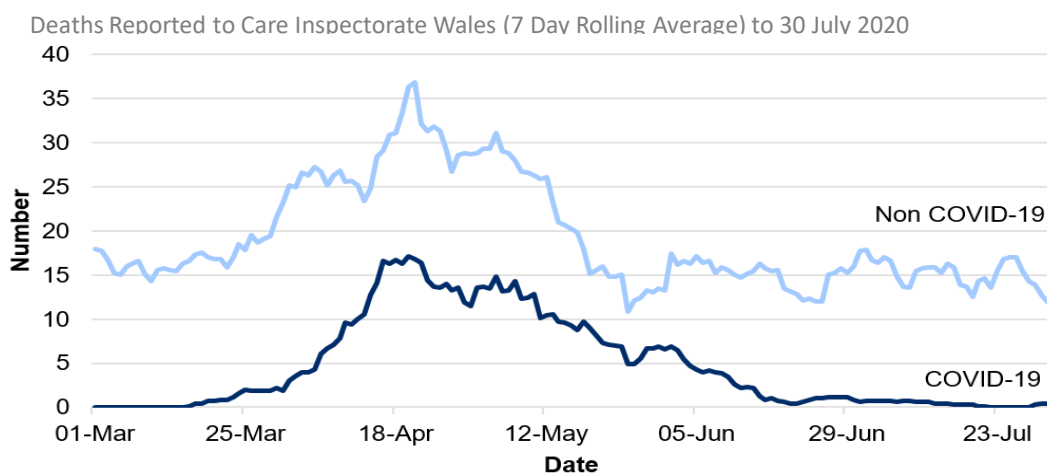
Source: Care Inspectorate Wales – 11 August 2020

As reported by Welsh Government on August 12th 2020 there had been 364 care homes for adults reporting a minimum of one case of the virus and 15 care homes for children with a report of the virus being present. This means that 35% of adult care homes reported a confirmed infection. This reached a peak at the end of May and though there has been a steady increase since (thanks to the increased testing) it has not been at the rate that was experienced in April and May. Care homes are now able to appropriately help those who have caught the virus (through social isolation etc).

Care homes were required to report all known Covid-related deaths to Care Inspectorate Wales. The diagram below shows that the Covid-related death rate (7 day rolling average) peaked in mid-April and has been declining since then. From the middle of June the newly reported deaths in care homes from Covid-19 has been very low. The period from the end of March to the beginning of June was particularly challenging for care homes and those helping them.

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Care Homes – Mortality (CIW)



*CIW are notified of deaths of all residents, regardless of location. Notifications are not based on clinical assessment as to cause of death.

** This data is now updated fortnightly

Source: CIW 4 August 2020

The Office for National Statistics³ report that “...in Wales mortality rates were statistically significantly higher for male Care Home residents than for female residents”. They also report that in Wales deaths involving Covid-19 were higher in the care home population than in the non-care home population. Finally, they report that residents of care homes were much more likely to die within their care home setting than in a hospital.

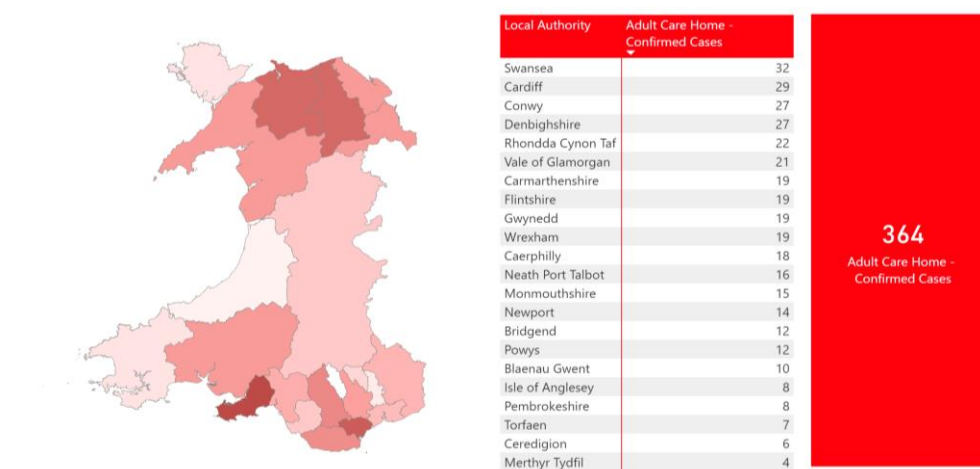
The infection rates in care homes for adults and older people have varied between regions with the higher numbers of care homes with reported infections in the Swansea and Cardiff areas followed by Conwy and Denbighshire and the lowest numbers in Merthyr Tydfil and Ceredigion. The reported cases in care homes for children included 4 for Powys and 2 for Bridgend and Vale of Glamorgan.

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³ Deaths involving Covid-19 in the care sector, England and Wales.

Care Homes – Infection by Location

Adult Care Homes that have reported one or more **confirmed** cases of Covid-19 since 16 March 2020



Source: Care Inspectorate Wales– 11 August 2020

3. Background: The Covid-19 Lockdown Phase

The Covid-19 pandemic hit Wales in February/March 2020. This led to action from the Government to ensure that there was enough capacity in the acute hospitals to meet the health needs of any citizens who required hospital care as a result of contracting the virus. During March 2020 some patients in acute hospitals who were medically fit were discharged from hospital and placed with care and support either in the community (mostly in their own homes) or in residential care homes. At this time there was much uncertainty in the United Kingdom about the nature of the virus, how it was transmitted and the associated risks. There were however studies from the United States⁴, Italy and Spain that all indicated that older people's care homes were places that were likely to be at significant risk.

It is worth noting that the evidence about the impact of Covid-19 that was available was not widely known in care homes at the outset of the Welsh experience of the pandemic in March 2020– though a few owners (and other professionals) had read some of the research (cited in summary in Appendix Two). As a result of medical advice and local initiative many care homes in Wales locked down “early” in March 2020 (usually about two weeks before the formal lockdown from Government), but this did not prevent the virus from getting into some care homes quite quickly before the local systems were in place.

⁴ McMichael TM, Currie DW, Clark S, Pogojans S, Kay M, Schwartz NG, et al. Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington. N Engl J Med. 2020.

It is also worth noting that in March 2020 little seems to have been known about how the virus might be spread. There was a belief that it was spread through droplets (coughs and sneezes) but this was not fully understood. This meant that there was little clear understanding of the purpose of personal protective equipment (PPE) and how it should be used. As “experts” became more aware of the need for PPE so the alarm bells rang out in care homes. They had at best a limited supply and many had no supply at all.

The response to the challenge of the virus in the very early stages was described by many stakeholders as being “fragmented” with many different professionals all working very hard to do their best to understand what was happening and looking to reduce the impact of the virus on care homes. It probably took between two and four weeks from the first signs of Covid-19 in care homes in most places for an orderly and better managed response to emerge. The challenges in the early days included:

- A perceived view by many in the care sector that the NHS acute services were getting priority support as opposed to people who had care needs;
 - A lack of knowledge of where and how the virus was spreading;
 - A lack of knowledge in some places of the best forms of infection control against the virus;
 - A lack of protective equipment (PPE) – specifically the right type of equipment to help protect staff;
 - A lack of testing for residents and staff in the care homes;
 - Staff off sick not being paid when they are required to shield or socially isolate (some coming into work);
 - Regular or agency staff being brought in who also worked in other settings;
 - A difficulty for some people in obtaining supplies for care homes including food and pharmaceutical goods;
 - A large number of public bodies all looking to play their role in the system but sometimes “tripping over” each other to collect data and to understand what was happening in specific care homes without obvious benefits to the care homes themselves;
 - Some professionals who were involved in assisting care homes had no previous experience of working in this sector and did not fully understand that a care home is a place where someone lives and that the quality of their life is one of the most important aspects of the care delivered;
 - The use of inappropriate interventions to “assist” Care Homes in addressing the virus especially the use of “Safeguarding Procedures”;
- A lot of advice and guidance (including formal guidance) issued in the first few weeks. Sometimes this was issued at short notice (e.g. on a Friday before a bank holiday weekend) and it was not always clear to people busy running care homes

how the latest guidance had been changed from the guidance issued the previous week;

- Some confusion between what was being said by politicians and press in Westminster and the official policy in Wales;

Fortunately this phase only lasted for a brief period in most places and quite quickly a good working relationship was established between those providing care and those advising them.

From the evidence collected in this quick review it is absolutely clear that care home owners and managers have overwhelmingly only had one primary concern - to protect older people and younger adults from the pandemic whilst trying to maximise their residents' enjoyment of life. Best practice suggests that care homes must be treated as equal partners - experts in providing day to day care - who are committed to their residents' welfare. There were areas where care homes required help and support. Some of this they received from other care homes (including Council-run homes) and other areas where Public Health Wales, Care Inspectorate Wales, Environmental Health officers, Infection Control Nurses, Social Care Commissioners, Health workers, GPs, Geriatricians, Public Protection, ambulance paramedics and other care professionals where co-ordinated advice and support proved invaluable. Where this support was disjointed, uncoordinated or disparate it was experienced by care homes as a bureaucratic nightmare.

It is important that the public sector works as a single agent in full partnership, recognising each other's roles and responsibilities in order to maximise the benefits of their advice and support for care homes. There are some excellent examples across Wales of local partnerships working together in a multi-disciplinary way to assist care homes, though in most places this took at least two weeks for it to all come together.

There are two major areas where concern has been expressed by stakeholders about the way in which the care home sector has been protected during the pandemic. These are the availability of personal protective equipment for staff (PPE) and the availability of testing for the virus for both residents and staff. These issues have been well documented and covered in local and national media. At the time of writing this report it appears that both of these matters have been resolved after a very worrying period (for staff and residents in care homes) through a combination of partners working well together led by Welsh Government. The availability of free personal protective equipment co-ordinated and purchased through Welsh Government and distributed locally is very much a welcomed action by local authorities and care homes alike.

Some care home owners reported that despite enormous efforts from the local authorities and multiple directions and guidance issued to them that they felt very much

on their own (there were places where local authorities were reported to be more supportive than others). These providers believed that they have got through the virus through mutual support, shared advice and by developing their own evidence of what has worked. In addition they stated that some of the guidance appeared to be written by people who had little understanding of the lives of residents in care homes and they would have benefitted of checking their advice with providers before issuing things that were impractical and unworkable.

4 The role of Health Boards and Local Authorities

4.1 Strategic arrangements

Each partnership might consider the nature of their relationship with their care home providers and ensure that future work is carried out in a spirit of true partnership with those providing care to some of the most vulnerable adults in the health and care system.

At a local level there needs to be an operational group that is clear on their roles and responsibilities that can coordinate the support that is needed by different care homes.

An important feature in tackling challenges such as the pandemic and its impact on residents and staff in care homes is to recognise that the concerted actions of professionals has to be undertaken as a partnership. The partnerships operate at a strategic level for senior managers as well as at an operational level. In addition, in many places people commented on the importance of local political leadership in both empowering their officers to do the “right thing” including allocating additional resources and as a conduit between local agencies and national government.

There was a need to bring together the very different cultures from health and social care as well as the different values that people brought to the effort. There was often a tension created between those who had a ‘can-do’ attitude and just got on with trying to ‘do the right thing’, and those who were concerned that the governance wasn’t in place for certain actions to be taken. These are natural tensions and they require good leadership to resolve them. In many places (but not all) it was reported that as time has gone on some of these cultural differences have been ironed out and much better working relationships and mutual respect are now in place.

In most Health Board regions a “cell” was established to support and co-ordinate the operational actions in relation to Covid-19. In parallel with this Local Authorities established their own working group to co-ordinate their efforts to reduce the risks of the pandemic. These initiatives have now led to a joint Strategic Board between the Local Authority and the Health Board and a joint operational (multi-disciplinary) group. It is

advised that the Strategic Board (but not operational multi-disciplinary meetings) should have representatives from independent care homes on that Board.

At local operational level this means ensuring that the skills and knowledge of all of the following are pooled: Health Care Staff (Health Board Commissioners/Planners/ Contract Staff/ Complex Care Leads/ Pharmacists, GPs, Palliative Care leads/ community/district nurses, Infection Control Nurses, mental health services); Local Authorities (commissioners, contract monitoring, social workers, environmental health and their corporate centre); Care Homes (including managers, staff, residents and relatives); Care Inspectorate Wales and community and advocacy-based organisations.

No one party can manage the range of issues that need to be addressed. Good communication, respect for and an understanding of each other's roles and a willingness to work as partners was found to be critical in supporting care homes to best manage the pandemic when it did occur and avoid it where it had not occurred. It is worth noting that there are some attitudinal differences in relation to how the public sector views care homes run by independent providers. In some places the care home owners, managers and staff are seen as partners playing a really important part in the health and care system looking after older people in their later years and caring for younger people who require intensive support. In other places they can be seen as "commissioned services" which require monitoring and support to ensure they were doing the right thing. The view of the care home sector that was taken locally by the professionals working in the health and care sector made a difference to how care homes experienced the help they received.

There are some excellent examples of operating procedures that spell out the specific roles of organisations and individuals in the health and care system which then helped clarify the different parts different professionals had to play. One important role for the strategic leaders was to ensure that the different skills available were brought to bear in the most effective ways.

Managers who are running care homes reported that they responded best to the advice offered where this was done in a spirit of partnership and collaboration. Where providers were seen only as 'providers' who needed to be directed by the local authority or health board, their response was more muted. One provider reported, *"There was too much command and control from the authorities and not enough practical help"*. Another said, *"I always felt they were making a judgement on me rather than trying to help"*.

In many councils local authorities run their own residential care homes. This gave them some direct insight into the problems that managers, staff and residents were facing. There are many examples of local authorities creating partnerships with the local independent care sector in order to share best practice and together face the

challenges that the virus brought. In the best examples the local authority brought together Social Care, Environmental Health, local health practitioners and Health Board officers, as well as care home managers to have regular calls to offer mutual support and to identify where there were risks in the care home sector. Local Authorities had to recognise their dual role as a provider of care but also their responsibility to advise and assist the independent care homes to protect their residents from the pandemic.

Local Authorities and Health Boards found that one of their roles was to advise care home owners and managers on new guidance when it was issued to ensure that it was understood and implemented appropriately. As has already been stated often guidance was issued at awkward times - late in the week, sometimes before a bank holiday weekend and it was sometimes seen as being unclear on its difference from previous guidance. Sometimes there was confusion for care home staff as to the media coverage of the guidance in England and announcements from the UK Government and the nuanced differences that the Welsh Government had chosen to make. This was sometimes compounded by the guidance being used by those providers who had care homes in both England and Wales. The role of health boards and local authorities to help interpret and communicate the guidance to care home managers who were busy keeping their operations running became an important feature of local work.

There are some excellent examples of joint strategic partnership boards working together to make executive decisions to ensure that the front line of care homes were being supported during the pandemic.

4.2 Operational support

4.2.1 Continuity planning and general support

The Health and Care partnership should support each Care Home to have a business continuity plan

There is an expectation that local authorities and health boards have continuity plans in place to address any “unforeseen events” that are likely to cause challenges to their emergency planning processes. It has emerged during Covid-19 that there should be continuity plans both for individual care homes and for the local health and social care partnership in relation to the actions that may be required from them to ensure the sustained running of the care home sector during a pandemic.

Care homes should have their own plans, but the public authorities will have a duty to care for and protect any residents who are at risk because of a shortage of goods/ supplies or staffing for a care home. Some local authorities had to ensure that food was delivered to care homes in the early stages when it was difficult to get food supplies from shops and also to link with local pharmacies at this same stage to ensure that the

right drugs were available and being delivered to care homes. Pharmacy advice was also required in some care homes in relation to managing the “Just in Case” boxes which are used for palliative care.

Many local authorities had daily calls with care homes to collect data and check how things were progressing. A couple of local authorities worked in partnership with health boards and CIW to ensure that there was one single form that their local providers had to complete before submitting it electronically to a place where the data could be safely stored and then used appropriately by different agencies.

Care home managers also found weekly webinars or Skype phone calls into which all providers could dial very useful (where they were made available). This not only ensured a consistent message to care homes but also offered a place to develop strong mutual support. Care homes developed good relationships with each other in places and this added to the support networks that helped managers get through the challenging times.

In the early stages of the pandemic some councils helped their local care homes to access provisions including food, cleaning materials and pharmacy goods as these were in short supply. Often the council could negotiate special arrangements with supermarkets and others when care homes’ regular suppliers were not able to get the provisions that were needed.

Appendix 1 includes a list of actions that care home managers, owners and some Health Board and Local Authority officers have advised might be the best ways to reduce the risks of such a virus in the future. This is worth consideration by anyone working in the sector. This of course relates closely to the recommendations laid out in this report.

4.2.2 Preventive measures to manage infection control

Each partnership might assist in ensuring that there is an “infection control” action plan in place for every care home in their area.

All care homes irrespective of their position need to be clear how they are meeting the required standards for infection control to ensure they are able to minimise risks. It is the professional responsibility of public health, infection control nurses and environmental health officers (part of Public Protection Teams in Councils) to ensure and support this. For some council in-house services there was also additional support from their Health and Safety Teams. These are really important but scarce resources at the time of a pandemic so need to be used well without duplicating effort. There needs to be a clear protocol in place to ensure that each of these professionals is clear of their responsibilities within the care home settings. Probably the best equipped professional

groups to carry out infection control audits in care homes are infection control nurses who already provide this service to all hospital wards. They are familiar with the associated risks, are skilled in self-managing their own risks of infection and can offer good quick practical advice and training to front line staff. In addition Environmental Health Officers can play an important advisory and supportive role here. However, they were in short supply given the scale of the problem. Locally, partners need to allocate the resources available according to need but with a strong emphasis on preventive actions to reduce the risks.

Telephone advice can play a part, but the best evidence that informed this work was that undertaking a full in-person audit of any premises and offering practical advice as a result of that audit was the best way of ensuring that managers and staff understood what was required of them to reduce the risks of passing on the virus. This action is particularly important given the numbers of either staff or residents who have been found to be asymptomatic during recent testing. Every care home should be supported to ensure that a clear evidence-based plan for infection control is in place. Many care homes “locked down” at least two weeks prior to the formal government announcement. However the pandemic had already reached some Homes before then. It was found by those professionals in touch with care homes that they only had a basic understanding of the detail of infection control. In some places audits took place in care homes (irrespective of whether they had the virus or not) in order to offer advice and to properly train the staff;

Infection control is by far the most important knowledge that a care home needs to understand in order to reduce the risks of any pandemic. It is best managed through action in the following areas:

- Ensuring that a process of decontamination is consistently taking place;
- Ensuring the staff understand the proper use of personal protective equipment (PPE) and understand how to don and doff that equipment;
- Ensuring that staff are aware for the need to wash their hands properly and regularly as well as using hand gel as a contributor to cleansing;
- Ensuring that staff at all times follow social distancing practices including not car sharing, maintaining distances during shift changes and on breaks;
- Ensuring that the right chemicals are being used to clean the care home (chlorine based)
- Ensuring that meal times are properly managed achieving the aims above;
- Ensuring that any professional visitors are kept to a minimum and where they are required to visit (e.g. to offer medical support to a resident or to visit a dying relative) that they follow the above rules, including the current visiting guidance.

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It has to be noted that after the initial uncertainties local authorities have done well to manage equipment stores with a good supply of PPE for all care homes. There may still be some advice required on the right form of protection for more specialist care but the distribution and availability of a stock was not reported to be an issue in recent weeks.

Care homes need to consider their layout and design in relation to the safest way to socially isolate individuals or groups of individuals who have tested positive for the virus whilst maintaining a reasonable quality of life. This space needs to be linked to an identified sterile area where staff who are caring for these residents can put-on and take-off their protective clothing. It has been easier to find appropriate spaces in some settings than in others. Once Covid-19 is known to be present within a care home, advice should be offered as to whether it is feasible and practical to divide the care home into zones where those with a diagnosis of Covid-19 or who are required to isolate themselves can be cared for in a separate environment from those who have tested negative. There needs to be a local decision made with each home as to the safest way they can identify how the home can be managed with either individuals or groups of residents socially isolating. If this is not possible then there needs to be consideration of a short term move for such residents to an intermediate care setting where they can be helped and supported in their recovery from the virus. (See section on Intermediate Care).

It has been found⁵ that the larger the care home the greater the likelihood that Covid-19 will be found in the home. There are of course a number of reasons for this ranging from the difficulty in ensuring all parts of the property are fully decontaminated to the coming and going of many people including staff, professional visitors, goods and services etc.

Some authorities made online training available for managers and staff around infection control. This is of course helpful although the busy schedule of people working in care homes during the pandemic has made access to these quite difficult. The broad view of infection control nurses who contributed to this review was that where possible it is best to offer direct training to staff on site. It is recognised that as this is scarce resource the on-line training does at least offer a sensible alternative.

Dealing with infection control and hearing the messages that need to be given can create anxiety and additional concerns amongst the staff team working in a care home. It is important that though this is probably the most important area that requires attention and detail that the messages are given with sensitivity and recognising the emotional support that staff need when the pandemic is either in or feels close to the

⁵ <https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report>

care setting. As one respondent put it, “it is our job to help the staff feel they have become experts in managing the pandemic”.

4.2.3 – Staffing for Care Homes

Each partnership might ensure there is a staffing contingency plan in place for their area. Health Boards may wish to seek guidance from Welsh Government on how this can be achieved within the current legal framework.

Each partnership might consider how they advise care homes on the best way to deploy staff during an outbreak eliminating those staff who work in more than one setting.

Each partnership might consider how they continue to support the well-being of all staff who have worked through the pandemic.

The other key area on which care homes may require support is to ensure a good supply of “Covid-19 free” staff (including nurses and managers).

There is clear evidence emerging⁶ that staff are the most likely carriers of the virus both from outside the care home and within the care home. In the section above, the importance of staff understanding infection control is laid out. There are other important considerations for staff.

When staff have been diagnosed as having the virus (Covid-19) they should not be at work. The evidence suggests that where staff are paid (sick pay) for socially isolating themselves there is a much higher rate of compliance.

It is also clear that staff who work in more than one setting (including agency staff) are much more likely to catch and spread the virus. Some Health Boards and Local Authorities asked the agencies they knew were used by their local care homes to limit staff to working in only one setting and a number happily complied. Other risks that have been identified include staff travelling to work together (car sharing) and staff socialising without observing social distancing during breaks in the day including in designated smoking areas.

With the need for a number of staff to be off whilst they socially isolated, the reduction in the numbers of staff who could be used from the agencies, and the shortage of staff working in the sector prior to Covid-19, there was a serious risk to the ability of some care providers to run their homes. This included the shortage of nurses who are formally required to be present in nursing homes. Some local authorities developed a bank of

⁶ <https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report>

their own redeployed staff to act as cover for any emergency situation. Often these staff had already been redeployed into the existing in-house care homes to act as additional staff often running activities for residents (as these were often staff whose substantive posts were in day centres). These staff became a pool of people who might be asked to volunteer to work in any care home setting across their authority area (including in independently run homes), though most local authorities only made these staff available for their in-house services. In most of these places staff were offered a course in basic care including manual handling, medication management, infection control and food hygiene before they were asked to start working. In one small council over 130 people were trained to be available if required. There were not only shortages of care staff but at times this could include catering and cleaning staff who were significant to the running of the home. One council redeployed their own staff into a privately run care home to meet an emergency when these critical staff were off.

All authorities might consider this being part of their contingency planning to support a care home under pressure – whether Council or independently run. It should be noted that these staff all volunteered to cover or add additional posts to care homes. Many care homes in both the independent sector and those run by councils paid an additional premium rate to care staff who have worked during the pandemic. One council increased its rate to time-and-a-half. These payments appear to have reduced the need for extra agency staff.

It was less clear whether Health Boards might adopt a similar approach to using nurses to support nursing care homes. There is a clear responsibility on Health Boards to ensure that there is good quality nursing available to support nursing homes as well as their duty of care for all residents. In a paper prepared for one Health Board (which noted the lack of precedent for action in 'failing homes') it was proposed that the Director of Nursing would provide staff to a nursing home in an emergency, if all other avenues had failed (e.g. there were no available agency staff), that the action would be short-term (no more than five days) and that the welfare of the residents would be seriously at risk if no action was taken. The Health Board determined to recruit a team of nurses that would work part time on other duties but who would be available to support a nursing home in the circumstances described above. The recruitment had not taken place before Covid-19 so a team of nurses were on stand-by but not required during the recent pandemic. This appears to be the best approach in an emergency. In more than one place the Health Boards have provided volunteer nurses to help out in an emergency on the basis that at the time it was "the right thing to do". This of course has only happened in an exceptional case where the alternative would be moving a whole group of residents – probably to a hospital ward.

A couple of Health Boards made their own bank staff available to the wider sector, but this was not used (to my knowledge). It was reported that at least two Health Boards

propped up a Nursing Home over a challenging weekend bringing in their own health and care staff. The thought in most Health Boards was that if a nursing home was unable to function that the Health Board would have to consider moving all of the residents to an intermediate health care or hospital setting (at a high cost and with great inconvenience to residents). Health Boards might usefully consider the contingency plans they should put in place to support the nursing homes during a pandemic.

Many care homes (including those run in-house) used additional staffing to assist them during the pandemic. This was necessary to maintain the social isolation of some residents in order to limit staff to working in smaller groups (to reduce the risks of cross infection) and to support residents in social activities including making contact with relatives. In many cases the additional staffing hours were made available requiring additional resources with staff prepared to work longer hours (overtime) to meet local needs. One pattern of shifts for staff was to work for 3 days on a 12-hour shift and then have a 3- day break. Initially these costs were met by care home owners. The hardship fund (see later section) was subsequently available for residential care homes.

There were a couple of occasions where the local multi-disciplinary team considered that advice from a senior nurse would assist in the running of a residential care home. This would not be for the nurse to run the home or to have any management responsibilities but to ensure that the best health care of residents was being considered in the home.

There is no doubt that there was pressure on staff and their managers whilst working in the context of Covid-19. Staff were required to shield themselves or to have periods of social isolation when they were absent from work. Those who remained at work were remarkably loyal and worked additional hours (some even sleeping in the care home to reduce the risks of infection). For everyone it has been stressful and emotionally draining. Local Authorities and Health Boards may wish to consider which of the facilities that they run for their own staff may be of benefit to staff in care homes during a pandemic (e.g. Occupational Health) and make these resources available to the independent sector.

There was a specific problem highlighted from one area where a number of staff who worked in a home for adults with learning difficulties had to be off work at the same time (included some shielding and some self-isolating). This left only two of the permanent staff on duty and this presented a challenge for the residents who felt much more comfortable having people they knew to care for them. It was hard to find a solution for this problem except to get the regular staff back as safely as was possible.

The well-being of staff was an important consideration. It is reported that staff can face very similar experiences to those who have Post Traumatic Stress Disorder (PTSD)

from working on the front line in the forces or in acute care. Various arrangements were put in place to offer counselling and support. These included using local psychological services, arrangements with local voluntary organisations such as MIND, access to human resources and occupational health services from within public bodies and counselling support offered on-line for staff to use including “mindfulness sessions”. One council ran a weekly webinar for staff to support their “well-being” which had originally been designed for their in-house services but the offer to join was extended to the independent sector. In one area an arrangement was made by the health board with the local hospice for counselling support and advice to be made available for care home staff.

Of course it is important that staff have time and space to wind down and support each other whilst they are at work. This may well be in a staff room or similar setting. It is important that staff understand the importance of maintaining social distancing during their breaks and other times when they might be together.

The Social Care Wales and the Social Care Institute for Excellence (SCIE) websites have some useful materials available to download which provide up to date advice and guidance for managers and for staff on how to manage in the pandemic.

There is an important issue in relation to the disproportionate Black, Asian and minority ethnic (BAME) staff who were in positions where they were vulnerable to the virus in both health and social care settings. One Health and Care partnership reported that they paid particular attention to this and included these risks in their risk assessment tool (All Wales Covid-19 Workforce Risk Assessment Tool). This also warrants further investigation in the near future.

4.2.4 Care for residents

Each partnership might consider how to assist all care homes in having meaningful activities in place for residents during any pandemic with a focus on activities that are appropriate for those who are socially isolating and for those with dementia.

Each partnership might consider how emotional and well-being support continues to be offered to all residents (including younger adults) even though the current pandemic appears to be easing in care homes.

A lot of concern has been expressed about the emotional impact of lockdown on residents; this may range from missing loved ones, to frustration and boredom from remaining in the same environment, and the result of rapid and unpredicted changes to

living arrangements in care homes. There has been a clear recognition of the impact on the psychological well-being of both residents and staff. It is important that someone is listening to both residents and staff about their experiences and that future action is undertaken in response to the comments made.

People living in care homes have all been able to maintain contact with family members mostly through the use of Ipads. The Welsh Government provided funding to Digital Communities Wales: Digital Confidence, Health and Well-being Programme to distribute around 1,000 digital devices to care homes, hospices and wards to support residents to connect with their loved ones. Other Ipads were donated to the care homes by Local Authorities and some through local community fund raising and some assisted with Wi-Fi connections. One provider said that a larger screen would actually have made this contact easier for some residents. He suggested a 52" screen would be ideal for his residents. It is important to note that probably the most important communication that is required during a pandemic is that between the residents in a care home and their close relations. Many care homes set up regular newsletters for relatives and made arrangements for times when they would receive calls from relatives or developed Facebook pages to ease communication. For some relatives it is distressing when they can see (on video calls) the deterioration of a loved relation but are unable to reach out to them. One idea that was popular with residents was to ask relatives to send in photographs of themselves, grandchildren, favourite places etc in order to keep a memory going of the "outside world".

Many care homes have either taken on additional staff (almost all in-house council run care homes redeployed their day care staff to work in their care homes) or in the independent sector they asked staff to work additional hours in order to sustain the quality of experience for residents. This has proved a necessity in order to both meet the requirements of infection control and ensure a good quality of life for the residents. Councils have offered some direct support to care homes with a range of actions including:

- Reminiscing programme that are available on-line;
- Specialist "games" to assist people with dementia (See Alzheimer Society Website);
- Sensory boxes for adults with dementia (a programme that was started prior to the pandemic but proved to be very helpful during it);
- Special activities such as VE Day celebrations, gardening competitions, dance and parties;
- Concerts in the car park;
- Introducing "corridor bingo";

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- Linking the home through Skype to local community organisations and friendship groups;
- Providing traditional games and games downloaded from the internet;

A study of what happened to residents during the SARS epidemic in Hong Kong⁷ emphasises the participation of the residents in reducing the risk of the spread. It is important that, where reasonable, residents should be fully engaged in the actions the home is taking to protect them from the spread of Covid-19. The engagement of residents, and the sense of agency this encourages, is known to have a positive impact on their well-being and of sustaining their quality of life.

The hardest part of delivering the care was when a resident was required to socially isolate because they either had a diagnosis of Covid-19 or had been close to someone who had a positive test. This was usually for a fourteen day period. This required additional staffing to be with the person to meet their needs. This could be a particular problem for those with dementia who may be prone to wandering around the home (sometimes referred to as “walking with purpose”) in normal times. Care homes were sometimes divided into red and green zones distinguishing between those who had a positive test for the virus and those who had not. One authority introduced a monthly questionnaire for residents to examine their Covid-19 care plan. This assessment used the “signs of safety” assessment for adults that focuses on: What are you worried about? What is working well for you? What would you like to happen? This is an approach which originated in Australia for child protection but has now been developed in working with adults⁸.

Sometimes the design of a care home allowed for people to operate in small “protective bubbles” or teams where they could be protected and remain safe, but for other care homes their design and layout meant this was not possible. It was reported that some care homes used a “buddying” system where two staff worked together on the same shift most of the time in order to reduce the risk of any virus spreading.

One of the big issues during the main peak of the pandemic was the fact that residents could not safely “entertain” guest in their homes. This was overcome by the use of I-Pads and video conferencing which was very important. Recent guidance has now enabled more visits to take place in safe settings. However, some care homes did (very carefully and ensuring full infection control processes were in place) allow relatives to

⁷ See MM, Pun SP, Benzie IF. Experiencing SARS: perspectives of the elderly residents and health care professionals in a Hong Kong nursing home. *Geriatric Nursing*. 2003;24(5):266-9.

⁸ See work of Dr Tony Stanley Principal Social Worker London Borough of Tower Hamlets – An introduction to signs of safety and well-being.

visit and meet with relatives who were known to be dying. Though this would be done in full PPE it was very consoling for relatives and very appropriate for residents to have a final farewell meeting. The visits of friends and relatives to residents of care homes are known to be very important for the person's overall health and well-being. It is important that this is safely sustained wherever possible. Blanket decisions to stop close relatives and friends visiting people in care homes should not be taken lightly. Each care home can be assessed according to its known risks and the ability to manage infection control in the home. Visitors who are brought into an infection free place can be protected with PPE, with sanitisation, with keeping safe distances and thorough cleaning of the appropriate areas. If this is properly managed the risks can be negligible and are well balanced against the known benefits to the overall well-being of residents.

In addition, mental health services were commissioned to provide ongoing support for both staff and residents. These included people who had experienced the trauma of living in close proximity to the virus, the death of fellow residents and people for whom they may have been caring for a number of years and for those who are recovering from the virus. The support available had been commissioned so that people who were identified as experiencing difficult traumas, bereavement, depression and social isolation could discuss their feelings with a professional person (usually online) in a confidential setting. Where this support has been made available it has not been heavily used but is much valued by the recipients.

There was an incident where an adult with a learning disability required a non-Covid-19 related hospital admission. A member of staff accompanied her to the hospital to ensure she had someone she knew and understood her needs whilst she needed acute care. They stayed together until the person was ready to return to the care home.

4.2.5 Primary health care during the pandemic

Each partnership might consider how they can assist local GPs in establishing clear enhanced arrangements for every care home in their area. Where this is not possible the practitioners who have patients in particular care homes need to be clear on their responsibilities and how they will carry them out.

All areas and many care home managers reported on the continued engagement of District Nurses in carrying out their invaluable work for the care of elderly patients in care homes during the pandemic.

In some areas there was a lack of clarity on the roles that GPs might play to support care homes during the virus. There was some excellent practice (cited below) but in other areas care homes were unclear what they might expect.

On July 1st the new role of the enhanced GP was due to come into effect for care homes in Wales (known as The Care Homes Directed Enhanced Service – DES). This was however suspended by a directive issued on June 2nd 2020 (COVID-19 Care Homes Scheme Directed Enhanced Service Specification). Enhanced services are, in essence, elements of essential or additional services delivered to a higher specification, or medical services outside the normal scope of primary medical services, which are designed around the needs of the local population. The new directive laid out the following roles for GPs:

- Optimise access to primary medical care for care home residents.
- Enable urgent access to primary health care advice for staff in residential Care Home.
- Continue provision of pre-emptive proactive and anticipatory care.
- Promote a high quality consistent approach across health boards whilst at the same time being flexible enough to be adopted by clusters or individual practices.

In addition, the guidance stated that the roles of the GPs were to:

- Regularly and effectively engage with care home staff in the comprehensive management of care home residents on a weekly basis, termed for the purposes of this DES a “weekly ward round”, followed up where necessary with structured clinical consultations to Care Home residents.
- Allow General Medical Practitioners to support a multi-disciplinary team to provide comprehensive management of care home residents and ensure appropriate assessments are completed.
- Work with the cluster lead practice, local general medical practices and care home managers, to reduce the numbers of clinicians and community staff that need to visit care homes during the Covid-19 pandemic, e.g. by streamlining patient registration policies where it will benefit care to residents whilst preserving and respecting residents’ choice

In addition, there were responsibilities for new residents to care homes to have an initial assessment: *‘Each care home resident must have a comprehensive review of their mental and physical health completed within 28 days of moving in / being admitted to the care home. (A pro-forma template outlining the areas for review is at Annex B in the guidance). The Care Home will hold a copy of the completed initial patient review. The assessment can be conducted via remote audio-visual means when the home and resident are more comfortable from an infection control point of view. This review will include discharge medicines review to:*

- Reconcile medicines prescribed.

- *Address issues of polypharmacy.*
- *Address any antipsychotic prescribing and other high risk medicines,*
- *Update the record of prescribed medicines, maintained by the GMS contractor.'*

In some places the GPs that were already piloting the new enhanced role for care homes continued to provide weekly telephone assessments available to all residents. This meant that the GPs knew the residents individually, understood their longer term conditions and could recognise when people were ill and how best to treat them. In particular circumstances these GPs would actually visit the homes to personally examine their patients but generally this was not required.

Most areas reported that District Nurses continued to visit their patients in care homes during the pandemic and they of course complied with the requirements for infection control within the care home during their visits. In one area they encouraged homes to have (where it was feasible) a medical room which visiting health staff could use. The room would be decontaminated after each visit and there would be space for the staff to don and doff their PPE.

It was seen to be very helpful when staff in care homes became competent in taking daily measurements from their residents e.g. tympanic temperature checks, checking pulse rates, blood pressures and using Oximeters to check blood oxygen levels and to report these to medical advisers. This assisted in prioritising the right medical help for residents. This is particularly important when older people are known to not always show the symptoms of their conditions (atypical symptoms) including Covid-19.

In the early stages of the pandemic it was important to ensure that the correct proscribed drugs were available for residents in care homes. This required ensuring that pharmacists were supporting care homes and working in partnership with medical practitioners and care home managers to ensure both the correct supply and the right drugs were able to be correctly administered.

There was some confusion with regard to “advanced care plans” which would normally be in place for any patients who had capacity and in receipt of palliative care. In some places there were reports that GPs were not able to visit to work with their patients on these plans. Care home managers often felt that they did not have the knowledge or the skills to draft the plans and required professional support from health care staff. It was unreasonable to expect any staff to draw up these plans. The plans should be drawn up by involving the person (who must have the capacity to do this), their family members and appropriate medical advisers. It was important to distinguish between the necessity for these plans to be in place for those residents whose medical conditions indicate that

they are likely to die soon and those who may or may not be at risk of Covid-19. One of the important issues is to be clear that each advanced care plan needs to be written on an individual basis for each resident who meets the criteria. These plans should include much more than the medical assessment where it is noted that a person should not receive further treatment at a particular point in their condition. It is in essence a plan to assist a person to die with dignity in a way of their choosing.

4.2.6 Personal Protective Equipment (PPE)

Each partnership might consider how they can assist care homes in ensuring they have equal priority for the available supply of PPE if there was a further pandemic.

The supply of free PPE for care homes worked well once it was centrally distributed to local authorities and their depots have then distributed the equipment to care homes as requested. Most of the distribution centres have been externally audited by military stores experts and they have all met the required standards.

It was reported that the availability of PPE caused the most worry at the onset of the pandemic with a mixture of uncertain supply, mixed messages from the guidance and lack of a co-ordinated strategy. However, for the past few months after the Government took control over the supply and its distribution to care homes via Local Authorities it has worked very well. There needs to be some consideration as to how these arrangements might work in the future. Who is responsible for creating an adequate supply?

One additional issue was ensuring that staff are properly trained in the use of PPE. There were some earlier experiences where health staff visiting care homes noted that staff had not been fully trained. This was of course immediately remedied.

In the early days of the pandemic as soon as it became apparent that PPE was not easily available for care homes in some places there was a fantastic response from the local community sewing and making protective equipment and then donating it to their local care homes.

At the time of writing this report it appears that the Government will maintain its commitment to ensuring a supply of free PPE “until the end of this pandemic”. This is a notable commitment from the Welsh Government.

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4.2.7 Tests for residents and staff

Each partnership might consider how they can ensure that they have the processes in place to back up the test and trace arrangements for care homes.

All partners interviewed said that they wanted an efficient and effective testing regime that enabled them to respond quickly to any risk this might include regular testing of both staff and residents in care homes, and an ability to track and trace where outbreaks are occurring and to take specific action to protect care homes and their staff.

Recent guidance that enables both staff and residents to be tested regularly has been well received in both care homes and with the public services. There were reported challenges in some places in getting back test results in a timely fashion.

Now that it is fully recognised that there are many people carrying the virus who show no signs of the symptoms (asymptomatic) it is even more important that staff can take tests regularly (for example, once a week) so that it is clear who may be carrying the virus and who may not. This makes a significant difference to the day-to-day running of any care setting.

The biggest concern expressed by many respondents was the policy for either returning residents from hospital or for new placements that were being proposed from an acute hospital. The current guidance enables care homes to not receive people back from hospital where they cannot make them safe (see sections above). This requires planning for intermediate care services (see below).

4.2.8 Risk Assessments for Care Homes

Each partnership might consider how their local risk assessments are undertaken and how these are shared with care homes enabling them to take action to reduce their risks.

Local multi-disciplinary teams from the public sector have tended to apply their own risk assessment approaches to care homes during the pandemic. At one level this can be quite simple – those care homes where the virus is present (or has been recently present) = Red Homes, and those where the virus is not known to be present = Green Homes. There is a desire in some places to look further at the running and management of the care home, at the known history of the care home in relation to regulation compliance, changes in senior staffing, assessment of compliance with safety standards etc. These together can make a more complex risk assessment. Other places have used a traffic light system to make a daily assessment of the “state of their care homes”.

It is essential that care homes have their own risk management action plans and that they are given confidence to believe in them – this is the best way for them to both take

ownership of the issues and to reduce the risks. If a risk assessment is going to be made on a care home and its ability to manage the pandemic, the evidence for the assessment must be shared with the owner/manager of the home and they should be assisted with an action plan to mitigate against the predicted risks.

4.2.9 Discharges from hospital

Each partnership might consider how they arrange for short term beds (intermediate care) to be available to help the recovery of patients who have been in hospital and are required to isolate to ensure they are not spreading the virus.

Each partnership should ensure that acute hospitals understand and can use the local arrangements that are put in place to support the discharge of patients.

There is no doubt that the virus spread into care homes in several different ways. One of the ways was when residents who had been in hospital returned to their homes having contracted the virus in hospital or new residents entering a Care Home for the first time after they had contracted the virus.

Guidance has been issued on the care pathways to support discharge from hospital during Covid-19⁹. It is expected that most people would return home and, in some places, 'Home-First Bureaus' were established to ensure that people could be supported in their own homes (in line with the guidance). It was recognised that a minority of patients may still require a bedded facility to support their recovery post-hospital and an even smaller number may be assessed as requiring permanent care at the point of discharge (though this is not considered to be good practice). One authority established a "find a place" website where providers could log when they had vacancies and when they were closed to new people. This is being developed across the country – "The Care and Support Capacity Tool" which currently has almost 900 Care Homes using it to post vacancies. (There is a separate system – Findaplace used in West Wales). The NHS Delivery Unit reported that they found most Regional Partnership Boards invested their additional monies (allocated to assist with speedy hospital discharges) in teams to support discharging people into their own homes (discharge to recover and then assess in their own homes), though recruiting staff quickly for these roles presented a challenge.

Guidance¹⁰ currently states that no older person should return from hospital or move from an acute hospital to a care home without a negative test for Covid-19. It is not

⁹<https://gov.wales/hospital-discharge-service-requirements-covid-19>

¹⁰<https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-healthcare-workers-in-wales/prevention-and-management-of-infection-and-outbreaks-of-covid-19-in-residential-settings-in-wales-version-4/>

appropriate for those older people who are unable to return to a care home to stay additional days in an acute hospital as they need to start their rehabilitation and recovery period post-acute care.

It is important that Local Authorities and Health Boards work together to ensure that there are sufficient intermediate care settings where older people who are either self-isolating or recovering from the virus can live safely with the best possible care both during a pandemic but also when there is no pandemic in order to help with their recovery and recuperation. Some care homes were able to take residents back to their home if they could assure themselves that they could isolate the older people within the home. However this gave challenges for staff as well as the overall infection control within the home.

In most parts of the United Kingdom for many years care providers have not been “commissioned” in the true sense of the word. Providers have mostly made decisions as to where they think they might provide a service and then hoped that the local authorities and health commissioners will procure services from them. This means that the care home market has in many places grown in a less controlled way than some areas may require. For example there are more standard residential care homes than are probably needed but fewer homes for older people with dementia, particularly when this includes challenging behaviours. At this moment in time there are sadly some care homes with high vacancy levels. This does however give an opportunity to explore where it might be best possible for Local Authorities and Health Boards to commission **“short term recovery to assess beds”**. (It is best that Intermediate Care beds are a separate group of beds designated for that purpose as part of a care home or as a separate unit). This could have a positive impact on both the need for recovery beds for patients who have experienced Covid-19 as well as helping to contribute to the overall plan for the winter¹¹. The National Primary Care Programme has established a work stream to look at the function of step-up / step-down beds including designing a minimum specification for this key function. This will include community hospitals. It will build on the “right-sizing” work undertaken last year.

In my work (Commissioning Out of Hospital Care Services to reduce delays) ¹² it is suggested that these beds should be:

- Short term, with a view to helping support the recovery of the resident with the prime aim to help them get back home (evidence suggests that a minimum of 75% of older people who are placed in these beds post acute care should be able to return home).

¹¹ https://ipc.brookes.ac.uk/publications/Out_of_hospital_care_to_reduce_delays.html

¹² https://ipc.brookes.ac.uk/publications/Out_of_hospital_care_to_reduce_delays.html

- Recovery-based so that they are overseen by therapists who can work with care staff at the best way of helping people to regain their strengths and confidence to assist them to return home;
- And that an assessment for the longer term needs of these residents is not made until after a period of working to support recovery has taken place (often at three weeks and again at six weeks after admission).

It is often good practice for commissioners to procure these beds on the basis of the outcomes they will achieve. In other words an expected standard can be set as a minimum on the numbers of older people placed in these beds who end up returning back to their own homes.

Health Boards and Local Authorities should look to ensure that they have in place sufficient intermediate care services (both bedded and in the community) to meet likely demand to support older people being discharged from hospital. The amount can be calculated from the work on “right-sizing community services”¹³. These facilities can then be specifically used to support patients/residents who are affected by any future pandemic as an alternative to moving to a care home. There are good examples of services being commissioned during the pandemic for this purpose and them delivering good outcomes for older people/ homeless people and those recovering from mental ill-health. Those who already live in a residential care home can return safely after their period of recovery and isolation. There were a range of different approaches to this to create intermediate care facilities at short notice. These included the purposeful use of a community hospital, the short-term use of former residential care homes, the use of proposed short-term beds in care homes and the use of a motel site. All of these services offered a short term place where people were safe and could receive rehabilitative support.

It is suggested that for those residents who are normally resident in a care home and who are offered care in an intermediate care facility, the fee for the care home should be used to cover part of the costs of the intermediate care bed. This will require some discussions with care home providers.

It is worth noting that there is an important recovery period post Covid-19 which can take quite a while. People who have had the virus and are recovering can feel lethargic and it can appear they are reluctant to take part in “normal activities”. It is important that this is recognised and appropriate therapeutic help is made available to assist with recovery that may take some time.

¹³Right Sizing Community Services to Support Discharge from Hospital - IPC Oxford Brookes University and NHS Delivery Unit (Wales). May 2020.

4.2.10 Communication

Each partnership might consider how they ensure that communication with care homes is managed in a spirit of sharing information to ensure that homes get the best possible support whilst limiting the burden on the care homes.

Each partnership might consider how they determine the best way to simplify and coordinate the dissemination of national and local guidance and to share it with their care home providers.

In most local authorities there was already regular communication between the council and the care homes and therefore it was a natural progression for them to work together to address Covid-19. The challenge was how to include other stakeholders in those conversations without either breaking the existing relationships or overburdening the care homes.

Every place reported regular contact between Local Authorities, Health Boards and care homes. For some places there was also communication with Care Inspectorate Wales, Public Health and other national organisations. It was important that this communication was rationalised and made as simple as possible to be supportive but to reduce the burden on the managers of care staff. Some managers reported so many contacts in a day they didn't know with whom they had spoken.

In most places a rational approach was taken in order that a single contact developed for each care home with public bodies and communication was channelled through a single agency and then shared through the multi-disciplinary teams. Comment has already been made that this worked particularly well when the data required was not covered through a phone call but was submitted electronically by care homes (at their own convenience) and then collated digitally with access to the appropriate data made available to each of the appropriate public organisations. Some places used the Microsoft "share-point" system to achieve this.

Many places developed special mailboxes and Covid-19 hotlines for care homes to communicate with public bodies during the pandemic.

Care home owners and managers made their own videos (and some put them on Youtube) to highlight how they were coping with the virus and this was shared widely with their colleagues. The Providers Forums also created WhatsApp groups where information and problems could be shared and mutual help offered.

It has already been noted that some care home managers reported positively that they really appreciated it when there were weekly webinar/Skype calls into which they could dial in where other care home managers were also on the call. This enabled them to

extend their support networks as well as receive advice from health and care professionals.

In some places special websites were established to share information between councils and care homes as well as with each other. In other places Facebook pages (and networks) were established with a particular focus on communicating between care homes and families.

Support to care homes worked on a seven-day week (including bank holidays) from the public sector. This was necessary and appreciated.

4.2.11 The Hardship Fund and Finances

Each partnership might consider how they will support their care sector financially now and in the future.

It is important to note that many care home owners took action that increased their costs at their own risk as soon as the pandemic looked like it would hit them. They purchased their own PPE sometimes at exorbitant costs; they had to increase their staffing costs for care staff (including activity co-ordinators) and cleaning staff as well as dealing with a loss of income due to lower occupancy.

Many local authorities made an immediate/temporary increase in funds to care homes once the pandemic started (it hit some care homes prior to the formal lockdown). The increases varied from 5% -10% fee increases. These decisions were made prior to any national announcements. In addition some local authorities increased the pay to the staff they employed who were working on the front-line during the pandemic. There was no equivalent uplift in the Continuing Health Care (CHC) or the Funded Nursing Care (FNC) rates.

All parties commented favourably on the existence of the provision made by Welsh Government for social care during the Coronavirus outbreak of £40 million. This is known as the “hardship fund” and the way in which local authorities were applying it both fairly and appropriately. The use of the fund to support additional costs such as higher costs for PPE before it was provided centrally, the additional staffing required (including auxiliary staff) in order to support homes during the height of the pandemic and the use of the fund to help where there were low occupancy rates were all welcomed. There are slightly different practices on funding voids in the care market – the most sensible one being a payment when occupancy went below 90% paying 90% of the costs of the voids.

There were many comments made on the concern that there was no similar fund established to assist nursing homes and this seemed to present a challenge to partners

trying to sustain (in the medium term) the current supply of care in their areas. **There is a new financial risk for many care homes as owners reported that they are either having difficulty in getting insurance to cover their work or the premiums have escalated to a very high level.**

The existence of this fund and its local administration should go somewhere to ensuring that the care sector is protected and there is less chance of unforeseen provider failures in the short/medium term.

4.2.12 Mental Capacity Act (2005)

Each partnership might consider how and when they are looking to undertake “best interest assessments” under the Mental Health Capacity Act.

There were some concerns expressed during this review on the use of the Mental Capacity Act. The Welsh Government issued guidance on how the Mental Capacity Act 2005 (MCA) should be applied during the pandemic¹⁴. This guidance is only valid during the COVID-19 pandemic and applies to those caring for adults who lack the relevant mental capacity to consent to their care and treatment.

The guidance advises that “decision-makers in hospitals and care homes, and those acting for supervisory bodies will need to take a proportionate approach to all applications, including those made before and during the pandemic. Any decisions must be taken specifically for each person and not for groups of people.

Where life-saving treatment is being provided, including for the treatment of COVID-19, then the person will not be deprived of liberty as long as the treatment is the same as would normally be given to any person without a mental disorder. The Deprivation of Liberty Safeguards (DoLS) will therefore not apply.

It may be necessary, for a number of reasons, to change the usual care and treatment arrangements of somebody who lacks the relevant mental capacity to consent to such changes. In most cases, changes to a person’s care or treatment in these scenarios will not constitute a new deprivation of liberty, and a DoLS authorisation will not be required. Care and treatment should continue to be provided in the person’s best interests. In many scenarios created or affected by the pandemic, decision-makers in hospitals and Care Homes will need to decide:

(a) if new arrangements constitute a ‘deprivation of liberty’ (most will not)

¹⁴ <https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-covid-19-pandemic>

(b) if the new measures do amount to a deprivation of liberty, whether a new DoLS authorisation may be required (in many cases it will not be)”

There were issues expressed during this review on whether there was sufficient clarity on when “best interest assessments” need to be undertaken to ensure that people who live in residential care who have capacity can make their own judgements about how they manage their safety.

The guidance seems clear that the existence of Covid-19 should not make a difference as to whether an assessment should take place or not. However, when making decisions during the pandemic, about the care and treatment of people who lack the relevant mental capacity, staff should seek consent on all aspects of care and treatment to which the person can consent. This particularly implies that there must be the involvement of residents in the decisions made about their care arrangements even where these are to protect them during the pandemic. **I am advised by local authorities that their current experience is that the courts are requiring new assessments to be made if an older person who is already subject to a DOLS assessment is further restricted because of the need to manage the virus in a care home.**

Decision-makers should always consider less restrictive options for a person. They should avoid depriving someone of their liberty unless it is absolutely necessary and proportionate to prevent serious harm to the person. In most cases, a best interest decision will be appropriate, and the person will not need to be deprived of their liberty. Those undertaking DoLS assessments are discouraged from going to care homes to carry out their assessments which mean they must use the current information they have, discussions with the care home and with close relatives if they are going to make an assessment.

This issue came up most in care homes or supported living accommodation for younger adults either with a learning disability or for those recovering from mental ill health. The challenge was how to ensure that these residents/tenants remained protected, adhered to the strict rules of social distancing whilst going about their daily lives and trying to retain as much independence as was feasible.

4.2.14 – Issues from Children’s Homes during the pandemic

In the interviews with health and care partners the focus was rightly on the impact of the virus on older people living in care homes. However, an interview did take place with the Children’s Commissioner in order to ensure that no serious issues had arisen for younger people in care during the period of lockdown. The one issue that was raised for the review was the challenge faced by those running children’s homes on how to

manage contact with parents where many children had a legal right to access that had been set up by the courts. Often this access takes place in special centres which were closed during the lockdown periods. It is not usual for the access to take place in the children's home (and this would be counter to guidance on visiting) but there were often no suitable places available for the access to take place particularly where the court order required this to be under some form of supervision. The care home managers were often caught between the legal right of the child in their care to have the access and their responsibility to protect them from the virus. This was further compounded by the rule that no one could travel more than five miles as many children are placed in homes away from where they lived prior to coming into care.

There was also a difficult challenge when new children were brought into care as to how to introduce them into a new care home placement and keep them socially isolated at the same time. It would be hard enough for the young person to be brought into care with a lot of emotional turmoil let alone then having to keep them isolated to serve their period of quarantine.

There is no doubt that those working with children in these homes had the best interests of the young people at heart. They had both a duty to protect their children from the virus and ensure their rights were protected. Both of these issues – parental access as agreed by courts and placing new admissions into children's homes may require some further consideration in preparing for any further pandemics.

4.2.15 – Learning from the actions taken during the pandemic

Each partnership might consider how they capture the lessons learned from their actions during the current pandemic where they have had to take emergency action.

It was impressive to hear of two examples of health and social care partnerships commissioning internal reviews of actions that they had taken during the pandemic to ensure that lessons were learned. One partnership actually undertook a review of the last 100 deaths that had occurred in care homes during the pandemic to ensure that the processes that should be in place had worked in every case.

The learning from the review proved invaluable and was shared across all agencies involved. In another partnership there was a review of a specific incident when a care home with some nursing beds was under pressure. Actions taken in an emergency over a weekend period were subsequently reviewed with an assessment made of the decisions taken and recommendations developed to assist if similar situations recurred and some pointers as to how the incident might have been avoided.

5.0 Summary of key considerations for health and care partnerships

- 1 Each partnership might consider the nature of their relationship with their care home providers and ensure that future work is carried out in a spirit of true partnership with those providing care to some of the most vulnerable adults in the health and care system.**
- 2 Each partnership might consider that they might assist in ensuring that there is an “infection control” action plan in place for every care home in their area.**
- 3. The Health and Care partnership should support each care home to have their own business continuity plan**
- 4 Each partnership might consider that they might assist in ensuring that there is a staffing contingency plan in place for their area. Health Boards may wish to seek guidance from Welsh Government on how this can be achieved within the current legal framework.**
- 5 Each partnership might consider how they advise care homes on the best way to deploy staff during an outbreak eliminating those staff who work in more than one setting.**
- 6 Each partnership might consider how they continue to support the well-being of staff who have worked through the pandemic.**
- 7 Each partnership might consider that they might assist all care homes in having meaningful activities in place for residents during any pandemic with a particular focus on activities that are appropriate for those who are socially isolating and for those with dementia.**
- 8 Each partnership might consider how the emotional and well-being support continues to be offered to all residents (including younger adults in care homes) even though the current pandemic appears to be easing in care homes.**
- 9 Each partnership might consider how they might assist local GPs in establishing clear enhanced arrangements for every care home in their area. Where this is not possible the practitioners who have patients in particular care homes need to be clear on their responsibilities and how they will carry them out.**

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- 10 Each partnership might consider how they can assist care homes in ensuring they have equal priority for the available supply of PPE if there was a further pandemic.**
- 11 Each partnership might consider how they can ensure that they have the processes in place to back up the test and trace arrangements for care homes**
- 12 Each partnership might consider how their local risk assessments are undertaken and how these are shared with care homes enabling them to take action to reduce their risks.**
- 13 Each partnership might consider how they arrange for short term (intermediate care) beds to be available to help the recovery of patients who have been in hospital and are required to isolate to ensure they are not spreading the virus.**
- 14 Each partnership should ensure that acute hospitals understand and can use the local arrangements that are put in place to support the discharge of patients**
- 15 Each partnership might consider how they ensure that communication with care homes is managed in a spirit of sharing information to ensure that homes get the best possible support whilst limiting the burden on the care homes.**
- 16 Each partnership might consider how they determine the best way to simplify and coordinate the dissemination of national and local guidance and to share it with their care home providers.**
- 17 Each partnership might consider how they will support their care sector financially now and in the future.**
- 18 Each partnership might consider how and when they are looking to undertake “best interest assessments” under the Mental Health Capacity Act.**
- 20 Each partnership might consider how they capture the lessons learned from their actions during the current pandemic where they have had to take emergency action.**

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6. Learning from the seminars

The process for this rapid review concluded with an on-line seminar/ workshop for each regional grouping involving key people from social care and from the NHS. An extract from this review was drafted and shared with all those who participated in the seminars. The extract focused on the best practice recommendations that are listed above in 5.0. Those attending the seminars generally welcomed the findings from the review and agreed that the report would assist them in establishing action plans.

The seminars did raise some questions that may require more local exploration.

1. The report urges Health and Care professionals to take a positive and helpful role in working in partnership with care home owners and managers. Where this had been the attitude of the public bodies the care homes found this much more helpful and constructive in these challenging times. However it was noted that this was not always possible where for example there were real concerns about the quality of care on offer at a specific care home or where the manager was reluctant to take good advice from individual professionals. It was concluded that the spirit in which public bodies should enter discussions with care homes to tackle the virus should always be in the spirit of “helpful partnership”. There may be a few rare examples where this was not possible but those examples should not change the way in which the overall system worked. In addition the report suggested that representatives from care homes should sit on strategic boards established locally to set the direction for work between the public bodies and the care sector. This has been successfully happening in North Wales for a period of time. Again it was recognised that representatives of care homes could not be involved in discussions about individual homes (which might compromise confidentiality and commercial interests) but should be involved in wider strategic discussions particularly about the future of the care markets in each region.
2. The section on intermediate care also raised some questions. There was a clear view from care home owners that no older person should be moved from hospital to a care home (either as a new patient or as a person returning to the place where they lived) without a negative test for the virus. (Some care homes wanted two negative tests). The report suggests that there should be some Intermediate Care beds commissioned specifically to both assist older people who are recovering from the virus and where their rehabilitation can take place. These beds should not be scattered around existing care homes but commissioned either in separate buildings or in separated wings of existing homes. Some places had arranged for this to happen during the pandemic. One participant in the seminar rightly raised the issue of people having too many moves when they

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are not well and another suggested that it was important that any intermediate care service followed all the correct protocols for infection control. In addition it was commented that there is always a challenge when the arrangements to protect someone requires that they are socially isolated. The final point made was, can care homes be assured in taking back older people who may be testing positive for the virus but are not spreading (shedding) the virus as the test shows they are no longer infectious?

3. There was a question raised about the nature of the help that can be offered directly to care homes when they are struggling and the difference between the circumstances where a home is struggling in normal times and when a home is struggling for staffing during the Covid-19 pandemic. It was acknowledged that the normal advice from CIW is that the public bodies should not involve themselves in the running of care homes when they are in a crisis as this could compound the difficulties being faced. However, is this different during a pandemic e.g. in relation to helping to find staff or redeploying their own staff to ensure a care home can continue functioning? The alternative to non-intervention is usually having to move all the residents to another location which is seen as both unpopular and risky (there is evidence that unplanned moves of older people place them more at risk of dying). It was accepted that these are very different circumstances and direct help should be offered whenever this is feasible.
4. Some managers were concerned about who has responsibility in the longer term to ensure there is always an adequate supply of PPE for care homes? How might this be best managed given the success of the national distribution for this pandemic? Fortunately the Welsh Government announced that it was going to continue the supply of free PPE for care homes for the duration of this pandemic. Some contributors thought that in the future there should be a local stock available in case a new pandemic hit the country.
5. There was a plea from one senior manager that we should recognise the commitment to the work and the skills demonstrated by many staff during the pandemic. This could be an opportunity to review the pay structures that exist for front line care workers. It was noted that however important that this point is - this was not within the remit of this review.
6. There was a plea from several regions that the plans that arise from this “rapid review” should be clearly linked to other plans e.g. winter planning arrangements which were well underway at the time of the seminars.

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Overall, the clear recommendations of the report were welcomed and specifically the proposal that every care home should be assisted to have a business continuity plan and an infection control plan was well received. This is reflected in the action plans that were submitted.

A few amendments were made to this final draft as a result of discussions that took place in the seminars. These did not change the recommendations.

There was a discussion that took place with the Equality and Human Rights Commissioner for Wales towards the end of the process. She rightly made the point that the interests of each individual older person must be respected whatever the risks of the pandemic. She wanted to be assured that there would be no blanket policies for care homes that impacted on the rights of residents. For example visits of close friends and relatives to a care home should not face a full stoppage in a region but each home should be assessed on its own level of risks and each resident assessed as to the balance between their overall well-being and any associated risks. Other policies such as issuing blanket Do Not Resuscitate (DNR) orders to care homes should definitely not be happening as it is again important that these orders are considered seriously only for those receiving palliative care that have capacity to make such a personal decision on an individual basis.

All the regions have now submitted an action plan which demonstrates that they have understood the draft report, taken account of most (in many cases all) of the recommendations and have clear plans to implement any changes required in the coming weeks as they face the second wave of the pandemic.

7. Conclusion

This has been a very rapid review of what has been a very challenging time for care homes. The review has operated in three phases: collecting information (one month); sharing best practice (a further month) and finally signing off individual action plans for each region (a further two weeks). It is now expected that the lessons that were learned in a hard way from the early days of the virus first hitting care homes are now clearly embedded in best practice for all those working from health and social care. Those responsible for helping the care homes manage the pandemic are now preparing for a potential second wave. It is accepted that if this hits our communities for a second time that the health and social care partnerships are much better prepared to offer good advice and support to care home owners and managers.

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Professor John Bolton

Professor John Bolton has over forty years' experience of working in social care. John qualified as a social worker in 1974 and has worked in both Local Authorities and National Roles in England becoming the Director of Social Services for Coventry in 2001. In 2007 John joined the Department of Health in Westminster as the Strategic Finance Director. Since 2010 John has worked as a freelance consultant in adult social care with a strong focus on making the best use of the resources available. In 2010 John was appointed as a Visiting Professor at Oxford Brookes University and he has worked and published many papers for the Institute of Public Care. In the last ten years John has worked across the United Kingdom and has been involved in several major projects in Wales including recent work on the cost of care in Care Homes (Lets Agree to Agree) and work with the NHS Delivery Unit on Out of Hospital Care. John is also an Associate at Newton (Europe) and has been the Efficiency Adviser for the Local Government Association. He sits on the advisory board for the Economics of Social Care and Health Research Units (ESCHRU).

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Appendix One: How Care Homes can protect themselves from the pandemic

During interviews with care home providers, local authorities and health colleagues the following picture emerged as to the common features of care homes that had avoided the virus:

- Many care homes locked down earlier than the formal government announcement – many up to two weeks earlier in early March.
- Care homes operated really strict infection control measures that included:
 - Strict control on people and goods entering the care home including special areas where staff could change from outside clothes into work clothes and don and doff PPE. Some home owners erected special constructions on the front of their care homes in order to have an infection control area through which any “visitor” had to pass and sanitise before entering the home.
 - In the early stage no visitors other than staff or professionals allowed into the home.
 - Strict use of PPE for all staff.
 - Strict cleaning regimes in place all of the time with regular sanitising of surfaces that people touched e.g. door handles, tables etc.
- Same staff working in smaller teams with set groups of residents (in a bubble).
- No use of agency or bank staff – asking existing staff to increase their shifts (which they responded to very well).
- No use of staff who work in more than one setting.
- Working 12 hour shifts and 3 day working week.
- Not receiving residents back from hospital with a negative test in previous 48 hours.
- Not receiving any new residents unless they had a negative test in previous 48 hours.
- Increasing staffing levels to ensure support was available to individual customers but only from within the existing staff group e.g. by asking them to do overtime.
- Ensuring those residents who were required to self-isolate were kept in a part of the home where they could be well supported (especially those with dementia).
- Ensuring there was good communication with other care providers to support each other in emerging best practice (in some places this was well facilitated by the local authority – was found to be additionally helpful when the local authority was also running its own residential care services or there was a strong long term relationship already achieved between the council and local providers who were used to working in partnership).

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- Having split shifts for meals so residents could be operate safe distancing during their communal times.
- Reducing times that some residents spent in lounges together (as above) to maintain social distancing.
- Having a clear contingency plan in place from the outset so that everyone was clear on their roles and responsibilities in the event of an outbreak.
- Staff were asked to commit themselves to only working in one setting or one Care Home (for those who worked part time in a number of settings).
- If any staff had any signs of the virus – they were sent home and told to self-isolate for a week. In some case homes made full pay for this (in others the finances did not allow this and they were sent home on statutory sick pay).

Appendix Two: Studies on how to manage a Pandemic

An important study (English study of Four Seasons Care Homes) was published in early July 2020 called the Vivaldi Study into Covid-19 in Care Homes¹⁵ . This study came to the following conclusions:

- Regular use of ‘bank’ staff (healthcare professionals who do temporary work in different settings as needed) is an important risk factor for infection in residents and staff.
- Infections in staff are a risk factor for infection in residents and infections in residents are a risk factor for infection in staff. However, the magnitude of this effect suggests staff are more likely to transmit infections to residents than vice versa.
- Emerging data suggests that the number of new admissions and return of residents to the care home from hospital, may be important risk factors for infection in residents and staff. This has only been tested in unadjusted analysis due to a high proportion of missing data across these variables.
- Region is an important risk factor for infection in staff and residents, but its effect is different in staff and residents. This may be due to temporal differences in the timing of testing between staff and residents.
- Important transmission risk is now likely to focus on staff, who will now be tested weekly via the new whole home testing rollout.

¹⁵ <https://www.gov.uk/government/publications/vivaldi-1-coronavirus-covid-19-care-homes-study-report/vivaldi-1-covid-19-care-homes-study-report>

There was some evidence around about the likely ways in which any pandemic spreads in care homes. There was a particularly important piece of work bringing together existing research undertaken by academics from the Centre for Evidence Based Medicine at Oxford University that was published in April 2020. They drew from studies that were already published in English¹⁶. This is a summary of their findings:

Effectiveness of infection control measures is dependent on a number of factors and a combination of strategies with the most significant being:

- Hand hygiene: access to hand hygiene facilities at the workspace, in addition to use of four or more of the WHO multi-modal strategy generally improve adherence to hand hygiene measures;
- Environmental decontamination: daily cleaning of most touches surfaces and weekly deep clean;
- Staff rotation: allocating staff to one facility consistently may reduce spread across several locations;
- Visitors: restricting visitation to only emergency / critical cases;
- Testing: creates rapid response in placing added measures to contain and prevent further spread

Hand Hygiene

The effectiveness of hand hygiene for preventing the spread of infection is well documented and a number of papers evaluated interventions to improve hand hygiene among staff in care homes. These were of mixed quality, often using a before and after study design without a control group. Infection control interventions focusing on education generally showed mixed or negative results. Cohort studies that evaluated care home characteristics similarly did not find a relationship between infection control training programmes and outbreaks

Key point: While education interventions to improve hand hygiene in Care Homes achieve limited results, adequate provision of hand sanitiser and gloves, along with line management support, have been shown to reduce infection rates.

¹⁶ How can pandemic spreads be contained in Care Homes? – study by Mona Koshkouei, Lucy Abel, Caitlin Pilbeam from Oxford University Centre for Evidence –Based Medicine.

Environmental decontamination

The spread and transmission of COVID-19 is now well documented in literature with an estimated life expectancy on a variety of surfaces. A before-and-after study in an American nursing home using Ultraviolet light in assisting disinfection processes found that weekly use of a pulsed-xenon disinfection device, in addition to daily manual disinfecting, reduced respiratory system infection rates and hospitalization by pneumonia.

Key point: Regular disinfection of high-traffic surfaces reduces infection spread. Disinfection devices may support this.

Staffing

Cohort studies and simulations that modeled care home characteristics found that larger care homes were at greater risk of pandemic outbreaks than smaller ones. These studies also found that staff were a key source of outbreaks and transmission; in particular, staff entry and re-entry, including community nurses working across a number of locations.

A number of surveys have been conducted on pandemic preparedness, one specifically for the UK context¹⁷. This study reported that UK care homes expected to be reliant on temporary “bank” staff as their own staff took sick leave. This may leave care homes particularly vulnerable.

Key point: The evidence supports limiting movement of staff between Care Homes. Care Homes relying on temporary staff should be aware that these staff are a key potential source of infection.

Visitors

We did not find any evidence specifically on the effectiveness of preventing or limiting visitors to the care home. However, as staff movement is a risk factor for outbreaks, so similarly may visitors be a potential source of infection during a pandemic with widespread community transmission.

Key point: No evidence on restricting visitors was identified, but if visitors have similar impact as staff re-entry, then restriction is supported.

¹⁷ Fell G. Preparedness of Residential and Nursing Homes for Pandemic Flu. Journal of Public Health. 2008;30(1):99-102

Testing

Evidence exists that prompt identification of an outbreak, typically less than three days, is required for providers to coordinate an effective response, in addition to routine/standard infection control precautions. Such measures include introduction of contact and droplet precautions such as PPE, isolating cases, and cancelling group activities and meals.

We did not identify any evidence on testing strategies for staff, although staff testing may be effective in limiting outbreaks given the evidence on staffing discussed above.

Key point: Rapid identification of cases among both staff and residents through testing may facilitate a coordinated response that minimises within-Care Home spread, although further evidence is needed.

Resident wellbeing

Holistic wellbeing in care homes is also an important consideration. Whilst there is some acknowledgement of the potential impact of different public health measures and emergencies on care home residents and their families, this area is under-researched.

Particular concerns expressed in literature include that physical isolation practices, suspension of visiting hours and care home activities, and restrictions on movement within the facility may increase loneliness and depressive feelings. For dementing patients, for example, regular interaction with familiar staff brings comfort, but staff wearing face-masks may be scary or confusing. There is also potential worry about and fear of health threats in care home residents, who may feel and be particularly vulnerable, or may not know very much about the public health emergency.

One study reviewed the perspective of care home residents in Hong Kong during the SARS epidemic. This study emphasised the participation of residents in reducing the risk of spread and recommended an education programme for residents, both to encourage buy-in to mitigation practices, and to address fears and safeguard residents' quality of life.

Key point: Quality of life is an important consideration when planning responses to public health emergencies in care homes. Education of residents can aid compliance with mitigation strategies, and address considerations of quality of life and anxiety. Further research on maintaining quality of life in care homes during outbreaks is urgently needed.

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Implementation challenges

Challenges in implementing infection control guidance during outbreaks was variable and included: maintaining adequate staffing; maintaining supplies necessary for implementation of infection control precautions; the potential negative impacts of restricting residents to their rooms; and difficulties controlling the movement of residents with dementia.

Isolation

Recommendations from Public Health England have included advice to isolate symptomatic patients. We did not identify any evidence on the effectiveness of this for viral infections in care homes.

Coronavirus case study

The only study yet published on COVID-19 in care homes is a report of the spread of an outbreak through an American care home, finding that the virus spread quickly among the majority of residents, staff, and visitors, with 81 cases among the approximately 130 residents.

The authors identified the following factors that contributed to the outbreak:

- staff continuing to work while symptomatic;
- staff members working in more than one facility;
- inadequate adherence to standard droplet and contact precautions, and eye protection recommendations;
- poor infection control practices due, in part, to inadequate supplies of personal protective equipment and hand sanitiser;
- delayed recognition of cases, limited testing availability, and difficulty identifying COVID-19 cases based on signs and symptoms alone.

These factors, although from a single site, closely match the findings of the available literature.

There is a list of the studies from which they drew their evidence that is available at:

<https://www.cebm.net/covid-19/how-can-pandemic-spreads-be-contained-in-care-homes/>

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