

Enhance Public Health Measures for COVID-19 Disease Management
Long-term Residential Care (LTRC)
NPHEP 31st March 2020

1. Introduction

People living in LTRC are vulnerable populations and have been identified by the World Health Organisation to be at a higher risk of being susceptible to infection from COVID-19 and for subsequent adverse outcomes¹. This is most likely due to their age, the high prevalence of underlying medical conditions and circumstances where high care support with the activities of daily living is required in collective high physical contact environments. The response to COVID-19 in LTRC should be based on preparedness, early recognition, isolation, care and prevention of onward spread.

Ireland is seeing a growing number of clusters in nursing homes and recent data from the Health Protection Surveillance Centre indicates that around 1/5 of cases, c20% are in LTRC. This data creates an urgency therefore to target specific focused and enhanced public health measures for LTRC. The challenges to build capacity for enhanced public health measures are recognised however given the level of risk priority must be given to these patient cohorts.

There are characteristics of LTRC in Ireland that make them a high-risk centre for Covid-19 outbreak and contagion across residents and staff. These characteristics include:

- Residents by their nature of age or other underlying conditions are at high risk of contracting Covid-19;
- Settings tend to be congregated and residents might be in shared rooms rather than individual rooms;
- High contact environments i.e. significant levels of physical contact and close proximity between care staff and residents, particularly in relation to personal care;
- High level of physical interaction i.e. high numbers of residents, staff, cleaners, caterers, service providers;
- Symptom ascertainment and room isolation can be exceptionally challenging in older residents with neurologic conditions, including dementia;
- Symptoms of COVID-19 are common and might have multiple etiologies in this population;
- A confirmed outbreak will see high levels of staff absenteeism due to sick leave and self-isolation requirements;
- To provide continuity of service absenteeism may result in the need for higher usage of agency/temporary, who in turn may be moving between facilities, increasing the risk of transmission;
- There is a risk that cases in LTRCs could present a risk of external transmission to families of staff and indirect staff;
- The need for increased levels of cleaning, hygiene activities and infection control measures will see new cohorts of staff and service providers entering the facility, thus creating a greater risk of transmission.

¹ WHO 2020, Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 Interim guidance (21 March 2020)

2. Long-term residential care (LTRC)

The scope of LTRC covers older people, disability and mental health residential care settings. LTRC provide long term care and short stay, transitional care and respite support either through the State, section 38's and section 39's or privately. All these facilities are registered with either HIQA or the Mental Health Commission for quality and adherence to standards for the sector.

The table below provides a snapshot of key activity data and or capacity data.

<p>Disability Residential Services</p> <ul style="list-style-type: none"> • 8,300 residential placements are provided in 1,200 designated settings (including respite centres). These include about 2,100 people living in congregate settings of more than ten people, and the remainder in group housing mainly of four to six residents • Largest centre had 43 people; smallest centres have just 1 • Average number of people living in each centre is just over 7 	<p>Mental Health Long-term Care</p> <ul style="list-style-type: none"> • 2,693 Total beds across 66 Centres • 161 Beds in 12 non-HSE Centres • 2,532 Beds in 54 HSE Centres • 40.8 Average beds per Centre • 32 Median beds per Centre
<p>(Older Persons) Nursing home sector</p>	
<ul style="list-style-type: none"> • 584 nursing homes • 440 private & voluntary nursing homes • 30,000 residents / 25,000 long term care • 19,000 in private nursing homes under NHSS and 5000 in public, also self-funders 	<ul style="list-style-type: none"> • Average nursing home capacity 55 beds, median 50 beds • 312 nursing homes with 50 beds or less, 207 with 40 beds or less • Approximately 2,000+ beds are currently unoccupied across the sector.

3. International Policy Measures to limit impact COVID-19 – Long-term residential care

The HRB conducted a summary of international evidence to date. This information and in tandem with information emerging from the WHO¹, ECDC² and a summary of international policy measures by Comas-Herrera and Fernandez-Plotka³ provide an outline of measures being taken in long term residential settings.

Measures include:

- Broader sector measures – guidelines, funding, regulatory, training and access to PPE
- Care home measures – external notification, visitor restrictions, staff restrictions, resident testing, cohorting, isolation, staff availability
- Community-based measures - closure of day centres, rapid response teams.

Measures emerging as important are clarity of respective roles of care homes and hospitals including clear protocols for both discharges from hospitals to care homes and for admission of care home

² <https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-infection-prevention-and-control-healthcare-settings-march-2020.pdf>

³ <https://ltccovid.org/2020/03/29/summary-of-international-policy-measures-to-limit-impact-of-covid19-on-people-who-rely-on-the-long-term-care-sector/>

residents with severe COVID-19 infections to hospitals. In addition, the importance of ensuring that, where care homes are required to provide acute healthcare or palliative care, they have access to the necessary medication, equipment and medical support.

4. Recommended - enhanced public health measures – COVID-19 LTRC

LTRC can be viewed as having:

- Known COVID-19 positive cases;
- COVID-19 positive cases but not known; or
- No COVID-19 cases

The priority is to keep those in LTRC that do not have COVID-19 as COVID-19 free. Enhanced public health measures are recommended. Responsibility bodies and proposed public health measures are set out as national actions, regulatory actions and LTRC facility actions. Appendices 1 and 2 set out sample checklists for LTRC with COVID-19 positive cases and those without.

4.1 National Actions – State Agencies

4.1.1 Public Health/Infection Prevention Governance [HSE]

Establish/update guidance and assure actions in the context of disease management. Terms of Reference should include responsibility for surveillance and strategic response at national/local level.

- Establish a National LTRC COVID-19 Infection Prevention and Control (IPC) Team **[PHA 1]**
- Establish Regional LTRC COVID-19 Infection Prevention and Control (IPC) Team (per CHO) **[PHA 2]**
- Each LTRC has an allocated IPC Advisor to liaise with **[PHA 3]**
- Each outbreak has a public health led Outbreak Control Team **[PHA 4]**
- Where LTRC staff (and homecare staff) cannot physical distance in their own residence support and pay for an appropriate residence and transport - *develop protocol and prioritisation framework* **[PHA 5]**
- No sharing of staff across LTRC settings **[PHA 6]**
- Immediate activation of CRM system for data capture by Outbreak Control Team supported by LTRC **[PHA 7]**
- Provision of guidance including specific admission and transfer guidance **[PHA 8]** (*consider use of transition beds in dedicated facilities until confirmed COVID-19 free and then transfer to long-term care – [different views here](#)*)
- Consider formal link to an acute hospital
- All avenues to build the capacity required including 3rd levels to be explored as a matter of urgency

4.1.2 Risk assessment – scale of risk based on disease progression, environment and staff [HIQA/MHC]

- Risk rate all LTRC settings based on disease progression, environment and staff **[PHA 9]**
- Recommend control/mitigation mechanisms and communicate with facilities and HSE regional teams

- A dynamic and immediate risk assessment where outbreaks occur (Public Health Outbreak Control Team)
- Establish HIQA IPC Advisory Hub – to provide advice and support outbreak preparedness
 - *Agree and establish an integrated pathway between Hub and HSE regional teams*

4.1.3 Operational Management [HSE]

- Ensure surge capacity plans for LTRC
- Provide for teams of last resort (crisis support team to go into individual LTRC facilities as required) to provide staffing for a short period of time to ensure service continuity **[PHA 10]**
- HSE preparedness planning for being provider of last resort to take over LTRC should this be required
- Prioritise LTRC staff for COVID-19 testing **[PHA 11]**
- Prioritise LTRC residents for COVID-19 testing

4.1.4 Support Mechanisms to LTRC Facilities [HSE]

- Provide PPE to all facilities - *develop national protocol and prioritisation framework for access* **[PHA 12]**
- Provide Oxygen to facilities - *develop national protocol and prioritisation framework for access*
- Establish teams (per CHO) to provide medical and nursing support and advice (building on established pathways potential for support through CHO clinical hub and local teams to be explored) **[PHA 13]**
- Support moving patients to other facilities on a case by case basis depending on risk if deemed medically appropriate
- Support access to the provision of training to LTRCs - Infection Prevention and Control, End of Life Care, Certification of death **[PHA 14]**

4.2 Facility Actions – Service providers

Facilities should:

- Develop a COVID-19 preparedness plan
- Identify surge plans to replace ill staff.
- Plan for cohorting of patients (COVID-19 positive and non-COVID-19)
- Plan for separate dedicated healthcare workers including cleaning and catering to support cohorting of patients to work on COVID-19 positive and non-COVID-19 units
- Immediately work within its own structures and external trainers to ensure programmes of training are promptly available

4.2.1 Staff

- Ensure mandatory training in:
 - Infection Prevention and Control
 - End of Life Care
 - Certification of death
- Active monitoring of staff for fever, cough and shortness of breath

- Consider universal use of facemask for staff while in facility as per IPC guidance (*different views here*)
- Ensure staff are tested for COVID-19 without delay in line with national guidance
- Staff to stay at home if ill

4.2.2 Residents

- Alcohol sanitizer provided in every resident's room
- Cocooning (Restrict residents to room - no visiting except for compassionate circumstances)
- Rapid identification of ill residents and priority access to testing
- Active monitoring of residents for fever, cough and shortness of breath
- Once one resident is positive operate on assumption that all residents are positive
- Testing of all residents (*different views here – give point above suggest take out*)
- Ensure residents are tested for COVID-19 without delay in line with national guidance
- Promote advance healthcare directives
- Put in place anticipatory care plan for all residents (including prescribing)
- Put in place communications plan with families

4.2.3 Environment/Cleaning

- Ready access to alcohol sanitizer throughout facility
- Appropriate use of PPE
- Enhanced cleaning regimes
- Adhere to waste management standards

4.2.4 Data Provision

- Report as per current legislation to local Department of Public Health
- Utilise national CRM
- Report to HIQA

5. Proposed - Priority national public health actions

PHA 1	Establish a National LTRC COVID-19 Infection Prevention and Control (IPC) Team
PHA 2	Establish Regional LTRC COVID-19 Infection Prevention and Control (IPC) Team (per CHO)
PHA 3	Each LTRC has an allocated IPC Advisor to liaise with
PHA 4	Each outbreak has a public health led Outbreak Control Team
PHA 5	Where LTRC staff (and homecare staff) cannot physical distance in their own residence support and pay for an appropriate residence and transport - <i>develop protocol and prioritisation framework</i>
PHA 6	No sharing of staff across LTRC settings
PHA 7	Immediate activation of CRM system for data capture by Outbreak Control Team supported by LTRC
PHA 8	Provision of guidance including specific admission and transfer guidance
PHA 9	Risk rate all LTRC settings based on disease progression, environment and staff
PHA 10	Provide for teams of last resort (crisis support team to go into individual LTRC facilities as required) to provide staffing for a short period of time to ensure service continuity
PHA 11	Prioritise LTRC staff for COVID-19 testing
PHA 12	Provide PPE to all facilities - <i>develop national protocol and prioritisation framework for access</i>
PHA 13	Establish teams (per CHO) to provide medical and nursing support and advice (building on established pathways potential for support through CHO clinical hub and local teams to be explored)
PHA 14	Support access to the provision of training to LTRCs - Infection Prevention and Control, End of Life Care, Certification of death
PHA 15	Relevant LTRC national actions also encompass homecare support

Appendix 1 - check list actions for LTRC with COVID-19 cases

i.e. COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community.

- Educate and train staff on COVID and Infection Prevention and Control.
- Facilities should notify the local public health department immediately.
- No new admissions.
- Residents with known or suspected COVID-19) should ideally be placed in a single room with their own bathroom.
- Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario.
- Cocooning:
 - Restrict all visitation except for certain compassionate care situations such as end of life situations
 - Cancel communal dining and all group activities, such as internal and external activities.
 - Remind residents to practice social distancing and perform frequent hand hygiene.
- Create a plan for cohorting residents with symptoms of respiratory infection, including dedicating healthcare workers to work only on affected units.
- Be aware that once residents have been confirmed with Covid19 in facility that asymptomatic patents are also likely to be infected and adequate infection control precautions should be used for all patients.
- Put alcohol-based hand sanitizer with 60–95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy rooms).
- Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Make tissues and facemasks available for coughing people. (*different views here*)
- Make sure that disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
- Avoid transfer to other facilities unless medically indicated and subject to end of life planning.
- Where transport is essential transport personnel and the receiving facility should be notified about any suspected diagnosis prior to any transfer.
- Encourage advanced healthcare directives.
- Actively monitor all staff in all long-term settings for fever and respiratory symptoms twice daily (start of shift and at one point during the shift).
- Remind staff to stay at home if ill and ensure staff are tested for COVID-19 without delay in line with national guidance
- Identify surge plans to replace ill staff.

5 Appendix 2 - Check list actions for LTRC with no COVID-19 cases

i.e. There are cases in their community but none in their facility.

- Educate and train staff on COVID and Infection Prevention and Control
- Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of personal protective equipment (PPE).
- Educate residents and families including:
 - information about COVID-19
 - actions the facility is taking to protect them and their loved ones, including visitor restrictions
 - actions residents and families can take to protect themselves in the facility
- Cocooning:
 - Cancel all visiting except for compassionate grounds
 - Cancel communal dining and all group activities, such as internal and external activities.
- Put alcohol-based hand sanitizer with 60–95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy rooms).
- Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Make tissues and facemasks available for coughing people. *[Different views here](#)*
- Make sure that disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
- Avoid transfer to other facilities unless medically indicated and subject to end of life planning.
- Actively monitor all staff in all long term settings for fever and respiratory symptoms twice daily (start of shift and at one point during the shift).
- Encourage advanced healthcare directives.
- Remind staff to stay at home if ill and ensure staff are tested for COVID-19 without delay in line with national guidance.
- Identify surge plans to replace ill staff.