Department of Health
15th June 2020

Nursing Homes - Summary paper provided to Special Committee on COVID-19 Response

Nursing Homes - background

Census 2016 showed that over half a million or 587,284 people are over 65 and living at home in the community. Nearly 30,000 are living in long term residential care. There are 584 nursing homes of which 440 are private or voluntary nursing homes. The average capacity of a nursing home is 55 beds and approximately 30,000 staff are employed in these settings. The State provides over €1 billion through the Nursing Home Support Scheme (NHSS) to support citizens to access nursing homes and nursing home providers to deliver care. In 2020, NHSS users contribute a further €0.376 billion in individual client contributions, of which €0.302 billion relates to payments directly to private and voluntary nursing homes. In addition, the State provides approximately €30m to private nursing homes for transitional care services.

The Health Information and Quality Authority (HIQA) has, among its functions under law, responsibility to regulate the quality of services provided in 'designated centres' for older people; nursing homes registered with HIQA are 'designated centres'. The purpose of regulation for designated centres is to safeguard people who are receiving residential services. Regulation provides assurance to the public that people living in designated centres are receiving services and supports that meet the requirements of National Standards, which are underpinned by regulations. HIQA inspection reports are published and available for examination by the public. The Health Act 2007 (as amended) empowers the Chief Inspector, a statutory officer within the Authority, to carry out this function through the processes of registration, continual monitoring and inspection and, where necessary, the application of its powers of enforcement. HIQA has contributed to on-going risk assessment and support of nursing homes in their implementation of control measures throughout the pandemic (see separate HIQA paper).

In the first instance, the primary responsibility for the provision of safe care and service to nursing home residents rests with individual nursing home operators. Registered providers must provide appropriate medical and health care, including a high standard of evidence-based nursing care in accordance with professional guidelines. Furthermore, regulations provide that the person in charge of a nursing home should be a medical practitioner or a registered nurse with the required qualifications and experience.

Nursing homes have a duty to ensure continued adherence to the existing framework of regulation and standards framework. The prevention and control of healthcare associated infections is a standard part of the operation of nursing homes and this is underpinned by regulation[1] and standards. HIQA's 2018 *National Standards for infection prevention and control in community services*[2] are particularly relevant in this regard including ensuring availability of PPE.

[1] e.g. Regulation 27 of S.I. No. 415/2013 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 "*The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.*"
[2] https://www.hiqa.ie/sites/default/files/2018-09/National-Standards-for-IPC-in-Community-services.pdf [accessed on 14/06/2020]

Members of staff in nursing homes are core to ensuring safe care and support are provided to the residents of the home. Given the nature and importance of the role of staff in delivering this care, significant provisions are included in regulation and national standards. Nursing home providers, for example, must ensure that "*at all times there are sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents…Contingency plans are in place in the event of a shortfall in staffing levels or a change in the acuity of residents*."

Notwithstanding the ongoing statutory responsibility of nursing home operators, in the context of the COVID-19 pandemic there has been a strong recognition on the part of the HSE, HIQA and the Department that nursing homes should be supported in meeting these obligations. For example, it has been recognised nationally that the COVID-19 pandemic has driven a significant increase in the required use of PPE, which in turn has placed significant strain on PPE stocks and supply chains which has been the global experience. Likewise increase in staff absenteeism as a result of COVID-19 has posed difficulties for staffing. It is for these reasons that the HSE and NPHET developed a substantial package of national measures to respond to the public health issues arising and to assist nursing homes, registered providers and persons in charge to discharge their duties and responsibilities.

It is recognised that the impact of COVID-19 on society in general and those living in nursing homes has been considerable. Nursing homes are people's homes as well as places where healthcare is provided and the introduction of physical distancing, isolation, reduced social activities and restricted contact with family and loved ones has changed the usual dynamic of social interaction. The focus on interrupting the transmission of the virus is part of a wider requirement to prioritise the wellbeing of residents of nursing homes, remain person-centred, be cognisant of their rights as citizens, and to be vigilant that in seeking to prevent infection that these rights are not infringed upon to an extent, or in a manner, that is disproportionate.

Comprehensive information, in the form of an "*Overview of the Health System Response to Date - Long-term residential healthcare settings"* was approved by NPHET and published at the end of May.[3] (See copy attached.) (Note the terminology used for nursing homes includes long term residential care (LTRC) and residential care facilities). The following paper, together with associated documents, provides further information in response to the Committee's request to the Department.

COVID-19 Pandemic

2020 has brought with it the most serious global pandemic in a century – something that was unimaginable a few short months ago. Since COVID-19 emerged first in China at the end of December last, the World Health Organisation (WHO) and countries have been monitoring the rapidly evolving situation and initiating and updating preparedness. During January the health service and the Government stepped up national public health and emergency responses. The National Public Health Emergency Team (NPHET) and HSE National Crisis Management Teams for COVID-19 were convened and commenced their work.

[3] https://www.gov.ie/en/news/7e0924-latest-updates-on-COVID-19-coronavirus/#overview-of-the-health-system-response-to-COVID-19-ltrcs

Vulnerable Populations

NPHET considers one of the most effective ways of protecting vulnerable populations is supressing the virus in the community. People living in long term residential care (LTRC) settings, which include nursing homes, are vulnerable populations and on 21st March were identified by the WHO to be at a higher risk of being susceptible to infection from COVID-19 and for subsequent adverse outcomes[4]. 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. There are characteristics of nursing homes in Ireland, including congregated living environments where the nature of care involves regular carer resident contact, that make them high-risk for COVID-19 outbreak and contagion across residents and staff.

The NPHET Vulnerable Subgroup held its first meeting on 6th March (see attachment on the Subgroup). A short-life nursing home working group operated for a period of time in March (see attachment – Report of working group). The report of this group led to the establishment of the Temporary Finance Support Scheme for nursing homes and provided important material for the framework of information which led to a set of significant NPHET actions emanating from the Meeting 31st March (see attachment – report to NPHET).

The level and extent of asymptomatic transmission in the population and atypical presentations in older people only emerged nationally and internationally in the latter half of March. The European Centre for Disease Control (ECDC)[5] in its recent technical report of 19th May recognises that a high proportion of LTRCs across Europe and globally have reported COVID-19 outbreaks, with high rates of morbidity and case fatality in residents and high rates of staff absenteeism. ECDC recognises in this report, *Surveillance of COVID-19 at long-term care facilities in the EU/EEA,* that the high COVID-19 morbidity and mortality observed among residents in long-term care facilities (LTCF) in EU/EEA countries poses a major challenge for disease prevention and control in such settings. This report outlines a set of multiple factors that may be contributing to spread including asymptomatic staff and residents and atypical COVID-19 clinical presentations or the absence of evident signs or symptoms until the patients' conditions deteriorate. The very infectious nature of this virus makes it difficult to prevent and control in residential care settings.

Public health led response

The response to COVID-19 in LTRC is based on preparedness, early recognition, isolation, care and prevention of onward spread. This involves case recognition, testing, contact tracing and examining disease patterns including mortality. During February and early March 2020 local public health departments were both proactively and reactively interacting with nursing homes. Initially the seasonal influenza guidance for LTRC was used as the source of advice; this guidance evolved to focused public health and infection prevention guidelines on the prevention and management of COVID-19 cases and outbreaks in nursing homes.

Prompt, effective public health surveillance and response is critical to the identification and control of outbreaks in healthcare settings. Ireland has a national public health surveillance system, called CIDR (Computerised Infectious Disease Reporting) in place to manage the surveillance and control of infectious diseases in Ireland. Ireland is in a stronger data collection position than a number of other

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

[5] https://www.ecdc.europa.eu/en/publications-data/surveillance-COVID-19-long-term-care-facilities-EU-EEA

countries as CIDR captures data (cases, clusters and deaths) from both the community as well as acute hospitals and has done so since the commencement of the pandemic.

Mortality rates have been the subject of much international discussion particularly the reporting of mortality in nursing homes. Unlike Ireland, official data on the numbers of deaths among care home residents linked to COVID-19 for many countries is not available. In addition, international comparisons are difficult due to differences in testing availability and approaches to recording deaths. In order to be assured that all deaths were being captured in LTRC in Ireland, both lab confirmed and probable, the Department undertook a mortality census of all LTRC facilities mid-April. Data was compared between the census of mortality and other sources of mortality data including the Health Information and Quality Authority (HIQA) NF02 notifications and CIDR. This comparison demonstrated that the number of cases matched closely between the sources.

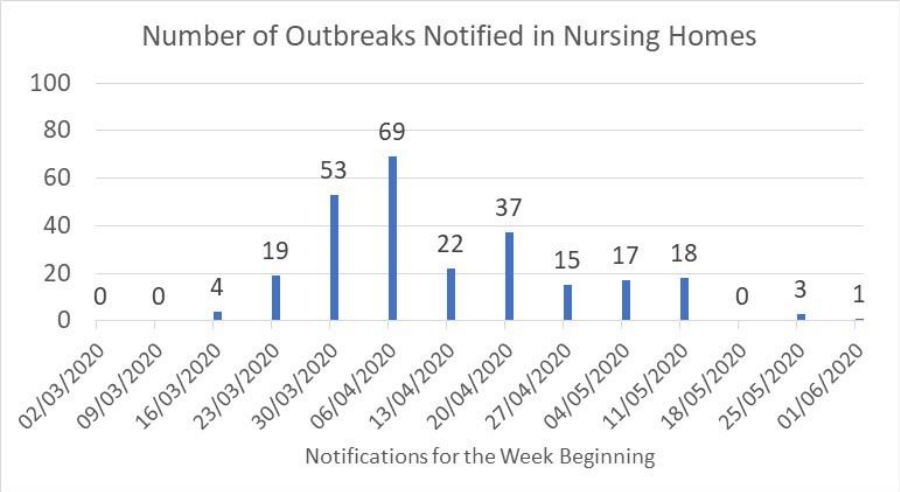
On 28th May NPHET published "*COVID-19: Comparison of Mortality Rates between Ireland and other countries in EU and Internationally"*. (Copy attached.)

The approach has been clear and consistent in recording COVID-19 cases and deaths in LTRC settings from the beginning of this pandemic. This places Ireland as one of the very few countries to take a comprehensive approach and use this data to inform public health actions in a measured, decisive and scientific manner. This was confirmed by Dr David Nabaroo, the WHO's Special Envoy on COVID-19 at the Special Committee on COVID-19 Response hearing last week when he said that Ireland's mortality figures may be more "honest" and that Ireland had the widest circle of inclusion in terms of capturing numbers.

COVID-19 LTRC surveillance information

On 16th March 2020, the HPSC was first notified of clusters in nursing homes (two were notified on that day in separate nursing homes with Outbreak Control Teams in place). As of 14th June, the HPSC has reported 258 clusters in nursing homes. These clusters are associated with 5,371 cases (21% of all cases). Of those cases in nursing homes, 407 were hospitalised. 943 deaths are associated with nursing home clusters. To date over half the clusters have been closed. A cluster is closed once there is no case for 28 days following the last case.

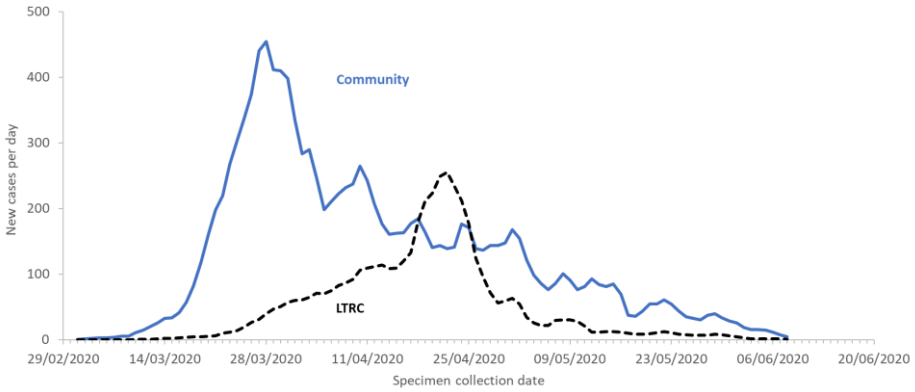
Graph 1: Number of COVID-19 Outbreaks in Nursing Homes



Analyses of the trajectory of the epidemic among the general population, healthcare workers and LTRC residents has been conducted by the Irish Epidemiological Modelling Advisory Group. Their work shows that the peak number of new confirmed cases in the general population was observed in the last week of March. The rate of increase of new cases among nursing home residents was slower and lagged behind both the general and healthcare worker populations. The first outbreak in nursing homes was not identified until the 16th March. Most outbreaks were identified after 23rd March into the first week of April.

Graph 2 shows that the peak number of new cases in the general population was on the 28th March. It was only when this peak was reached that the number of cases in long-term residential care settings began to increase. From early April there was a rapid rise in cases in long term care settings. The peak in new confirmed cases in these settings in mid-April coincided with the expanded testing undertaken in the sector.

Graph 2: Number of COVID-19 rolling average cases in LTRC by date



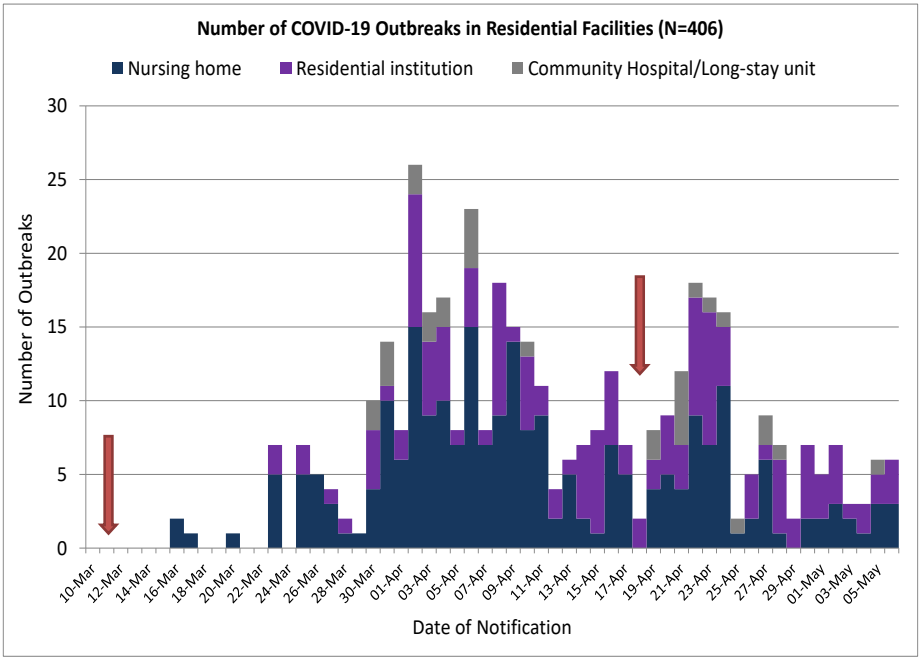
Data 5-day rolling average. Community: all cases excluding healthcare workers and cases associated with outbreaks in LTRC.
The peak in cases in LTRC in late April due to targeted testing in these facilities.

Graph 3 provides a view of the number of COVID-19 outbreaks by date in LTRC settings. The first outbreak was not identified until the 16th March – 4 days after the implementation of visiting restrictions (12th March[6]). In addition, most outbreaks were identified after the 23rd March into the first week of April. Another spike in outbreak identifications coincided with the implementation of the expanded testing programme in the last week of April.

The graph shows the timeline along which new clusters in nursing homes, residential institutions and community hospital/long stay units were identified and notified to the HPSC by local Departments of Public Health. The first red arrow corresponds to the time at which the first public health measures, including the restriction of visitors to residential care facilities, were implemented. The second arrow refers to the implementation of the expanded testing programme of residents and staff in residential care facilities.

[6] Implementation of NPHET recommendations from meeting 11th March were announced by the Taoiseach on 12th March

Graph 3: Number of COVID-19 Outbreaks in LTRC by date



Impact of COVID-19 and disease progression in Ireland

The impact of COVID-19 in LTRC facilities has, like many other countries, been considerable. In recent years[7] the impact of influenza on this sector has been recorded by the HPSC in its weekly and annual reports describing the annual influenza epidemics. In the most recent severe season of 2017/ 2018, 200 influenza outbreaks were reported including 158 influenza outbreaks that season in residential care facilities. 53 deaths were laboratory confirmed to be associated with these outbreaks. There are a number of reasons why LTRC have been more severely impacted in this COVID-19 pandemic and these lessons are becoming more evident as epidemiologists and public health experts have learned more about the transmission of this novel virus over the preceding weeks and months.

This virus is much more infectious than influenza. A recent review of 12 modelling studies reports the mean basic reproductive number (R_0) for COVID-19 at 3.28, with a median of 2.79.[8] The median R value for the pandemic of influenza H1N1 2009 was 1.46 and for seasonal influenza was 1.28.[9] This means that every person with COVID-19 spreads the infection to double the number of people as a person with influenza.

The ECDC in its 5th Rapid Risk Assessment of 2nd March 2020, stated that there remains no strong evidence of transmission preceding symptoms onset. However, in their 6th Rapid Risk Assessment released on the 12th March 2020 ECDC described a case report where possible asymptomatic transmission had occurred and advised that major uncertainties remain in assessing the role of pre-symptomatic transmission.

[7] Health Protection Surveillance Centre https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/surveillance/influenzasurveillancereports/seasonsummaries/Influenza%202017-2018%20Annual%20Summary_Final.pdf

[8] Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK – eighth update 8 April2020

[9] Estimates of the reproduction number for seasonal, pandemic, and zoonotic influenza: a systematic review of the literature Matthew Biggerstaff, Simon Cauchemez, Carrie Reed, Manoj Gambhir and Lyn Finelli

The serious impact on LTRCs was subsequently identified by ECDC in their 9th rapid risk assessment of 23rd April 2020. Internationally the role played by those with asymptomatic or very mildly symptomatic disease in spreading infection is now much more clearly recognised. Such asymptomatic transmission adds significant challenge to public health and infection control strategies. An important component of such strategies is to achieve overall reduction and control of virus levels in the community so as to avoid unwitting spread by those that are asymptomatic into vulnerable settings, such as nursing homes. Within nursing homes testing to ascertain asymptomatic cases is now a core strategy. Ireland's testing of all staff in all facilities and all patients in affected facilities contributed to the identification of asymptomatic cases and the interruption of transmission.

In addition, a clinical picture in vulnerable and older populations has emerged that did not meet the case definition as established initially through the WHO. Evidence has emerged that presentation of COVID-19 in LTRC can differ from that of the general population from no temperature to confusion and the pace of progression of disease is much faster, likely due to the age and frailty of older people in such settings.

The Department of Health and other agencies have been engaging with the research community on an ongoing basis to identify information, guidance and evidence internationally on COVID-19 and LTRCs, including in relation to impacts, management and interventions. A substantial package of guidance has been published and continues to evolve and be updated in line with new national and international evidence. Regular research is undertaken of national and international literature, such as rapid reviews of public health guidance on protective measures for vulnerable groups from COVID-19, to ensure that the best available information and evidence is considered in this rapidly evolving environment.

Summary Timeline of Response

By the 27th of January 2020 NPHET had been established and held its first meeting. At this meeting NPHET noted that "the ECDC's risk assessment for the EU / EEA is now 'moderate' but that, subject to appropriate control measures being in place, the risk of onward transmission is rated as 'low'." At this meeting the HSE briefed NPHET about the HSE's High Consequences Infectious Diseases Group, which had already had several meetings and had produced algorithms/procedures for all key sectors. On 30th January 2020 the HSE circulated guidance and posters on coronavirus to various settings, including private nursing homes.

Nursing Homes Ireland through various communique to its members provided ongoing advice on preparedness, planning and guidance. The Department of Health and the HSE maintained ongoing engagement and communications with Nursing Homes Ireland (as demonstrated by the detailed correspondence between the Department and Nursing Homes Ireland numbering 165 separate records forwarded to the Committee by the Department) and individual nursing homes. Issues raised such as access to guidance, finance support, staff and PPE have been worked through, managed and progressed as quickly as possible.

The public health advice during Ireland's containment phase was in line with ECDC guidelines and sought to reduce the risk of transmission through personal hygiene and respiratory etiquette while

remaining vigilant regarding the identification of cases. Ireland recorded its first confirmed COVID-19 case on 29 February.

On 6th March the Vulnerable Subgroup of NPHET was established and held its first meeting.

On 10th March Interim Guidance on Transfer between Care Facilities was disseminated and through HIQA was circulated directly to all LTRC registered centres.

On the 11th March NPHET recommended that Ireland move to "delay phase" and social distancing measures were recommended and announced, including:

- Visiting restrictions in long-term care facilities;
- Individuals who have symptoms should self-isolate for a period of 14 days.

On 13th March HIQA provided the Department with a list of 19 HSE/HSE-funded nursing homes having identified based upon inspection histories that the nature of their multi occupancy rooms created infection prevention risk. The information was sent to by the Department to the HSE the same day and the HSE has confirmed ongoing risk management of these centres.

The Government's COVID-19 Action Plan was published on 16th March and included key actions relating to the protection of vulnerable groups in community settings, including long-term care settings, through maintenance of existing services and enhanced support actions.

Preliminary Clinical and Infection Control Guidance for COVID-19 in Nurse-led Residential Care Facilities (RCF) was published by the HSE and circulated to the nursing homes sector on 17th March 2020. The document provides guidance on general measures to reduce the risk of accidental introduction of COVID-19 into a LTRC, procedures to be followed for clinically suspect residents, guidance on clinical investigations and monitoring and on IPC. The document also provides detailed step-by-step instructions across a range of scenarios.

On 18th March the NPHET subgroup on Vulnerable People agreed that an urgent short-life working group should be established to examine issues relating to COVID-19 arising in the nursing home sector and to develop proposed measures, including temporary financial support to respond to those issues, where necessary. This interagency working group met on three occasions from the 19th to 26th March and held a consultative engagement with Nursing Homes Ireland and with what was, at the time, the first nursing home dealing with confirmed COVID-19 cases. The chair of the working group supported the chair of the Vulnerable Persons Subgroup to develop a paper on LTRC issues for the NPHET meeting on 31st March to ensure timely input to NPHET considerations and to progress a proposal for a temporary assistance payment scheme for private and voluntary nursing homes.

NPHET met on 23rd and 24th March and across both meetings considered the ECDC's technical document "Considerations relating to social distancing measures in response to COVID-19 – second update" published on 23rd March. In line with this document, NPHET recommended enhanced social distancing measures, and specifically in relation to LTRCs recommended "social distancing measures, in as far as is practicable, is to be ensured between the clients/patients in confined settings, such as long-term care facilities, either for the elderly or persons with special needs".

On the 24th March HIQA issued to all designated centres and registered provider's COVID 19 guidance on sector wide preparedness arrangements.

On 25th March 2020 ECDC published its 7th Update which upgraded the risk of "severe disease associated with COVID-19 for people in the EU/EEA and the UK is currently considered moderate for the general population and very high for older adults and individuals with chronic underlying conditions." In respect to long-term care facilities, the RRA outlined the following specific measures:

- Long-term care facilities should implement infection prevention and control measures
- Social distancing measures affecting multiple people can include measures to limit outside visitors and limit the contact between the residents of confined settings, such as long-term care facilities;
- Long-term care facilities should implement the baseline options for preparedness for COVID19 described in an ECDC guidance document, given that the rapidity of an onset of a COVID19 outbreak may result in insufficient time to implement the necessary infection prevention and control (IPC);
- The ECDC guidance document 'Infection prevention and control for the care of patients with novel coronavirus in healthcare settings – first update' highlights best practices for PPE and options for hospitals and long-term care facilities that have limited access to such materials;
- Testing all cases of acute respiratory infection in hospitals or long-term care facilities in order to guide infection control and PPE use to protect vulnerable persons and healthcare staff; testing of symptomatic healthcare staff, even those with mild symptoms, to guide decisions on exclusion from, and return to, work;

At its meeting of the 27th March 2020, the NPHET discussed infection prevention and control in community and acute settings, in particular in relation to vulnerable people, and the group noted the necessity for the HSE to ensure the establishment of individual Outbreak Control Teams with appropriate public health input in respect of each such setting where clusters of infection are identified. On foot of the latest national data and the updated ECDC risk assessment, the group considered the existing policy and the related public health measures currently in place and agreed that a package of additional measures should be recommended to slow the spread of COVID-19 with particular focus on those aged over 70 years and the extremely medically vulnerable groups – introducing "cocooning" for these groups.

Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19 was published by the HPSC on the same day, including specific reference to the application of the guidance to those in residential care facilities.

Two extraordinary meetings were convened by the Department of Health on 29th and 30th March to further focus on nursing homes. A number of significant considerations and actions arose, including:

- a requirement for the HPSC to examine additional data in relation to confirmed COVID-19 cases in residential healthcare settings in Ireland;
- the preparation of a detailed framework of information to support NPHET's focused consideration of residential care facilities and

- an agreement that HIQA undertake risk assessments of those residential healthcare settings with confirmed COVID-19 outbreaks to inform responses at these services.

In response on the 30th March HIQA identified specific designated centres and underlying issues where the registered provider would be challenged to effectively manage this public health emergency. Those at greatest risk were those small providers who did not have access to (a) a group nursing home structure, and (b) a large work force of sufficient scale. The physical premises in which a number of services were provided posed an increased risk associated with multi occupancy rooms, insufficient bathrooms, and minimum day/dining space.

On 31st March, NPHET considered a specific paper on LTRCs and made a series of recommendations in relation to LTRC facilities comprising six national public health actions (see paper attached). The objective was to support the maintenance of residents in LTRCs unless there is clinical or other advantage, and to interrupt transmission of the disease and prevent onward spread in LTRC and the community.

On 3rd April 2020 the NPHET recommended that the HSE should immediately deploy an integrated outbreak crisis management response across LTRC settings, home support and acute hospital settings, to drive the infection prevention and control and the public health measures agreed by NPHET at the meeting on Tuesday, 31st March.

The Minister for Health announced on 4th April the establishment of a Temporary Assistance Payment Scheme (TAPS) for private and voluntary nursing homes.

HIQA issued a regulatory notice to service providers regarding the establishment of the Infection Prevention and Control Hub for designated centres on 6th April.

On 7th April the HSE COVID Residential Care/Home Support COVID Response Teams Operational Guidance issued.

On 10th April, it was agreed at NPHET that there should be continued focus on the long-term residential care sector and to continue to collect, expand and monitor data. The NPHET considered that mortality data should be further refined including specifically categorising COVID-19 deaths as suspected or confirmed. Data on identifying place of death and more timely data on confirmed cases among staff would also be important to get a more complete picture.

There was continued focus on LTRCs at NPHET's meeting on 14th April where it was agreed that the HSE was to put in place a coordinated national process for carrying out prevalence surveys across nursing homes and other residential healthcare settings, with a particular focus on detecting COVID-19 infections in these settings.
On 17th April NPHET considered and endorsed a further set of immediate additional actions focused on long term residential healthcare settings, to further inform and direct the public health response including:

a) a survey of mortality to be conducted to collect data on the total number of deaths (January 2020 to present), the number of laboratory confirmed COVID-19 deaths

(March 2020 to present) and number of possible COVID-19 deaths (March 2020 to present). The survey to commence on 17th April;

b) national testing of staff across all settings with an initial widespread approach and thereafter ongoing testing, which may include both staff and patients, to be conducted on a rolling basis;
c) the publication and assessment of a COVID-19 quality assurance regulatory framework for LTRCs by HIQA;
d) the implementation of previous recommended actions with enhanced reporting through an expanded 'Nursing Homes/LTRC settings Actions Tracker', which is to include the roll out of the Contact Management (CRM) system.

On 17th April the Temporary Financial Assistance Scheme for Nursing Homes opened for applications.

At its meeting on the 21st April NPHET accepted the advice of the Expert Advisory Group on the use of surgical facemasks indicating that that surgical masks should be worn by healthcare workers (HCWs) when providing care to patients within 2m of a patient, regardless of the COVID-19 status of the patient; and surgical masks should be worn by all HCWs for all encounters, of 15 minutes or more, with other HCWs in the workplace where a distance of 2 metres cannot be maintained. The Department wrote to relevant nursing home and home support representative bodies informing them of this decision advice on the 22nd April.

In line with NPHET's endorsement HIQA published its regulatory assessment framework of the preparedness of designated centres for older people for a COVID19 outbreak on 21st April.

The HIQA assessments of compliance under the regulatory assessment framework of the preparedness of designated centres for older people for a COVID19 outbreak commenced on 29th April.

At NPHET's 14th May meeting, it recommended the establishment of an expert panel (COVID-19 Nursing Home Expert Panel – examination of measures to 2021) which, through examination of national and international measures to COVID-19 as well as international measures and emerging best practice, will make recommendations to the Minister for Health, by the end of June 2020, to ensure all protective COVID-19 response measures are planned, for in light of the expected ongoing COVID19 risk and impact for nursing homes over the next 6-18 months. The Minister established this Panel on 21st May (see detailed note attached).

Testing

As Ireland sought to scale up testing for COVID-19 nationally, the National Ambulance Service (NAS) initially offered a home-based testing service to all patients who met the case definition criteria set out for COVID-19 by HPSC/NPHET including residential care facilities. As the 'home-based' testing model transitioned towards community-based testing centres of larger scale a dedicated pathway for nursing home testing was established with NAS.

On the 27th March the case definition was expanded to alert clinicians to the need for a higher index of suspicion being warranted regarding possible atypical COVID-19 presentations in nursing homes.

Given the highly infectious nature of COVID-19 in these facilities, and in order to protect residents, should there be a testing delay, LTRC facilities were advised to treat all residents with symptoms as likely COVID-19 positive in facilities where a COVID-19 diagnosis had been confirmed.

Ireland is one of the few countries that has undertaken a mass testing programme in long-term residential care. On 17th April, following a NPHET recommendation, the testing of all staff in LTRC facilities was conducted. Over 95,900 tests were completed with a relatively low overall positivity rate (5.5%) at that time. As recommended by ECDC, HSE is now introducing a weekly rolling programme of testing staff in nursing homes for a four-week period so that any new emerging infection can be continuously tracked and targeted.

COVID-19 operational responses

As the disease has progressed and new information emerged, a range of enhanced measures for these settings were recommended by NPHET on 31st March 2020 and 3rd April 2020. These enhanced measures build on actions already adopted for nursing homes, at the initiation of the relevant Outbreak Control Teams and the existing infection prevention and control advice provided by the HPSC, including general and specific infection prevention measures, specific public health and clinical COVID-19 guidance, social distancing measures, visitor restrictions and cocooning. A substantial package of focused guidance for LTRCs has been put in place and continues to evolve and be updated in line with new national and international evidence and guidance.

Many nursing homes remained COVID-19 free (56%). Others had the capacity to manage COVID-19 outbreaks to the point where over half of the clusters are now closed. While all LTRC facilities have been affected the most considerable impact seen has been in the nursing home sector. As of the 14th June public health data shows that approximately 18% of the resident population in nursing homes have had a confirmed diagnosis of COVID-19. The vast majority of nursing home residents never contracted the virus. While this has been an extremely challenging time for the staff, residents and families, most have been able to remain virus-free and healthy.

Some nursing homes were significantly challenged in being able to maintain staffing levels and manage enhanced infection prevention measures. This was particularly so since many nursing homes operate as single entities. Additionally, every registered nursing home is obliged, under law, to have a person in charge and that person, subject to specific circumstances must be a registered medical practitioner or a registered nurse. The person in charge has a range of legal responsibilities with regard to the care of residents in the nursing home. Private nursing homes are generally clinically supported by local GPs and therefore do not have a formalised clinical governance relationship with the HSE.

The State's responsibility to respond to the public health emergency created the need for the HSE to stand up a structured support system in line with NPHET recommendations. This has been a critical intervention is supporting the resilience of the sector in meeting the unprecedented challenges associated with COVID-19. In addition to public health support, in line with NPHET recommendations and in order to enable continuity of service delivery and infection prevention management, support for nursing homes over the last three months has encompassed:

- Enhanced HSE engagement;
- Temporary HSE governance arrangements for some non-public nursing homes;
- Multidisciplinary clinical supports at CHO level through 23 COVID-19 Response Teams;

- Access to supply lines for PPE, medical oxygen etc. To date, the HSE has provided PPE to the value of approximately €20m to private nursing homes;
- Access to staff from community and acute hospitals – from an early stage the HSE mobilised considerable staff resources, making them available to nursing homes where possible. An early example of this can be seen in the one of the first nursing homes that dealt with a cluster in late March where the HSE provided significant staff resources (45 whole time equivalents) to provide cover and support. As structured information systems were developed later in April, data on staff deployments could be collated centrally– the data shows that between 27th April and 2nd June the HSE deployed an average of 77 staff per day to a total of 68 private nursing homes;
- Suite of focused LTRC guidance;
- Temporary financial support scheme (€72.5m);
- Temporary accommodation to nursing home staff - approximately 32% of all Temporary Accommodation beds provided up to 28th May were provided to private and voluntary nursing homes amounting to over 1,000 beds;
- HIQA Infection Prevention Hub and COVID-19 quality assurance regulatory framework.

International guidance

The Department of Health and other agencies have been engaging with the research community on an ongoing basis to identify information, guidance and evidence internationally on COVID-19 and LTRCs, including in relation to impacts, management and interventions. Regular research is undertaken of national and international literature, such as rapid reviews of public health guidance on protective measures for vulnerable groups from COVID-19, to ensure that the best available information and evidence is considered in this rapidly evolving environment. Where learning has been identified from other jurisdictions it has been rapidly incorporated within advice and supports being made available. At the Special Committee's hearing last week Dr David Nabarro, WHO Special Envoy for COVID-19 said in relation to nursing homes that he could not think of something Ireland has not done but as experience evolves here and internationally it will be essential to keep up with best practice.

In this regard HIQA provides a weekly review of public health guidance for residential care facilities. This review notes a range of guidance has been issued internationally to protect residents and staff of LTRCs in the context of COVID-19. Guidance includes recommendations on testing, screening, monitoring, isolation, cohorting, social distancing, visitation, environmental cleaning, immunisation, providing care for non-cases, caring for the recently deceased, and governance and leadership. Many similarities exist between guidance documents, including recommendations to screen people entering facilities, to monitor staff and residents for new symptoms, to restrict visitation except on compassionate grounds, to isolate suspected and confirmed cases, to cohort symptomatic residents, to regularly clean frequently touched surfaces and to develop outbreak management plans.

The latest advice from the WHO and ECDC has been tracked daily and public health and operational advice and supports for LTRCs have been revised as evidence has emerged. It was mid to late March 2020 before specific guidance for the LTRC sectors was produced by the WHO. The reported international experience increasingly indicated the significant threat posed to the most vulnerable older people in nursing homes by the rapid spread of COVID-19 in these settings. The serious impact

on LTRCs was subsequently identified by ECDC in their 9th rapid risk assessment of 23rd April 2020. In its special technical report of 19th May, *Surveillance of COVID-19 at long-term care facilities in the EU/EEA,*[10] ECDC identified that the high COVID-19 morbidity and mortality observed among residents in long-term care facilities in EU/EEA countries poses a major challenge for disease prevention and control in such settings. This report outlines a set of multiple factors that may be contributing to spread including asymptomatic staff and residents and atypical COVID-19 clinical presentations or the absence of evident signs or symptoms until the patients' conditions deteriorate.

The timeline set out in the "*Overview of the Health System Response to date Long-term residential healthcare settings"* (26th May 2020) (Page 2) and summary table in Appendix 4 outline from the first COVID-19 case onwards the actions taken and how each actions, if not already in place, commenced swiftly and decisively following recommendations from both ECDC and the WHO.

Planning for the future

The National Risk Assessment 2019 identifies 'an *ageing population including pensions and health system challenges'* as a social risk and highlights the strong imperative to ensure the sustainability of our health and social care provision and its responsiveness to demographic trends including:

- the population aged 65 and over is projected to increase from one in eight in 2015 to one in six in 2030 and the number of people aged 80 and over is projected to almost double during this period (ESRI);
- furthermore, the proportion of the population aged 65 years and over will double from 12.8% in 2015 to 25.6% by 2050, and that the proportion aged 80 years and over will almost treble from 3% in 2015 to 8.1% by 2050 (OECD).

Sláintecare sets out to redesign our health and social care services to meet these challenges and to improve the health and wellbeing of the population. Consistent with this is focusing on keeping people well in their homes and communities for as long as possible i.e. "*get the right care, in the right place, at the right time*". The policy objective is to support people with care needs to continue to live in their own homes and communities for as long as possible. Important reforms include the planned for Statutory Homecare Scheme and the need to enhance access to homecare, expansion of the range of housing options within local communities as people's needs change and enhanced integration of services across the care continuum underpinned by multi-disciplinary teams with strong systems of clinical governance. This requires working with a range of stakeholders and other Departments. Key relevant policy documents include the National Positive Ageing Strategy, the Dementia Strategy, Housing Options for our Ageing Population, the Carer's Strategy and the Palliative Care Strategy. The policy framework *Housing Options for Our Ageing Population Policy Statement* (Department of Health and Department of Housing, Planning and Local Government) (February 2019) has a set of actions to develop new housing models, including those with associated care and support models which fall between home care and full-time nursing home care. The objective is to ensure older people stay socially connected within their community and to provide essential care and supports where needed, while preserving and protecting independence, functionality, and social connectedness for as long as possible, in a way that is as affordable as possible for older people themselves and sustainable for the State.

[10] https://www.ecdc.europa.eu/en/publications-data/surveillance-COVID-19-long-term-care-facilities-EU-EEA

Other policy areas under development include the Safe Staffing Framework for residential care (Phase 3 of the work of the Taskforce on Staffing and Skill Mix for Nursing will focus on nursing homes), the Nursing Home National Care Experience Survey which has been selected by the National Care Experience Programme as one of the priority areas for expansion and the use of InterRai as a standard assessment tool across all older person care in both the community and residential care.

The pandemic and its impact raise questions that require focused and strategic consideration in the future, in particular for services for older people, with regard to existing policies, areas of potential new policy development, the model of care for older persons, the configuration of service delivery, congregated environments, clinical governance, a safe staffing framework and the role of the health services alongside the role of other State bodies and the private sector.

In recognition that there is an expected ongoing COVID-19 impact over the next 6-18 months NPHET has emphasised the importance of real-time learning and a forward-looking approach for nursing homes. Therefore at the meeting 14th May, NPHET recommended the establishment of an expert panel (*COVID-19 Nursing Home Expert Panel – examination of measures to 2021*) which, through examination of national and international measures in response to COVID-19 and emerging best practice, will make recommendations to the Minister for Health, by the end of June 2020, to ensure all protective COVID-19 response measures are planned, for in light of the expected ongoing COVID-19 risk and impact for nursing homes over the next 6-18 months. This panel comprises public health, geriatric, nursing and public representation expertise. (A detailed note on the Expert Panel is attached).

Attachments

1.	Overview of the Health System Response to date *Long-term residential healthcare settings* (26th May 2020) https://www.gov.ie/en/news/7e0924-latest-updates-on-covid-19-coronavirus/#overview-of-the-health-system-response-to-covid-19-ltrcs
2.	a. Nursing Homes Working Group Report b. Response - Working Group Report
3.	a. Long-term Residential Care (LTRC) Paper to NPHET 31-03-20 b. Final LTRC Actions from NPHET Meeting 31-03-20
4.	HIQA Documents
5.	*COVID-19: Comparison of Mortality Rates between Ireland and other countries in EU and Internationally*. (28/05/2020) https://www.gov.ie/en/publication/84bc5-covid-19-comparison-of-mortality-rates-between-ireland-and-other-countries-in-eu-and-internationally/
6.	COVID-19 Nursing Homes Expert Panel Briefing
7.	Temporary Assistance Payment Scheme Briefing
8.	NPHET Vulnerable Subgroup