NHI Survey on Nursing Homes' COVID-19 Experience

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Background

In December 2019, a new variant of coronavirus, COVID 19, emerged in the city of Wuhan, China. Within a relatively rapid timeframe, this virus spread across the globe, leading to the World Health Organisation (2020) declaring a pandemic on March 11th 2020. Ireland's first case was declared on February 29th. From this point, public health measures were taken, however, the greatest mortality impact has been within the older population, particularly residents in nursing homes. The pandemic represents an unprecedented health crisis, which required substantial measures in infection prevention and control. In order to better understand the extent of the impact of COVID 19 in residential care settings for older people, Nursing Homes Ireland (NHI) undertook an e-survey between the period 26th May-1st June 2020. A factsheet summarising the key learning points was shared with the Nursing Homes Expert Panel in July 2020.

Survey

A survey was developed to elicit the experiences of private and voluntary nursing homes in Ireland during COVID 19. The survey was comprised of 12 sections. Data were collected through a total of 53 questions which enabled both quantitative and qualitative responses. A Survey Monkey ® link was forwarded to the Director of Nursing/Person in Charge of 460 facilities. Accounting for duplicates, there were 129 responses, representing a 28 percent response rate. Data were imported into Excel for analysis. Descriptive statistics was used to describe the quantitative data and thematic analysis underpinned the exploration of the qualitative responses.

Key Findings

There were a number of repetitive findings due to flaws in the design of some of the questions. While all findings are outlined within the full report under each individual topic they have been summarised here and are presented under five overarching themes.

An isolated and disconnected health service

The survey demonstrated that private and voluntary nursing homes were disconnected from both the national and local Health Service Executive (HSE) acute and community services. Ninety one percent of the nursing home responses (n=117) indicated that prior to the pandemic, they had no standard, regular contact with their local Community Healthcare Organisation (CHO). However, this changed as a necessity for support and information flow as the pandemic progressed.

Prior to the pandemic, over half of the respondents (n=73) reported not having previous access to a geriatrician, however, 30 respondents indicated that this subsequently changed. Just under 10 percent of respondents (n=12) also indicated a need to increase access to HSE allied health services for residents. The disconnect manifested in an undercurrent theme

running throughout responses. In particular, this translated to a need to recognise and value the staff who work in private and voluntary nursing homes and the need to highlight the unique voice of the gerontological nurse working in the sector.

Respondents noted that one of the most beneficial changes was the collaborative and supportive relationship that had built up with the HSE in recent months. Many identified that this brought an overdue recognition that nursing homes were a critical part of the health service rather than simply being a peripheral healthcare setting.

The continued relationship with HSE was a development that many nursing homes valued and its continuance post-crisis was desirable.

Challenges

Respondents identified a number of challenges both in the preparedness phase and during the outbreak. These related to the supply chain (n=44), training and staff development (n=27), staffing (n=26), information (n=14), implementing visiting restrictions (n=14), and managing fear, anxiety and stress among staff, residents and relatives (n=14). Access to a continuous supply of PPE was evident, however supply issues also extended to other critical items such as oxygen and including hand hygiene products and chemical/ cleaning supplies as these were in high demand or were being redirected to the HSE. While nursing homes did have a general stock of PPE, they did not have the necessary quantities available nor did they have a need for specialist items such as hospital gowns or respirator masks that the pandemic now required.

Challenges with training and staff development were mainly impacted by time pressures, physical distancing and staff availability. Whilst nursing homes would have regular infection control training for all staff there was a need to upskill staff on the specifics of COVID-19 and the donning and doffing of PPE. The speed at which an outbreak occurred and the resulting impact on staffing the roster when many staff were required to self-isolate also made scheduling training more difficult.

Staffing issues were primarily impacted by losing staff to the HSE recruitment drive, staff being unable to work due to being in the vulnerable category themselves or requiring to self-isolate following a COVID-19 positive testing result or being a close contact of a confirmed case. For some respondents, another issue of concern was obtaining access to test results. Responses indicated that the average time taken for staff test results was in the region of 4-6 days for the majority of respondents (n=37, 40%) or in excess of 7 days for one quarter of respondents (n=23). Residents' test results were also delayed, with the majority of nursing homes that responded to this question (n=29, 32%) reporting that the slowest time took between 6-10days for results to be returned. Six nursing homes reported it took three weeks or more. Given the high levels of asymptomatic cases this delay in response times severely impacted the ability of nursing homes to limit the transmission of the virus.

Level of Preparedness and Information

Accessing information and the lack of sector-specific information contributed to the workload and a degree of uncertainty particularly in the early days of the pandemic. Respondents spoke of having to navigate constantly changing guidance, sift through and respond to multiple information requests (often duplicated by different agencies) and ensure all staff were kept adequately informed (see appendix 2). Despite the challenges and the level of disconnect from state services, nursing homes demonstrated a proactive approach in the management of their preparedness for the pandemic. Using their specialist gerontological knowledge and expertise, coupled with learning from the emerging evidence and practices occurring internationally, many nursing homes took preventative steps in advance of formal HPSC guidance. These included:

- Visiting restrictions (n=86, 87%) in advance of 13th March 2020
- Twice daily staff temperature checks (n=62, 66.7%) in advance of 1st April 2020
- Wearing of facemasks (n=54, 58.6%) in advance of 22nd April 2020
- Cessation of large group activities (n=86, 91.5%) in advance of 7th April 2020
- Cohorting of staff (n=62, 71.3%) in advance of 14th April 2020
- Risk assessment of staff living and travelling together or working elsewhere (n=56, 61.5%) in advance of 1st April 2020

Another indirect but important finding indicated that there were very high levels of influenza vaccination among residents, with the majority of nursing homes having more than 95 percent vaccinated (n=60, 65%). Conversely, forty-seven nursing homes indicated they had less than the HSE recommended target of 65% uptake of the vaccine among staff. Although the reasons for this may be multifactorial it is critical that this anomaly is addressed as we approach the winter months, to further safeguard residents, aid in differential diagnosis and continue to bolster staff availability for work.

Communication and a new way of working

The risks presented with inadvertent transmission of the virus meant that all but essential staff were restricted from entering nursing homes. This presented its own challenges with accessing medical and allied health supports; maintaining occupation and connectedness for residents; keeping relatives informed and updated; and maintaining regulatory compliance, all while juggling the extra demands of service delivery, often with reduced staffing levels.

In over half of nursing homes (53%, n=68), anxiety and stress were recurrent experiences, considerably impacting the emotional well-being of staff. Although small in number (n=8), the testimonies of those who had experienced a large outbreak demonstrated a profound and lasting impact, which culminated in feelings of devastation, grief, fatigue and being emotionally spent. Although residents and relatives missed face to face interactions, they were reported as being resilient, grateful for staff efforts and accepting of the situation. Respondents reported that frequent and supportive communication was critically important at all levels to manage emotions and maintain coping mechanisms. Consequently, nursing homes used a number of communication methods including one-to-one support, daily

briefings, video calling (e.g. WhatsApp®, FaceTime®, Zoom ®, etc), telephone, email, letters, text messaging and nursing home websites and social media accounts for these purposes.

Recognition and Media portrayal

At various points throughout the survey, many respondents indicated their dismay at the constant and often unfounded media portrayal of the sector, much of which they felt was overly negative and not based on the reality of nursing home life. Some respondents specifically highlighted the need to stop the public apportioning of blame as this was not helpful and impacted negatively on both staff and residents.

One respondent suggested that instead of focusing on the negatives (i.e. clusters and deaths), that the media and other agencies should recognise the high standards of care and skilled care which enabled many residents to recover from COVID-19.

Conclusion

This survey has provided insights into the experiences of private and voluntary nursing homes in Ireland during COVID-19. While COVID-19 has continued to require public health measures beyond the point of data collection, there are valuable lessons to be learned from the experiences of the sector. What is clear is the need for a cohesive and collaborative partnership between public, private and voluntary healthcare providers. Nursing homes are not peripheral to healthcare but an essential environment where specialised, person centred care is delivered. The COVID-19 pandemic has enabled an enhanced relationship between sectors and this should be foundational to further collaborative interactions to continuously improve care for older people. Furthermore, it is recommended that policy should be revised to mandate a joint cohesive approach for any similar future health crises. Moreover, public, political and media discourses should have a representative balance, recognising the responsibility of transparent reporting.

Background

In December 2019, a new variant of coronavirus, COVID 19, emerged in the city of Wuhan, China. Within a relatively rapid timeframe, this virus spread across the globe, leading to the World Health Organisation (2020) declaring a pandemic on March 11th 2020. Ireland's first case was declared on February 29th. From this point, public health measures were taken, however, the greatest mortality impact has been within the older population, particularly residents in nursing homes. The pandemic represents an unprecedented health crisis, which required substantial measures in infection prevention and control. In order to better understand the extent of the impact of COVID 19 in residential care settings for older people, Nursing Homes Ireland (NHI) undertook an e-survey between the period 26th May-1st June 2020.

Purpose

This report provides insights into the experiences of nursing homes in preparing and responding to the COVID-19 pandemic. Using a survey methodology, the primary purpose was to ascertain what worked well and what could have been improved so that lessons could be learned and shared among the sector. It was also hoped that information generated could be used to inform the work of the newly established *COVID-19 Nursing Home Expert Panel* and highlight any particular supports required for the sector and nursing home residents as well as identifying additional issues which may require further examination.

Methodology

A survey was designed and uploaded into Survey Monkey ® software (Appendix 1). This contained a total of 53 questions divided into twelve sections. These were: demographic details, Health Service Executive Services (HSE), preparedness, staffing, staff training, premises, Health Information & Quality Authority (HIQA), mass testing, outbreak, impact on residents, innovations and future care arrangements.

A survey link was circulated on Tuesday 26th May 2020 via the NHI email distribution lists to Directors of Nursing and Registered Provider contacts in all private and voluntary (NHI member and non-member) nursing homes. The collection of data occurred between Tuesday 26th May and 1st June 2020. Two email reminders were sent on Thursday 28th May and Friday 29th May 2020.

Response Rate

A total of 192 responses were received however 45 of these were duplicate entries. Duplicates were identified by using conditional formatting in Excel on two columns, the IP

address and the Nursing Home Name. There were two principle reasons for duplication. Firstly, some individual respondents had entered data up to three times, however skipped large numbers of individual questions. This appeared to be due to problems with data entry from feedback received to the NHI office. Secondly, other duplicates were a result of more than one respondent entering data from the same nursing home, usually the Registered Provider Representative and the Director of Nursing (PIC).

Duplicate entries were reviewed to compare responses to each individual question. In all cases the response which had the most individual questions answered was selected. Following the removal of duplicate entries 156 unique responses remained. However on further examination it was found that several respondents had completed the demographic data only and left the rest of the survey blank. These entries were therefore discounted leaving a total of 129 individual nursing home responses. At the end of 2018, there were 460 unique registered nursing homes that were privately owned or were HSE funded bodies under Sections 38 and 39 of the Health Act (HIQA, 2018). The percentage response rate therefore was 28 percent.

Furthermore, not all respondents answered all questions hence the individual item response rate varies throughout the survey. Missing data is indicated under the relevant section within the analysis.

Analysis

Data were imported into Excel for analysis. Descriptive statistics was used to describe the quantitative data and thematic analysis underpinned the exploration of the qualitative responses.

Limitations

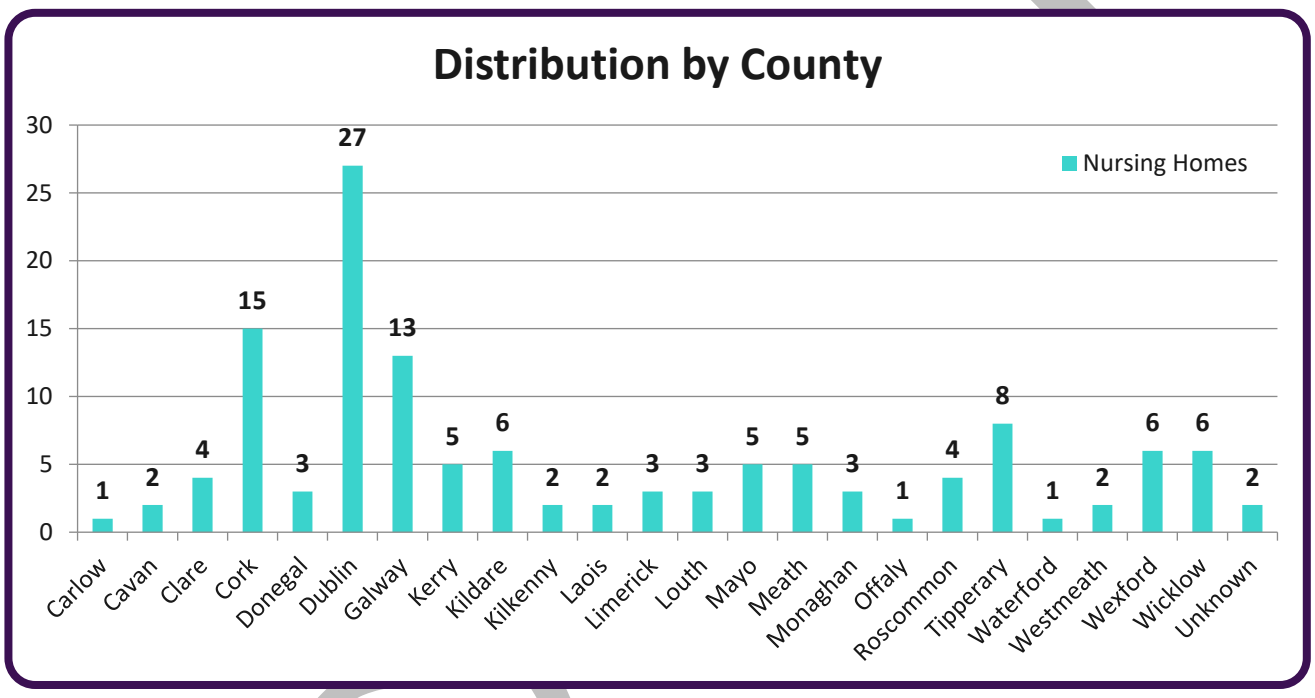
The primary purpose of the survey was to assess the learning from the lived experience of nursing home staff and residents so that this could be used to inform the Nursing Homes Expert Panel, other state agencies and to share the learning within the sector to drive quality improvements. The associated time pressures diluted the usual rigour in the design process. As a result, the design of some of the survey questions was flawed and this resulted in a degree of misinterpretation and therefore a variation of responses to individual questions. Furthermore, there was some duplication in certain questions. As a result, there is some repetition within certain sections of this report which was difficult to eliminate due to the variation in individual response rates to each question.

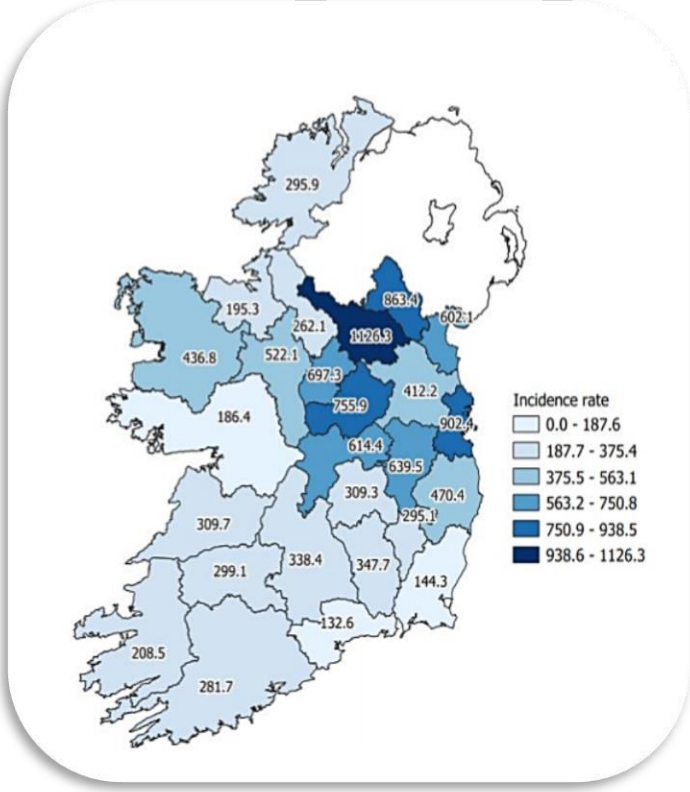
It is acknowledged that the response rate was relatively low. This is compounded by individual items having diverse responses. Thus, caution should be taken in generalising results.

Nursing Home Profile

Regional Distribution

There was a broad national representation of nursing homes in the survey with 23 of the 26 counties participating. Locations by county are demonstrated in the following chart:





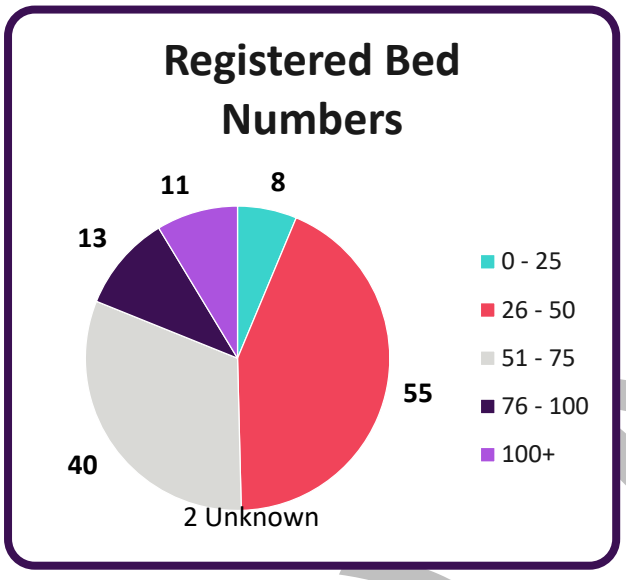
Nursing homes from counties with high levels of confirmed cases are also represented in the sample.

Forty-one percent of nursing homes (n=53) reported that they had not experienced an outbreak or had a confirmed case in either residents or staff following their initial mass testing exercise which occurred from 23rd March to 8th May 2020.

As of midnight 06/06/2020 there were 258 outbreaks notified that had occurred in nursing homes.

Source: HPSC Cumulative Incidence Rate as of 06/06/2020. Available at: www.hpsc.ie

Size and Design



The bed occupancy within the respondents ranged from 18- 184. Almost 80 percent of nursing homes (n=103) were registered to provide a maximum occupancy of 75 beds or under.

Over half of respondents (n=74) reported that the design of the premises enabled the easy introduction of cohorting in specific zones, with the vast majority using their fire compartmentation as a model for zoning which often included separate entrances. Many reported that their buildings were purpose-built with separate wings and predominantly consisted of single en-suite bedrooms.

Fifteen percent (n=20) were unable to accommodate zoning for multiple reasons which included:

- Being a small nursing home where cohorting of staff or creating zones was challenging.
- Being located in an older building with narrow corridors which mitigated against PPE stations in corridors.
- Having full occupancy, therefore, being unable to provide isolation facilities.

A total of thirteen homes indicated that they could not maintain physical distancing between beds in their multi-occupancy rooms with the maximum distance between beds being reported as between 1 – 1.5 metres. Four nursing homes had reduced the number of beds in these rooms to comply with the public health guidelines. The remaining nursing homes indicated this had not been done due to being at full occupancy, providing care for a married couple who wished to continue sharing or having had vacancies elsewhere in the nursing home which allowed the redistribution of residents.

Fifty seven percent (n= 74) indicated that they had sufficient communal spaces to enable physical distancing within the nursing home when 'cocooning' ended. Some highlighted the various methods that they had implemented to operationalise this such as demarcation for positioning of furniture, installation of Perspex panelling, alternating days that residents could utilise 'popular' areas, additional times for staggering meal-times or activities, removing chairs, etc. Six nursing homes, however, indicated that residents didn't always want to observe the physical distancing or were not in a position to understand the requirements.

Two respondents highlighted the need for additional staffing levels to assist with the new requirements and to maintain adequate support and supervision of residents in a variety of different rooms.

Sixteen percent (n=21) indicated that while their communal space met the regulatory requirements, they did not have sufficient communal space for physical distancing and in particular would not be able to implement the 2 metre rule based on the number of residents.

Findings and Discussion

HSE Services

Access to Geriatrician

As demonstrated in table 1, two thirds of the respondents indicated that they had access to a geriatrician (n=86). Of these, over a third (n=30) indicated that this service was not in place before the pandemic. When asked to rate the importance of this service, just over half of those who had access (n=44) rated it as 'Very Important or Important'.

Table 1: Access to a Geriatrician

	Yes	No	Missing data	Total
Access to a Geriatrician	86 *	41	2	129

*Number in place before pandemic=56

The respondents that had indicated they had access before the pandemic mostly highlighted that this was only after referral from a GP. Whereas, the increased access provided by the pandemic enabled nursing homes to often engage directly with their local Geriatrician teams. Thus providing greater oversight of residents reflecting the complexity of older persons' needs and the atypical presentation of COVID-19 in this population. This is an important change to the model of nursing home care which must be sustained.

Local Community Healthcare Organisation (CHO) office

An overwhelming 91 percent of nursing homes (n=117) indicated that prior to the pandemic, they had no regular contact with their local CHO office except for one off contacts or for specific issues such as safeguarding, finance or infectious disease outbreaks. However, the vast majority indicated that since the pandemic, there has been regular supportive communication which ranged from daily contact in a fifth of cases (n=29) to weekly or alternate weekly teleconferences.

> *"Communication prior to the Pandemic was on a needs based contact, however this has changed and we are in daily contact now."*

> *"Daily communication through phone call and email updates - very important as this has been a good source of information though confusing at times"*

Almost all respondents expressed their gratitude for this support and remarked on how positive the relationship was now and how it was extremely helpful in enhancing care delivery to

residents. Three respondents indicated however that the support did not materialise until after they had an outbreak or well into the pandemic.

> *"Previously no contact. Approx 4 weeks into pandemic, started having daily telephone contact with a nominated person from CHO7 who would enquire about numbers of cases, arrange PPE and advise on supports available."*

When asked to rate the support currently received 81 percent of nursing homes (n= 104) stated that they were 'Very Satisfied' (n=49) or 'Satisfied' (n=55).

Most beneficial change

Sixty one percent (n=78) of respondents spoke of the importance of the collaborative and supportive relationship that had built up in recent months. Having a single point of contact and regular communication with HSE staff was cited time and again as being particularly helpful throughout the crisis. Ten percent of nursing homes (n=18) referred to finally being included in formal responses. This inclusion recognised that they are a critical part of the health and social care service, rather than a feeling of a 'them' and 'us' mentality that the respondents' experienced prior to COVID-19. This change in recognition by the HSE was highlighted as having also been extended to the rights of residents to such support, although some feared that the changes would be temporary:

> *"An acknowledgement that the people we care for are entitled to the same supports as those cared for by statutory and voluntary providers. "*

> *"Private nursing homes are often out on a limb, essentially operating alone, even establishing contact with services has helped us to feel part of the health service not in opposition to it. This change I feel is fleeting - the apparent collaboration between state and media has once again shifted the emphasis away from successes in nursing homes."*

Having access to specialist advice, information and education was also highlighted as very important to just under a third of respondents (n=39) with a number of them highlighting specific staff and teams in the HSE, most especially the Director of Nursing/ National Lead for Older Persons Services. Getting timely access to up-to-date and streamlined information, including the use of WhatsApp®, webinars and email distribution lists were cited as being particularly effective for shared learning.

> *"…support and information dissemination so we can all work along the same guidelines and learn positively from others"*

> *"Networking...Pathway for essential information and updates. Availability of essential training for staff."*

Finally, over a quarter of respondents (n=37) reported that the most beneficial change for them was getting access to critical supplies such as oxygen and PPE and other supports like accommodation for staff and occupational health input.

Additional comments

Eighty-nine respondents provided further commentary. Over a quarter of respondents suggested areas for improvement particularly in the governance of these services (n=24)

to ensure there was consistency of personnel, standardisation and enhanced communication both between various different departments within the HSE and with contracted services such as GPs to ensure awareness and implementation of national guidelines without unnecessary duplication.

> *"Too many people involved and causes major confusion as most do not know what the others are doing and communication within the HSE is very fragmented and does not flow from top down or between different sections of the same departments."*

A further twenty nine percent of respondents reiterated the supportive nature of the services provided (n=14) and their wish that this collaborative working would continue into the future (n=12). Moreover, one tenth of respondents (n=9) used the opportunity to highlight the inequity of access to allied health services for residents with medical cards in private and voluntary nursing homes and called for change:

> *"Hopefully this pandemic will see HSE services extended to private nursing home residents such as SLT, OT, Dentistry, Podiatry etc. It is unacceptable that residents cannot avail of these services once they are admitted to a nursing home."*

It is heartening that the final report of the Nursing Homes Expert Panel (DOH, 2020) mirrored these findings and included two specific recommendations to this effect. Firstly, that there should be the establishment of dedicated Community Support Teams to engage directly with and support and advise private and voluntary nursing homes and secondly that nursing home residents should be provided with full medical card eligibility to services that are available to their community peers. It is critical that both of these recommendations are implemented.

Preparedness

Summary of measures undertaken

This section of the survey focused on ascertaining if there were any additional activities that nursing homes were engaging with which differed from the national guidelines or which were not captured elsewhere in the survey questions. It was deliberately front-loaded to capture those respondents that may not complete the survey in full. A total of ninety-five nursing homes provided a detailed description of all of the measures they had taken. This provided further insight into the level of preparedness and activities that some providers had engaged with to ensure residents and staff were protected.

Many nursing homes had implemented additional infection prevention and control and business measures which were not highlighted in the national guidance. A sample of such is as follows:

- Purchasing scrubs for staff instead of uniforms
- Laundering all staff uniforms onsite
- Changing shoes before entry or using foot baths
- Purchasing 'fogging'/ ozone/ air sanitising units
- Providing PPE for staff to use outside the nursing home
- Provision of alternative accommodation and transporting staff to and from work to avoid the need to use public transport
- Limiting all admissions to the nursing home
- Sanitising all delivery items/ 'quarantining' post
- Asking local Infection Prevention and Control teams or Public Health services to facilitate a site visit for audit/ recommendations
- Purchasing extra storage units to enable freezing of large quantities of food
- Purchasing camp beds and bedding should staff be required to 'bed in'
- Paying a 'contingency team' of staff to be on stand-by

Findings also demonstrated the particular challenges associated with gaining access to PPE with some nursing homes ordering these supplies from as early as January 2020. Accessing PPE was described as challenging.

> *"Travelled (drove) all over Ireland to get FFP2/3, surgical masks (to buy) Hardware suppliers, English suppliers, Nursing Colleagues, Local hospitals. (Bought as much as we could)"*

Furthermore, survey findings demonstrated that nursing home staff were using foresight and their unique gerontological expertise to seek out the latest evidence to inform their policies and implement practices well in advance of when any national sector-specific guidance required them to. Overall, despite the level of preparedness that some nursing homes had

undertaken, with every public health recommendation followed, these anticipatory actions were insufficient in preventing outbreaks in some nursing homes.

Challenges

Ninety three respondents highlighted a number of challenges that were multifactorial. These predominantly centred around five key themes which are presented below. These challenges included getting access to testing and results (n=5), managing the admissions/ transfers process (n=4), the financial impact (n=3) as well as difficulties associated with providing isolation, caring for residents with dementia and getting access to medical and allied health supports.

Supply chain

The challenges associated with obtaining access to a continuous supply of PPE have been well versed throughout this pandemic. For example, just under half of respondents (n=44, 47%) cited issues with the supply chain as being one of their main issues in the preparedness phase; gowns, masks and goggles were particularly difficult to obtain. However, supply issues also extended to other critical items such as hand hygiene products including alcohol-based hand gel, chemical and cleaning supplies and oxygen. Several respondents referred to the ring-fencing of supplies by the HSE where orders had been placed with their usual suppliers but then redirected for public service use.

> *"The acquisition of PPE was hugely problematic. It had been either held back for the HSE or else was not in stock."*

Although nursing homes have their own supplies of PPE, they would not generally have a requirement for specialist items such as long sleeved hospital gowns or respirator masks due to the nature of the care they provide. Moreover, the volume required for a pandemic was not routinely stocked. Early March was identified as particularly problematic with many citing that they did not have sufficient time to prepare and the PPE was simply not available. At this time, there was a global shortage of PPE which resulted in the HSE and some nursing homes having to source items directly from China. Whilst a small number referenced the spiralling costs associated with the increased demand and were concerned about the financial impact on the nursing home (n=3), others stated that finance was not the barrier.

> *"Acquiring stocks of suitable PPE in sufficient quantities to meet demand. Finance was never an issue, but there was no supply to be bought at the time."*

> *"We had our own stock for everyday use but required specialised which became a huge problem for us. We sent away to China and UK for supplies and received some. We continued to do this until we had a substantial stock"*

Staffing

One quarter of respondents (n=26) highlighted issues in respect of staffing which predominately related to losing staff to the HSE recruitment drive (n=7), difficulties in recruiting additional staff (n=5), staffing the roster due to issues with lack of childcare (n=1), staff being in the vulnerable category themselves (n=2) or losing large numbers of staff either due to the mass testing results (i.e. being COVID-19+) or through being contacts of a confirmed case (n=5). Other issues identified focused on preventing staff working in other workplaces and the challenges of relying on agency staff (n=4). Two homes spoke of the challenge of motivating their staff and getting them to realise how serious the situation was, whereas one referred to the lack of a sick pay scheme resulting in staff showing up for work when they should not.

> *"Ability to prepare was really impacted by HSE hiring 6 of our most senior nurses/nurse managers."*
>
> *"…didn't know the extent of panic that covid would bring with it. Told on a Sunday eve that 23 of my employees were covid positive and take them off the roster. This left gaping holes that could not be filled.."*
>
> *"Agency staff were an enormous challenge because in many instances they work in other settings. Without an in-house sick pay scheme, staff showed up for work when they should not."*

Information

The volume of information received (n=14) was highlighted as contributing to the workload and confusion, particularly in the early days of the pandemic. Respondents spoke of the constantly changing guidance and the struggle to keep up to date with all of the requirements with one respondent referring to having to deal with the 'tsunami' of e-mails related to policy changes and information requests. Others highlighted the often repetitive nature of such information requests.

> *"Lack of co-ordination across various Government departments resulted in a lot of time being spent preparing what was essentially the same requested information in various different formats for different departments, discussing this information with people from each department all whilst trying to ensure we were up to date with the ever changing recommendations, guidelines, policies and procedures from these departments and communicating all of this to staff, residents and their families."*
>
> *"…amalgamation of information on the double and triple sometimes hence time consuming"*

Similarly, the lack of national sector-specific public health guidance and information (n=7) was cited as hampering efforts to prepare and to be adequately informed:

> *"…guidance at the time in early/mid-February from NPHET, HSE etc was minimal if at all"*

"Having access to information to allow us make informed decisions."

Fear, anxiety and stress

Fifteen percent (n=14) of respondents spoke of the constant fear, anxiety and stress among staff, families and residents particularly at the beginning of the pandemic. Respondents associated this with being negatively impacted by the lack of clear guidance, the portrayal of the sector in the media and false information about the virus circulating on social media.

Staff fears predominately centred on having contracted the virus themselves with a concurrent fear of transmitting the virus to residents and the devastation it could bring. Others discussed the fear of the unknown and how you could possibly plan for such an eventuality. One respondent highlighted the added stress caused by the prospect of a HIQA inspection, which they cited they were still anxiously awaiting, when they felt that HIQA should be supporting nursing homes. Constant reassurance, education and supports for staff as well as the passage of time were indicated as being helpful in reducing the fear and anxiety among staff.

"Fear, Staff residents and families were very afraid that anybody would get covid. Media and fake media contributed to this."

"I believe the most difficult part was dealing with fear. .. fear of staff residents and families this was not helped by the paperwork that was being sent through at the time from the HSE which basically told us everyone was going to die."

"The most Difficult challenge was reassuring staff and relieving their fears. Keeping them up to date as we went along was OK, but the challenge was clearing staff minds of the "rubbish" and "chatter" that the social media filled peoples mind with."

" The mental strain of trying to prevent it entering our facility"

Visiting restrictions

The implementation of visiting restrictions and the impact of these was also acknowledged by a further fifteen percent of respondents (n=14). The impact both on residents and families coupled with an increased workload for staff were highlighted as being the most challenging. Two respondents highlighted that the lack of government support for the measure aggravated the situation with families, whereas a further two highlighted their lack of preparedness due to the suddenness of the recommendation.

"Restricting visitors and the castigation received from HSE / NPHET for doing so in the early stages. May have been prevented if NPHET 'paid more attention to what was happening in RCF's globally'!"

"The other great challenge was reassuring the families and having a lot of communication, as time went on we had no outbreak we set up all sorts of

communication where they could talk directly to their loved ones and they were able to see life was going on as normal."

Preventative measures

This section of the survey explored the extent of the preventative measures implemented in the sector and whether these were in line with national guidelines. Response rates varied for each individual question as outlined below. The results presented here are therefore crude statements based on individual responses provided. Further analysis is required to ascertain if there is any correlation between the measures implemented and the nursing home's COVID status from a statistical perspective.

Visiting restrictions

Ninety-eight responses were received for this question. Of these eighty-seven percent of nursing homes (n=86) implemented the visiting restrictions either in advance of, or in line with the NHI guidance on March 6th. This guidance was issued seven days in advance of national guidance to implement restrictions from 13th March. Five nursing homes indicated they had commenced some form of visiting restrictions as early as the middle to the end of February with one of these qualifying that from:

> *"Feb 16th visiting to the home was 'managed' ie...handwashing/ visiting in specific areas of the home"*

Only four nursing homes indicated that they did not restrict visiting until up to a week after the national guidelines.

Just six nursing homes reversed the decision and reopened visiting following the public declaration by NPHET that these restrictions were not necessary. All but one of these nursing homes experienced an outbreak or had confirmed cases and the majority were located in Dublin (n=4). One Dublin nursing home implemented restrictions on 1st March and was given a directive by public health services via telephone to lift their restrictions the following day. Restrictions were reintroduced on 10th March and the home experienced an outbreak on 15th March.

Staff temperatures

Ninety-three nursing homes responded to this question. Undertaking a staff temperature check at the entrance of the nursing homes was recommended in the World Health Organisation (WHO) infection control guidance for long-term care facilities, published on 21st March 2020. However, it did not become an Irish directive in the HPSC guidance until almost two weeks later on 7th April 2020 (following a NPHET recommendation issued to nursing homes on 01/04/20).

Two thirds of these nursing homes (n=62) implemented this practice in advance of the NPHET recommendation with almost three quarters of these (n=48) having commenced even in advance of the WHO guidance. Two nursing homes were observed as initiating this practice from 1st March 2020, with a total of forty having this practice in place by 20th March.

Eight nursing homes commenced after the recommendation with the latest of these being recorded as 21st April 2020.

Wearing of facemasks

A total of ninety-two responses were received for this question. The wearing of facemasks in all clinical areas when caring for a patient within 1 metre or where physical distancing could not be maintained between staff was recommended by NPHET on 22nd April 2020.

Over half of these nursing homes (n=54, 58.6%) stated that they were already implementing this measure in advance of the guidance and had commenced in March or early April 2020.

Seventeen nursing homes were later in implementing the measure, with the latest date provided as being 15/05/2020. One nursing home qualified their reason for this:

> *"May 2nd as we didn't have adequate masks prior to that date and could not access masks"*

Cessation of large group activities

Guidance around the cessation of large group activities in the early stages of the pandemic was limited and could be deemed somewhat confusing. The first sector-specific guidance issued to nursing homes from HPSC was published on 17th March 2020, *'Preliminary Clinical and Infection Control Guidance for COVID-19 in nurse- led Residential Care Facilities (RCF)'.* This guidance only required the cessation of group activities if there was a suspected or confirmed case.

The WHO guidance published on 21st March highlighted that physical distancing should be ensured and where this was not possible, such activities should be ceased.

Follow on guidance from HPSC on 21st March and 30th March (v.1.1) referred to the suspension of group activities that involved close contact and it was not until guidance published on 7th April 2020 that recommendations referred to ceasing congregated activities such as watching TV in groups. Specific guidance aimed at limiting residents to small group activities with the same persons' participating consistently was similarly delayed.

Nevertheless, some nursing homes took the initiative to cease large group activities from as early as 28th February with over ninety percent of the ninety-four nursing homes responding to this question (n=86. 91.5%) discontinuing these in advance of 7th April.

Six nursing homes were later in implementing the guidance, whereas two nursing homes indicated that they had continued as normal whilst implementing physical distancing.

Cocooning of residents

The Department of Health issued *'Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19'* on 27th March 2020 in line with national restrictive measures introduced at that time. This document was highlighted as being applicable to all those over 70 years of age or extremely medically vulnerable living in

long-term care facilities. However, it was not added to the HPSC guidance for residential care facilities until V2 on 7th April, despite there being a V1.1 published on 30th March. It stated:

> *"Residents should be encouraged to stay in their bedroom as much as practical but with regard for the overall wellbeing of the resident"*

Of the ninety-two nursing homes that responded to this question, a third (n=30) implemented this practice in advance of the guidance however 'cocooning' in general was not well implemented with one fifth of respondents (n=27) stating that they had not implemented this, it did not work or it was only used if a resident was in isolation due to being a suspect or confirmed case:

> *"…we never did this, we introduced social distance measures in all our public areas and did resident education, we introduced social distancing signs in all our public areas."*
>
> *"…where possible - This is the residents' home - Not always practical - Dementia residents - who walk with purpose"*

Cohorting of staff

Guidance that each ward or floor should try to operate as a discreet unit was included in v3.1 of the guidance published on 14th April. This guidance recommended that staff and equipment should be assigned to a particular unit and not rotate to other areas of the nursing home.

Over 70 percent of the eighty-seven nursing homes responding to this question (n=62, 71.3%) reported that they had implemented this in advance of the guidelines with six nursing homes stating this had always been the case prior to the pandemic.

There was a recognition in the guidelines, however, that this may not be suitable or achievable in smaller nursing homes and therefore ten percent of nursing homes (n=14) had reported that this had not been done, was not possible or was not applicable to them.

Risk assessment of staff

The risks of staff living and travelling together and working elsewhere had been identified within specific nursing homes that experienced an outbreak at an early stage. At a meeting of NPHET on 31st March 2020, a list of six enhanced measures were introduced to support nursing homes. The second measure on this list included the statement that the HSE would provide support for appropriate alternative residence and transport for staff (where deemed required) and that there should be a minimisation of staff movement between long-term residential care facilities. These measures were communicated to the sector on 1st April 2020, however, only one of these recommendations have been included in the sector-specific infection, prevention and control or occupational health guidance documents to date- the recommendation that staff should only work in one residential setting and not move across settings.

Nevertheless, there is evidence that many nursing homes were already proactively managing these risks, at considerable cost to themselves, from as early as 16th February. Under two thirds of the ninety-one nursing homes responding (n=56, 61.5%) reported they had implemented this in advance of the guidance.

Four nursing homes did not implement this until late April or early May, whereas another four nursing homes reported that this had not yet been done.

Twenty four nursing homes reported that the provision of alternative staff accommodation was not required.

Vitamin D supplementation

A TILDA (The Irish Longitudinal Study on Ageing) report examining the Vitamin D deficiency in older adults in Ireland and the implications for COVID-19 was published on 7th April 2020. Whilst supplementation has not been recommended by NPHET or included in the HPSC guidance there is widespread support among leading academics and gerontologists for its use due to its potential in strengthening the immune system.

Over forty percent of the seventy-eight respondents (n=35) reported that they had commenced this measure in advance of the TILDA report being published with many citing that residents had always been taking a Vitamin D supplement.

Eight nursing homes reported that they had discussed the matter with the GP but that they had not implemented it:

> *"Discussed with GP, he was not convinced of evidence"*

Additional measures

Eleven nursing homes highlighted additional measures which included:

- Nutritional supplements/ snacks (n=3)
- Recording of resident temperatures (n=2)
- Vitamin D supplementation in their staff (n=1)
- Created separate changing rooms for staff with own entrance (n=1)
- Use of a sanitising system Zoono® (24hr hands – 30day surfaces) (n=1)
- Ginger and lemon and steam inhalations for residents with coughs (n=1)
- Multivitamins for all residents (n=1)
- Training (n=1)

This section demonstrates that nursing home staff were often at the forefront of decision-making and were implementing many of the preventative factors before being advised to do so within national guidance. It should be noted that early in the pandemic, evidence was emerging from various different countries globally, that indicated outcomes for older persons contracting COVID-19 were considerably poorer and that long-term care facilities were severely impacted (DOH, 2020). The government response and the national HPSC

guidance, as demonstrated here, did not always appear to keep in line with the emerging international evidence. Despite this, the findings demonstrate nursing home staff were actively seeking out this evidence for themselves. Indeed, some nursing homes went over and above what was required in the guidance, indicating that they were doing all in their power to prevent introduction of the virus. The Expert panel report (DOH, 2020) has recommended that senior nursing staff will have undertaken post-graduate gerontological training. Whilst the qualification of nursing staff was not examined in this survey the findings demonstrate that the intuition shown and skills adopted by the sector indicate that the practice of gerontological nursing was clearly evident.

Staffing

Staff risk factors

Nursing homes were asked to identify how many of their staff presented particular known risk factors such as working elsewhere, living with other healthcare workers, travelling to work together or were required to cease working due to being in the medically vulnerable category themselves. Results are indicated in the following table 2 where n = number of nursing homes that responded to the question:

Table 2: Number of staff who worked elsewhere, lived with other healthcare workers, travelled together or were medically vulnerable

Number of staff	Worked elsewhere	Lived with other healthcare workers	Travelled together	Medically Vulnerable
0	54	21	45	25
1	16	16	4	17
2	7	14	14	16
3	6	10	6	11
4	2	7	11	9
5	2	5	2	6
6	2	9	3	3
7	1	2	1	2
8	-	3	2	3
9	-	-	-	-
10+	-	3	-	-
Unknown[1]	5	4	5	2
Total	95	94	93	94

[1] Unknown data relates to either being unknown at the time of completing the survey, was not risk assessed or provided an invalid response

There has been some public discourse and assertions that many staff in nursing homes would be working in multiple locations due to low pay. This is not widely demonstrated in the sample with over half of nursing homes (56%) not having any staff that worked elsewhere. Those nursing homes that did have staff working elsewhere reported this occurrence in small numbers of three staff or less (n=29). Where this was the case, staff were generally given a choice of three options: which was to be their primary place of work (n=7), increase their hours to compensate for any loss of earnings elsewhere (n=2) or to be laid off (n=8). Agency working was also discontinued in three nursing homes or a definitive contract was entered into in one nursing home to ensure agency staff worked exclusively for the nursing home:

> *"We contacted 4 agencies to provide both nursing and carers. We insisted that they staff that came to us did not work for 14 days in their current place of work and were tested prior to commencement of work with us. They were guaranteed work for at least 3 months and continue to work with us presently"*

Staff living with other healthcare colleagues was commonplace in over three quarters of nursing homes. One nursing home highlighted that they employed four married couples who all worked in the nursing home. Anecdotal reports to NHI would also indicate there is a high incidence of migrant workers sharing accommodation, particularly in Dublin due to high rental prices. Sharing of accommodation would, therefore, present staffing issues due to the requirement to self-isolate if there was a suspect or confirmed case in the household. Mitigating factors included risk assessment and greater monitoring (n= 8); providing alternative accommodation (n=31) or advertising HSE accommodation which was made available at a later stage (n=3). Another option was to ask the staff member to cease work, occasionally with full pay (n=3).

> *"Provided / paid for alternative accommodation"*
>
> *"…healthcare workers living together isolated from each other at home and monitored their symptoms"*
>
> *"One member of Staff is off on full pay at present as her partner is a nurse in another care facility."*

However, it was recognised that it was not always possible to mitigate the risk for a variety of reasons.

> *"…Attempted to get accommodations for others but was very difficult and cultural issues emerged"*

Car sharing was also a feature in just over half of the nursing homes (n=48) which was ceased immediately (n=5) or where not possible, staff were instructed to wear face masks during travel (n=5). Alternative transport, such as taxis, was provided to staff in five nursing homes:

> *"Staff car share ceased and taxi used for individuals."*

One nursing home risk assessed the situation and believed that continuing car sharing was less of a risk than the staff member using public transport.

Seventy three percent of nursing homes had at least one staff member that required to 'cocoon' or self-isolate due to being in the medically vulnerable category. Five nursing homes employed extra staffing to accommodate for these staff and some paid their staff in full during this period.

Twenty five nursing homes reported that they provided staff with information, training and advice about the various risks which enabled heightened awareness and greater vigilance in reporting.

Finally, one nursing home highlighted an extra measure they had taken to reduce the risk of community transmission among their staff:

> *"Provided 'Shop' services internally for all foodstuffs and household goods."*

Staff isolating for other reasons

Sixty six nursing homes reported that their staff had been required to self-isolate for reasons other than connected with an outbreak in the nursing home or the results of the mass testing exercise as follows:

- Foreign travel (n= 33)
- Close contact with someone who was positive in their household (n=26)
- Symptomatic or awaiting results of testing (n=20)
- Confirmed cases due to community transmission (n=16)
- Medically vulnerable (n=3)
- Lived with persons who were medically vulnerable and were fearful (n=3)
- Newly recruited staff as a precautionary measure prior to commencing work (n= 1)

Three nursing homes highlighted that their staff were symptomatic but unfortunately never received a test:

> *"2 staff self-isolated on 15 March had signs and some symptoms, they contacted the GP and all the necessary paperwork was sent. they did 14 days +5 in isolation THEY WERE NEVER TESTED. with the GP approval they returned to work…."*
>
> *"Other staff out for sometimes up to 3 weeks waiting for testing results or told that testing was inappropriate by their G.P. even after guidelines for health care workers were issued by NPHET"*
>
> *"Symptoms , but didn't fit the criteria for testing"*

Emotional well-being

There was an almost palpable difference in the tone of the ninety-four responses provided to this section of the survey. The nursing homes that had remained COVID-19-free generally provided short descriptors in one or two sentences. These responses demonstrated a progression of emotions that got better over time, from initial panic and stress to reassurance and calm. Many of those that had experienced an outbreak with large numbers of confirmed cases and deaths, described the COVID-19 experience as an overwhelming sense of being emotionally spent, exhausted and demonstrated that they were still actively grieving for the residents that had died.

Anxiety and stress

Just under three quarters of the ninety four nursing homes that answered this section (n=68), stated that the emotional well-being of their staff had been considerably impacted, regardless of their COVID status. Anxiety and stress were the predominant emotions which culminated in feelings of fear, nervousness, worry, apprehension, uncertainty, confusion and in a small number of cases panic (n=5), particularly in the very early stages of the pandemic.

Fear of the unknown, worry about transmitting the virus to residents or families and being overwhelmed by the enormity of the task left staff and management in a precarious situation:

> *"For staff the fear of the unknown. Anxiousness around feeling that they themselves may bring the virus into the nursing home."*

Two respondents reported that the emotions impacted staff retention efforts – three staff left one nursing home whereas staff in the other nursing home threatened to leave if there was a positive case confirmed. In two other cases, staff called in sick as they just couldn't cope with the intensity of their emotions:

> *"Emotional well-being challenged seriously in March 2020 with serious shortage of staff due to fear and not reporting on duty."*

Resilience and camaraderie

Twenty two nursing homes reported that the staff morale and well-being was good and that staff were very resilient throughout the period, despite initial concerns. Team work, peer support and regular communication and input from management were common themes among respondents.

> *"Resolve and spirits remained high, good support and well-being advice from management including newsletters etc. "*

> *"Staff have responded well to the pandemic and emotional well-being and morale among them is higher now than ever."*

Fragility, exhaustion and grief

Although relatively small in number (n=8[1]), the testimonies of those who had experienced a large outbreak with high numbers of resident deaths were hauntingly powerful. They spoke of their devastation and loss, emotional fragility and being fatigued and emotionally spent:

> *"Worried, stressed, shocked and the acute deterioration of residents was very disturbing."*

> *"Exceptionally stressful due to increased workload and grief relating to loss of residents. This was heightened due to widespread societal restrictions, which whilst necessary, made life harder. Social distancing rules meant staff could not comfort each other or seek comfort from family members. At the peak, 15 staff were living in on-site accommodation or hotels which also had a significant effect on mental health due to loneliness."*

Two nursing homes in particular spoke about how the public health measures had impacted their ability to provide the standard of care that they had grown accustomed to for residents, family members and staff both at end of life and following death and how distressing this was:

> *"I would describe our staff family as close knit. There is a good % of staff here a long time. These staff are mostly mature ladies, who minded other staff. We cried together. Staff texted and phoned each other. As DON I was able to recognise stress and when some staff were upset. Talk to them and cry it out. Things that aggravated the emotional well-being of myself and staff was the care "some" --NOT ALL undertakers took with the deceased bodies……. A MAJOR impact on the emotional well-being of staff was the passing away of XX[2] of our residents --so quickly with staff NOT being able to offer their families a hug or comfort and staff not being able to give each resident a guard of honour as they each left the building- which is a huge part of our practice. Staff worked extra shifts so were exhausted. Staff were not sleeping- Hard to clear covid from heads after work. Staff also found it hard seeing our residents PINING for their families and Friends."*

> *"The worst was the loss of residents. Our EOL <end of life> care with respects to the residents in dying phase and family piece was gone due to restrictions. The leaving the NH was awful. No touch contact with families. That whole piece was terrible and took a toll emotionally on staff."*

One respondent also explained how they had to come to terms with the loss of "*a very dear colleague in the middle of all of this*" - a nurse who had worked in the nursing home for 21 years died suddenly at home, was suspected to have COVID but then tested negative.

[1] Eleven nursing homes reported an outbreak before mass testing however only eight described their experiences here
[2] Number redacted to remove traceability and protect residents' families

Aggravating factors

The primary aggravating factor highlighted by thirteen percent of respondents to this section (n=13) was in relation to the media portrayal and the inferences this was conferring on the sector:

> *"Some staff who saw some of the media coverage about nursing home found the reporting to be very negative and felt totally undervalued. A lot of reassurances were needed. Unfortunately the media negativity is only getting worse"*

> *"The negative media on care homes was very stressful for staff whom were working incredibly hard and whom had followed all public guidelines"*

Lack of government action (n=2), changing guidance (n=3) or guidance that staff felt was unsafe or not conducive to best practice in infection, prevention and control intensified the anxiety and stress:

> *"Staff were very concerned about lack of guidance for our sector and found HSE PPE guidance to be very lax (no PPE unless within 1 metre) - we did not implement this and we provided full PPE for all contact or entry into isolation rooms, but there was fear that we would run out and would not be able to maintain this."*

At the time, there was a dearth of PPE and dedicated infection, prevention and control information which was specific to nursing home settings. The HPSC first published interim Covid19 infection control guidance for residential care facilities on 17th March 2020. This was followed by the WHO whose guidance for long-term care facilities was published four days later, on 21st March, and included additional details that were not contained in the initial Irish guidance.

Access to testing and delays in results (n=3) was also a significant stressor:

> *"The inconsistency with testing and delay in results was the most significant stress."*

Ameliorating factors

Supportive and frequent communication and training with staff to enable them to voice their concerns, ask questions, get updates and seek clarity on policy and practice guidelines was cited as the primary method to reassure staff and allay their fears (n=28).

> *"Staff -De-brief / Meetings for all staff commenced daily to allow staff to engage and 'vent' concerns. these continue."*

> *"Staff required huge amounts of reassurance and asked some questions that were not addressed by way of guidance until some time later."*

Ten percent of nursing homes (n=12) reported that they had provided mental health supports to their staff. Some had Employee Assistance Programmes whereas others were

grateful to have the support of the HSE Occupational Health team and counselling/ psychology supports:

> *"HSE's provision of Psychologist Support is very welcome"*

The sense of community spirit and support which recognised and often rewarded the staff efforts was cited by seven nursing homes as providing a good morale boost:

> *"Kindness of community, i.e. delivering flowers, cakes, toiletries to staff is a great boost. Relatives sending supportive emails, texts, cakes"*

Five nursing homes mentioned a variety of incentives that they had introduced for staff to include daily staff appreciation treats, vouchers, bonuses and salary increases:

> *"As a staff retainer, management gave all staff members a 10% pay rise."*

A further five respondents stated that having visible hands-on leadership with an 'open-door' policy was also helpful.

> *"Working with staff on the floor, putting on PPE and assisting with positive cases to take the fear out of the disease."*

Finally, access to mass testing and PPE helped to bring about a sense of confidence and relief:

> *"What made the most noticeable improvement was the mass testing of all staff and residents in the nursing home with all Negative results."*

Staff Training

Respondents were asked to provide information on the specific infection prevention and control training that they had delivered as part of their preparedness for COVID-19, including detail on the method of training and the challenges they encountered. There were ninety-one respondents to this section of the survey, however, not all individual items were completed.

Type of training

Nursing homes provided detail on the various training topics that were provided or accessed by staff. In general, training centred predominately on three key areas: infection prevention and control (n=78, 86%), hand hygiene (n=59, 65%) and the donning and doffing of PPE (n=72, 79%).

However, over half of nursing homes (n= 48) had engaged in additional training ranging from COVID-19 specific training, end of life care, pronouncement of death, swabbing for testing purposes, HACCP training, risk management, safeguarding and health and safety. Eleven nursing homes also provided additional tailored training in environmental hygiene and cleaning techniques, including the management of clinical waste.

Method of training

Nursing homes used a blended learning approach utilising a variety of training methods to upskill staff as follows:

- Self –directed study via HSEland – (n=75, 82%)
- Internal teaching – (n=54, 59%)
- Additional online training (mixed methods) – (n=38, 42%)
- External companies teaching in-house (n=6, 7%)

Challenges

The restrictions imposed in respect of external trainers being prevented from attending the nursing home coupled with the challenges associated with having to conduct training in smaller socially distanced groups was the primary area of concern for thirty percent of nursing homes (n=27).

> *"….It was difficult to organise small groups of staff for informal talks whilst maintaining social distancing."*

However, just under a quarter of nursing homes (n=21, 23%) reported that their training went well and that there were no issues as staff were keen to learn.

Finding the time to schedule and provide in-house training was a factor for sixteen percent of nursing homes (n=15). This was exacerbated by the challenges associated with staffing the roster during periods of staff unavailability due to sickness/ self-isolation (n= 8).

"It is very difficult to free staff from rostered duties to provide training."

"Getting staff to attend when so many were off sick."

Finally, respondents discussed particular challenges associated with online training which included the monitoring that staff had actually completed the training (n=4), the quality of the content (n=4), broadband and IT issues (n=4) and the requirement to follow up with staff to assess their understanding of what they had learned (n=1).

"….checking training was completed and making sure they understood the training especially infection control"

"Living in Co Mayo we have very poor internet so this has been our biggest challenge"

Suggestions

Just over one third of respondents (n=32) provided suggestions in relation to training as follows:

- Requirement to recognise and continue with quality online training (n=6)
- Need to develop in-house experts both in teaching and in infection prevention and control (n=5)
- Need for bespoke training for different grades of staff (e.g. household staff) or bespoke systems to host training courses as HSEland website too complex (n=5)
- Acknowledgement of the benefit of access to HSEland for private and voluntary nursing homes and the need to ensure continued access (n=4)
- Need to ensure infection prevention and control training is deemed mandatory training for all staff (n=3)
- Request for more training to be made available (n=2)
- Greater acknowledgment of the different learning needs of staff (n=2)
- Frequency of updates/ repetition needed (n=2)
- Need to provide training before an outbreak (n=1)
- Training needs to be practical with demonstrations (n=1)
- Benefits of outdoor training i.e. reduce risk of transmission (n=1)

Respondents suggestions are presented below.

"…develop a course in relation to PPE/ hand hygiene and infection control that is mandatory in line with manual handling etc"

"Consider Virtual classroom training which would allow interaction and shared learning."

"I found courses that were expressed in simple terms worked best. In order that all staff and residents benefit I found repetition important."

"HIQA prefer face to face training rather than online - however, online training gives greater flexibility for staff and the nursing home."

"A specific site for training and updates would be helpful. HSELand is valuable but staff with limited IT training find it hard to wade through the amount of content on HSELand in

order to find Covid specific information that we are asking them to view. A one stop shop would help in this situation. We are not HSE and therefore our staff are not used to accessing HSE information."

"RCF's should be offered training going forward so that there is a designated person with an IPC qualification in each centre"

Responses to this section were mixed and demonstrates that a 'one size fits all' solution to training and staff development is not always practicable in this sector for many reasons. Although infection control training would have been standard practice in the majority of nursing homes the findings demonstrate that there would have been a need to update and refresh all staff with the unique requirements needed to respond to COVID-19.

The Expert panel report (DOH, 2020) has highlighted a need for greater oversight of training records by HIQA, enhanced training so that there is a dedicated IPC lead on each shift, a minimum of QQI level 5 training for healthcare assistants and that nursing homes continue to have access to HSEland training modules.

Whilst the recommendation to continue access to HSEland training is welcome, there is a need for greater clarity on the level and content of training that would be required to be an IPC lead or which QQI modules are deemed necessary within the nursing home context. Previous regulatory requirements in respect of post-registration qualifications in management and an inclusion of FETAC 5 training in previous HIQA national quality standards for residential centres for older people (HIQA, 2009) have been problematic in the sector due to this ambiguity and therefore varying practices have emerged.

HIQA

Contact

Over 80 percent of nursing homes (n=79) reported that they had received regular contact from a HIQA inspector. The level of contact varied from daily telephone calls and emails to contact every two or three weeks. The vast majority of respondents felt supported by this process (76%, n=71) reporting that their inspector was accessible, reassuring and provided advice and information to assist them. Two respondents indicated that HIQA staff helped navigate supports from the HSE at critical points in the outbreak whereas one respondent stated that they were very understanding and supportive in respect of unsolicited complaints that had been received. However, a small number of respondents identified that the supports did not materialise until well into the pandemic (n=5).

A quarter of respondents felt that HIQA were not supportive (n=22). Reasons provided ranged from the contact just being a desktop review/ asking lots of questions to the timing of the contact when they were already under a huge deal of pressure. Two respondents highlighted that the interaction was more inspection-focused rather than supportive.

Inspections

Although HIQA had issued a number of prior communications to Providers, it was not until 21st April 2020 that they published their *'Regulatory assessment framework of the preparedness of designated centres for older people for a COVID19 outbreak'* (HIQA, 2020a). This document highlighted that it *"aims to support those centres that are currently free from COVID-19"*. It further highlighted that all Providers were expected to perform a self-assessment of their preparedness and that on-site assessment visits would commence from 29th April 2020.

Of the 95 responses to this question, just under half (n=42) reported that they had received an assessment which was broadly in line with the number of COVID-free nursing homes identified in this survey. Respondents indicated that the majority of these were conducted on the telephone (n=24), with eighteen assessments conducted on-site. A total of 190 assessments were carried out by HIQA in April and May (HIQA 2020b).

Only eight nursing homes reported that they had received a compliance plan. Two were non-compliant in two or three regulations each, whereas the other six homes indicated that one regulation was identified for improvement. Although the judgement awarded by HIQA was not provided in all cases, three reported that they were deemed substantially compliant. Where highlighted, the regulations identified as requiring improvement included:

- Regulation 23: Governance and Management
- Regulation 26: Risk Management
- Regulation 27: Infection Control
- Regulation 15: Staffing
- Regulation 4: Written Policies and Procedures

The findings here demonstrate that in the main respondents felt supported by HIQA during the preparedness phase. Although, it is important to note that at the time of data collection, the assessments and inspections conducted by HIQA related only to those nursing homes that were COVID-19 free and not those nursing homes that had experienced an outbreak.

However the recently published HIQA report 'The impact of COVID-19 on nursing homes in Ireland' (HIQA, 2020c) identifies a worrying trend whereby they cite findings from 44 risk inspections of nursing homes that had experienced an outbreak of COVID-19 and where they purport to have found *"levels of non-compliance … considerably higher when compared to the findings of the contingency planning and preparedness self assessments".*

Firstly, as referenced in their report many of the inspection reports were still being prepared at the time of publication, meaning that nursing home providers had not had the opportunity to utilise the feedback and submissions processes that are a key element of ensuring accuracy and fairness in inspection reporting.

Secondly and as previously reported, the only regulatory framework in relation to COVID-19 published to date by HIQA (HIQA, 2020a) clearly stated that it was for centres that were COVID-19 free and therefore it is unknown what methodology was employed by inspectors when conducting these inspections.

Thirdly, it is a matter of public record that the Chief Inspector of HIQA has outlined on several occasions that some of the regulations (as currently written) have posed challenges and that regulatory reform is required to enable HIQA to take enforcement action:

> " *The regulations are weak when it comes to staffing. HIQA would very much welcome those regulations being looked at and would be happy to work on and contribute to that discussion."* (Presentation to Oireachtas Special Committee on COVID-19 Response debate, 26 May 2020)
>
> " *Chief Inspector advised the Board that some aspects of the legislation and the regulations as currently written, posed challenges to responding in a timely manner to the evolving COVID-19 situation…. there is a requirement for more radical reform of the regulatory framework"* (HIQA Board Minutes 24 June 2020)
>
> *"It is the opinion of the Chief Inspector that the current regulation on infection prevention and control in nursing homes are not commensurate with what is required to respond and manage a COVID 19 outbreak."* (HIQA, 2020c)

It will therefore be important to examine these inspection reports closely when published to ensure that they have not strayed outside of their stated legal purpose of assessing

compliance with the regulations and standards under Section 41 (1) (c) of the Health Act 2007.

It is hoped that HIQA will continue to be supportive to nursing homes during post-COVID-19 inspections and that these reports reflect the unprecedented nature of the pandemic. It is also our fervent belief that HIQA will realise and action their ethical obligation not to add further to the trauma experienced by staff (working in nursing homes that have experienced an outbreak of COVID-19), through unfair and unbalanced reporting.

Mass Testing

Ninety-two respondents (71%) provided details of their individual results of the universal Mass Testing exercise which for them occurred between 23rd March and 8th May 2020. The majority of nursing homes (72%) reported that they were either very satisfied (n=34) or satisfied (n=32) with the sampling process. Eleven nursing homes reported that they were neither satisfied or dissatisfied. Eight nursing homes reported they were dissatisfied whereas seven nursing homes indicated they were very dissatisfied.

Conversely, 53 percent of respondents reported they were either dissatisfied (n=27) or very dissatisfied (n=22) with the results turnaround. However, over one fifth reported they were satisfied (n=24) and ten reported they were very satisfied with the results turnaround.

Test Results: Staff

Tables 3-5 highlight the numbers of staff testing positive for COVID-19, the number of positive staff that were asymptomatic or symptomatic at the time of testing and the number of nursing homes in each range. As can be seen in table X, 58 nursing homes reported having no staff test positive for COVID-19. This contrasts with 9 nursing homes having 26 and above staff test positive. Having such a high proportion of staff testing positive demonstrates the intensity of stress related to continuity of care for residents and meeting high care standards within challenging circumstances.

Table 3: Number of staff testing positive for COVID-19 and number of nursing homes in each range

Number of Staff with Covid- 19 +	**0**	**1-5**	**6-10**	**11-15**	**16 -20**	**21-25**	**26+**	**Total**
Number of Nursing homes within range	58	16	4	1	2	2	9	92

As COVID-19 is not symptomatic for all people infected, table X demonstrates that 19 nursing homes had 1-5 staff who were asymptomatic with two nursing homes having 26 or more staff without symptoms. Without the warning symptoms, it was difficult to proactively limit the spread of infection.

Table 4: Number of positive staff that were asymptomatic at the time of testing and number of nursing homes in each range

Number of COVID-19 Positive Staff that were asymptomatic	**0**	**1-5**	**6-10**	**11-15**	**16-20**	**21-25**	**26+**	**Total**
Number of Nursing homes within range	4	19	6	1	0	1	2	33

Note: Missing data = 1

Conversely, table X shows that some staff did have symptoms and testing confirmed infection with COVID-19. As demonstrated, four respondents reported 26 or more staff having symptoms and testing positive.

Table 5: Number of positive staff that were symptomatic at the time of testing and number of nursing homes in each range

Number of Positive Staff that were symptomatic	0	1-5	6-10	11-15	16-20	21-25	26+	Total
Number of Nursing homes within range	14	4	4	0	4	1	4	31

Note: Missing data = 3

As demonstrated in the data, a number of nursing homes experienced significant challenges in managing continuity of care where staff had to self-isolate due to testing positive. Nine nursing homes reported that they received assistance with back-filling staff that were required to self-isolate as a result of receiving positive results, with mixed provision:

> *"Received nursing support after 3 weeks begging for same."*
>
> *"yes 5-10 staff nurse shifts over a period of 1 month"*
>
> *"We received 2 nurses whom worked 20 hours each but had to work in pairs. They were very enthusiastic but were not familiar with electronic records and had not completed kardexs so we were restricted in how they could help. Due to the issues of redeployment*

and it being voluntary by the time we received the nurses, our own were starting to return to work."

Health care assistants were identified as the group of staff most affected in fifteen nursing homes, followed by nurses in five respondents with seven nursing homes reporting they were both affected.

The survey also investigated the percentage of staff that received the flu vaccination in the 2019-2020 season. Table 6 demonstrated that sixteen nursing homes had less than twenty percent of their staff vaccinated, while eight reported very high levels of 91-100 percent vaccination. Sixteen respondents indicated that they were unaware of the flu vaccination uptake among staff, within their nursing home at the time of completing the survey.

Table 6: Percentage of staff that had received the flu vaccination in the 2019-2020 season and number of nursing homes in each range

Percentage of Staff that received the flu vaccination	**0 – 20%**	**21-40%**	**41-60%**	**61-80%**	**81 – 90%**	**91 – 100%**	**Unknown**	**Total**
Number of Nursing homes within range	16	12	18	6	4	8	16	80

Note: Missing data=12

The results demonstrate that the uptake of flu vaccination among staff in those nursing homes that provided details is quite varied, with the majority of nursing homes (n=47) having less than the HSE recommended target of 65% uptake for healthcare staff (HSE, 2019). However, the findings show that the uptake in over half of the nursing homes is actually higher than reported in the 2016 HALT (Healthcare Associated infections in Long-Term care) (HPSC, 2016) study where only 26% of staff had availed of a vaccine during the 2015-16 influenza season. The reasons for the lower than expected uptake of vaccination by staff needs exploring further but it may be due to a multitude of factors to include:

- vaccination not being a mandatory requirement for staff[3]
- private and voluntary nursing homes not having direct access to the 'cold chain' supply of vaccinations, coupled with multiple GP practices serving the needs of individual residents in nursing homes

[3] The Nursing Homes Expert Panel Final Report includes a recommendation to consider making influenza vaccine a mandatory requirement for staff (DOH, 2020)

- the HSE 'peer to peer' vaccination training programme not being previously accessible to private and voluntary nursing homes
- the annual vaccination programme run by the HSE is generally limited to only healthcare staff employed by them
- prohibitive costs associated with accessing the vaccine through community pharmacies or the staff members' own GP

This reduced uptake among staff could present difficulties in obtaining a differential diagnosis and place additional stressors on workforce due to potential staff illness during the coming winter season.

Respondents also reported on the fastest time for staff test results to be returned (table 7). It can be observed that the common reported time was 3-5 days with three nursing homes identifying a fastest time of more than eleven days' wait for results.

Table 7: Fastest time for staff results to be returned and number of nursing homes in each range

Number of days for results to be returned	<1 Day	1-2 Days	3-5 Days	6-10 Days	11 Days +	Total
Number of Nursing homes within range	3	19	49	17	3	91

Note: Missing data = 1

Respondents identified the slowest time for staff results to be returned. As table 8 demonstrates, this ranged from 2-3 days for seven nursing homes to over 21 days for ten nursing homes, with the most common being 6-10 days. Waiting a period of 3 weeks or more for staff test results would have seriously hampered nursing homes' ability to prevent the onward transmission of infection by staff that were displaying no symptoms of the virus.

Table 8: Slowest time for staff results to be returned and number of nursing homes in each range

Number of days for results to be returned	**2-3 Days**	**4-5 Days**	**6-10 Days**	**11-15 Days**	**16-20 Days**	**>21 Days**	**Still outstanding at time of survey completion**	**Total**
Number of Nursing homes	7	12	30	14	10	10	6	89

within range								

Note: Missing data=3

While there were variations in the fastest and slowest times for test results to be returned, the average time for staff results to be returned ranged from one day to over 11 days, with 4-6 days being the most common return time reported.

Table 9: Average time for staff results to be returned and number of nursing homes in each range

Average Number of days for results to be returned	**1 Day**	**2-3 Days**	**4-6 Days**	**7-10 Days**	**11 Days +**	**Total**
Number of Nursing homes within range	1	22	37	19	4	83

Note: Missing data=9

Test Results: Residents

Tables 10-13 highlight the numbers of residents testing positive for COVID-19, the percentage of residents testing positive in relation to the registered bed numbers in each nursing home, the number of positive residents that were asymptomatic or symptomatic at the time of testing and the number of nursing homes in each range.

In table 10, sixty-four respondents reported not having any positive resident tests for COVID-19. However, it can be observed that ten nursing homes had positive tests for 26 and above residents. Six of these homes had reported a wait time of two to three weeks for some of their staff test results to be returned. In addition, four of these had more than 10 staff who were asymptomatic testing positive. Both of these factors would render it almost impossible to prevent the onward transmission of the virus.

Table 10: Number of residents testing positive for COVID-19 and number of nursing homes in each range

Number of Residents with COVID-19 +	**0**	**1-5**	**6-10**	**11-15**	**16 -20**	**21-25**	**26+**	**Total**
Number of Nursing homes within range	64	9	2	3	2	2	10	92

The percentage of residents testing positive for COVID-19 in relation to the registered bed numbers of each nursing home is presented in Table 11. This ranged from nine respondents identifying less than ten percent to one nursing home reporting 60 percent and above.

Table 11: Percentage of residents testing positive for COVID-19 in relation to the registered bed numbers of each nursing home and number of nursing homes in each range

Percentage of Residents with COVID-19 + per registered beds	**0%**	**1 – 10%**	**11 – 20%**	**21 – 30%**	**31 – 40%**	**41 – 50%**	**51 – 60%**	**61% +**	**Total**
Number of Nursing homes within range	64	9	2	4	5	2	3	2	91

Note: Missing data = 1

Table 12 demonstrated the number of positive residents that were asymptomatic at the point of testing and the number of nursing homes in each range. It can be observed that eight nursing homes had 1-5 asymptomatic residents who tested positive for COVID-19 at the point of testing while three nursing homes reported having 26 or more residents with no symptoms.

Table 12: Number of positive residents that were asymptomatic at the point of testing and number of nursing homes in each range

Number of asymptomatic Residents with COVID-19 +	**0**	**1-5**	**6-10**	**11-15**	**16 -20**	**21-25**	**26+**	**Total**
Number of Nursing homes within range	7	8	5	5	0	0	3	28

Conversely, table 13 highlights the number of positive residents that were symptomatic at the time of testing and number of nursing homes in each range. While seven nursing home respondents reported none, it can be observed that the range varied and six respondents reported a figure of 26 or more residents who were presenting with COVID-19 symptoms at the point of testing.

Table 13: Number of positive residents that were symptomatic at the time of testing and number of nursing homes in each range

Number of symptomatic Residents with Covid-19 +	**0**	**1-5**	**6-10**	**11-15**	**16 -20**	**21-25**	**26+**	**Total**
Number of Nursing homes within range	7	9	3	0	1	2	6	28

The percentage of residents that had received the flu vaccination in the 2019-2020 season is presented in table 14. As a general public health recommendation for older people, this table demonstrates that the uptake of flu vaccination among residents is very high with the majority of nursing homes (n=60) having more than 95% of residents vaccinated. This is considerably higher than the 87 percent of residents in HSE-owned long-term care facilities, which was a finding of the 2016 HALT study (HPSC,2016). It will be important to continue this trend as we move towards the next flu season to aid in differential diagnosis among residents with respiratory symptoms. Nine nursing homes did not have the information available to hand at the time of survey completion.

Table 14: Percentage of residents that had received the flu vaccination in 2019-2020 season and number of nursing homes in each range

Percentage of Residents that received flu vaccine	**<79%**	**80 – 84%**	**85 – 90%**	**91-94%**	**95 - 99%**	**100%**	**Unknown**	**Total**
Number of Nursing homes within range	2	4	13	4	30	30	9	92

Tables 15 and 16 demonstrate the fastest and slowest time for residents' results to be returned to the nursing home. Table 15 shows that, for three nursing homes, the fastest time was less than one day, however, this contrasted with a further two indicating that results could take nine days or more. Table 16 demonstrates that the slowest time for resident results was reported most commonly as 6-10 days by twenty-nine respondents, while six reported this took twenty one days or more.

Table 15: Fastest time for resident results to be returned and number of nursing homes in each range

Number of days for results to be returned	<1 Day	1-2 Days	3-5 Days	6- 8 Days	>9 Days	Total
Number of Nursing	3	25	45	17	2	92

homes within range						

Table 16: Slowest time for resident results to be returned and number of nursing homes in each range

Number of days for results to be returned	2-3 Days	4-5 Days	6-10 Days	11-15 Days	16-20 Days	21 Days	>21 Days	Still outstanding at time of survey completion	Total
Number of Nursing homes within range	10	24	29	14	5	3	3	2	90

Note: Missing data = 2

The average time experienced for resident results to be returned was identified by respondents. This ranged from one day to eleven days and over (table 17) with the majority averaging between four to six days for resident results to be returned.

Table 17: Average time for resident results to be returned and number of nursing homes in each range

Average Number of days for results to be returned	1 Day	2-3 Days	4-6 Days	7-10 Days	11 Days +	Total
Number of Nursing homes within range	2	27	35	15	6	85

Note: Missing data = 7

Staff training for sampling purposes

Fifty-three respondents provided a response to this question. Sixty-two percent (n=33) reported that they have staff who have been trained to perform COVID-19 sampling for testing purposes, if required. Over three quarters of these respondents (n=26) reported having two or more staff trained.

This section demonstrates that timely access to test results was problematic both for staff and residents, particularly where there were asymptomatic cases. This is a finding which is mirrored in the Expert Panel report (DOH, 2020). As we approach the 2020-21 influenza season it is reassuring to note the high vaccination rates among residents demonstrated,

however a concerted effort is now required to increase uptake of the vaccine among healthcare staff.

Outbreak[4]

Outbreaks prior to the Mass Testing Exercise

Eleven nursing homes reported that they had experienced an outbreak prior to the universal Mass Testing. Within the nursing homes, the time range of the outbreaks was reported from 15/03/20 to 25/04/20 with an average outbreak lasting 46.2 days. Tables 18-20 details the number of residents with COVID-19 positive tests, the number of COVID-19 related deaths and the number of staff who had tested positive for COVID-19 within the eleven nursing homes.

In table 18, it can be observed that the number of residents with COVID-19 positive tests ranged from zero (n=1) to 21 + (n=2), with five nursing homes reporting 1-5 residents with COVID-19 positive tests.

Table 18: Number of residents with COVID-19 positive tests and number of nursing homes in each outbreak range

Number of Residents with COVID-19 +	**0**	**1-5**	**6-14**	**15-20**	**21 +**	**Total**
Number of Nursing homes within range	1	5	0	3	2	11

The number of COVID-19 related deaths in nursing homes ranged from three reporting no deaths to one reporting 20 or more deaths (table 19).

Table 19: Number of COVID-19 related deaths and number of nursing homes in each range

Number of Deaths	**0**	**1-5**	**6-10**	**11-15**	**16-19**	**20 +**	**Total**
Number of Nursing homes within range	3	2	4	1	0	1	11

[4] Outbreaks at the time of the survey distribution were defined as *'a single suspected case or one confirmed case in a resident or staff member'*

Three nursing homes reported no staff infections with COVID-19, however, one nursing home had 16 or above staff infections while three reported between 11 and 15 staff infections (table 20).

Table 20: Number of COVID-19 staff infections and number of nursing homes in each range

Number of Staff with Covid- 19 +	**0**	**1-5**	**6-10**	**11-15**	**16 +**	**Total**
Number of Nursing homes within range	3	3	1	3	1	11

Only three of the eleven nursing homes received on-site visits from the HSE CHO Public Health department despite these outbreaks occurring relatively early on in the pandemic. Six nursing homes reported that they had received regular contact or daily telephone calls from the Outbreak Control teams in the CHO. Two other nursing homes reported limited support either in the first week of the outbreak or towards the end of the outbreak. One nursing home received onsite staffing support from the Rapid Response Team which equated to a total of five staff nurse shifts covered over a month period from the local acute hospital.

Eight nursing homes had accepted hospital admissions in the three weeks before the outbreak occurred with an average of three residents being admitted in each case. Half of these nursing homes (n=4) had requested testing before transfer but three nursing homes were refused as the residents did not meet the case definition for testing at that time point. One of these nursing homes did not isolate a total of three residents as the national guidelines at that time only required isolation for residents who met the case definition or had tested positive.

A further nursing home that requested testing was provided with an email stating that there were no COVID-19 positive cases on the ward and this nursing home also did not isolate a total of four residents as the national guidelines did not require it at that time.

Potential source of the outbreak

Ten respondents reported that they were in a position to provisionally establish the first case[5] and thereby provide a potential source of the outbreak although only eight of these provided more detail. It is unknown if these potential sources have been independently verified by public health/ contact tracing or whether it is based solely on the opinion of the nursing home respondent. Potential sources highlighted included:

[5] It is acknowledged that the incubation period before symptoms for COVID-19 differs, however, this question refers to the onset of identifiable signs or symptoms.

- Staff (n=4): asymptomatic (n=1) and household member (n=1)
- Hospital attendance or admission (n=3)
- Items sent in from a family member that had tested positive (n=1)

Most challenging aspect

Twenty nursing homes discussed the predominant challenges during the management of their outbreak which centred on three key themes: staffing (n=9) compounded by issues with testing (n=4); access to supplies (n=5); and managing anxiety (n=4).

Staffing the nursing home was particularly challenging for some with one respondent stating they had 50% of their nurses off at one time whereas another Director of Nursing reported that they, themselves, had worked 24-hour shifts. A further two respondents highlighted the scale of the outbreak and the rapid progression of the disease contributing to the increased workload for staff.

Learning/tips

Thirteen respondents offered multiple suggestions as learning points or tips for others. These are listed below:

- implement universal mask wearing policy from the beginning (n=3)
- insist on obtaining tests from hospitals in advance of admissions or would have refused admissions (n=2)
- undertake early and routine testing to identify asymptomatic cases (n=2)
- seek external advice from local IPC teams at an earlier stage (n=2)
- reiterate advices to staff relating to their practices outside of work (n=2)
- cohort and isolate all residents in their rooms earlier (n=2)
- increase vigilance of asymptomatic residents post- 14 day isolation period (n=1)
- audit accidents/ incidents as a marker of pre-symptomatic cases (n=1)
- be equipped with the necessary communication aids and WiFi to support communication (n=1)

  "1. I would have insisted that staff wear masks when the first case of Covid was identified in Ireland. 2. I would have insisted that any admissions/ transfers to the Nursing Home when the first case of Covid was identified in Ireland were tested prior to admission. 3. As above, ensure good WIFI, Have the necessary equipment for communication with families. 4. Have a good stock of Equipment--even the basics. 5. Our Kitchen staff wore masks , aprons and gloves from very early on in the identification of Covid in Ireland. A yellow line was placed on the floor so other staff could not go past this point. This avoided non-kitchen staff touching kitchen surfaces. Juice and supper toiletries were prepared by kitchen staff rather that staff go into kitchen and get these trolleys ready. THESE precautions resulted in NO member of Kitchen staff becoming Covid positive. 6. DONT RELY ON A NEGATIVE or NOT DETECTED RESULTS----- monitor your residents for symptoms. If you have a gut feeling about a resident-- go with it. 7. Residents that get a POSITIVE result but are asymptomatic --may complete their 14 days with No symptoms

and then you move them back to their own area or ward---PLEASE be aware that they could become symptomatic at any time. I'd advise DO not move back to their own ward if you can. Observe closely."

One additional respondent noted that they were yet to review the learning.

Preparedness due to previous knowledge of infectious outbreaks

Respondents were asked whether nursing homes should have been better prepared due to the frequency of infectious outbreaks that occur in the sector on an annual basis. Forty two nursing homes provided a response to this question. Over a fifth (n=9) stated that they agreed with the statement or were prepared as they had been able to use their previous knowledge of infection, prevention and control to support their preparedness. Three respondents reported that only those who were unfamiliar with the sector could make a statement like that, one of whom found it *"highly insulting"*. For the remaining responses, themes were similar across those nursing homes that had remained COVID-19-free and those that had experienced confirmed cases.

Unprecedented

The majority highlighted that this was a new and unprecedented virus which was incomparable with anything they had experienced before (n=11), that there was limited evidence based knowledge about its behaviour (n=4), there had never been a pandemic declared before (n=3), that it was highly transmissible with no vaccine (n=3) and that even hospitals were not prepared (n=2):

"Nursing Homes are prepared for "what they know about", for "what we have studied " and for infectious outbreaks that have been researched and that there is evidence based information on. This is a TOTALLY NEW VIRUS with an extremely quick and radical rate of transmission. We done everything we should and had to do."

"…over the last 18 years we successfully managed a very small number of norovirus and flu outbreaks which remained small and very contained. the COVID-19 pandemic is completely different to this in terms of the behaviour of the virus"

"This is a Pandemic All around the world no country were able to stop the spread of the illness. In most cases it was too late for nursing homes."

"Its hard to establish how the Nursing Homes could have reacted any faster as even the Hospitals were not capable of doing so. Testing has been abysmal across our sector. My own daughter contracted Covid 19 Virus in the hospital she works in, through lack of Patient testing and lack of PPE, her whole ward was closed as the majority of the staff tested POS. So I really question how the Nursing homes could have coped with no testing and no idea what they were dealing with."

Lack of action by State agencies

Just under a fifth of respondents (n=8) highlighted that the lack of action by State agencies left the nursing home staff and residents vulnerable (n=2) and isolated (n=2), citing specific areas that they felt compounded the problem which are now well versed such as PPE (n=5), transfers without testing (n=3) or lack of sector-specific training and guidance (n=2):

> *"We did everything we possibly could to stop it getting in. Our provider made available every resource - human and financial without restriction and we implemented guidance well ahead of public health advice. We did not know what we were facing….. We saw nobody from public health, HIQA, CHO7 and barely saw our GP. We were left to fend for ourselves for the most part aside from telephone advice and webinars mainly focused on palliative care. We are already skilled in palliative care - we did not need advice on how to assist people with dying - we wanted help to keep people alive and well, both residents and staff."*

> *"I don't feel the onus is completely on nursing homes - the information we were receiving was contradictory in some cases which had the potential to leave us floundering had we not taken the initiative ourselves…"*

A further three nursing homes spoke of how they felt let-down and how their trust in the authorities was broken:

> *"I would consider myself very informed and began planning in February prior to the first case in Ireland. We had some PPE and were re-assured that the HSE would provide us more if needed. We were also told initially that positive cases would be cared for in hospital and that testing capacity was sufficient. All of these assumptions were false and we were repeatedly let down on these aspects for weeks and weeks until the problem was so serious it could not be ignored any further. We had no guidance until late March, by which point the virus had already been seeded in our staff, if not also our residents and we were on a trajectory which could not be avoided at that stage..."*

'Home from Home'

Four nursing homes specifically spoke of how the environment was not suited to true isolation and that they had strived for years to ensure the model of care and the environment for residents was more home-like and less clinical in its design and use.

> " *"Nursing homes are not designed with isolation areas etc if you look at the HPSC guidance on isolation areas I would question if all hospitals would actually have isolation areas that would meet this standard let alone nursing homes"*

This 'home from home' concept has been actively promoted in the sector for many years and is in demand by residents and their families. Standard 2.6.4 provides for residents to decorate their own personal space with furnishings from home (HIQA, 2016). However, often these furnishings are not conducive to the requisite cleaning and disinfection that would be required in a pandemic. The concept of smaller 'home-like' facilities has also been

highlighted as a potential solution to prevent widespread onward transmission of the virus by some leading academics/ Geriatricians.

However, respondents highlighted the additional challenges associated with implementing strict infection, prevention and control practices in this type of environment and how they reluctantly had to change what had become a new and lauded way of working that was beneficial to residents:

> *"…we have spent 11 years trying to become more homely and person centred and now we have to change and become a more clinical environment in order to try to keep this virus out of our homes"*

This demonstrates the unique environment of nursing homes which balance clinical expertise and 'home'. While nursing homes provide person centred environments, there is an evident challenge in reverting to an increased clinical focus, yet, when the pandemic occurred, this was necessary.

Could the outbreak have been prevented?

Twenty respondents answered this question with the majority (n=15) stating that the outbreak in their nursing home could not have been prevented. Reasons given included the nature of the asymptomatic presentation of the virus (n=4); that staff acquired the infection due to the high levels of community transmission in their area (n=3); that there were multiple factors which were outside the control of the nursing home (n=2); and that visiting was still taking place at the time of the outbreak (n=1):

> *"There are too many factors that are out of our control, such as staff living arrangements, community transmission and asymptomatic presentations"*

> *"As long as asymptomatic/pre-symptomatic transmission is a factor, it will not be possible to prevent an outbreak…."*

For the five nursing homes that believed the outbreak could have been prevented, they attributed the following as potential sources of the infection:

- outpatient hospital attendances or admissions (n=3)
- lack of early testing for staff (n=1)
- staff travelling to work together (n=1)

> *"We had two residents attending dialysis three times per week- if HSE had accommodated these residents in hospital it possibly may have deferred or prevented the outbreak due to reduced risk of exposure. Both attended different dialysis units and different advice in relation to PPE requirements for attendees was given from each unit!!!"*

Additional comments about the outbreak

Eleven nursing homes provided further information. Six respondents highlighted the need for better integration and respectful collaborative decision-making with State agencies, particularly related to reducing the risk of transmission between services:

"I stopped visitors very early. When CMO said restrictions were not necessary, I received a very hard time from families who felt I was over reacting."

"What happened here was very small <the outbreak> but it highlighted to me that the HSE have no regard for my residents or my staff. I think this is shown totally by the fact that they tested <my resident> on his admission to hospital but not his discharge nearly two weeks later"

Two nursing homes used the opportunity to highlight that all of residents made a full recovery. Whereas the remaining three spoke of the lasting impact it has had on their day-to-day lives and appealed for the staff that were on the frontline to be consulted if we truly wanted to learn from this experience:

"…all we can do right now is take one day at a time and in hope it never comes to our doors again , but we cannot become complacent, not now - not ever"

"it was and still is hell on earth…"

"..the Front line <staff> in the Nursing homes need to be the people who talk to others about the experience of their Covid outbreak-- NOT their managers or others that didn't or couldn't Enter the homes ….They didn't see the staff cry behind their masks or buy sweets or goodies out of their own pockets for the residents that had no one to come and drop them in for them. They didn't sit with the dying resident whose NOK was over 70 and was cocooning at home and couldn't come in and hold their hand. The front line staff did."

Resident Impact

Ascertaining the views of residents

Seventy four respondents answered this question. Just over half, had completed a resident satisfaction survey (n=38, 51%). A quarter of residents expressed satisfaction with the efforts taken by nursing home staff (n=9) and the information given to them (n=4). Residents also understood the reasons for the measures taken and were accepting of the situation (n=9) but they missed their families (n=8) and were getting tired of the restrictions/ reduced mobility (n=3). One respondent however highlighted anxiety among residents at the prospect of lifting visiting restrictions as time went on.

> *"Most were very contented and did not feel any adverse effects and were satisfied with information given to them and implementations made. Small percentage felt lonely due to visitor restrictions and or missed seeing some of their friends within the home and the large group activities."*
>
> *"We have carried out a few surveys with the residents and overall the response has been positive with the residents stating they feel very safe, do not want the "virus" to come in and understand the rationale for social distancing, regular hand hygiene, no visitors in house."*

Two respondents indicated that residents were acutely aware of the impact of the virus and the measures taken at a national level and this was negatively impacting their thought processes:

> *"Residents are becoming "fed up" with the continuous ban on visitors but know the reasons and are going with it. They are more upset about what their funerals may look like and the lack of religious services.*
>
> *"Media coverage too much!"*

One respondent, however, indicated that COVID-19 had affected all residents' mental well-being, especially those with pre-existing mental health issues and they had been in weekly contact with the psycho-geriatrician team.

These findings have been mirrored in both the HIQA impact report (HIQA, 2020c) and the Expert Panel report (DOH, 2020) and are reflected in recent changes to HPSC guidance in respect of local visiting restrictions when community transmission rates increase in a particular area. The balance however of assuring residents rights are upheld whilst also simultaneously employing all necessary infection control measures to prevent introduction of the virus is particularly challenging for nursing homes.

Clinical Indicators

The survey explored any clinical indicators which may have indicated how restrictions were impacting residents' general care and welfare. Respondents were asked to highlight if there were any changes in a number of key areas. A limitation of this question was its potential for a wide interpretation, which reflects the diversity of responses. For instance, some respondents simply provided the number of incidences that had occurred or simply stated a percentage but did not indicate if it was a percentage increase or decrease. These answers are therefore, noted but deemed as invalid responses, while the strength of other responses is tentative.

Crude results are therefore summarised in the following table:

Table 21: Reported changes in clinical indicators by type and the number of nursing homes in each range

Indicator	No. of responses	Decrease	No change	Increase	Invalid response
Falls	69	13	38	5	13
Pressure Ulcers	70	1	38	9	22
Safeguarding	70	2	37	2	29
Responsive Behaviours	70	6	32	9	23
Delirium	70	1	39	3	27
Significant Weight Loss	70	0	33	10	27
Complaints	71	7	20	5	39

The prolonged cocooning and reduced opportunities for mobility may have contributed to the reduction in the number of falls and the increase in the incidence of pressure ulcers. When pressure ulcer responses were cross referenced with responses for falls, it was observed that only one respondent reported a decrease in falls and an increase in the incidence of pressure ulcers. Four of the five homes with increased falls all had large outbreaks.

In the two nursing homes that reported an increase in safeguarding incidences, one qualified that this was as a result of family complaints.

Two of the three respondents that highlighted an increase in delirium and four of the five respondents reporting an increase in falls had confirmed cases of COVID-19 in their nursing home. Both of these are identified as atypical symptoms or predictors of COVID-19 in older people (BGS, 2020).

Over half of those that reported an increase in the incidence of significant weight loss among residents (n=6) did not experience an outbreak, nor did they have any confirmed cases among residents or staff. There are many factors which could contribute to a loss of appetite/ nutritional intake in COVID-19 free nursing homes, however, in three of these

responses, residents were more likely to have expressed indicators of a psychological impact in resident satisfaction, surveys such as loneliness,

anxiety and the impact of the media with one respondent highlighting a surprise in this finding:

> *"… [weight loss] much more than expected, residents are eating well, difficult to identify the reasons beyond progressing frailty."*

Relatives Feedback

Fifty five percent of respondents (n=70) indicated that they had received feedback from relatives. Whilst the method of feedback was not sought, responses seemed to indicate that this was provided through the regular communications that had been put in place as a result of the visiting restrictions. For example, through weekly telephone calls from the nursing home to update relatives or during regular scheduled communications between residents and their families via telephone or video calling services. Three key themes emerged.

Supportive

Just under half of respondents (n=32, 45.7%) reported that the relatives had been very supportive of the nursing home and many highlighted that they had expressed sincere gratitude towards the staff for all they were doing to keep residents safe. Three nursing homes referred to families sending in a continuous supply of cards, emails, small gifts and flowers to show their appreciation to staff.

> *"Mostly very concerned for how the staff are all coping and very complimentary of all that the home is doing to care for their relative and keep them safe."*

One nursing home respondent that had one third of the residents test positive for COVID appeared surprised at the level of support they received:

> *"Very positive about measures we have taken and our communication with them. Overwhelmingly appreciative of the risks we have put ourselves at for their loved ones and just generally concerned with everyone's safety. There have been no complaints or concerns raised by families about our actions, the care of residents or our responses to pandemic which was surprising. We are perpetually grateful for the support received from families - emails, letters, cards, small gifts, donations of PPE etc..."*

Resident Well-being

Forty percent (n=28) highlighted that relatives were mostly concerned about the well-being of their loved one and the COVID status of the nursing home. Overwhelmingly, the concern expressed was that the residents remained safe, although five respondents indicated relatives were specifically anxious that the residents were not lonely or depressed.

> *"We have received a lot of feedback from relatives, main concern is that the residents are lonely or depressed. All very supportive of management of care and wellbeing of residents to date"*

Visiting Restrictions

Less than a third of nursing homes (n=22) indicated that the visiting restrictions was highlighted by relatives. The respondents indicated that the majority of concerns related to visiting restrictions and when these may be realistically relaxed. Two respondents indicated the upset and confusion caused, due to the public declaration by NPHET that the visiting

restrictions were not deemed necessary at the time and one of these also eluded to the finite nature of time for visiting:

> *"All relatives very supportive although the advice that we closed too early caused major upset , however they quickly understood what our policy was and why. The concern of families is regarding the precious time to spend with their loved ones that is lost and time is not always plentiful in this frail vulnerable cohort."*

Innovations

Nursing homes were asked to highlight innovative practices which demonstrated the efforts taken to ensure residents' safety and enhanced support of their biopsychosocial needs throughout the pandemic. The responses reflect a plethora of activities which were initiated or enhanced to combat the social, physical, psychological and medical consequences of COVID-19.

Communication Methods

Almost all of the seventy nursing homes responding to this question (n=63) specifically reported that they had introduced regular video-calling services to maintain family connections during the 'cocooning' period. Services such as Whats App®, FaceTime®, Zoom® and Skype® were most regularly used with some nursing homes reporting they had purchased extra devices, increased their WiFi provision or assigned dedicated staff to ensure that each resident had assistance and regular access to this type of communication. Two homes spoke of how they adapted the service through the use of large screen televisions and headphones to ensure the residents' particular communication needs were also addressed.

Other methods of communication included telephone calls (n=28) with two homes referring to the majority of residents having their own mobile phones; letter writing and postcards (n=18), and email (n=4).

Over a third of nursing homes (n=25) had continued some form of controlled visiting following a risk assessment, such as window visits or outdoor visits with social distancing beyond the current guidelines of 2 metres. One nursing home reported using a feature of social media to book these visits.

Regular updates to family members by sending photographs and videos of the residents was specifically highlighted in just under a fifth of nursing homes (n=13) with half these using their nursing home Facebook® pages to support this and four homes referring to developing newsletters for this purpose. One home highlighted that they had a dedicated staff member specifically to support family contact.

Eight nursing homes described how they had rostered additional and dedicated staff to increase the level of one-to-one activities for residents in their bedrooms whilst also enabling small group activities to continue. One nursing home specifically highlighted the clinical and managerial oversight of residents' well-being:

> *"Skype Whats App Writing Phone Calling Window visits In -House - have dedicated "Listeners" who visit individuals and groups twice weekly to ascertain any issues Senior Management - Have taken a Unit each to deliberately visit the residents in that unit on a weekly basis"*

Four homes used their PA systems to live stream religious services or online music concerts whereas three nursing homes highlighted how family members had sent in recordings of

themselves 'reminiscing' or of music/ videos tailored to the residents' specific individualised preferences.

Exercises to maintain physical functioning

Lots of walking and making the most of the good weather and outside spaces was the predominate feature highlighted by over half (n=36) of the sixty-seven nursing homes responding to this section. Both residents cocooning and those in strict isolation (due to testing positive for COVID-19) were encouraged and supported to ensure they were continuing to keep active during the restrictions, A fifth of respondents (n=13) reported that they continued with their normal exercise programmes supported by their in-house physiotherapy/ physical therapy or activities staff.

Small socially distanced based exercise programmes such as chair-based exercise and exercises to music also continued in one fifth of nursing homes (n=13), following a risk assessment to reduce the use of ball games or other activities which would involve sharing items.

Specific programmes such as 'Fit for Life' and the online exercise programmes offered by 'Siel Bleu' were undertaken in a further twenty percent of nursing homes (n=13). One nursing home however highlighted that their own physiotherapist and occupational therapist had recorded USB videos which were available to all residents in their rooms to use 'as and when' they wanted.

Others tailored individualised programmes to the residents' specific needs or preferences (n=9) supported by the use of exercise machines, such as exercise bikes, cross trainers, etc. In addition, one nursing home reported they provided Yoga and used the Nintendo Wii® for residents.

Activities

The normal activity programmes continued in the majority of homes albeit they were adapted to reduce group size, ensure physical distancing, limiting the need for touch or sharing of items and without external entertainers. One home conducted groups via live streaming into bedrooms whereas another concentrated on corridor activities where residents sat at the entrance to their bedrooms. A further home developed a '100 page book' of activities for residents. A sample of the activities included Afternoon Tea, Arts and crafts, Auctions, Baking, Bingo, DIY projects, Films, Flower arranging, Games, Gardening, Karaoke, Knitting, Letter writing and postcards, Pottery, Puzzles, Quizzes, Reading, Religious activities (e.g. prayers/ rosary), Sewing, Singing and Virtual Golf and Horseracing, etc.

Where live music continued, this was generally provided by way of 'outdoor concerts', online, sing-alongs, or via staff that were musically talented. Lots of BBQ's and outdoor activities were arranged making the most of the good weather, to include an ice-cream van and regular visits from a horse.

"Individually tailored activity plans rather than group activities, …… storytelling and reminiscence, doll therapy, household jobs -washing dishes, sorting laundry, watering plants and flowers, creating murals on walls. Putting collage of photo albums to share with family members "what we did while you were way", small group activities - table quizzes, sing alongside, learning circles. Etc."

Method of establishing resident feedback

Sixty one nursing homes provided a response to this section. Of the responses, almost forty percent indicated that they had each conducted a formal Resident Satisfaction Survey (n=24)[6].

Under a fifth of nursing homes (n=11) stated that they had continued residents' meetings albeit adapting them to smaller groups, using rotating learning circles (n=1) or conducted them live online from the residents' bedrooms (n=1).

Maintaining medical and allied health provision

Just under two fifths (n=25) of the sixty-seven nursing homes reported that in the main they had maintained GP and allied health provision through video or telephone consultations, supported by healthmail (n=5) and photographs (n=2).

Nineteen percent (n=13) of respondents reported that GPs continued visiting as normal whereas, ten nursing homes stated that visiting of GPs or allied health professionals was only undertaken if deemed essential and when wearing full PPE.

Five nursing homes reported they felt very supported by their GP, particularly those that had outbreaks:

"We had an excellent service from our attending GP. DAY AND NIGHT AND WEEKENDS."

"All GP 's have been supportive and we have not wanted for anything."

"…GP rounds x 2 weekly via video/phone and daily contact during the outbreak. Mobile numbers given to DON for out of hours contact."

One nursing home stated that although their GP service was limited they had enhanced medical services through their local hospital:

"Very limited GP support. Stronger links with acute setting re. medical support Respiratory support team from local hospital have reviewed residents."

Communication with families

Individualised personal telephone calls were the primary method of communication for over two thirds of the sixty seven nursing homes (n=45) followed by email (n=29), text (n=16) and letter (n=9). Updates via social media and via the nursing home were utilised in six and two

[6] Note there is a variation among the numbers of nursing homes that responded to this section and the section on Resident Impact. The difference in response rate would make up the difference in the numbers of nursing homes that had completed a formal resident satisfaction survey

nursing homes respectively. Four nursing homes provided a dedicated newsletter and one nursing home facilitated a relatives' meeting via Zoom®.

The majority of communications were scheduled (n=28) and highlighted as being performed by dedicated staff in four nursing homes. For those that stated the frequency of the communication, it ranged from daily (n=3), biweekly (n=3), three times per week (n=1), weekly (n=4) or every 10 days (n=2).

Enabling choice and resident input

This section was predominately repetitive with the section on establishing resident feedback and therefore was a flaw in the survey design. Some answered this section that choice was always enabled or that they had either held a resident meeting, issued a resident satisfaction survey or that the residents meeting was not due.

Maintaining physical distancing

Fifty nine nursing homes responded to this question. Whilst designed to indicate innovations that nursing homes were using to ensure physical distancing was occurring, most simply stated that they had it in place or were doing their best to ensure residents complied, however it was difficult to implement with cognitively impaired residents and in an environment which was the residents' home (n=32):

> *"It is such a challenge with residents, they go close to each other especially with hearing impairment, Dementia, needs regular reminders."*

Seven nursing homes reported that strategic placing of furniture (apart at the recommended distances) was used whereas a further three highlighted that they had removed furniture. It is unclear whether these nursing homes marked the flooring to indicate where furniture should be to avoid displacement (e.g. after cleaning or if residents or staff moved the furniture). However a further six nursing homes specifically indicated that they had marked up all indoor and outdoor spaces, some using floors and walls to indicate positioning:

> "…physical signs on walkways, walls, seats tables, etc., to remind staff and residents"

Other nursing homes specifically reported that they were staggering their meals (n=4), utilising all areas of the nursing home (n=4), cocooning residents (n=3) or rotating residents use of communal rooms (n=1).

Training and Awareness

Again there was misinterpretation of this question and repetitive information from the staff training section. The innovations highlighted here included:

- Daily briefing sessions with staff (n=10)
- Emailing all policy updates and online training links to staff (n=4)
- Use of WhatsApp® groups for different staff groupings to provide updates (n=4)
- Instructional posters (n=2)
- Resident information leaflets (n=1)

- Outbreak simulations drills (n=1)
- COVID lead on each unit to monitor practices (n=1)
- Hourly hand washing with residents (n=1)
- Training videos for residents (n=1)

One particular innovation in raising awareness for residents was the delivery of hand hygiene training for residents via the televisions in their rooms. In addition, this information was reinforced by staff during the day.

> *"Hand hygiene training videos via USB for all residents in their rooms delivered via their TV. Staff delivering care reminding and demonstrating to residents how to wash hands, cough etiquette and social distance."*

Managing resident and staff anxiety

Almost one quarter of sixty nursing homes (n=14) had provided posters advertising HSE psychology services available for their staff, whereas six nursing homes contracted in a psychologist to work directly with staff. One nursing home also provided access to an Employee Assistance Programme.

> *"We organised a psychologist in March to look after our staff's mental health, staff could contact that person by themselves. Now more services available through HSE"*

Daily briefings (n=11), direct discussion and reassurance (n=14) and having an open door policy (n=6) were all cited as being particularly helpful to ensure staff could openly discuss their concerns:

> *"We had "Staff Stops" on a regular basis-where everyone in the house at that one time came together in our large dining room --and the DON updated everyone and answered questions. If a staff member was physically upset and clearly anxious over the situation- they were sent home and followed up the next day."*

Regular communication and information via WhatsApp® groups and email (n=5) ensured that staff were fully informed. One nursing home reported they ensured staff were directed to validated websites such as HSE/ HPSC/ DOH. Two nursing homes provided staff newsletters whilst one other nursing home produced a dedicated Mental Health booklet.

Barrier Nursing Preparedness

Twenty seven percent (n=16) of the fifty nine nursing homes were more acutely aware of being task-conscious and had engaged in timing care interventions with residents. Contacts with residents (when delivering direct care interventions) was limited to under 15 minutes at any one time (acknowledging the 'Risk Assessment of Healthcare Workers with Potential Workplace Exposure to COVID-19' on the HPSC website). However, more frequent interventions maintaining social distancing were maintained throughout the day. Four nursing homes reported that they had a specific contact signatory list for this purpose. This

was to reduce the risk of potential exposure for staff or to prevent staff being deemed as 'close contacts' if a resident was later suspected or confirmed to have COVID-19 (HPSC, 16 April 2020).

> *"Staff note contact times and awareness has affected their understanding of the risks"*

> *"Preparedness prior to any procedure. using the time to multitask and co-ordinate nursing, medical and direct care needs"*

Nine nursing homes reported the specific training they had undertaken, particularly the 'donning and doffing' of PPE. One nursing home reported that they had established a 'buddy system' to help in the supervision of this process and provide feedback to staff.

Three nursing homes participated in 'Outbreak drills' to practice scenarios in a safe environment so that it was familiar to all staff. Nursing homes would be familiar with simulation and drills as this is common practice in fire prevention and control training.

Two nursing homes had purchased two-way monitors so that residents in isolation could have their breathing and general condition closely monitored without having to risk exceeding the recommended contact times.

Preparations for safer visiting

When the survey was circulated the national guidance for recommencing visits to nursing homes had not yet been published. Therefore, just under half (n=29) of the sixty-one nursing homes reported that they had a dedicated plan in place to recommence visiting when permitted. While thirty percent (n=18) indicated they were waiting on specific guidelines from NPHET/ HPSC. These were later published on 5th June to take effect from 15th June 2020 (HPSC, 2020).

Six nursing homes had installed perspex panelling either fixed (from floor to ceiling) or free standing which could be moved into position. Four had purpose-built visiting areas to separate them from the main nursing home with their own entrance whereas one nursing home had installed a marquee in the garden for this purpose, examples as detailed in the descriptions below:

> *"…construction of a sheltered dwelling attached to a lounge area is underway to facilitate no contact visiting ASAP, without the need to use face masks."*

> *"Visitor hub created . Partition created in a reception room with a heavy duty Perspex screen and intercom to aid hearing each other. Visitor room section has its own entrance..."*

Many of these activities were adopted prior to the publication of the national guidance on visiting. Nursing homes therefore were trying to prepare for the resumption of visiting in advance of national guidelines and opted for measures which they believed would ensure physical distancing would be complied with, whilst also affording residents and their visitors the right to privacy (without the need for supervised visiting). The guidance when published

did not require Perspex panelling but did encourage the use of a separate entrance for visitors.

Five nursing homes reported that window visits were already occurring and three nursing homes had commenced socially distanced outdoor visits. One nursing home reported they were having a ‘Hug Sleeve Curtain’ made.

Caring in the next 12 – 18 months

Just over half or sixty-seven respondents outlined their concerns about care provision in the next 12-18 months, some coining the phrase 'caring in the new norm'. Unsurprisingly, over half (n=37) of these respondents reported that their biggest concern was either experiencing another outbreak or keeping the nursing home COVID-free until public health responses have developed natural or acquired immunity (vaccine). This was highlighted as being particularly challenging in the context of accepting new admissions and when facing into the winter months with all of the usual infectious diseases that circulate annually:

> *"Maintaining COVID free status for all residents and staff in view of the relaxation of visiting restrictions, hospital appointments and transfer to acute service settings."*

> *"The winter - when influenza, head colds, norovirus are starting and how challenging it will become to differentiate between them and covid."*

A quarter of respondents (n=17) mentioned the reintroduction of visits and how these would be managed safely to reduce the risk of transmission of the virus.

> *"Gradual phasing in of visiting with control measures in place, anxiety remains with the accidental introduction of Covid into the centre."*

Maintaining the momentum of the strict infection prevention and control measures among staff, residents and visitors over a long period of time was of concern to sixteen percent of nursing homes (n=11). Many highlighted their fear of complacency setting in among staff due to the intensive nature of the work and vigilance required which was mentally and physically difficult to sustain:

> *"Staff fatigue particularly if there is a ressurgence in the winter months. Not just physical fatigue but mental fatigue from the constant worry of contracting the virus outside of work which could then result in transmission to the nursing home if asymptomatic."*

> *"That once this critical phase of the pandemic has passed people may not take the precautions as seriously e.g. hand hygiene, not visiting when ill. Essentially that a sense of complacency will creep in."*

Finance and staffing, was individually highlighted by over thirteen percent of respondents (n=9), again related to the sustainability of this over a longer period of time. Nursing homes were concerned in relation to loss of income due to having to keep isolation beds free and the ongoing increased costs associated with maintaining a high standard of infection prevention and control, including the requirement for additional staffing. In addition, they feared attrition of staff and an inability to recruit new staff with increased recruitment and retention costs.

> *"The vastly increased costs associated with almost every aspect of addressing covid in a residential setting."*

Finally, six respondents pointed to the lack of a regular and timely testing process, while five commented on the difficulties in implementing social distancing measures within the nursing home when residents stopped 'cocooning'.

Rehabilitation Requirements

Emerging evidence (HSE, 2020, MMUH, 2020) and anecdotal reports from those that have had a significant outbreak in Ireland would indicate that residents recovering from COVID-19 have a high demand for rehabilitation supports. Nursing homes were therefore asked to consider how equipped they were to respond to this increased demand. Fifty-five nursing homes responded to this question. Six of these respondents indicated that the question was not applicable as they had not had an outbreak, while a further four provided an invalid response as they had not interpreted the question correctly. This left 45 respondents who commented on rehabilitation requirements.

Twenty four percent of nursing homes (n=13) highlighted that they would need to roster extra staff or increase the hours of contracted allied health services such as physiotherapy, occupational therapy and speech and language therapy:

> *"Residents are clearly deconditioning following weeks of reduced mobility and social interaction. Additional speech and language therapy Physio and OT is needed"*

A total of eighteen percent (n=10) of nursing homes identified the need for financial assistance to support the increased need for rehabilitation supports and additional staffing that may be required to accommodate these needs, such as activity coordinators:

> *"The current model of care for fair deal residents will not support this as there is no provision made for allied healthcare professional input and residents cannot access HSE community services. We will do what we can within the resources available to us."*

Twelve nursing homes specifically mentioned the need to increase access for residents in private and voluntary nursing homes to HSE services, such as allied health, gerontology and psychiatry of later life. Successive policy decisions over many years and an under-resourced primary care system has resulted in little or no access for residents despite retaining their entitlements under the General Medical Services Schemes or otherwise. This means that residents quite often have to supplement the cost of providing such services, through additional fees in their contract for care. An unpublished HSE audit in 2013 highlighted that the vast majority of nursing home residents did not have access to physiotherapy, speech and language therapy, occupational therapy and dietetics (Burke, 2013).

> *"We need input from psychiatry of later life/ gerontology and community occupational therapy we do not feel supported in any of these areas."*

One fifth of nursing homes (n=11), however, felt that they were equipped to manage any rehabilitation needs for residents and many cited the access to allied health services that

they had in place, although one respondent reported that they would need to increase their provision.

Future Model of Nursing Home Care

Forty-five respondents provided their thoughts on the model of nursing home care going forward, representing a response rate of 35 percent for this question. Almost a quarter of nursing homes who responded (n=11) suggested that nursing homes into the future would have to be smaller in size with an additional five nursing homes specifically highlighting the need to move more to a household type model of care:

> *"Design needs to include the ability to provide social distancing easily and zoning into smaller groups and staffing."*
>
> *"Household model for us was a huge contributor to successful management."*

A further eleven respondents reported that single ensuite bedrooms would most likely be required, as well as smaller units which facilitate zoning with their own dedicated communal areas. Although there was a recognition that this model required additional staffing and hence increased funding to support:

> *"Single ensuite rooms built in sections that can be isolated easily. More communal areas of a manageable size (which will also mean greater staffing and greater cost). The NTPF need to step up and pay the RCF's <Residential Care Facilities> the true value of the cost of care"*

Over a fifth of respondents (n=10) highlighted the need for nursing homes to be better integrated into local health and social care services to provide better access to timely and standardised information and enhanced services to residents:

> *"There needs to be closer ties to Clinical centres such as hospitals. Discharges need to be more planned and hospitals need to have a better understanding of the capabilities of nursing homes "*
>
> *"Older persons with co morbidities will always need nursing care. We need to be part of the wider healthcare community Better access to Geriatrician"*

A further two nursing homes called for HIQA to have a greater role in supporting nursing homes. One felt that HIQA's role during the pandemic and in general needed to be reviewed:

> *"HIQA's role as regulator requires review. It is autocratic and subjective. They have taken a higher road in this pandemic and no responsibility. It's very easy to keep coming in and pointing out gaps, concerns, etc., and when we ask for help we are pointed back to a regulation and told to meet it. The vast majority of nursing homes are well run but we are often made out to be incompetent and it's very demoralising."*

As suggested in the previous section, the fiscal support for nursing homes was also a focus. Six respondents highlighted the challenges of adapting the model of care due to the current insufficient and inequitable funding mechanism:

"This centre has been re modelled since 2011 to offer new, modern, spacious and comfortable facilities. This is not reflected in the pricing model in <named town> through NTPF, and unless there is a realization of the costs involved we see a very bleak future for this model of nursing home."

Impact of COVID-19 on the sector

Staffing

Over half of the sixty-three respondents (n=33) believed that this pandemic would make recruitment and retention difficulties in the sector even more difficult. Reasons provided included the media portrayal of the sector and lack of support from a small number of TDs; and that some staff may now fear working in the sector as they might believe nursing homes to be high risk:

"There may be a reluctance of people to take up roles in nursing homes, particularly when the media tend to focus on the negative rather than on the excellent service and care that nursing homes provide."

Four nursing homes particularly highlighted the continuing attrition of their staff due to HSE recruitment drives which was also in effect before the pandemic. One nursing home attributed this to insufficient funding paid to nursing homes:

"This is a problem anyway we cannot compete with the HSE on pay and we have no access to people outside the EU. Also we get approx €6 per resident per hour! there is the big problem"

One quarter of nursing homes (n=17) believed that there would now be a need for additional staffing levels or a higher compliment of staff moving forward.

Regulation

Thirty percent of fifty nine nursing homes (n=18) stated that they believed there would likely be regulation changes leading to increased regulation and whereas under a quarter thought there would be more scrutiny on inspection (n=14):

"It will take time but I believe <Regulations> and structural demands will change. This will be the biggest challenge for the NH sector as many of us have already invested heavily in line with the 2016 standards"

"I am afraid that there will be more regulation for the sake of regulation"

"Increased focus on infection prevention and control, staff training, environment"

Six nursing homes feared this would result in more administrative burden on nursing homes which some referred to as a box-ticking exercise:

"Endless paperwork and burdensome administrative duties will not prevent outbreaks of infection or a further Pandemic"

A further five nursing homes thought that HIQA's approach to regulation needed to change to become more supportive to nursing homes and to provide clearer information and guidance on achieving quality improvement:

"HIQA to become what is says on the title...Information. The Standards etc. are very good and give us goals to meet, however, its infuriating when you question HIQA and they say they are not an information centre. I feel HIQA should supply policies, audits etc. which they feel meets and excels the standards so that there is uniformity throughout the whole sector. It has become very obvious during this pandemic how little support is actually out there for private nursing homes and all appear to be individual entities, no cohesion. I think HIQA should be that cohesion….."

Public confidence

Just under half of the sixty one responses to this section (n=30) suggested that public confidence in the sector would now be lower than before. Those that provided reasons indicated the negative media and associated public discourse around who was to blame (n=5), as well as the large numbers of clusters and deaths that had occurred in some homes:

"Reduced. it will take a long time to rebuild confidence"

"…reduced in view of the high incidence of outbreaks and clusters in the nursing homes in general"

"We have been slaughtered in the media who seem intent on blame. The reputations of the best homes is being put in question."

Nine nursing homes provided their suggestions to counteract the negative media with calls for specific messaging that showed the reality of life in nursing homes including the lived experiences of residents and relatives; the expertise of the staff working there; their planning and preparedness; and in particular the numbers of residents that had recovered from COVID and the numbers of nursing homes that had remained COVID-free:

"Reassurances will be required. Everyone is nervous and the media are not helping. Recovery figures do need to be captured and more good news shared."

"A lot of unnecessary negative media coverage was allowed which will need to be addressed as it has resulted in a false representation of the families who have relatives in well run nursing homes. This should not have been allowed to happen and more work needs to be done to show the reality of care in nursing home and the level of expertise and compassion among the staff who work there."

Only eight homes believed that the public were generally supportive of the sector or that public confidence had increased:

"I think that the public can see through the political wrangling and blame game, and its up to us to show the public that we do care and we do work incredibly hard. I deplore the bad press and the near sneering down at us coming from our TV screens…"

"Most public realise that nursing homes were not supported initially by NPHET. But as time goes on families may be fearful of placing residents in nursing homes"

Message for Minister/ Expert Panel

A total of 57 respondents (44.1%) highlighted a number of key messages for the then Minister for Health, Simon Harris, TD, Department of Health and the members of the Expert Panel which largely centred on three key areas. A factsheet summarising the key messages of this survey was submitted by NHI for review by the Expert Panel in advance of finalising their report.

Recognition and Voice

Over a third of respondents (n=20) called for greater public recognition of the reality of nursing homes and the specialist, dedicated, caring and committed staff working within the sector. In tandem, others highlighted the need for the unique voice of the private and voluntary nursing home sector to be represented (n=16) on the expert panel and at all relevant levels of decision-making. The specialism that is gerontological nursing care is distinct and has a requirement for specific competencies, expertise and attributes.

"Nursing Homes are staffed and run by people who genuinely care for residents - why is everyone so afraid of allowing us to have a voice on any panel or body such as EAP/NPHET etc... There is widespread acknowledgement that people outside our sector do not know how we operate, so why not engage with us and ask us. If our concerns had been listened to early on, lives could have been saved."

"Recognise that Care of the Elderly in the nursing homes are very specialized and as nurse led facilities we are well trained in what we do. Include us in your key decision making processes and policy developments and Heath care strategies for Care of the Older person, both public and private equally."

"Nursing Homes are not a statistic or an inanimate object. Nursing Homes are communities of staff and residents and their loved ones. We are all human and we are all trying our best - please respect that."

"Nursing Home sector should be represented by people who are at ground level. We are professional people with years of expertise this is what should be highlighted. Not every home was "unprepared"."

Support and Equality

A further third of those who responded to this question highlighted the need to support nursing homes in dealing with the pandemic (n=9) through greater testing and information; and also by ensuring equality of service provision (n=9) and finance (n=4), ultimately for the benefit of residents in their care:

> *"I feel that we as a nursing home did everything possible to ensure our residents safety. We didn't feel supported from Public Health in the beginning… it takes too long for decisions to be made by HSE."*
>
> *"HIQA have a great place to help improve the sector but that's what they should do help - not just tell you what your doing is wrong but how you can improve it. presently your told your breeching a regulation not given detail how your breeching but you need to fix it - how if you don't know what's wrong?"*
>
> *"…access to MDT's for private nursing home residents should not be blocked because they are not in public homes e.g. OT – can't come cause your private even with medical cards."*
>
> *"A closer look at the [cost of] care difference between private and HSE nursing homes needs to be part of the review [Government appointed COVID-19 expert panel]."*
>
> *"Their expectations of what we can deliver without ongoing cooperation needs to be re-examined. We cannot be the sector that takes on medically unfit for discharge patients whilst vast sums of money are paid to private hospitals. Invest that money in us instead to improve pay for staff, facilities and services, none of which can be provided without proper funding."*

Provision of national programme of testing (n=7) was the primary suggestion for the ongoing prevention and management of the virus with a recognition testing needed to be performed in-house by nursing home staff to improve efficiency and timeliness.

> *"The only thing that is going to keep us in anyway safe at the moment is a constructive testing regime. Residents both in and out of other institutions Staff before commencing work in an establishment, and then continued blanket testing."*
>
> *"All homes need to be kitted with test kits so we can test, drop off and receive results within 24 hours. This includes staff who soon will start travelling home to their respective counties. FAST EFFICIENT TESTING is essential and I truly believe if we had a testing system like the hospitals the national numbers would be very different."*

Media Portrayal and Blame

One fifth of respondents (n=13) indicated the unfairness of the media portrayal of the sector and the negative impact this had on their staff and relatives in particular. Four of these respondents also specifically mentioned the unhelpfulness of the attempt to apportion blame in public, either one way or the other and called for more collaboration going forward:

"…was appalled of some the media blame on nursing homes & [a named] TD"

"Stop playing a blame game! - Accept Responsibility For What has Happened And What Could Or Will Happen! - Move forward positively and work together!"

"To the Minister I would say to stop the media from giving such bad press to N Homes / All the hard work we do in private N Homes and we do a good job --It is painful to listen to bad press on a daily basis some of this is so negative . I am a long time in my role and if I was the sole owner I would certainly challenge some of the reports in the media."

"Ensure agencies of the state spend more time supporting the people being cared for within the sector & the people who work in the sector & less time finger pointing and apportioning blame. It is unhealthy for us to engage in this as a society."

Conclusion

In his opening statement to the *'Oireachtas Special Committee on COVID-19'* on Tuesday 26th May 2020, the CEO of HIQA stated that:

"…the HSE did not know this sector. As a consequence, the infrastructure required by the HSE to support the private sector was under-resourced and became increasingly challenged."

This fact was borne out in the survey. All sections demonstrate the difficulties nursing homes experienced in preparing and managing care within the pandemic. What is apparent is that nursing homes who experienced COVID-19 outbreaks could struggle to ensure continuity of care, without the necessary supports and were left deeply traumatised by their experiences. Moreover, this continuing experience is impacted by continued revisions in policy and guidance and while access to mass testing has improved, the data demonstrates significant challenges in time scales for results for both staff and residents. As the pandemic continues, the resilience of nursing homes has increased further. However, it is important to learn from these experiences in order to better equip the nursing home sector for similar future outbreaks.

At the time of writing this report, two key documents have been published, the HIQA report entitled 'The impact of COVID-19 on nursing homes in Ireland' (HIQA, 2020c) and the final report of the Nursing Homes Expert Panel 'Examination of Measures to 2021' (DOH, 2020). Whilst different in their focus, both acknowledge that nursing home staff and residents have been through a very difficult and traumatic time, and commend the staff for working "tirelessly and with admirable resilience to continue to provide care to residents". This is important and timely recognition as nursing home staff continue to battle the virus over the coming months.

A number of the recommendations identified in the Expert Panel report have been highlighted by the sector for many years, some of which are again mirrored in this report. It could be

asserted that the State has abdicated its duty to private and voluntary nursing home residents for many years, and it is now time that they are afforded equal access to care and support, through timely access to HSE services and entitlements, such as Geriatricians, Psychiatry of Old Age and allied health services. It is our fervent hope that all recommendations are implemented in full and that this important opportunity to enhance the model of nursing home care is realised in memory of all of the residents who contracted COVID-19 and sadly died with the disease.

Recommendations

1. That the gerontological expertise and the unique voice of those who work in private and voluntary nursing homes, is recognised and involved at all relevant levels of decision making about the sector
2. That guidelines provided for the sector are in line with both the timing and content of international recommendations. A defined list of 'must do' preventative or 'best practice' measures that are sector-specific should be created and supported by posters, etc,, as per the national campaign.
3. The collaborative working arrangements set up during this pandemic to align and support private and voluntary nursing homes into the general governance and management structures of the HSE (specifically the contacts with the local CHO office) should continue indefinitely to improve cohesion between service providers and improve the lived experience for all in receipt of services.
4. That the serial testing programme for staff in nursing homes continues to be undertaken regularly for the foreseeable future, with improved timelines for results for all staff
5. The high level of residents receiving the influenza vaccine should continue into the 2020-21 season with a concerted effort required to increase the uptake of the vaccine among staff. Providing direct access for private and voluntary nursing homes to the 'cold chain' supply of vaccines or providing access following consultation with a nominated GP is preferable.
6. Given the intensive nature of rehabilitative supports that is now required for residents that have recovered from COVID-19, there is a need to ensure residents with medical cards in private and voluntary nursing homes are afforded access to Geriatricians and all allied health services from the State to ensure equity of access for all citizens.
7. Recognising the resultant trauma and residual emotional and psychological impact for nursing home staff following the management of an outbreak, it is essential that the necessary supports are made available to staff e.g. Employee Assistance Programmes, counselling and/ or psychotherapy services
8. The supportive nature adopted by HIQA inspectors during the regular phone calls and the regulatory assessments of the preparedness of nursing homes should continue in post-COVID-19 inspections to maximise the opportunities for identification of learning points that can be applied to the whole sector. In addition, there is an urgent need for HIQA to publish updated 'Assessment and Judgement' or regulatory frameworks for post-outbreak inspections so that nursing homes who have experienced an outbreak are assured of fairness and transparency in the inspection process.

9. To account for time lost when all efforts were concentrated on the pandemic, HIQA should provide recognition and allowances should be made during any regulatory activity when assessing individual nursing homes' regulatory compliance or continuous quality improvement. In particular, in relation to items such as training and staff development, implementation of actions in previous compliance plans or annual review reports, etc.
10. Media reporting of nursing homes should provide greater balance and context to enable consumers to have a more comprehensive overview of the issues being discussed. All media outlets should apply an ethical framework in their decision-making around publication, cognisant of the impact discussion may have on residents, families and staff. Furthermore staff working in private and voluntary nursing homes should be recognised and valued and be attributed with the same accolades as colleagues in the public sector who are often branded "HSE Heroes".

Appendix 1: Survey Questions

NHI Survey: Experience of the Preparedness and Management of COVID-19 Pandemic

This survey has been designed to elicit nursing homes' views on the issues which have presented during the preparedness, management and response to COVID-19. It is intended to provide NHI and the sector with an overall view of the challenges and opportunities which presented during the pandemic. Your answers will assist other nursing homes who have not yet had an outbreak, to prepare for the potential for Wave 2 of the pandemic and will also contribute to wider representation and lobbying by NHI for the sector. You will be aware that a *COVID-19 Nursing Home Expert Panel* has been convened by Minister Simon Harris, TD without representation from NHI. This panel is due to report to the Minister by the end of June 2020. The responses to this survey therefore will be compiled into a report and will be submitted to the Minister and the Expert Panel for their due consideration.
Only one response is required from each nursing home/ group. Responses should be discussed and agreed in advance between the Person in Charge and the Registered Provider Representative to ensure accuracy and completeness.

All responses will be treated by NHI in the strictest of confidence and your identity will not be disclosed to third parties without your expressed permission.

Demographic Details:

1. Name
2. Nursing Home Name
3. County
4. CHO Area
5. Registered bed number (maximum occupancy):
6. Are you willing to be contacted if further information is required? Yes/ No. If Yes:
    a. Preferred method of contact – Email/ Telephone
    b. Contact details

HSE Services

7. Do you have a gerontology outreach service? Yes/ No. If Yes:
    a. Was this in place prior to the pandemic? Yes/ No
    b. How would you rate this service? Likert Scale
8. Prior to the pandemic, did you have regular contact with your local CHO office? Yes/ No.
    If yes, please provide detail of the relationship and if there have been any significant changes since the pandemic commenced:
    If No, how would you rate the level of support you currently receive from your local CHO office:
9. In your opinion, what do you believe has been the most beneficial change to HSE services in recent months?
10. Is there anything else you would like to add here about HSE services?

Preparedness

11. Please provide a brief summary of the range of measures you undertook to prepare for this pandemic. Provide as much detail as possible, particularly where you believe the measures were unique or required significant resource inputs or gerontological expertise:
12. In the preparedness phase what was your most difficult challenge? Please provide specific detail of the challenge e.g. what you believe may have contributed to this or how it may have been prevented:

13. Please provide the date that you introduced the following specific preventative measures and provide any additional details you feel is relevant?
    a. Visitor Restrictions
    b. Staff temperature checks
    c. Wearing of facemasks for all staff at all times
    d. Cessation of large group activities for residents
    e. Cocooning of residents in their bedrooms for the majority of the day
    f. Cohorting of staff working in designated zones
    g. Risk assessments of staff living, working and travelling to work arrangements
    h. Provision of alternative accommodation for staff
    i. Vitamin D supplementation for residents
    j. Other, please specify
14. If you introduced visitor restrictions on or before 6th March 2020 did you reverse this decision when NPHET deemed them un-necessary? Yes/ No. Please provide details:

Staffing

15. Where known, how many of your staff:
    a. Worked in other nursing homes/ healthcare facilities or other public places e.g. shops, etc:
    b. Lived with other healthcare workers that worked elsewhere:
    c. Travelled to work with other staff:
    d. Were required to cease working due to them being within the vulnerable category:
16. Where applicable, please provide detail of any provisions you put in place to mitigate these risks:
17. Did any of your staff have to self-isolate for reasons other than being a close contact to a case within your nursing home? Yes/ No. If yes, please explain e.g. community transmission, foreign travel, etc:
18. How would you describe the emotional well-being of your staff throughout this pandemic? Is there anything that particularly aggravated this or made it better?

Staff Training

19. Please provide the following detail on the specific infection, prevention and control training that the nursing home arranged/ provided for staff (please note this does NOT include external webinars arranged by third parties):
    a. Title(s) of all training courses delivered:
    b. Primary method of training e.g. in-house, online/ HSELand, external, etc:
20. What was your biggest challenge in accessing or providing training for your staff?
21. Do you have any suggestions in relation to staff training?

Premises

22. Did the design of your premises lend itself well to the introduction of cohorting in defined zones/ units? Yes/ No. Please explain:
23. If you have multi-occupancy rooms, can you maintain physical distancing between beds? Yes/ No.
    a. If yes, what is the maximum distance you can achieve between beds:
    b. If No, have you reduced the number of beds in these rooms? Yes/No. Please explain:
24. Do you have sufficient communal space to maintain physical distancing between residents when cocooning ends? Yes/ No. Please explain:

HIQA

25. Has your inspector been in regular contact throughout the pandemic? Yes/ No. If yes, did you feel supported? Please explain your answer:

26. Did you receive a HIQA inspection? Yes/No

27. If Yes:
    a. Was the inspection a telephone or site visit?
    b. Did you receive a compliance plan? Yes/ No. If yes, please provide detail of the actions highlighted:

Mass Testing

This section of the survey is designed to capture the extent of transmission among residents and staff and to provide indicators of the percentage of asymptomatic positives.

28. What was the date of your mass testing?

29. How would you rate your satisfaction level with the sampling process? Likert scale 1- 5. Please explain your answer:

30. How would you rate your satisfaction level with the results turnaround? Likert scale 1-5. Please explain your answer:

31. In relation to results:

Staff:

a. What was the fastest turnaround time for staff (in days)?
b. What was the slowest turnaround time for staff (in days)?
c. What was the average turnaround time for staff (in days)?
d. Total number of positive results for staff:
e. Number of asymptomatic positive staff:
f. Number of symptomatic positive staff:
g. Did you receive any assistance from CHO to backfill staff that were required to self-isolate following a positive result? Yes/ No. If yes please provide details here:
h. Which staff grouping was most affected:
i. Where known, what percentage of staff had received the flu vaccination in the 2019-2020 season:

Residents:

j. What was the fastest turnaround time for residents (in days)?
k. What was the slowest turnaround time for residents (in days)?
l. What was the average turnaround time for residents (in days)?
m. Total number of positive results for residents:
n. Number of asymptomatic positive residents:
o. Number of symptomatic positive residents:
p. What percentage of residents had received the flu vaccination in the 2019-2020 season:

32. How many of your staff have been trained to take swabs for COVID testing?

Outbreak

This section of the survey aims to correlate the extent of the outbreak with the preventative measures taken and whether there are any linkages.

33. Did you experience an outbreak before the mass testing was introduced? If yes:
    a. State the number of residents affected?
    b. State the number of staff affected?
    c. How many COVID related deaths have you had?
    d. How many of these deaths were in residents that had recently been transferred from hospital? (Feb - April)
    e. Where you able to confine the outbreak to a dedicated zone?

34. Date the outbreak commenced?

35. Date the outbreak was declared over?

36. Did you receive support from public health on-site? If yes, please detail:

37. Did you receive support from CHO Rapid Response Team? If Yes, please detail:

38. How many residents were admitted from hospital in the 3 weeks in advance of the outbreak? Of these:
    a. Did you insist on and receive a 'not detected' result for each of these residents prior to admission?
    b. Did these residents self-isolate for 14 days following transfer? Yes/ No. Please explain your answer:

39. Was it possible to establish the first case which may have been responsible for the outbreak? Yes/ No. If yes, please provide details:

40. What was the most challenging aspect during the management of the outbreak? Please explain and provide any suggestions for how this could have been averted:

41. In terms of learning from the outbreak, what would you have done differently or what tips would you provide to others?

42. In your opinion, do you think the outbreak could have been prevented? Yes/No. Please explain your answer:

43. Some people would assert that nursing homes should have been better prepared due to the frequency of infectious outbreaks in the sector. How would you respond to this:

44. Is there any other information you would like to provide about the outbreak?

Impact on residents:

Much has been asserted in public about the impact the measures are having on residents that live in nursing homes. This section aims to establish if residents have provided any feedback on this or if there are any clinical indicators that may provide an indication of any real/ perceived impact:

45. Have you conducted any resident satisfaction surveys during this pandemic? Yes/ No. If yes, please provide a brief synopsis of the results:

46. In relation to changes in clinical indicators from before the pandemic to now, please provide information whether there has been No change, increase, or decrease in the following areas (please state percentage increase/ decrease where relevant):
    a. Incidence of falls:
    b. Incidence of pressure ulcers:
    c. Safeguarding incidents:
    d. Responsive behaviour incidents:
    e. Delirium:
    f. Significant Weight loss:

g. Number of complaints:

47. If you have received any feedback from relatives, what has been their primary concern?

Innovations:

NHI recognises that the sector continues to go over and above in responding to this pandemic and the new challenges that present. We wish to identify and applaud these areas of innovation and expertise and showcase these to the wider public.

48. Please provide a synopsis of your innovations under the following categories:
    a. Communication methods to combat social isolation for residents cocooning/ in isolation:
    b. Exercise programmes to maintain physical functioning:
    c. Activities/ entertainment for residents:
    d. Establishing residents' feedback on the impact of the measures introduced:
    e. Maintaining medical and allied health service provision:
    f. Communication with relatives/ families in relation to residents' wellbeing, care needs and general nursing home status updates:
    g. Enabling choice and resident input e.g. maintenance of residents' committees, etc:
    h. Maintaining physical distancing:
    i. Training and awareness:
    j. Managing resident and staff anxiety:
    k. Barrier nursing preparedness. E.g. simulation or reducing contact times <15mins
    l. Preparations for the resumption of 'safer' visiting:

Future care arrangements

49. What is your biggest concern in providing care to your residents over the next 12-18 months?

50. Evidence suggests that there will be an increased need for rehabilitation services for residents recovering from COVID-19 or from the effects of prolonged cocooning/ isolation. How equipped do you believe your nursing home is to respond to this demand? Please explain and suggest any solutions you think could assist:

51. Have you any thoughts on whether changes are required to the model of nursing home care provision going forward?

52. How do you believe COVID-19 will impact the following in the sector:
    a. Staffing:
    b. Regulation:
    c. Public confidence:

53. Lastly, is there anything in particular you would like to say to the Minister or Expert Advisory Panel:

END

NHI greatly appreciates the time taken to respond to this survey in full. Your responses will help shape the narrative and decision-making as we progress throughout the phases of this pandemic. As always your professionalism, commitment and care shines through. We continue to thank you for all that you do and we applaud your efforts. Please continue to feedback and provide suggestions to NHI on further actions we can take to support you. Thank you.

Appendix 2: Chronology of Notable Events and Publication Schedule of sector-specific Guidance Documents

Date	Event	Comment/ Link
29/02/2020	First case of COVID-19 in Ireland	
O6/03/2020	NHI issues guidance on restriction of visits	
10/03/2020	NPHET deems restrictions unnecessary	
12/03/2020	First notification to HIQA of a suspected/ confirmed case in a nursing home	https://www.hiqa.ie/sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf
13/03/2020	NPHET recommends implementation of visiting restrictions	
19/03/2020	First guidance relating to the transfer of patients from hospitals to nursing homes issued	First guidance relating to transfer of patients – recommended isolation ONLY for those who were known contacts of a confirmed case. Guidance on the Transfer of Hospitalised Patients from an Acute Hospital in the Context of the Global COVID-19 Epidemic 19th March 2020
19/03/2020	First comprehensive infection control guidance issued to nursing homes	Preliminary Clinical and Infection Control Guidance for COVID-19 in nurse- led Residential Care Facilities (RCF) (CD19-001. V1/19_03_2020)
21/03/2020	World Health Organisation publishes infection control guidance for long term care facilities which recommends staff temperature checking	Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 Interim guidance
21/03/2020	Additional comprehensive guidance to include outbreak management for residential care and similar units	Note two similar preliminary guidance documents in operation at the same time which could add confusion - this version becomes the primary document Preliminary Coronavirus Disease (COVID-19) Infection Prevention and Control Guidance include Outbreak Control in Residential Care Facilities (RCF) and Similar Units
25/03/2020	First revision of the original document	Preliminary Clinical and Infection Control Guidance for COVID-19 in nurse- led Residential Care Facilities 25/03/2020_V2
27/03/2020	DOH publishes guidance on	Guidance on cocooning to protect people over 70

	'cocooning'	years and those extremely medically vulnerable from COVID-19

Date	Event	Comment/ Link
30/03/2020	Preliminary IPC and outbreak control guidance updated	Preliminary Coronavirus Disease (COVID-19) Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities (RCF) and Similar Units V.1.1 30/03/2020
01/04/2020	NPHET issues six enhanced measures to nursing homes	Enhanced Public Health Measures for COVID-19 Disease Management: Long-term Residential Care and Home Support
07/04/2020	Title of main guidance changes from Preliminary to Interim guidance and is updated further to include the need for temperature checking of all staff	Interim Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities (RCF) and Similar Units for pandemic COVID-19 V2 07/04/20
10/04/2020	Interim guidance updated	Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units V3 10/04/20
14/04/2020	Interim guidance updated	Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units V3.1 14/04/20
17/04/2020	Interim guidance updated – to include that all other staff and residents be tested if there is an outbreak	Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units V3.2 17/04/20
22/04/2020	Interim guidance updated – to include testing of all staff where there is no outbreak and need for staff to wear facemasks at all times when caring for residents within 1 metre	Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units V4. 22/04/20
01/05/2020	First guidance for nurses performing sampling published	Guidance for Registered Nurses performing sampling for COVID-19 in Residential Care Facilities V1.0 01/05/2020
04/05/2020	Interim guidance updated	Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units

		V4.1 04/05/20

Date	Event	Comment/ Link
02/06/2020	Interim guidance updated – to include specific section on transfers	Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units V5 02/06/2020
08/06/2020	Interim guidance updated	Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units V5.1 08/06/2020
19/06/2020	Interim guidance updated	Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities V5.2 19/06/2020
17/07/2020	Sampling guidance updated	Guidance for Registered Nurses performing sampling for COVID-19 in Residential Care Facilities V2.0 17/07/2020
21/07/2020	First dedicated visiting guidance published	COVID-19 Guidance on visitations to Long Term Residential Care Facilities V1.1 21/07/2020
28/07/2020	Interim guidance updated	Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities V6.0 28/07/2020
28/07/2020	First dedicated guidance on Admissions and Discharges published	Interim Public Health, Infection Prevention & Control Guidelines on: Admissions, Transfers to and Discharges from Long Term Residential Care Facilities during the COVID-19 Pandemic V1.0 28/07/2020
24/08/2020	Visiting guidance updated	COVID-19 Guidance on visitations to Long Term Residential Care Facilities V1.2 24/08/2020
02/09/2020	Sampling guidance updated	Guidance for Registered Nurses performing sampling for COVID-19 in Residential Care Facilities V3.0 02.09/2020
07/09/2020	First guidance on COVID-19 and Influenza testing	Guidance for COVID-19 and influenza testing – Winter 2020/21 V1.0 07/09/2020
21/09/2020	Admissions and Discharges guidance updated	Interim Public Health, Infection Prevention & Control Guidelines on: Admissions, Transfers to and Discharges from Long Term Residential Care Facilities during the COVID-19 Pandemic V1.1 21.09.2020
01/10/2020	Visiting guidance updated	COVID-19 Guidance on visitations to Long Term Residential Care Facilities V1.3 01.10.2020

Please note the above listing demonstrates the number of iterations of guidance documents specific only to residential care facilities (RCF) and hosted on the HPSC dedicated webpage for RCF here: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/

Nursing home staff would have also been required to consult other HPSC guidance documents in relation to the occupational health management of staff, PPE and various algorithms e.g. risk assessments and those directing the management of staff who may have been in contact with a confirmed case. In addition, HIQA have produced two dedicated assessment frameworks to guide their assessment of compliance in the sector and which nursing homes must use to self-assess in preparation for an inspection, further adding to the administrative burden for nursing home staff during a time of unprecedented challenges.

References

BGS (2020) COVID-19 in the Older Adult Poster Final

Burke, S (2013) 'Nursing Home residents denied essential services'. *Wordpress.* December 9, 2013.

DOH (2020) COVID-19 Nursing Homes Expert Panel Examination of Measures to 2021 Report to the Minister for Health. Department of Health: Dublin

HSE (2019) Flu vaccine for healthcare workers. Available at: https://www.hse.ie/eng/health/immunisation/pubinfo/flu-vaccination/healthcare-workers/ (Accessed 01/07/2020)

HSE (2020) Evidence Summary: COVID-19 - physiotherapy rehabilitation [v2.0]. Health Service Executive: Dublin

HIQA (2009) National Quality Standards for Residential Care Settings for Older People in Ireland. Health Information and Quality Authority: Dublin

HIQA (2016) National Standards for Residential Care Settings for Older People in Ireland. Health Information and Quality Authority: Dublin

HIQA (2020a) Regulatory Assessment Framework of the preparedness of designated centres for older people for a COVID19 outbreak. Health Information and Quality Authority: Dublin

HIQA (2020b) HIQA News Issue 37 – June 2020: Update on Nursing Homes

HIQA (2020c) The impact of COVID-19 on nursing homes in Ireland. July 2020. Health Information and Quality Authority: Dublin

HIQA (2020d) Minutes of the board meeting of the Health Information And Quality Authority 24 June 2020

HPSC (2016) Point Prevalence Survey of Healthcare-Associated Infections & Antimicrobial Use in Long-Term Care Facilities (HALT): May 2016

HPSC (2020) Epidemiology of COVID-19 in Ireland. Report prepared by HPSC on 08/06/2020 for National Public Health Emergency Team.

HPSC (2020) Risk Assessment of Healthcare Workers with Potential Workplace Exposure to COVID-19 Case V8.1 16th April 2020

HPSC (2020) COVID-19 Guidance on visitations to Residential Care Facilities V1.0 05.06.2020

MMUH (2020) HSCP COVID 19 Rehabilitation Manual. Mater Misericordiae University Hospital: Dublin

Oireachtas – Special Committee on COVID-19 Response debate – Tuesday 26th May 2020 Congregated Settings: Nursing Homes (Resumed)

Report compiled by Sinéad Morrissey Consulting Ltd on behalf of Nursing Homes Ireland.

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If you have any queries about the contents of this report please direct these to your usual contacts within NHI.

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