

Nursing Homes: Preparedness and Ongoing Response to COVID-19

Department of Health and HSE (with input from HIQA)

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1 Introduction

The impact of COVID-19 on society in general and those living in nursing homes has been considerable. Nursing homes are people’s homes as well as places where healthcare and social care is provided. People living in nursing home settings are vulnerable populations and have been identified by the World Health Organisation (WHO) and ECDC¹ to be at a higher risk of being susceptible to infection from COVID-19 and for subsequent adverse outcomes². This is most likely due to their age, the high prevalence of underlying medical conditions, congregated settings and circumstances where high care support with the activities of daily living is required in collective high physical contact environments. The November ECDC risk assessment reiterates the overarching message that residents of long-term residential care services (LTRCs) are one of the most vulnerable populations and continued focus should be placed on preventing COVID-19 from being introduced into such facilities and the control of outbreaks when they do occur. Consistent with the learning arising from the pandemic to date, the ECDC highlights that the probability of COVID-19 introduction into an LTRC depends on the level of COVID-19 circulation in the community.

At the last census an estimated 5.0% of those aged 65 years and older were living in communal establishments in Ireland. There are 575 registered nursing homes in Ireland of which 461 are private or voluntary nursing homes and 3.6% of those over 65 reside in these settings.

Table 1: Nursing Home Sector - Key Statistics

Nursing home sector – Key Stats	
<ul style="list-style-type: none">• 575 nursing homes• 461 private & voluntary nursing homes• 30,000 residents / 25,000 long term care• 18,350 in private nursing homes under NHSS and 4,480 in public, also self-funders• NHSS budget >€1b	<ul style="list-style-type: none">• Average nursing home capacity 56 beds, median 50 beds• 306 nursing homes with 50 beds or less, 296 with 40 beds or less• Approximately 2,000+ beds were unoccupied across the sector in April 2020

The very infectious nature of COVID-19 makes it difficult to prevent and control in residential care settings. The transmission of the virus into and within nursing homes is multifactorial. As identified by the Nursing Homes Expert Panel where there is ongoing community transmission, settings like nursing homes are more vulnerable to exposure.

Nursing homes are people’s homes as well as places where healthcare is provided. NPHE has recognised the need to retain a holistic view of the wellbeing of residents of LTRC facilities, remain person-centred, be cognisant of their rights as citizens, and to be vigilant that in seeking to shield them from infection that these rights are not infringed upon in to an extent, or in a manner, that is disproportionate. One of most difficult aspects of COVID-19 is the sad deaths of those living in LTRC settings. NPHE has been particularly conscious of balancing protective actions with support and

¹ <https://www.ecdc.europa.eu/sites/default/files/documents/Increase-fatal-cases-of-COVID-19-among-long-term-care-facility-residents.pdf>

² WHO 2020, Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 Interim guidance (21st March 2020)

compassion and endorsed the paper *“Ethical Considerations Relating to Residential Care Facilities in the context of COVID-19”*³.

This paper provides an overview of nursing homes in Ireland, including the current epidemiological situation; the challenges that have arisen over the year; details on the significant supports that have been made available to nursing homes, both public and private, in the protection of the health of residents; the degree to which supports have been utilised; the body of work conducted to examine national and international response to COVID-19 in nursing homes, resulting in the COVID-19 Nursing Homes Expert Panel (NHEP) report; emerging best practice; and recent risk assessment from the European Centre for Disease Prevention and Control (ECDC) providing options on response to COVID-19 in nursing homes and LTRFs. The NHEP report makes a number of recommendations with associated timelines for implementation over the short, medium and long term; the progress of implementation of these recommendations is given in section 4. A detailed summary of Ireland’s response to COVID-19 as it relates to emerging best practice internationally and how it aligns with the options as published by the ECDC is given in section 7. This paper highlights and re-emphasises the need for continued and ongoing interagency cooperation, that the set of supports in place by both HIQA and the HSE and the focus on prevention and management of COVID-19 transmission must remain in place.

1.1 Public Health Measures Adopted in Ireland

In Ireland, the approach to the COVID-19 pandemic has been a whole of Government co-ordinated approach. The National Public Health Emergency Team (NPHE) and HSE National Crisis Management Teams for COVID-19 were convened and commenced their work at the end of January. A National Action Plan was published on 16th March 2020, setting out a whole-of-society response and the mobilisation of resources across Government and society to fight the spread of this virus.

The NPHE approach is public health led in line with data, evidence and best practice as it emerges. Ongoing learning from national and international experience, including through the ECDC risk assessments has been integral to the continuing evolution of the response to COVID-19. The COVID-19 Nursing Homes Expert Panel, established on foot of a NPHE recommendation has added substantially further to our learning and provided an ongoing framework for the continued response to COVID-19 in relation to nursing homes, as well as recommending a range of systems reforms with regard to the design and delivery of older persons care.

*An Overview of the Health System Response to date Long-term residential healthcare settings*⁴ was published in May by the Department of Health. This paper outlined responses and learning from COVID-19. In addition, in recognition of the expected ongoing COVID-19 impact over the next 6-18 months NPHE emphasised the importance of real-time learning and a forward-looking approach for nursing homes. Therefore, at its meeting 14th May, NPHE recommended the establishment of an expert panel (*COVID-19 Nursing Homes Expert Panel – examination of measures to 2021*).

Interagency collaboration and coordination are critical factors in the ongoing response, as is continued engagement with key national stakeholders. The document *“COVID-19 Response: Nursing Homes - Overview of Roles of Key Stakeholders”*⁵ was recently published by the Department of

³ <https://www.gov.ie/en/publication/37ef1-ethical-considerations-relating-to-long-term-residential-care-facilities/>

⁴ <https://assets.gov.ie/74796/d09c1f51-435f-4b73-9433-923ce3d531f9.pdf>

⁵ <https://www.gov.ie/en/publication/c7f5b-covid-19-nursing-homes-expert-panel-report-implementation-oversight-team/#covid-19-response-nursing-homes-overview-of-roles-of-key-stakeholders>

Health. Developed on foot of a Nursing Homes Expert Panel recommendation, this document provides a comprehensive overview of the roles of key stakeholders in the response to COVID-19.

1.2 General Supports - Summary

The State's responsibility to respond to the public health emergency created the need for the HSE to stand up a structured support system in line with NPHEP recommendations. This has been a critical intervention in supporting the resilience of the sector in meeting the unprecedented challenges associated with COVID-19.

In line with NPHEP recommendations and in order to enable continuity of service delivery and infection prevention management, support for nursing homes, including prioritised public health supports, over the last number of months has encompassed:

- Enhanced HSE engagement;
- Temporary HSE governance arrangements for some non-public nursing homes;
- Multidisciplinary clinical supports at CHO level through 23 COVID-19 Response Teams;
- Access to supply lines for PPE, medical oxygen etc.
- Serial testing programme of all staff in nursing homes, for the prevention, management and control of outbreaks;
- Access to staff from community and acute hospitals – from an early stage the HSE mobilised considerable staff resources, making them available to nursing homes where possible;
- Suite of focused LTRC guidance;
- Temporary financial support scheme to June 2022;
- Temporary accommodation to nursing home staff;
- HIQA COVID-19 quality assurance regulatory framework.

Section 3 provides a further detailed update on supports being provided.

2 Current Epidemiological Position – Nursing Homes

COVID-19 has had a significant impact on nursing home residents to date. Of the 575 nursing homes registered with HIQA, 364 had experienced an outbreak as of 12th December. 34 of these outbreaks are currently classified as open.

The number of new nursing home outbreaks occurring has averaged around 5 per week, meaning nursing home outbreaks remain a challenge. However, this figure represents a reduction in the number of outbreaks reported in early to mid-October, 8-15 per week.

A serial testing programme is ongoing in nursing homes, testing staff on a fortnightly basis. The programme is currently in its sixth cycle, staff across 585⁶ facilities have been tested, over 350,000 swabs have been taken and a total of 1,086 cases have been detected. The programme remains to advantage in identifying positive cases in the nursing homes sector, many of which are asymptomatic at time of testing. This allows for a prompt public health response and outbreak management.

HPSC data as of 12 December 2020 as presented in Table 2 below identify the continuing trend regarding new COVID-19 outbreaks and cases in nursing homes. This data underline the ongoing urgency to continue to suppress the disease and to ensure that specific focused and enhanced public health measures for nursing homes continue to be maintained.

⁶ A number of designated centres have been registered and deregistered across the year.

Table 2: HPSC data on nursing home outbreaks and cases

Nursing Homes	
	#
# Clusters in nursing homes up to midnight 12/12/2020	364
of which are OPEN	34
of which are CLOSED	330
# OPENED in the last week	4
# of deaths in nursing homes linked to NH outbreaks (up to 13/12/2020)	1,112
# of cases in nursing homes linked to NH outbreaks (up to 13/12/2020)	7,754
# of hospitalisations from nursing homes linked to NH outbreaks (up to 12/12/2020)	554
# of hospitalisations from nursing homes linked to open clusters (up to 12/12/2020)	64

The data above relates to all case classification types (confirmed, probably and possible COVID-19 cases). The table below details cases and deaths linked to nursing home COVID-19 outbreaks by month up to midnight on 13th December. It shows the significance of the impact of COVID-19 in relation to nursing homes in March, April and May, including in relation to the number of outbreaks and deaths. There was a steady decline in cases and deaths over the summer months, however the data shows a concerning upward trend commencing from September, with the number of cases and deaths increasing again in October and November.

Table 3: Comparison of cases and deaths linked to Nursing Home outbreaks by month *

	March/ April [~]	May [~]	June [~]	July [~]	August [~]	September [~]	October [~]	November [~]	December [~] (to 13/12/20)
Total Confirmed Cases Nationally	20,742	4,320	415	632	2,916	7,572	26,153	9,794	3,651
Total Deaths Nationally (all classifications)	1,265	385	88	25	14	29	111	136	57
<i>Confirmed only</i>	1,038	352	87	29	13	30	109	136	56
Nursing Home Outbreaks	220	38	-3#	15	7	16	44	17	8
Cases linked to NH outbreaks (all classifications)	4,003	1,348	591	130	41	171	731	547	164
<i>Confirmed only</i>	3,841	1,313	587	130	41	172	730	546	164
Deaths linked to NH outbreaks (all classifications)	647	268	65	10	5	8	39	47	20
<i>Confirmed only</i>	499	237	63	13	5	9	44	46	20

*Data as provided by the HPSC to the Department of Health in daily reports extracted from CIDR

[~] Calculated as the difference between the cumulative total number of cases and deaths on the last date of this month with the cumulative total on the last date of the previous month. Due to ongoing quality checks and validation, cases may be denotified or reclassified.

Significant data validation exercises were undertaken and some suspected Nursing Home outbreaks may have been denotified or reclassified.

Figure 1: Number of COVID-19 Outbreaks in Nursing homes (n=93), notified from 02/08/2020 to midnight on 12/12/2020. Data source: CIDR.

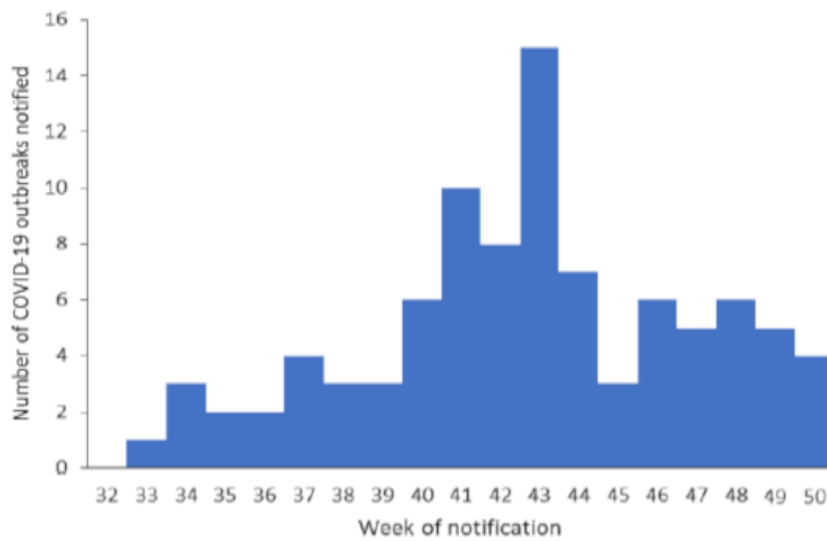
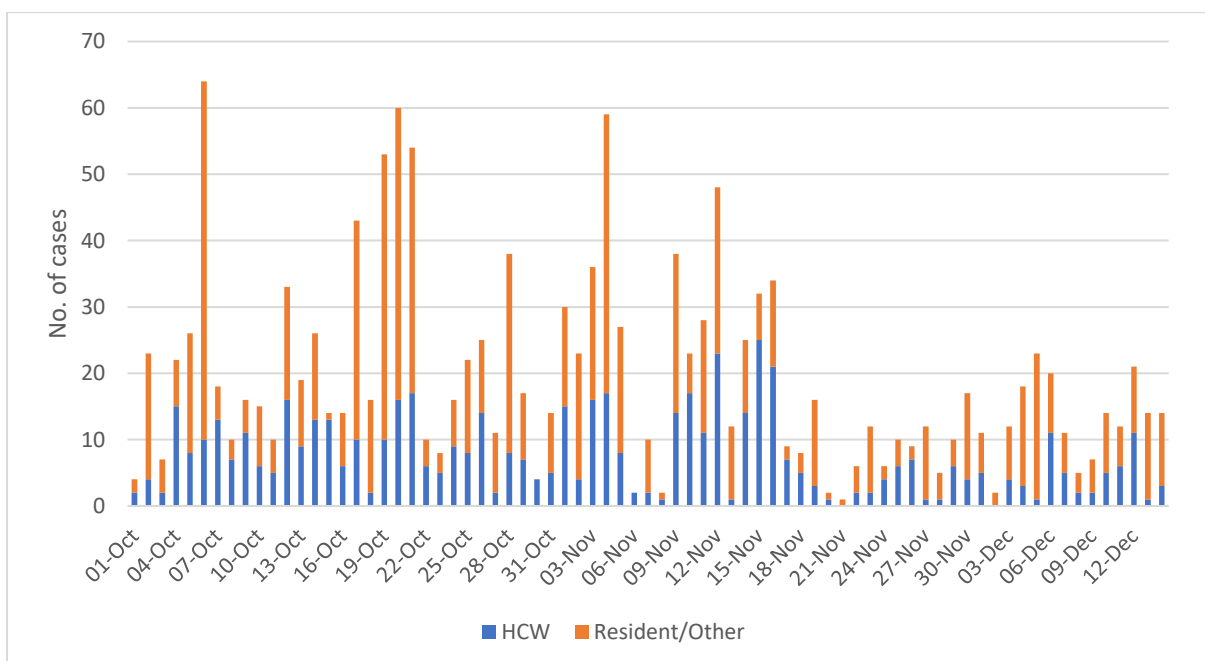


Figure 1, above, represents the number of outbreaks per week in nursing homes, showing a spike in early October, and a levelling off in the weeks November to early December. It is important to note that outbreaks continue to occur at a rate of about 5 each week in nursing homes, representing a continued risk to nursing home residents. Figure 2, below, gives details on the number of confirmed cases associated with outbreaks, showing that although new nursing home outbreaks continue to be opened each week, the number of cases associated has declined in December since highs in October and early November, but the number of resident cases remains relatively high.

Figure 2: Confirmed Cases Linked to NH Outbreaks by Event Creation Date since 01 Oct



The number of deaths reported since the beginning of October, represented in Figure 3, below, based on association with nursing home outbreaks, shows a lower number of relative deaths among

nursing home residents. However, given the continued incidence of nursing home outbreaks and notwithstanding the lower number of cases associated with these outbreaks, the potential for further deaths in nursing homes remains, underlining the importance of the continued implementation of protective measures designed to safeguard nursing home residents, including the provision of PPE, COVID-19 Response Team deployment and the serial testing programme, which allows for an early and measured response to new cases detected in nursing homes.

Figure 3: Deaths by date of death

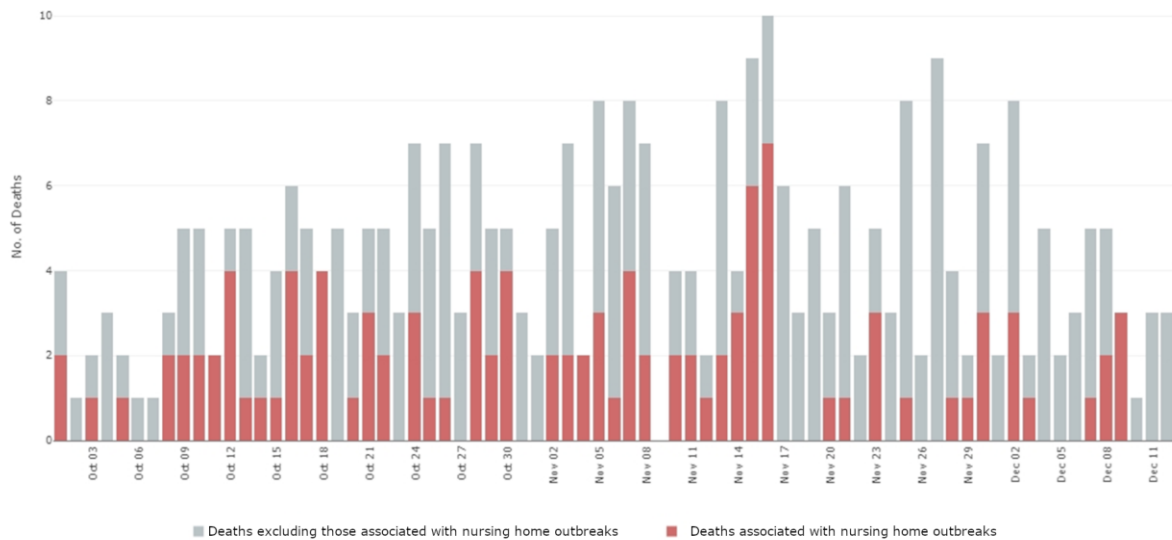
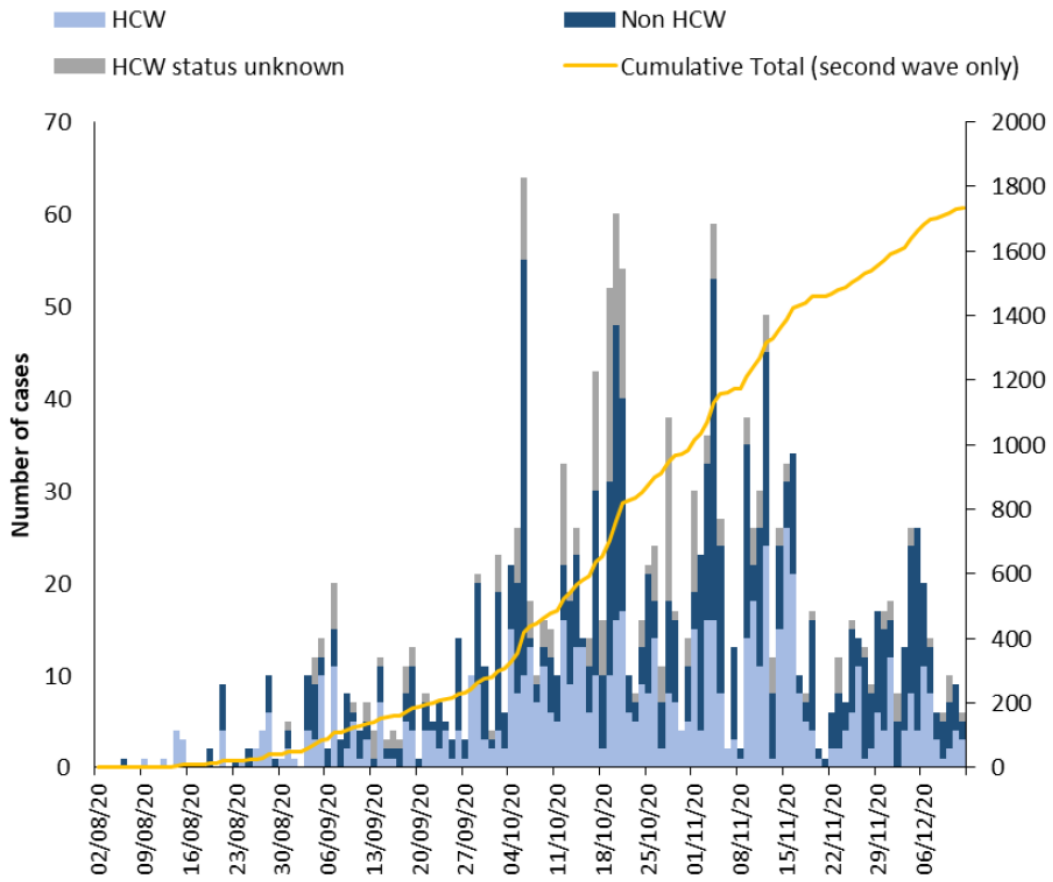
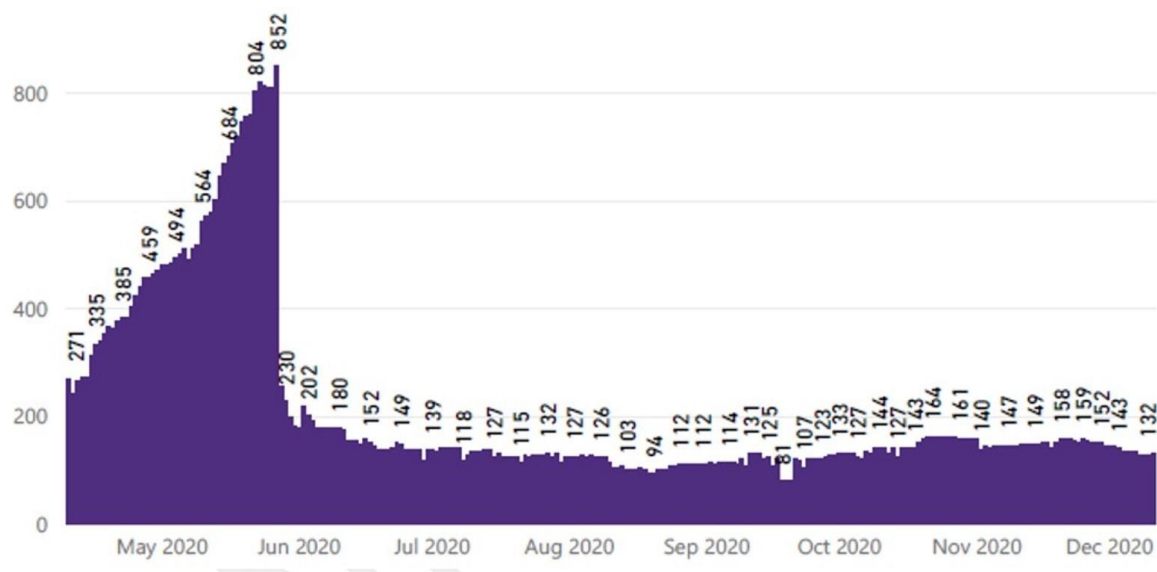


Figure 4: Epi-curve of confirmed COVID-19 cases linked to outbreaks in nursing homes and community hospital/long-stay units by healthcare worker (HCW) status and by date of notification and cumulative number of confirmed cases during the second wave of infection by date of notification, from 02/08/2020 to midnight 12/12/2020. Data source: CIDR



3 Update on Supports to Nursing Homes

Figure 5: LTRFs in receipt of COVID-19 supports by day⁷



3.1.1 Guidance

A substantial suite of guidance which is reviewed regularly has been developed for the sector including: visitations to Long Term Residential Care Facilities; various Infection Prevention & Control Guidelines, and Ethical Guidance.

3.1.2 COVID-19 Response Teams

The HSE COVID-19 Response Teams (CRTs) were established to support Public Health Outbreak teams covering all residential services as well as home support settings. The purpose of these multi-disciplinary teams is to support the prevention, identification, and management of COVID-19 outbreaks across these services (public and private). The teams will operate for the duration of the pandemic. 23 COVID Response Teams are currently in operation.

3.1.3 Provision of Personal Protective Equipment (PPE)

The HSE has established extensive logistics at national and Community Healthcare Organisation (CHO) level providing daily requirements of PPE, free of charge, to all residential care settings and other service areas. The continued supply of PPE on both a precautionary and an outbreak basis is a key support mechanism and will continue to be provided in line with clinical and public health recommendations. In the week ending 1 December, approx. 8.3m items of PPE were supplied to residential care settings (including public and HSE nursing homes), representing 46% of all PPE items supplied that week. Typically, on average, about 21m pieces of PPE is provided to nursing homes per month, costing circa €12.5m per month, €11m of which relates to private nursing homes.

It is important to note that each nursing home provider has a legal responsibility with regard to the provision of safe care to their residents and a safe working environment for their staff. In that regard, irrespective of the source of supply of PPE, each provider must ensure that it has sufficient PPE to cover its need, has contingency plans in place, and alternative supply chains to mitigate risk.

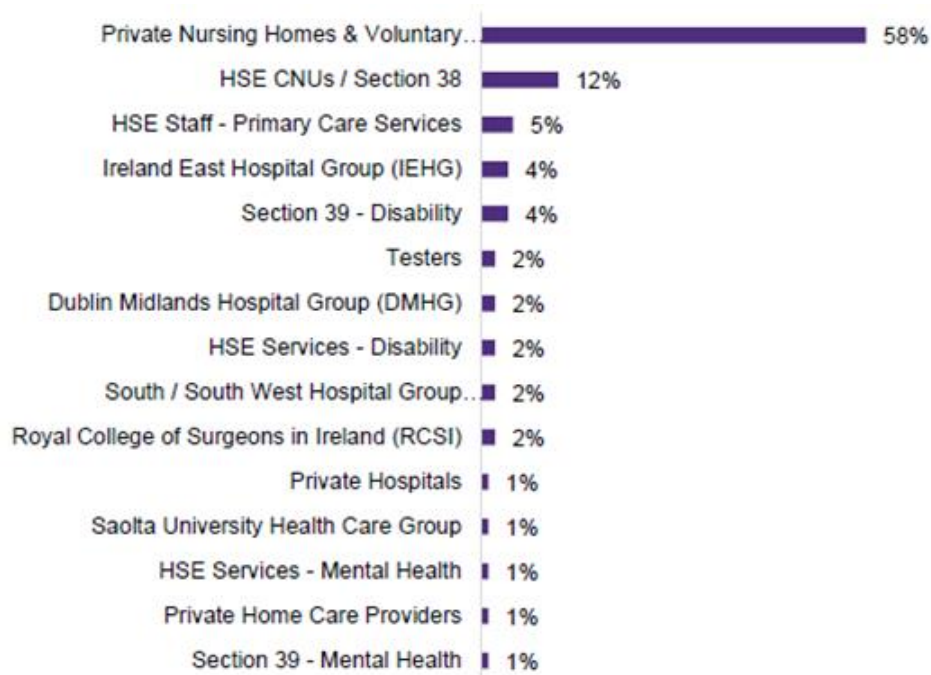
Figure 5, above, denotes the number of LTRFs in receipt of COVID-19 supports by day, including CHO phone advice, IPC support, Public Health support, PPE provision, and external staff input.

⁷ HSE COVID-19 Situational Report, 14th December 2020

3.1.4 HSE Temporary Accommodation Scheme

The HSE established a temporary accommodation scheme for healthcare workers affected by COVID-19 and is in place since April 9th. This scheme is available to healthcare workers in all nursing home settings. It aims to provide temporary accommodation, where required, for situations such as where the worker lives in a congregated domestic setting. There was high utilisation of this facility from late April to June; utilisation has increased again since late October, with beds occupied per week averaging in excess of 1,100 over this period. Over 50% of the healthcare workers who are currently availing of this service work in private and voluntary nursing homes.

Figure 6: Breakdown of the overall uptake in temporary staff accommodation per healthcare subcategory for week 34



3.1.5 Serial Testing Programme

NPHEP requested a planned programme of **serial testing** of all staff in nursing homes. The programme commenced on 24 June 2020.

- To date, the programme has completed 356,034 tests and identified 1,086 detected cases. This is a detection rate of 0.31%.
- Cycle 6 of serial testing in nursing homes commenced on 9 December for a four-week period. As of 14 December, Cycle 6 of serial testing has completed 14,087 tests and identified 58 detected cases. This represents a detected rate of 0.41%.

The testing programme is a critical part of the ongoing response to COVID-19 in nursing homes and allows for the early detection of cases and targeting of the early intervention of COVID-19 Response and Outbreak Control Teams.

3.1.6 COVID-19 Temporary Assistance Payment Scheme for Nursing Homes

In April 2020, the Temporary Assistance Payment Scheme (TAPS) was established as a temporary support mechanism to contribute towards costs associated with COVID-19 for private and voluntary nursing homes. The Scheme has been extended until the end of June 2021. Under the extension of the Scheme, the primary focus of the new eligibility under the Scheme will support private and voluntary nursing homes in progressing the implementation of various recommendations of the

COVID-19 Nursing Homes Expert Panel. As of 10 December, over 4,100 claims have been processed, approved and paid some €58 million of direct financial support to the sector.

In December, funding to further support nursing homes to enhance and create additional safe visiting spaces was announced. TAPS has been expanded on a once-off basis to allow a claim of up to €2,500 per eligible nursing home. This will enable them to create additional safe visiting spaces and enhance current visiting spaces.

Up to €1.125m is now being made available through the €92.5 million 2020 TAPS sanction for this once-off winter claim. Up to €92.5m is available for the Scheme in 2020. Through Budget 2021 up to €42m is available in 2021. Some nursing homes have started to take creative steps to develop safe, comfortable internal and external spaces to address these challenges. It is the Department's expectation that nursing home providers will continue to provide and invest in such measures.

3.1.7 Regulator Supports

As COVID-19 has impacted many services and access to services across health and social care, HIQA has responded to the changing needs in terms of inspections and reporting. This includes, for example, inspections of nursing homes both with and without cases of COVID-19, the expedition of applications to open new nursing home beds and the receipt and review of a large number of mandatory notifications.

HIQA developed and published a regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak and a self-assessment in April 2020. The aim of the framework is to support nursing homes to prepare for an outbreak of COVID-19 and put in place the necessary contingency plans. Providers were asked to self-assess their preparedness and inspectors then validated the provider's own self-assessment.

In September 2020, HIQA published a further assurance framework for registered providers for preparedness planning and infection prevention and control measures. Providers are required to comply with the minimum requirements of the regulations. HIQA will undertake inspections as part of this programme.

HIQA's Standards Team developed an online Infection Prevention and Control (IPC) learning module, launched on 18 August 2020, to support the implementation of the national IPC community standards. The IPC module was first hosted on the HIQA website and has moved to HSELand to increase accessibility on 02 October. Approximately 15,000 people have completed the module to date; the majority of whom are frontline staff working in health and social care services in the community. A dissemination plan was prepared to raise awareness about the module; this included extensive coverage on social media and sending targeted emails to a wide range of stakeholder groups. As part of this engagement all registered providers of designated centres for older people and designated centres for people with a disability were contacted and asked to share details of the module with colleagues and staff. A more detailed analysis of feedback on the module will be undertaken in the coming weeks at which point additional findings will be shared and additional tools to support implementation of national standards will be identified and developed.

4 COVID-19 Nursing Homes Expert Panel Report and Implementation Oversight Team

On 19 August the COVID-19 Nursing Homes Expert Panel's report was published. The Panel, formed in May 2020, was established to examine emerging best practice and recommendations to ensure that all protective COVID-19 public health and other measures to safeguard nursing home residents are planned and in place to respond to the ongoing impact of the COVID-19 pandemic over the next 6-18 months.

In summary, the Panel's 86 recommendations centre around 15 thematic areas of: Public Health measures; Infection prevention and control; Outbreak management; Future admissions to nursing homes; Nursing home management; Data analysis; Community Support Teams; Clinical – general practitioner lead roles on Community Support Teams and in nursing homes; Nursing home staffing & workforce; Education; Palliative care; Visitors to nursing homes; Communication; Regulations; Statutory care supports. Consideration has been given to recommended timelines, recognising urgent and immediate actions that are needed, as well as identifying requirements for the planning and development of actions over the next 18 months, in light of the expected ongoing impact of COVID-19 over that timeframe.

Implementation Oversight Team

The Minister for Health established an inter-agency Implementation Oversight Team to oversee the implementation of the recommendations of the report, to provide regular updates on the progress of implementation of recommendations to identify and mitigate any barriers to implementation and to report to the Minister on an ongoing basis. The Oversight Team is chaired by the Department of Health and has met eight times since its establishment. In addition, a Reference Group was formed to facilitate ongoing early engagement and involvement in the implementation process with relevant national stakeholders is also being established.

Implementation Progress

The first progress report of the Implementation Oversight Team has been published⁸. This includes an outline of progress up to and including October 2020. A second progress report is now in development. This second report will have a particular focus on individual nursing home provider progress on implementation. The below outlines highlights of national/strategic actions progress since the first progress report was completed.

COVID-19 Response: Nursing Homes, Overview of Roles of Key Stakeholders

Recommendation 14.1 of the COVID-19 Nursing Homes Expert Panel report recommended the development of a document outlining the roles and responsibilities of key stakeholders in the ongoing response to COVID-19 in nursing homes, including a clear overview of the roles and responsibilities of the National Public Health Emergency Team (NPHE), the Department of Health, HSE, HIQA, and individual providers.

A document entitled "*COVID-19 Response: Nursing Homes, Overview of Roles of Key Stakeholders*" has been developed by the Department in consultation with relevant agencies, the Implementation

⁸ <https://www.gov.ie/en/publication/c7f5b-covid-19-nursing-homes-expert-panel-report-implementation-oversight-team/#progress-report>

Oversight Team and the Reference Group established to support the implementation of the Expert Panel's recommendations.

The document outlines the roles and responsibilities of the NPHE, Department of Health, HSE, HIQA, NTPF, and individual nursing homes providers and gives a clear overview of the measures that have been put in place to help reduce the impact of COVID-19 in nursing homes, as well detailing the existing functions of stakeholders in the provision of nursing home care.

This document provides a valuable background to the current COVID-19 response in nursing homes and ensures that the roles of each of the stakeholders in providing safe long-term residential care in the context of the COVID-19 pandemic are clearly described.

As well as outlining the legal role and functions of the various stakeholders the document also outlines and provides detail on the enhanced support and other measures developed by agencies throughout the pandemic to support nursing homes and their residents to manage the challenges of COVID-19.

It is intended that this will be a living document and will be updated periodically, where the need arises, as the response to COVID-19 and the implementation of the Expert Panel's recommendations evolves.

Temporary Assistance Payment Scheme

The Temporary Assistance Payment Scheme (TAPS) which provides additional funding to private and voluntary nursing homes that require it has been extended until the end of June 2021. Detail of developments in relation to the extension of the Scheme are provided in section 3.

New visiting guidance in line with the 5-level framework

On Monday 30th November the Health Protection Surveillance Centre (HPSC) published new COVID-19 guidance on visitations to long-term residential care facilities. The new guidance came into effect on 7th December. It provides further support to long-term residential care services (including nursing homes) and residents in planning visits across all levels of the framework for restrictive measures in the Government's Plan for Living with COVID-19. This new guidance outlines an updated definition for 'critical and compassionate circumstances', which now provides that residents may be facilitated to receive:

1. up to one visit by one person per week under Levels 3 and 4 of the framework and
2. up to one visit by one person per two weeks under Level 5 of the framework

It also notes that at all framework levels every practical effort should be made to accommodate an additional visit on compassionate grounds during the period of a major cultural or religious festival or celebration of particular significance to the resident, such as the Christmas/New Year period.

5 Interagency Engagement and HIQA Risk Assessment

5.1 Interagency cooperation

Interagency cooperation has been very effective in problem solving and providing supports to nursing homes. Recommendation 14.1 of the Nursing Homes Expert Panel Report provides for a framework outlining the roles of various agencies and maps out the support and escalation pathways in place. A framework document on the roles and responsibilities of the various agencies

has been finalised and will be published on the Department's website in the coming days. This document will be updated regularly as it will be treated as a living document.

On the 15th October the Minister for Health and the Minister for Mental Health and Older Persons, along with senior Department officials met with the CEOs and Chairs of the HSE and HIQA, the Chief Inspector of Social Care Services (HIQA) and the Chief Operations Officer (HSE) to discuss the current position with regard to nursing homes and COVID-19.

Both HIQA and the HSE outlined and assured that all of the relevant supports that are in place are fully activated and the various local teams are engaging with nursing homes on a proactive basis to ensure preparedness and, where required, management of outbreaks if they occur. HIQA has confirmed that it is continuing to maintain a risk analysis of nursing homes and an "at-risk" list. It is prioritising its inspectorate resources towards those nursing homes that are identified as being at higher risk. The HSE and HIQA have an ongoing structured collaboration and escalation pathway, whereby concerns in respect of individual nursing homes are referred between the organisations to activate proactive supports where risk is identified. Both organisations have confirmed that these pathways and collaborative engagements are active and working well.

On 31st March, NPHET requested HIQA to risk rate all long-term residential care settings (LTRCs), including nursing homes, based on disease progression, environment and staff, and liaise with national and regional governance structures and LTRCS as necessary in light of mitigating actions. The Risk Assessment Report was provided on 9th April. Of the then 580 nursing homes HIQA estimated that 124 nursing homes would need some level of additional support. As part of the ongoing interagency engagements the Minister requested that HIQA develop an updated risk assessment. The purpose was to take the opportunity to review current risk and taking account of the significant and ongoing supports from the HSE and HIQA identify if there is anything else that could be considered to further mitigate the current risk.

5.2 Overview of HIQA November risk assessment

On 26th November HIQA provided an updated risk assessment of nursing homes. The HIQA aggregate risk profile provides an overview of potential risks and outlines in further detail the various monitoring and pathways for referral for supports to the HSE.

The Department convened an interagency meeting (Department, HSE and HIQA) on 2nd December to discuss the report on the COVID-19 risk assessment for nursing homes. The risk assessment identified there is a strong correlation between high levels of COVID-19 in the community and risk of an outbreak developing in a nursing home. The HSE confirmed that as part of its daily monitoring of all nursing homes that the daily HIQA provided information (see below) is reviewed and the HSE combines this information with its own daily updates from the HPSC CIDR data, the serial testing programme and operational information from the frontline through the CRTs proactive and other engagements directly with nursing homes and other teams in the community. This collective consideration of all the information inputs then creates a comprehensive view to ensure a focused daily response to provide nursing homes with the required supports on a proactive and informed basis.

The HIQA risk assessment also provides an informative and timely reminder of the monitoring and escalation pathways that have been established to provide a continuous oversight and support for the nursing home sector – this has been outlined in previous papers and in the recently published document *"COVID-19 Response: Nursing Homes, Overview of Roles of Key Stakeholders"*. HIQA utilises the risk data in combination with its daily notifications from nursing homes in order to create

triggers for (i) HIQA inspections and (ii) to provide live information to the HSE in order to inform its ongoing response to COVID-19 for its own public units and its support role for private nursing homes.

In that context, daily, HIQA inspectors:

- review NFO1⁹ and NFO2¹⁰ trackers¹¹;
- contact each nursing home with a confirmed or suspected COVID-19 case and/or unexpected residents deaths - assessing their current status and capacity to manage the COVID-19 outbreak. Confirm they are supported by Public Health and operating in line with their advice. Review their regulatory history (to include the aforementioned criteria), escalate as appropriate for HSE CHO area support;
- review by the inspector with case holding responsibility for the nursing home and schedule a risk inspection as appropriate;
- The Chief Inspector issues a daily cumulative report to include nursing homes of actual or potential risk requiring HSE support to the National Director of Community Services, the Assistant National Director for Older Persons, the HPSC and the relevant regional Public Health areas.

The intensive ongoing monitoring and daily reporting between the HIQA and HSE demonstrates the ongoing necessary focused response to risks across nursing homes in the context of COVID-19.

The European Centre for Disease Control has also recently published its latest risk assessment. This includes a framework of options for response to the ongoing risk. In response to both the ECDC and HIQA risk assessments, the Department has prepared a table of the ECDC suggested options to respond to the risk to LTRCs and measures adopted in Ireland to complete a comparative analysis. Through the Expert Panel Implementation Oversight Team (IOT), agencies were also asked to input and provide material for this analysis. This also assists in considering the ongoing response to identified risk. The next sections discuss this in more detail.

6 European Centre for Disease Control – Risk Assessment Overview

On the 19th November the European Centre for Disease Control (ECDC) published a rapid risk assessment – *“Increase in fatal cases of COVID-19 among long-term care facility residents in the EU/EEA and the UK”*¹². The risk assessment reiterates the overarching message that residents of long-term residential care services (LTRCs) are one of most vulnerable population and continued focus should be placed on preventing COVID-19 from being introduced into such facilities and the control of outbreaks when they do occur.

Consistent with the learning arising from the pandemic to date, the ECDC highlights that the probability of COVID-19 introduction into an LTRC depends on the level of COVID-19 circulation in the community. Where there are higher incidences rates in the community the level of risk to LTRC residents is also heightened. Mirroring the national and international learnings, the risk

⁹ The unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre

¹⁰ Any outbreak of any notifiable disease

¹¹ Registered providers are legally required to notify HIQA within certain time frames about certain incidents, events or changes within their centre.

¹² <https://www.ecdc.europa.eu/sites/default/files/documents/Increase-fatal-cases-of-COVID-19-among-long-term-care-facility-residents.pdf>

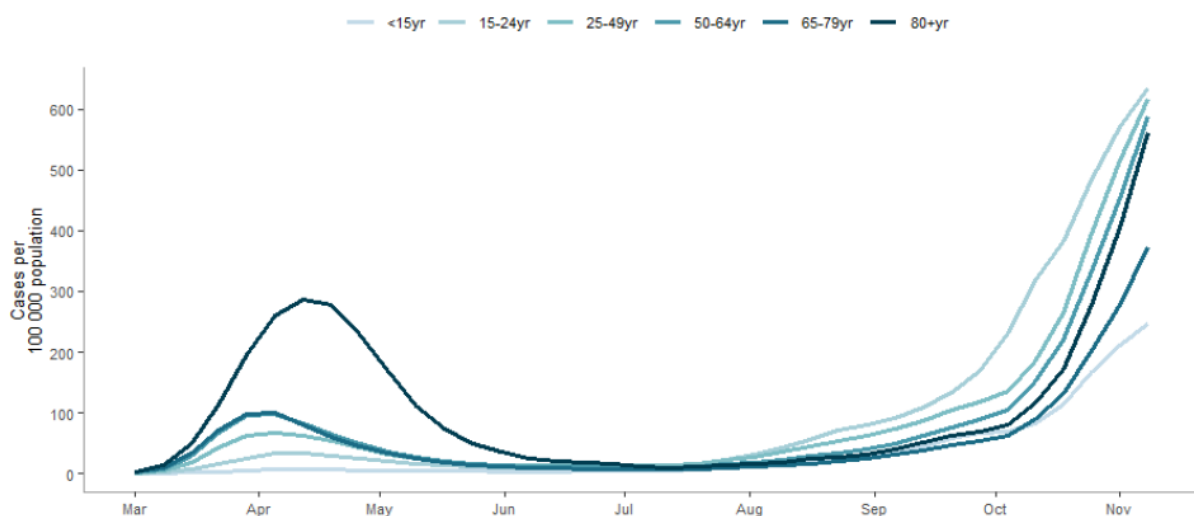
assessment notes that once the virus is introduced to an LTRC facility the risk of ongoing transmission is high.

6.1 Epidemiological Overview – Europe and UK

The ECDC outlines that in respect of the overarching COVID-19 epidemiological situation as of 8 November, all EE/EEA countries and the UK, with the exception of Finland, were assessed as being countries of serious concern as per the ECDC classification¹³. Across Europe notification rates started increasing in July after a period of low notification rates in the late spring to early summer. The ECDC notes that “all countries have reached a level above those observed during the first wave of infections, with the higher rates most likely related to more widespread testing across the region since the spring, but nonetheless indicating high levels of transmission in most countries.”

Figure 7 below shows the ECDC’s analysis of the 14-day age-specific COVID-19 case notification rate in the EU/EEA and UK and Figure 8 shows the Irish position. Figure 9 shows the incidence rate per age group in older adults and highlights the significantly higher incidence in those aged 85+, even when general population incidence is in decline. This suggests a continued upward trend in nursing home resident case rates that tracks case rates in the general population, in a slightly delayed manner, with the situation in October to December similar to that of the first wave in March to May.

Figure 7: 14-day age-specific COVID-19 case notification rate in the EU/EEA and UK



ECDC. Figure produced 11 November 2020. Source: TESSy COVID-19, national weekly data (from 28 Member States for week 45)

¹³ Epidemiological situation is ‘of concern’

A country with at least two of the following:

1. High ($\geq 60/100\ 000$) or sustained increase (≥ 1 week) in 14-day case notification rates
2. High ($\geq 3\%$) or sustained increase (≥ 1 week) in test positivity
3. High ($\geq 60/100\ 000$) or sustained increase (≥ 1 week) in 14-day case notification rates in the older age groups (65-79yr AND/OR 80+yr)
4. High ($\geq 10/1\ 000\ 000$) or sustained increase (≥ 1 week) in 14-day death notification rates.

Epidemiological situation is ‘of serious concern’

A country whose epidemiological situation is ‘of concern’ and in which at least one of criteria 3-4 are met.

Figure 8: 14-day age-specific COVID-19 case notification rate - Ireland

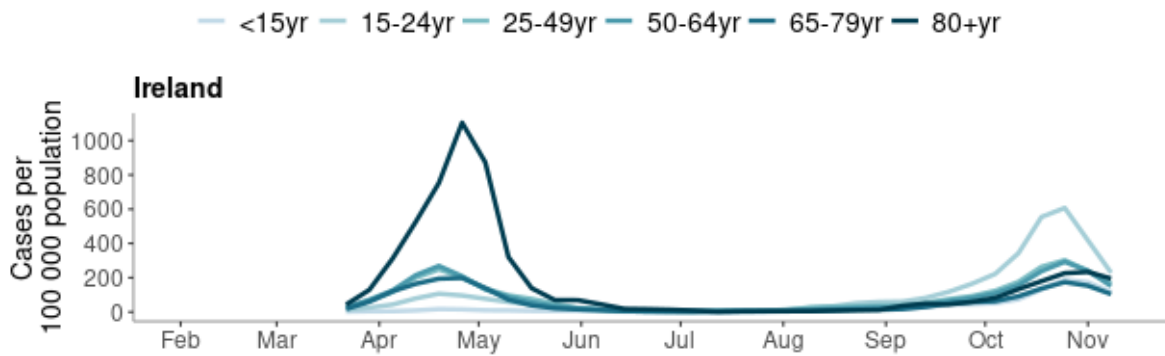
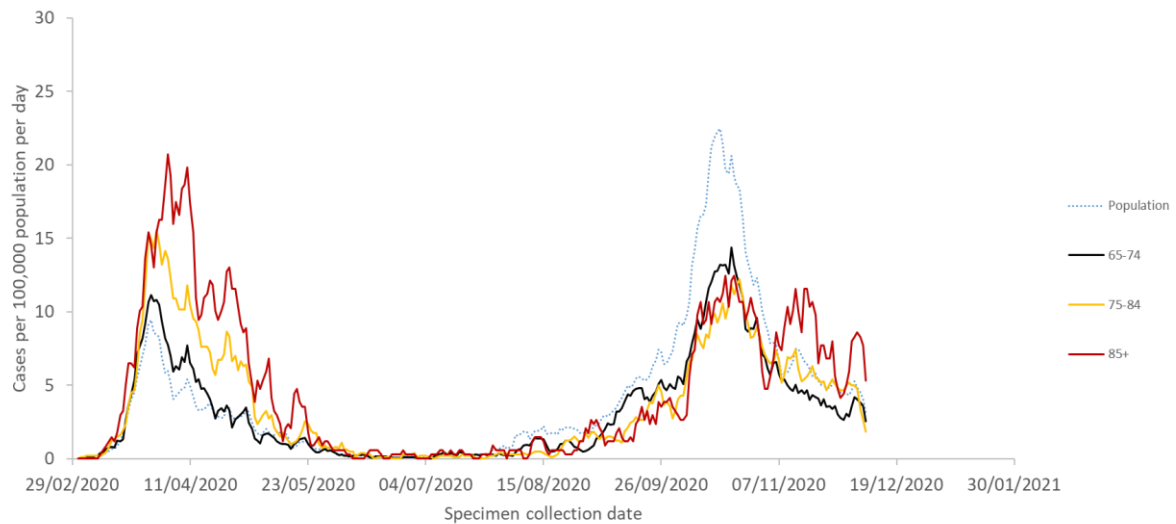
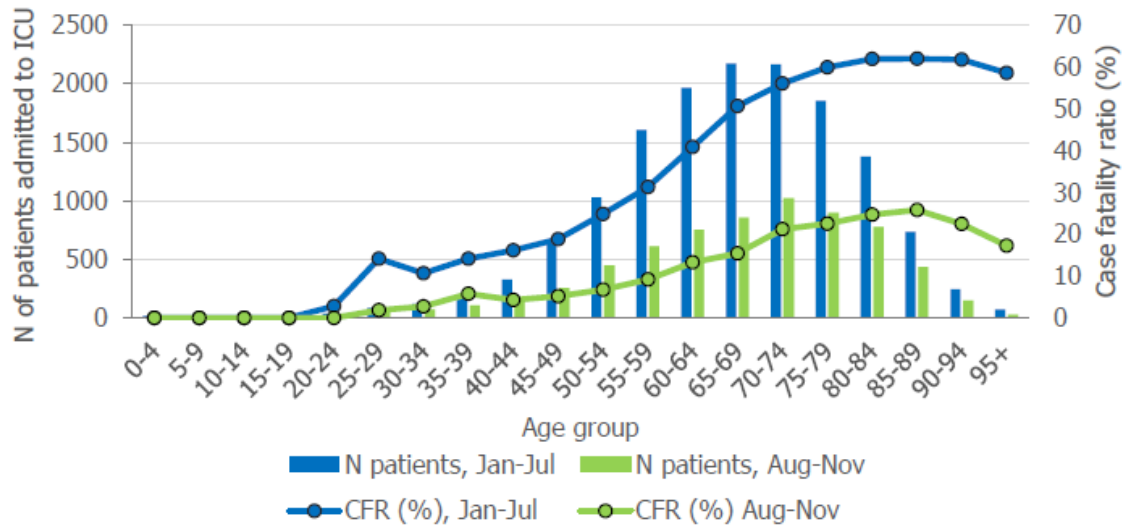


Figure 9: Incidence by age in older age groups



In terms of case fatality rates, the ECDC observe that this is currently lower than that seen in March and April 2020. It further states that this is “partly attributable to a higher case identification capacity, which detected more younger and asymptomatic cases. However, decreases in case fatality can also be seen among cases in older age groups, in hospitalised patients and in patients admitted to intensive care” (Figure 10). Finally, the ECDC states that the improved outcomes observed may relate to improvement in the clinical management of severe cases.

Figure 10: Age-specific case-fatality among patients admitted to intensive care units, in countries that reported* case-based data, 1 January — 31 July and 1 August— 10 November 2020, EU/EEA and UK (N=25 094 patients)



Source: TESSy; CFR — case fatality ratio; * Austria, Czech Republic, Germany, Estonia, Finland, Ireland, Iceland, Italy, Lithuania, Latvia, Norway, Poland, Portugal, Sweden, Slovakia

In the context of LTRCs specifically, examining the recent trends across Europe the ECDC notes that all EU/EEA countries and the UK have experienced LTRC outbreaks since August. It also notes that based on its examination of national surveillance data in countries that publish such data reports that include longitudinal data on COVID-19 in LTRCs, seven countries¹⁴ including Ireland, have reported an increase since July 2020, in both cases and deaths among LTRC residents.

6.2 ECDC Commentary on Outbreak Causal Factors

The ECDC highlights the output of a root cause analysis of LTRC outbreaks undertaken in UK-Scotland¹⁵. This analysis identified factors that directly contributed to increased likelihood of spread of COVID-19 to and within LTRCs, summarised as:

#	Factor
(i)	A high community prevalence of COVID-19 in the same sub-national region;
(ii)	Larger care home size (>20 beds) and higher occupancy;
(iii)	Staff who unknowingly worked while asymptomatic, due to delays/errors in reporting screening test results;
(iv)	Staff members (including nurses, carers and kitchen staff) who worked in more than one LTCF, or who were not cohorted to floors/units, who continued to work across these until outbreaks were confirmed;
(v)	Missed opportunities to identify early warnings in safety data (e.g. staffing absence data, single positive cases);
(vi)	Insufficient training and adherence of staff to IPC measures and delays introducing additional transmission-based precautions when a case was suspected or identified;
(vii)	Challenges in implementing the most effective infection control practices (e.g. keeping up to date with the latest guidance and lack of expert advice or specific guidance such as for cleaning products);
(viii)	Inadequate staff IPC measures to minimise staff-to-staff transmission (e.g. situational awareness regarding the risk in changing rooms, break rooms, smoking shelters, car sharing and while socialising outside of work);
(ix)	Delayed recognition of cases in residents because of a low index of suspicion, i.e. being unfamiliar with the broader syndrome of COVID-19 in older people;
(x)	Delayed identification of cases (e.g. limited availability of punctual testing or test reporting; asymptomatic/pre-symptomatic residents);
(xi)	(LTRC residents at risk for severe morbidity and death sharing a location, e.g. LTCFs with high proportions of residents with dementia and receiving end-of-life care);
(xii)	Health system arrangements to support staffing in crisis, e.g. for staff absenteeism. For example, larger care homes groups tended to have less well-established relationships with national health services, and had less utilisation of the available and identified support.

The ECDC notes that high community prevalence of COVID-19 increases the risk of importation of the virus into an LTRCs by possibly asymptomatic COVID-19 positive visitors and LTRC staff. Highlighting other international studies, the ECDC states that larger facilities have a greater footfall with more staff and visitors coming through the doors and this increases the risk of COVID-19 introduction. It highlights the risks associated with staff working across multiple sites (citing UK examples), high occupancy rates (particularly in “crowded” rooms) and shared washing facilities.

¹⁴ Belgium, Denmark, Ireland, France, the Netherlands, Sweden and the UK

¹⁵ Scottish Government - Community Health and Social Care Directorate. Coronavirus (COVID-19): care home outbreaks - root cause analysis. [updated 3 November 2020; cited 16 November 2020]. Available from: <https://www.gov.scot/publications/root-cause-analysis-care-home-outbreaks/pages/1/>

6.3 ECDC Risk Assessment Conclusions

The ECDC notes that there has been a general increase in the levels of COVID-19 testing and this is leading to the identification of additional cases. However, it further states that this increased testing does not fully explain the emerging epidemiological situation and the risk assessment identifies that this increase in case identification, along with increases in hospital and ICU admissions indicates an escalating epidemiological situation. As a result, the ECDC concludes:

the overall probability of infection for LTCF residents in these countries is assessed as very high.

The ECDC risk assessment finally concludes that *“although the case fatality rate appears to have decreased compared to the peak in March and April...unfavourable outcomes remain very high among older people patients with COVID-19”*.

Therefore, the overall impact of infection for LTCF residents is assessed as very high.

For residents of LTCFs, who have a very high probability of infection and a very high impact of disease, the overall risk related to COVID-19 infection is assessed as very high.

7 European Centre for Disease Control – Options for Response

7.1 ECDC Options for Response

The ECDC risk assessment provides an overview of key recommendations for national public health authorities and LTRC providers to take in relation to mitigating and managing COVID-19. The ECDC outlines the need to take a systems level approach to supporting LTRCs to prevent the introduction and transmission of COVID-19, noting that there is no single intervention or response, rather a coordinated package of interventions is required to successfully tackle the virus.

The ECDC outlines its options for response across 5 thematic areas:

- A. Management of LTCFs;
- B. SARS-CoV-2 testing at LTCFs;
- C. Minimising the risk of COVID-19 introduction into LTCFs;
- D. Minimising risk of COVID-19 transmission within LTCFs;
- E. Vaccination.

7.2 Summary Overview of Options

A. Within the area of LTCF management, the following options should be considered

1. National health authorities should ensure access to COVID-19 resources, such as a comprehensive online repository guidance, guidelines and training materials to enable long-term care facilities (LTRCs) establish safe routines for staff and residents. Resources should include guidance on psychosocial care, continuity of healthcare, access to hospital healthcare and palliation. EU legislation on occupational safety and health (OSH) should be adhered to and proper coordination should be in place when staff work across various sites.
2. Each LTCF should have a lead person to ensure:
 - the implementation and coordination of OSH and public health measures;

- supplies and training of staff and residents;
 - COVID-19 surveillance and testing for identification of outbreaks;
 - access to healthcare; and
 - co-ordination of visitors.
3. To ensure adequate registration and access to external healthcare services, national health authorities should:
- ensure a comprehensive register of LTCFs be developed;
 - ensure LTCFs have a register of staff and residents, including contact details; and
 - consider pairing LTCFs with local hospitals and public health authorities.

B. With regard to SARS-CoV-2 testing within LTCFs:

1. All staff at LTCFs in areas of community transmission should be regularly tested, with isolation and testing of residents in place for any possible and/or confirmed case.
2. National authorities should consider Rapid Antigen Tests in addition to Reverse Transcriptase Polymerase Chain Reaction (RT PCR) for:
 - early identification of infectious individuals at a stage when the viral load is higher;
 - support outbreak investigation and contact tracing; and
 - screening of staff every two to three days.
 Trained staff are needed to operate any Rapid Antigen Testing programme.

C. In order to minimise the risk of COVID-19 introduction into LTCFs, the following options should be considered:

1. Reinforce messaging on minimising introduction of COVID-19 into LTCFs by those working there to ensure:
 - staff are a priority for testing;
 - guarantee financial support and security for staff to stay at home when necessary;
 - mechanisms are in place for trained cover staff;
 - ongoing training around IPC measures, including staff compliance outside LTCFs;
 Additional measures include:
 - staff experiencing symptoms have facility and knowledge to:
 - self-isolate;
 - contact LTCF to get advice and inform of absence;
 - not attend work; and
 - get a COVID-19 test
 - hand hygiene and mask use for all staff in contact with residents;
 - staff providing services across multiple LTCFs should be trained in IPC practices and symptom monitoring;
 - awareness of increased risk of larger facilities with associated training for staff;
 - increased resources to LTCFs experiencing outbreaks; and
 - coordination across LTCFs when setting measures to reduce cross-contamination.
2. LTCFs should establish procedures for (re)-admission of residents post COVID-19 to mitigate the risk of infection. This it can do by, monitoring for COVID-19 symptoms and consider testing before and after (re)-admission. For recovered hospitalised cases, (re)-admission should only occur after 2 negative tests at least 10 days after onset of symptoms, or 20 days if no testing capacity, test remains positive or immune suppression of the resident.

3. LTCFs should establish balanced IPC and risk-based measures to facilitate visits, with face masks, appropriate hand hygiene practices, separate entrance and egress and staff training for symptom screening. Symptomatic visitors should not attend, and all visitors should be registered for contact tracing. Essential service delivery visits should be short and avoid entering residential buildings if possible. Finally, procedures should be in place for PPE
4. LTCFs should ensure capacity to mobilise external resources.

D. Minimising risk of transmission of COVID-19 within LTCFs

1. Management of residents with symptoms of COVID-19:
 - Symptomatic residents should be urgently medically assessed for isolation, testing and possible transfer to acute care hospital.
 - Staff should be aware of symptoms of older people.
 - Rapid Antigen Testing can assist assessment.
 - Residents with mild symptoms and not needing hospitalisation should be isolated.
 - Create 'bubbles' to isolate 2 or more cases with associated staff in separate area.
 - Post accessible IPC information throughout facility.
 - Train and provide full PPE to staff in contact with symptomatic or confirmed-case residents.
 - To minimise personal contacts with risk of COVID-19 infection, LTCFs should:
 - ensure occupancy rate permits physical distancing;
 - use universal masking;
 - have adequate ventilation;
 - ensure hand hygiene is practised;
 - undertake environmental cleaning;
 - ensure proper waste management practices are in place.
 - organise activities to incorporate physical distancing.

2. Vaccines: pneumococcal and influenza and future COVID-19 vaccination

Pneumococcal and influenza vaccines should be considered for residents and staff. 60+ cohort and health care workers in contact with residents should be prioritised for the COVID-19 vaccine.

7.3 Brief Overview Comparisons

Across all options identified by the ECDC, Ireland has a comprehensive set of public health measures, actions and responses that align with each. These measures are either direct actions or supports undertaken by State agencies and public health authorities or are measures aimed at supporting/facilitating nursing homes (and other LTRCs) to implement actions related to the relevant options. The below gives a summary overview of these comparisons ([Matters related to the ECDC are in blue text](#) to distinguish ECDC stated options from Irish measures)

Within the area of LTCF management ECDC provides that access to COVID-19 resources such as guidance and training materials should be available. In Ireland the HPSC maintains a comprehensive package of guidance which is reviewed and updated regularly. Regular webinars and other training programmes are delivered, and all nursing home providers and their staff have access to comprehensive training tools via HSElanD.

The ECDC recommends that each LTRC has a lead person to coordinate various aspects of the COVID-19 response and oversight. Irish nursing home regulations require each nursing home to have

a “person in charge” to oversee the operation and management of the nursing home. Many of the legal duties and functions of the person in charge align and/or overlap with the ECDC recommendations. In addition, on 31st March 2020, NPHET recommended that each nursing home provider designate a team or at least one full-time staff member as lead for COVID-19 preparedness and response. HIQA’s regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak and a self-assessment also include provisions in relation to the requirement of nursing homes to have a designated lead.

Further ECDC recommends that there is a comprehensive register of nursing homes and that each nursing home has a register of staff and residents. Since 2007, HIQA has maintained a national register of nursing homes. The regulatory framework in Ireland also requires nursing homes to maintain a directory of residents and of staff employed.

With regard to COVID-19 testing within LTRCs the ECDC recommends that all staff should be regularly tested with isolation and the testing of residents in place for any possible and/or confirmed case. In June 2020 the serial testing programme for nursing home staff was established and this programme of testing is currently active and in its sixth cycle, with fortnightly testing being undertaken. As required residents are also tested and there is comprehensive guidance in place with regard to isolation of residents. COVID-19 Response Teams and Outbreak Control Teams provide further support and advice to nursing homes in this regard, as required.

The ECDC further recommends that national authorities should consider Rapid Antigen Tests in addition to Reverse Transcriptase Polymerase Chain Reaction (RT PCR) for early identification of infectious individuals, support outbreak investigation and for screening staff. While rapid antigen testing is currently being examined through a validation process, it should be noted that the serial testing programme and the deployment of the various support Teams, including teams assigned to responding to outbreaks, a range of rapid control measures and supports are put in place to manage the outbreak. A recent report published by the ECDC¹⁶ outlines a range of considerations and potential benefits associated with Rapid Antigen Tests, but also notes: “[t]here are currently several rapid antigen tests on the EU/EEA market, but data on their clinical performance are limited and many of those data are based on a limited number of mainly symptomatic individuals. In addition, many of the reports are still preprints, and the data should therefore be interpreted cautiously. The validation studies conducted to date show variable performance between tests. ECDC recommends Member States perform independent validations of the rapid antigen tests against RT-PCR...” It concludes “[f]urther clinical validation studies, especially in asymptomatic persons and with different specimen types and comparing head-to-head with quantitative RT-PCR test, need to be conducted urgently.” As noted, Ireland is examining such tests via a validation process and this fully aligns with the ECDC advices.

In order to minimise the risk of COVID-19 introduction into LTRCs the ECDC recommends a range of measures relating to nursing home provider actions, staff actions, and wraparound supports. It notes, *inter alia*, the staff should be a priority for testing, there should be ongoing IPC training, staff with symptoms should be facilitated to self-isolate, not attend work and receive a COVID-19 test. It also outlines that hand hygiene and mask use should be in place within nursing homes. Finally, it

¹⁶ European Centre for Disease Prevention and Control. Options for the use of rapid antigen tests for COVID-19 in the EU/EEA and the UK. 19 November 2020. ECDC: Stockholm; 2020. https://www.ecdc.europa.eu/sites/default/files/documents/Options-use-of-rapid-antigen-tests-for-COVID-19_0.pdf [accessed 14th December 2020]

highlights that there should be increased resources to LTRCs experiencing an outbreak and LTRCs should have capacity to mobilise external resource.

The package of public health measures and supports established by the HSE and HIQA in the early part of the pandemic and which continue to be actively deployed support nursing homes and staff to undertake the ECDC recommended actions. Staff can receive testing as required and the serial testing programme ensures that there is a structured ongoing testing regime in place. Comprehensive public health guidance is in place and communicated regularly with regard to IPC controls and management of symptomatic staff. The Government has established relevant illness benefit schemes to support staff to stay off work. The Temporary Assistance Payment Scheme (TAPS) provides substantial financial support to nursing homes to ensure staff training, adherence to IPC guidance, and amongst other things can also be used to support staff management.

Under *minimising risk of transmission of COVID-19 within LTRCs* the ECDC covers a wide range of IPC management protocols with regard to residents including the proper use of PPE, isolation and cohorting, basis cleaning, waste management and hand hygiene measures, managing occupancy levels etc. The detailed IPC guidance and related guidance, training including webinars and online training resources, access to PPE and funding through TAPs for maintaining single rooms for isolation purposes all support the implementation of the options identified by the ECDC.

Finally, with regard to *vaccines*, the ECDC recommends that *healthcare workers and staff working in health care facilities should be offered appropriate vaccination against influenza to reduce the risk of infecting vulnerable groups*. The HSE Flu programme, which is underway, is rolling out vaccine to various groups and settings. Healthcare workers may receive the vaccine free of charge. Targeted uptake for 2020 is significantly increased from 2019. The influenza vaccine has been distributed in nursing homes.

In relation to the COVID-19 vaccine the ECDC recommendations that “[a]mong the priority groups to be vaccinated against COVID-19, we indicate the following groups: elderly from 60 years of age and especially those residents in the [LTRCs], HCWs providing direct care to [LTRC] residents”

The Government recently established the High-Level Task Force on COVID-19 Vaccination. This group is led by the Department of the Taoiseach and will develop a national vaccination plan for the COVID-19 vaccine in Ireland. The Taskforce is working with the HSE and the Department of Health to prepare for the national COVID-19 vaccination programme. The COVID-19 Vaccine Allocation Strategy¹⁷ lists the groups of people who will be the first to access a COVID-19 vaccine in Ireland, once a safe and effective vaccine(s) has been authorised. These priority groups include people over the age of 65 living in long-term care facilities, frontline healthcare workers and people aged 70 and over. The Strategy has been developed by the National Immunisation Advisory Committee (NIAC) and the Department of Health and approved by Government.

Appendix 1 provides a detailed comparison of the ECDC’s options for response and outlines relevant measures and responses established in Ireland across the various themes and sub-options.

8 Conclusions

As outlined by the Nursing Homes Expert Panel and the recent ECDC risk assessment, nursing homes residents are one of the most vulnerable populations and continued focus should be placed on

¹⁷ <https://www.gov.ie/en/publication/39038-provisional-vaccine-allocation-groups/>

preventing COVID-19 from being introduced into such facilities and the control of outbreaks when they do occur. Consistent with the learning arising from the pandemic to date, the ECDC highlights that the probability of COVID-19 introduction into an LTRC depends on the level of COVID-19 circulation in the community. ECDC rates that for residents of LTCFs, who have a very high probability of infection and a very high impact of disease, the overall risk related to COVID-19 infection is assessed as **very high**. As can be seen throughout this paper, Ireland has aligned itself with best practice in supporting those living in nursing homes and Ireland has especially put in place those measures as recommended by the ECDC that will help reduce the introduction and spread of COVID-19 among nursing home residents, and that will help prevent and manage ongoing and further outbreaks in these settings.

There has been significant learning with regard to COVID-19 and nursing homes since March. The Nursing Homes Expert Panel report, following examination of international and national experiences, provides a set of evidence-based and essential recommendations. Implementation of these recommendations must remain a priority. The continued and ongoing interagency cooperation, the set of supports in place by both HIQA and the HSE and the focus on prevention and management of COVID-19 transmission must remain in place.

9 Appendix 1 - ECDC Options for Response and Measures Established in Ireland – A comparison

ECDC Options	Ireland
A. Within the area of LTCF management, the following options should be considered	
<p>Ensuring access to information and resources in the form of guidelines, guidance and procedures on the prevention and control of COVID-19, as well as access to appropriate equipment, which will support and ensure all facilities establish safe routines for care.</p> <ul style="list-style-type: none"> Competent authorities, such as the national public health institute, should ensure accessibility to COVID-19 information and resources for the control and prevention of COVID-19, for both LTCFs and LTCF-like settings, e.g. by maintaining a comprehensive online repository of guidelines, guidance and training materials 	<ul style="list-style-type: none"> Guidance Public health guidance, including for vulnerable groups, is updated regularly and published by the Health Protection Surveillance Centre (HPSC) on its website at: [https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/] <u>Infection, Prevention and Control Guidance long-term residential care settings guidance</u> Specific infection prevention and control guidance is available and updated regularly by the HPSC for LTRCs: Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities. This comprehensive guidance targeted directly at LTRCs provides guidance across a range of key areas including: <ul style="list-style-type: none"> Clinical features of COVID-19, routes and control of transmission, incubation period and environmental survival; General measures to prevent an outbreak including: planning, education (staff and residents), physical distancing, controls to prevent inadvertent introduction, surveillance and early identification; Management of an outbreak, including: Declarations and engagement with Outbreak Control Teams, management of possible or confirmed cases, cohorting of residents, management of close contacts, infection prevention and control measures including standard and transmission-based precautions, and management of care equipment, waste, laundry, environmental hygiene and cleaning, communications and support services for staff and residents; Care of the dying and recently deceased; Monitoring outbreak progress and declaring an outbreak over; Hand hygiene, use of and donning and doffing of PPE; Comprehensive guidance on safely managing admissions, transfers and discharges. The HSE continues to provide a range of supports to all Nursing Homes, public, voluntary and private, primarily through Specialist Public Health, Geriatrician and IPC advice and support, provision of PPE, alternative accommodation, staffing supports if necessary and additional funding to the private nursing home sector under the TAP Scheme. These supports are primarily managed through the HSE's network of COVID-19 Response Teams (CRTs) across the nine Community Health Organisations, in addition to Public Health Outbreak Control Teams in relevant circumstances. All centres have access to information on HSEland and the HPSC online

	<p>repository and are directed to relevant information.</p> <p>Each CHO has a listing of religious orders within their area and there is a lead from a religious order forum engaging with a number of CRTs</p> <ul style="list-style-type: none"> • <u>Visiting guidance</u> <p>Visiting guidance has been developed and evolved through the pandemic as new information and learning is identified. Current visiting guidance aligns with the overarching Government framework of restrictive measures (COVID-19 risk management strategy) contained in <i>Resilience and Recovery 2020-2021 - Plan for Living with COVID-19</i></p> <p>- New HPSC guidance for LTRC visits, including nursing homes, was published on the 30th November and came into effect on 7th December 2020.</p> <p>This new guidance outlines an updated definition for ‘critical and compassionate circumstances’, which now provides that, subject to risk assessment in each case, nursing homes residents may receive:</p> <ul style="list-style-type: none"> • up to one visit by one person per week under Levels 3 and 4 of the framework; • up to one visit by one person per two weeks under Level 5; <p>It also notes that every practical effort should be made to accommodate an additional visit on compassionate grounds during the period of a major cultural or religious festival or celebration of particular significance to the resident, such as the Christmas/New Year period.</p> <p>The guidance notes that restrictions on visiting are of themselves a source of stress for residents, their friends and families. Therefore, it is essential that the service providers engage with residents, involve them in decision making and communicate clearly with each resident and relevant others regarding visiting policy including any restrictions.</p> <p>The guidance notes that visiting restrictions should be applied on the basis of a documented risk assessment that is reviewed regularly in view of the evolving public health situation and guidance. A risk assessment should take account of the overall care needs, rights and wishes of residents, the vulnerability of the residents, the current incidence of COVID-19 in the surrounding community and the capacity of the LTRC in terms of buildings, grounds and human resources to manage risks associated with visiting. The document provides detailed guidance across each of the 5 levels of the framework of restrictive measures, outlining measures that should be taken to provide for safe visiting having regard to the overarching level of risk at any given time.</p> <ul style="list-style-type: none"> • <u>Transfers to, admissions, discharges from long-term residential care facilities</u> <p>As noted above, specific comprehensive guidance on admissions, transfers to and discharges from Long-term care facilities guidance can be found in:</p> <p>Interim Public Health, Infection Prevention & Control Guidelines on: Admissions, Transfers to and Discharges from Long Term Residential Care Facilities during the COVID-19 Pandemic</p>
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- **Education, Training, Information and Resources**

- Training:

All nursing homes and relevant multidisciplinary teams can access HSELand, the HSE's online learning and development portal, containing over 170 eLearning programmes, resources and tools. Relevant eLearning courses available to access include:

- Hand Hygiene for Clinical Staff; Hand Hygiene for non-Clinical Staff;
- Breaking the Chain of Infection;
- Introduction to Infection Prevention and Control;
- Putting on and taking off PPE in community healthcare settings;
- Pronouncement of Death by Registered Nurses in the Context of the Global COVID-19 Pandemic 2020;
- Resource Pack for Registered Nurses and Registered Nurses Returning to Professional Nursing Practice (Older Persons Services) in response to COVID-19 outbreak 2020.

In addition to HSELand, the HSE has developed and delivered webinars, HSE training and ongoing regular education programmes. Antimicrobial Resistance and Infection Control and Community Operations Webinars have been ongoing since March and were repeated when guidance changed. IPC video resources are available on the HPSC's website. The Office of the Nursing and Midwifery Services Director (ONMSD) has delivered regional IPC training, which was open to wider participation.

In line with the European Centre for Disease Control (ECDC) – Risk Assessment Long-term residential care facilities, the webinar series hosted by the Office of the Nursing and Midwifery Services Director (ONMSD) and the National Clinical Advisor & Group Lead Older Persons was to inform the overall information campaign for nursing homes to support older persons during this time.

- The aim of the series is to harness experience of those caring for residents in the Long-Term Residential Care setting and provide relevant clinical updates on care issues to support the care of residents in nursing homes;
- This programme, delivered across 4 webinars, is available to all clinical staff managing care of residents in long-term residential care settings (both HSE and non-HSE);
- Webinars were scheduled at evening time from (7-8:15pm) to accommodate staff and encourage as many participants as possible;
- Webinar format was divided into four key topics with four speakers per event;
- Each webinar concluded with a Q&A session that was hosted jointly by the DoH and the HSE;
- Speakers and Q&A moderators provided valuable contributions to the series of webinars.

Total numbers attending over four webinars (19th Nov, 26th Nov and 03rd Dec 2020): **1,056 attendees**

	<p>The webinar series were disseminated widely to the DoH, HSE divisions and to key stakeholders in external organisations requesting wider circulation as appropriate within their own networks:</p> <ul style="list-style-type: none"> • CCO office • Clinical Design and Innovation (CDI) • Department of Health • Health Information and Quality Authority (HIQA) • HSE Community Operations • HSE Comms training and events broadcast email, their weekly partner email and on LinkedIn • Irish College of General Practitioners (ICGP) • Irish Gerontological Society (IGS) • Irish Hospice Foundation • Irish Society of Physicians in Geriatric Medicine (ISPGM) • Nursing Homes Ireland • Office of the Nursing and Midwifery Service Director (ONMSD) • Quality and Patient Safety Social Care Division • RCPI, Clinical Advisory Group, National Integrated Care Programme for Older Persons <p>Health and Information and Quality Authority (HIQA)</p> <ul style="list-style-type: none"> • <u>Assessment Framework</u> <p>The Chief Inspector within HIQA developed and published a regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak and a self-assessment in April 2020¹⁸. The aim of the framework was to support nursing home provider to prepare for an outbreak of COVID-19 and put in place the necessary contingency plans. Providers were asked to self-assess their preparedness across a number of key regulations. Inspectors then validated the provider’s own self-assessment of compliance against specified regulations.</p> <p>In July, HIQA published a report on <i>“The impact of COVID-19 on nursing homes in Ireland”</i>, which amongst other things outlines the findings of HIQA’s validation of nursing homes’ self-assessment of preparedness. The Report notes that <i>“inspectors found a good level of compliance across the nursing homes where the contingency arrangements were assessed. Where regulatory noncompliance was identified, the relevant provider was required to take action and revise its COVID-19 preparedness plan to address these areas.”</i></p> <p>In late May the Chief Inspector recommenced risk inspections, with a primary focus on nursing homes that had reported confirmed cases of COVID-19.</p>
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¹⁸ https://www.hiqa.ie/sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf

	<ul style="list-style-type: none"> • <u>Assurance Framework</u> On 17th September 2020 the Chief Inspector, published a further assurance framework for registered providers for both nursing homes and centres for people with disabilities for preparedness planning and infection prevention and control measures¹⁹. Regulation 27 of the current regulations pertaining to nursing homes requires compliance with the National Standards for Infection Prevention and Control in Community Services (2018)²⁰. Therefore, this framework focuses on the national standards and key regulations to ensure that each designated centre has effective preparedness and contingency plans and infection prevention and control measures in place. Inspections as part of this programme where inspectors will ask to see evidence of improvement actions taken by providers to address any deficits arising from their self-assessment under the framework. HIQA has also provided education supports through webinars for nursing homes and centres for people with disabilities.
<p>Ensuring the designation of lead persons within each LTCF who will lead and support the implementation of measures within the facility.</p> <ul style="list-style-type: none"> • National authorities should ensure that LTCFs designate and train lead persons, or teams, to ensure the implementation of measures, including occupational safety and health (OSH) measures and procedures to address IPC measures, supplies and training of staff and residents; (2) COVID-19 surveillance; (3) COVID-19 testing for the timely identification and control of outbreaks; (4) access to medical and psychosocial care; and (5) visitors. Teams or responsible people need to be provided with the necessary means and resources. • Coordination of public and occupational safety and health authorities is recommended to ensure that measures 	<p>(i) Regulation 14: Care and Welfare of Residents in Designated Centres for Older People (Regulations 2013) <i>Regulation 14</i> of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 provides that there must be a person in charge of each designated centre, either a medical practitioner if it is the registered provider, or a registered nurse with 3 years (in the last 6 years) experience in nursing older people if employed by the registered provider. Such a person must also have 3 years management experience in a health and social care area and a post registration management qualification in a health or related field. This person has a substantial set of responsibilities for overseeing the day-to-day operations of a nursing home, supervising and the care of residents.</p> <p>(ii) NPHET Recommendations – 31st March 2020 On the 31st March 2020, NPHET recommended a package of public health measures and supports for LTRC settings to be continued and/or established. It recommended that “<i>depending on size of LTCF or homecare provider designate a team or at least one full-time staff member as lead for COVID-19 preparedness and response</i>”. Related to this it also recommended that “<i>LTRC settings have COVID-19 preparedness plans in place to include planning for cohorting of patients (COVID-19 and non-COVID-19), enhanced IPC, staff training, establishing surge capacity, promoting resident and family communication, promoting advanced healthcare directives</i>”</p> <p>(iii) HIQA Assessment Frameworks The Chief Inspector developed and published a regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak and a self-assessment in April 2020. The aim of the framework was to guide and support nursing homes to prepare for an outbreak of COVID-19 and put in place the necessary contingency plans. Providers were asked to self-assess their preparedness and inspectors then validated the provider’s own self-</p>

¹⁹ <https://www.hiqa.ie/sites/default/files/2020-09/COVID-19-Assurance-framework-for-registered-providers.pdf>

²⁰ <https://www.hiqa.ie/sites/default/files/2018-09/National-Standards-for-IPC-in-Community-services.pdf>

<p>are appropriate and cover both OSH and public health requirements</p>	<p>assessment of compliance. Under the provisions of Regulation 23 (Governance and management) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, the assessment of preparedness framework requests providers to assess the requirement to have a COVID-19 lead in their service, through the following question <i>“Has the provider identified a COVID-19 lead in the centre?”</i> The regulatory assessment framework requires providers to self-assess against the key questions asked, with inspectors following up via self-assessment validation exercises, including onsite visits in the months following the publication of the assessment framework.</p> <p>Following this, in September 2020 the Chief Inspector published a comprehensive <i>“assurance framework for registered providers - preparedness planning and Infection prevention and control measures”</i>. Providers are required to comply with the minimum requirements of the regulations which in the area of infection prevention and control mandate compliance with the National Standards for Infection Prevention and Control in Community Services (2018). Therefore, this framework focuses on the national standards and key regulations to ensure that each designated centre has effective preparedness and contingency plans and infection prevention and control measures in place. Inspections will be carried out as part of this programme where inspectors will ask to see evidence of improvement actions taken by providers to address any deficits arising from their self-assessment under the framework. HIQA also provided education supports through webinars for nursing homes and designated centres for people with disabilities.</p> <p>In this framework it states that <i>“in each centre, the provider will have a nominated person or people with the appropriate knowledge and skills to lead on, manage and ensure good infection prevention and control practices.”</i> It further identifies that a compliance indicator under the assurance framework is that <i>“there is a nominated lead for COVID-19 preparedness and response in the designated centre.”</i></p> <p>The assurance framework provides detailed guidance on the capacity and capability required by providers to ensure the overall delivery of the service and to be prepared for and able to manage outbreaks of infection and public health emergencies, such as COVID-19. A further (non-exhaustive) selection of the requirements is outlined below:</p> <ul style="list-style-type: none"> • The provider has governance structures that can assure it as to the effectiveness and quality of infection prevention and control practices. These governance structures include effective and ongoing oversight, feedback from staff, residents and relatives of each centre under its control; • The provider has clear lines of accountability. All members of the workforce are aware of their infection prevention and control responsibilities, national guidance and public health advice, and to whom they are accountable; • The provider has adequate resources in each centre under its control with established supply chains for hygiene and infection prevention and control products, equipment and personal protective equipment; • The provider ensures that the most up-to-date national guidelines on infection prevention and control in residential care settings are easily accessible to staff, and are implemented and adhered to by staff.
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	<ul style="list-style-type: none"> • The provider will have a training strategy that is designed to achieve the educational goals of the centre. There is focused infection prevention and control training and information available for all staff (including agency and contract staff) that informs good quality care to residents, improves the skill set of staff, better prepares staff for dealing with outbreaks, and develops and further enhances staff competencies in infection prevention and control. • The provider will have a system in place to support staff and manage their occupational health requirements. During this public health emergency, the provider will have systems for taking and recording staff members' temperature and their health status. In the event of members of staff not being able to work due to the requirements for self-isolation or restricted movements (also known as self-quarantine), the provider has a contingency plan. • Providers have networks in place to support staff to manage the emotional impact of working during and after outbreak situations. Staff know how to access these supports and assistance, and the provider re-evaluates the adequacy of these supports on an ongoing basis. • The provider has systems in place to gather and use information — which includes feedback from residents, families and members of staff — to assess and improve the quality of its services. Relevant information also includes microbiology reports, testing results, resident and staff health data, outbreak reports and infection prevention and control audit data. <p>(iv) Expert Panel and Surveys of Interest</p> <p>The independent COVID-19 Expert Panel on Nursing Homes was established to examine the complex issues surrounding the management of COVID-19 among this particularly vulnerable cohort. They were also tasked with examining emerging best practice and recommendations to ensure that all protective COVID-19 public health and other measures to safeguard nursing home residents are planned and in place to respond to the ongoing impact of the COVID-19 pandemic over the next 6-18 months. The report of the Panel, including 86 recommendations was published in August. The Ministers for Health and for Mental Health and Older Persons established implementation structures to drive and oversee implementation. This work is progressing with a priority on measures that the Expert Panel identified as requiring immediate to short-term focus.</p> <p>To identify early progress of nursing homes providers in implementing the Expert Panel's recommendations. The HSE and NHI conducted surveys of nursing homes under their remit to identify progress on a set of key recommendations/questions. Some of the questions posed and results returned are relevant to this ECDC option, including:</p> <ul style="list-style-type: none"> • Has your Nursing Home a documented IPC strategy? <ul style="list-style-type: none"> ○ Yes: 100% HSE; 84% private • Have all staff at your Nursing Home undertaken infection control training? <ul style="list-style-type: none"> ○ Yes: 100% HSE; 93% private
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	<ul style="list-style-type: none"> • Has your Nursing Home a documented plan to allow for isolation and cohorting of residents? <ul style="list-style-type: none"> ○ Yes: 100% HSE; 97% private • Has your Nursing Home a documented contingency plan for when senior management are unavailable? <ul style="list-style-type: none"> ○ 100% HSE; Yes: 93% private • Has your nursing home a documented deputization structure (with named individuals) to take over responsibility when the person in charge is unavailable? <ul style="list-style-type: none"> ○ Yes: 100% HSE; 94% private • Centre has adequate supports in place to mitigate against staff working while COVID-19 symptomatic or ill <ul style="list-style-type: none"> ○ Yes: 100% HSE; 72% private <p>(v) Supports and resources available for implementation</p> <p>As noted above, in NPHET recommendations of the 31st March a package of support and other public health measures have been established to support nursing homes. A number of the recommendations made were already in development or had been established in March.</p> <p>a. The HSE COVID-19 Response Teams (CRTs)</p> <p>The CRTs were established to support Public Health Outbreak teams covering all residential services as well as home support settings. The purpose of the teams is to support the prevention, identification, and management of COVID-19 outbreaks across these services. The teams provide support across a range of nursing and medical care areas, as well as infection prevention and control (IPC). There are currently 23 teams in operation providing support to public, private and voluntary long-term residential facilities. The roles and responsibilities of the COVID-19 Response teams include the following:</p> <ul style="list-style-type: none"> • support provision of clinical care and be a point of contact with GPs and/or Directors of Nursing during management of COVID-19 outbreak in residential centres for older people; • provide clinical input into management of outbreaks within Disability or Mental Health services; • provide infection prevention and control (IPC) guidance to individual facilities/services; • advise on further preventative measures that can be implemented; • assessment of staffing levels/governance & management oversight; • assessment of health & welfare of residents through the PIC & Medical Officer/GP, in conjunction with Public Health; • provision of supports to centre/service with outbreak; • monitoring outbreak review and reporting processes; • reporting requirements to the HSE Area Crisis Management Teams (ACMT) and onwards; • where possible, arrange staff resources as a measure of last resort; • escalation of concerns to HIQA where regulatory input or action may need to be considered. <p>b. Outbreak Control Teams</p>
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All outbreaks of COVID-19 must be reported to the regional Medical Officer of Health (MOH) at the Department of Public Health at the earliest opportunity. The MOH from the Regional Department of Public Health has the responsibility to investigate and manage the outbreak of COVID-19. At local level HSE public health outbreak control teams (OCT) assist the MOH in discharging this responsibility. The OCT monitor outbreaks through ongoing surveillance to identify new cases and to update the status of ill cases. The OCT review issues of ongoing transmission and the effectiveness of control measures. Comprehensive, detailed and accurate information of all events including actions and decisions taken are maintained in line with the relevant guidance. The OCT ensure timely and accurate data on outbreak cases to be entered into the CIDR system (national surveillance database), including linking cases to outbreaks. The OCT is responsible for the timely communication of test results to relevant individuals, noting that timely communication will facilitate return to work of staff. OCTs advise and support nursing homes to implement control measures to reduce the risk to public health.

c. Supply of PPE

The HSE has established extensive logistics at national and CHO level providing daily requirements of PPE, free of charge, to all residential care settings and other service areas. Each public, private and voluntary provider has a link to a named person in Public Health with regard to PPE supply. The continued supply of PPE on both a precautionary and an outbreak basis is a key support mechanism and will remain in place for the foreseeable future.

d. Serial Testing Programme for nursing home staff

A serial testing programme for nursing home staff was introduced in June 2020 following NPHEP recommendations. The programme is now in its fifth cycle and will continue on a fortnightly basis for the foreseeable future. See later in the table for a comprehensive overview of the testing programme.

e. Other supports and guidance

In addition to public health support, in line with NPHEP recommendations and in order to enable continuity of service delivery and infection prevention management, other support to nursing homes continues to be provided, including:

- Temporary redeployment/provision of HSE staff to nursing homes, where feasible;
- Suite of focused guidance, including public health, IPC, visitation (see earlier in the table for a comprehensive overview of guidance developed to support LTRCs);
- HSE established a temporary accommodation scheme for healthcare workers affected by COVID-19 in place since April 9th. This scheme is available to healthcare workers in all nursing home settings. It aims to provide temporary accommodation, where required, for situations such as where the worker lives in a congregated domestic setting.
- Temporary Assistance Payment Scheme (TAPS) for provide and voluntary providers, providing up to €92.5m in funding in 2020 and up to €42m in 2021, to the end of June 2021. This Scheme provides a financial support as a contribution to nursing homes in the context of COVID-19 costs (further details later in the table)

	<ul style="list-style-type: none"> • HIQA’s Standards Team developed an online Infection Prevention and Control (IPC) learning module, launched on 18 August 2020, to support the implementation of the national IPC community standards. The IPC module was first hosted on the HIQA website and has moved to HSELand to increase accessibility on 02 October. Approximately 15,000 people have completed the module to date; the majority of whom are frontline staff working in health and social care services in the community. A dissemination plan was prepared to raise awareness about the module; this included extensive coverage on social media and sending targeted emails to a wide range of stakeholder groups. As part of this engagement all registered providers of designated centres for older people and designated centres for people with a disability were contacted and asked to share details of the module with colleagues and staff. A more detailed analysis of feedback on the module will be undertaken in the coming weeks at which point additional findings will be shared and additional tools to support implementation of national standards will be identified and developed. This is reflected in the HIQA 2021 Business Plan.
<p>Ensuring adequate registration and access to external consultation services for healthcare, in order to safeguard continuity of care.</p> <ul style="list-style-type: none"> • The first step to ensure provision of services to LTCFs is to develop a comprehensive register of LTCFs at regional, national and federal levels • National authorities should ensure that LTCFs have a register of residents, and all who work in the LTCF, that includes contact details • If not already established, countries may consider pairing LTCFs to a local hospital and local public health authorities, for external advice on IPC and continuity of provision of essential healthcare services. The external IPC advice should ensure that LTCF staff are aware of signs and symptoms of, and risk factors for healthcare acquired infections (HAIs) and enable risk-based, context-specific, implementation of IPC guidance. 	<p>(i) Register of LTRCs In accordance with s.41 of the Health Act 2007, the Chief Inspector in HIQA maintains a register of designated centres including nursing homes and disability residential services.</p> <p>(ii) Register of residents and staff Regulation 19 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and Regulation 21 Health Act 2007 (Care and Support of Residents in Designated Centres for person (Children and Adults) with Disabilities) Regulations 2013 requires registered providers to maintain a directory of residents. The directory must contain comprehensive information for each resident as prescribed under law, including: personal details, details of admissions and discharges, nursing and care notes, medication notes and the residents individual care plans.</p> <p>The regulations also require that each provider maintain a record of all persons currently and previously employed at the designated centre (nursing homes; disability residential service), including in respect of each person so employed. This record must also include training records.</p> <p>(iii) External IPC and Medical advice <i>Regulation 6 (2) of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013</i> provides that the person in charge shall, in so far as is reasonably practical, make available to a resident –</p> <ol style="list-style-type: none"> a. a medical practitioner chosen by or acceptable to that resident b. where the resident agrees to medical treatment by the medical practitioner concerned, the recommended treatment, c. where the care referred to in paragraph (1) or other health care service requires additional

professional expertise, access to such treatment.

Additionally (see earlier in this table for a comprehensive overview), the established HSE COVID-19 Response Teams support the prevention, identification, and management of COVID-19 outbreaks across nursing homes and other settings. The teams provide support across a range of nursing and medical care areas, as well as infection prevention and control (IPC). There are currently 23 teams in operation providing support to public, private and voluntary long-term residential facilities. This support includes, but is not limited to: supporting provision of clinical care and be a point of contact with GPs and/or Directors of Nursing during management of COVID-19 outbreak in residential centres; provide infection prevention and control (IPC) guidance to individual facilities/services.

HIQA collates daily, through mandated notifications the number of designated centres with confirmed numbers of COVID-19 residents and staff and suspected numbers of COVID-19 residents and staff. Through engagement with registered providers through inspections, check ins and review of notifications and other information, HIQA informs the Crisis Management Team in each CHO area of actual or potential risk when appropriate. HIQA regularly engages with Community Operations (HSE) to formally discuss ongoing issues and escalate risk as appropriate. This pathway is for the purpose of identifying service providers that may require additional external support (HSE) such as advice, PPE, clinical input etc. This support, where possible and appropriate, is typically provided by the HSE COVID-19 response teams.

The COVID-19 Nursing Homes Expert Panel has made a number of relevant recommendations in regard to these matters in both the short and long-term, including:

- Continue the enhanced public health measures for COVID-19 Disease Management in Long-term Residential Care (LTRC) adopted by NPHE at its meetings of 31st March 2020 and 3rd April 2020, including PPE supply to nursing homes; staff accommodation; contingency staffing teams; preparedness planning etc.
- HSE COVID-19 Response Teams have been a critical initiative. These teams must remain in place. These
- teams should be standardised in terms of operation and composition and must be overseen jointly by HSE CHOs and Hospital Groups, who should have joint responsibility and accountability for their operation;
- Establish new integrated Community Support Teams with clearly defined joint leadership and responsibility across each CHO and hospital group area on a permanent basis, in line with the discussion in this chapter. In the interim, the existing COVID-19 Response Teams should remain in place;
- A GP will be a key member of each Community Support Team (and in the interim each COVID-19 Response Team);
- One of the GPs, already caring for their patients in a nursing home, will be appointed to the additional role as a nursing home's GP Lead, and working with the Person in Charge and other senior nursing home staff will contribute to the nursing home's general oversight and governance. The Person in Charge has overall responsibility for clinical governance;

	Implementation of the Expert Panel report is ongoing.
B. With regard to SARS-CoV-2 testing within LTCFs:	
ECDC guidance recommends regularly testing all staff at LTCFs located in areas with community transmission, to isolate and test possible cases as soon as possible and to comprehensively test all residents and LTCF workers upon identification of a confirmed case amongst residents or LTCF workers.	<p>Serial testing A serial testing programme for nursing home staff was introduced in June 2020 following NPHEP recommendations. The programme is now in its sixth cycle and will continue on a fortnightly basis for the foreseeable future. The approach to testing is under ongoing review and consideration. In the sixth cycle of testing, up to 14th December, just under 12,488 swabs had been taken from nursing home staff, with 39 cases detected. This represents a positivity rate of 0.31%. Since commencement on 23rd June the programme has completed over 350,000 tests and identified 1,086 detected cases. This represents a positivity rate of 0.31%.</p> <p>The testing programme is a critical part of the ongoing response to COVID-19 in nursing homes and allows for the early detection of cases and targeting of the early intervention of COVID-19 Response and Outbreak Control Teams.</p>
Whilst Reverse Transcriptase Polymerase Chain Reaction (RT PCR) remains the gold standard for all SARS-CoV-2 confirmatory testing, within LTCFs it is suggested to consider favourably the use of Rapid Antigen Tests as they may; support the early identification of infected individuals; they can support outbreak investigations and contact tracing; and as they can be used for regular screening staff or persons in high-risk settings such as LTCFs	Validation of rapid antigen testing is ongoing within the HSE. Until this work is completed the gold standard of RT-PCR is the test recommended in nursing homes.
C. In order to minimise the risk of COVID-19 introduction into LTCFs, the following options should be considered:	
<p>Reinforcing messages on the essential measures for minimising the introduction of COVID-19 infection into to LTCFs by those working there.</p> <p>Strong positive incentives and support mechanisms need to be established for all those working in LTCFs in order to be confident that all can and will stay home if they develop or suspect any symptoms. Some examples of this include:</p>	<p>(i) Serial testing See earlier in table - a serial testing programme for nursing home staff was introduced in June 2020 following NPHEP recommendations. Staff are proactively tested regularly as part of this programme.</p> <p>(ii) COVID-19 enhanced Illness Benefit If a worker is told to self-isolate or diagnosed with COVID-19, they can apply for a COVID-19 enhanced Illness Benefit payment of €350 per week. Both employees and self-employed people can qualify for the COVID-19 enhanced Illness Benefit. Enhanced Illness Benefit can cover a COVID-19 diagnosis (or self-isolation following contract tracing) up to a certain number of weeks. If a person needs to self-isolate because they may have COVID-19, it is paid for a maximum of 2 weeks. This can be extended for another 2 weeks, if the person is told to self-isolate again following contact tracing by</p>

<ul style="list-style-type: none"> Defining this occupational group as a priority for testing, Guarantee financial support and security for all who need to stay home due to suspected or confirmed symptoms, Establish mechanisms for quick recruitment/surge of trained staff to avoid a gap in care due to absenteeism, Ensure continuous communication, training and encouragement on the use of infection prevention and control practices within the facility as well as reminders on the importance of following the basic non-pharmaceutical measures when outside the LTCF/in the community. This is especially true for larger facilities with a large number of individuals working. <p>Additional measures that can prevent or minimise the introduction of infection into an LTCF are as follows:</p> <ul style="list-style-type: none"> Ensure that any individual working in an LTCF that exhibits respiratory infection symptoms does not come, or continue, to work, can self-isolate and contact a pre-designated telephone number or contact point at the LTCF to inform of their symptoms and get advice on how and where to obtain a COVID-19 test. In addition to practising meticulous hand hygiene, consider reinforcing the use of medical masks by all LTCF 	<p>the HSE²¹. Enhanced Illness Benefit can cover a COVID-19 diagnosis for a maximum of ten weeks, or, where a person is self-isolating/restricting movements, up to two weeks on the first claim.</p> <ul style="list-style-type: none"> Public health service employees who are eligible for Special Leave with Pay for COVID-19 Special leave with pay while absent from work due to COVID-19 is based on basic salary and fixed allowances only. Public servants who can avail of the special leave with pay for COVID-19 are excluded from claiming the special DEASP COVID-19 illness benefit payment. <p>To identify early progress of nursing homes providers in implementing the Expert Panel’s recommendations. The HSE and NHI conducted surveys of nursing homes under their remit to identify progress on a set of key recommendations/questions. Some of the questions posed and results returned are relevant to this ECDC option, including:</p> <ul style="list-style-type: none"> Has your Nursing Home a documented IPC strategy? <ul style="list-style-type: none"> Yes: 100% HSE; 84% private Have all staff at your Nursing Home undertaken infection control training? <ul style="list-style-type: none"> Yes: 100% HSE; 93% private Number and % of nursing homes that have implemented single-site employment arrangements for nursing and healthcare assistants. <ul style="list-style-type: none"> Yes: 99% HSE; 86.5% private Number and % of nursing homes that can provide assurance that no nursing or healthcare staff are actively working across multiple sites including settings with elevated risk. <ul style="list-style-type: none"> Yes: 98% HSE; 92% private Centre has adequate supports in place to mitigate against staff working while COVID-19 symptomatic or ill <ul style="list-style-type: none"> Yes: 100% HSE; 72% private <p>(iii) Temporary Assistance Payment Scheme (TAPS) The Minister for Health established a Temporary Assistance Payment Scheme (TAPS) for private and voluntary nursing home providers. The core concept of the scheme is that the State will provide additional funding to those private and voluntary nursing homes that require it, to contribute towards costs associated with COVID-19 preparedness, mitigation and outbreak management. The Government has made up €92.5m available under TAPS in 2020. The Scheme was extended to the end of June 2021 and through Budget 2021, total funding of up to €42m is available in 2021 for the Scheme. This Scheme may be utilised for staffing related costs, including in relation to pay, additional staff and training, as well as infection prevention and control related costs. As of the 4th December, some €58m had been paid to private</p>
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²¹Government Website: How to apply for illness benefit for Covid-19 absences: << <https://www.gov.ie/en/service/df55ae-how-to-apply-for-illness-benefit-for-covid-19-absences>>> accessed 06 December 2020.

<p>workers, including LTCF staff, who provide care for residents or have contact with residents or communal areas of the LTCF (universal masking).</p> <ul style="list-style-type: none"> Workers who provide services to several LTCFs should be trained to reinforce IPC practices and self-monitoring of symptoms of COVID-19. Business continuity consultations by employers with local authorities should pay particular attention to the possible absenteeism of such workers. Larger facilities should be mindful of the increased risk of introduction, due to the more numerous workforce. Competent authorities should consider options to mobilise resources to LTCFs requiring support to their current response to a COVID-19 outbreak (e.g. healthcare workers), including, if appropriate, medical care that would have otherwise been provided in an outpatient or inpatient setting (e.g. oxygen therapy and medical staff). Those working in larger facilities should be appropriately trained and informed about the increased risk of introduction in such facilities. Appropriate coordination between different sites or employers needs to be ensured when setting measures, including OSH measures, for individuals who work in multiple LTCFs, i.e. measures to reduce the direct risk of COVID-19 (i.e. importation), and indirect risks (e.g. staff absenteeism). 	<p>and voluntary nursing home providers, of which approximately 70% relates to staff/pay costs.</p> <p>(iv) Ongoing education and training supports</p> <p>All nursing homes and relevant multidisciplinary teams can access HSElanD, the HSE’s online learning and development portal, containing over 170 eLearning programmes, resources and tools. Relevant eLearning courses available to access include:</p> <ul style="list-style-type: none"> Hand Hygiene for Clinical Staff; Hand Hygiene for non-Clinical Staff; Breaking the Chain of Infection; Introduction to Infection Prevention and Control; Putting on and taking off PPE in community healthcare settings; Pronouncement of Death by Registered Nurses in the Context of the Global COVID-19 Pandemic 2020; Resource Pack for Registered Nurses and Registered Nurses Returning to Professional Nursing Practice (Older Persons Services) in response to COVID-19 outbreak 2020. <p>(See also section A above on HSE-provided training)</p> <p>(v) Information campaign targeting persons-in-charge</p> <p>National Clinical & Advisory Group Lead, Older Persons, HSE with the Office of the Nursing & Midwifery Services Director, Health Service Executive and the Office of the Chief Nurse, the Department of Health supported by Nurse Project Manager, Older Person Policy Development Unit, the Department of Health have developed a 4-part communication strategy to convey very specific educational messages and support nurses in charge during the COVID-19 pandemic. This Communication strategy was developed in response to growing concern regarding increasing numbers of COVID-19 cases in nursing homes; the Implementation Oversight Team of the Nursing Homes Expert Panel Report agreed at its meeting on 7th October that an information campaign targeting persons-in-charge of nursing homes should be developed and launched in the coming weeks.</p> <p>The campaign is focused on areas of particular concern in nursing homes, such as infection prevention and control, asymptomatic presentation in older people, understanding frailty and management of staff presenting with symptoms and public health requirements on staff refraining from attending work when they are COVID-19 positive, are symptomatic or are a close contact of confirmed case, in line with public health advice.</p> <p>1. Webinars</p> <p>Four Webinars were developed and delivered in consultation with the Integrated Care Programme for Older People every Thursday evening over 4 weeks. Total numbers attending webinars (19th Nov, 26th Nov, 3rd Dec and 10th Dec 2020): 1056 attendees.</p> <p>Webinar 1: Preventing COVID-19 infection and early defence to stop transmission 19th Nov 2020</p>
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Webinar 2: Managing COVID-19 Outbreak – key essentials	26th Nov 2020
Webinar 3: Managing C 19 outbreak- supporting residents and families (1)	3rd Dec 2020
Webinar 4: Managing COVID-19 outbreak- supporting residents and families (2)	10th Dec 2020

2. Dedicated website page

These are now hosted on a dedicated HSE Website page: COVID-19 Guidance for staff working in residential care facilities for older people on the following link: <https://www.hse.ie/covidnursinghomeresources>. The link will sign post nurses to all the relevant HPSC and HSE supports and guidance documents for ease of access, as well as a number of algorithms to support clinical decision making.

3. Safety Pause Handover tool.

In addition, this online guidance resource includes 2 “Safety Pause” leaflets specifically developed for use as Patient Safety Toolbox Talks to address COVID-19 safety aspects.

Safety Pause 1 – Preventing Transmission today and *Safety Pause 2- What to watch (Asymptomatic presentation)* which are for daily use at handover for all shift changes to facilitate discussion at local level with all staff on duty thus assisting nurse in charge to convey essential safety messages to staff.

4. Relief Staffing Contingency Plan

In the event of an outbreak situation whereby staff who are not familiar with residents require access to short resident profile guides for base line care needs and personal preferences. Nurses in charge are advised to have a profile prepared in advance for each resident and kept inside their wardrobe doors for ease of access. Sample profile documents supplied should they be useful for adaption.

The message will be distributed by HIQA directly to nurses in charge (persons in charge) during the week beginning 14th December 2020. Whilst most facilities have these measures in place already, evidence is demonstrating that staff adherence to effective monitoring and action will prevent outbreaks occurring and/or spreading even when the community transmission is high.

(vi) Guidance

Public health guidance, including for vulnerable groups, is updated regularly and published by the Health Protection Surveillance Centre (HPSC) on its website at:

[<https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/>] Infection, Prevention and Control Guidance long-term residential care settings guidance

Specific **infection prevention and control guidance** is available and updated regularly by the HPSC for LTRCs:

- Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-

19 Cases and Outbreaks in Residential Care Facilities.

This comprehensive guidance targeted directly at LTRCs provides guidance across a range of key areas including:

- Clinical features of COVID-19, routes and control of transmission, incubation period and environmental survival;
- General measure to prevent an outbreak including: planning, education (staff and residents), physical distancing, controls to prevent inadvertent introduction, surveillance and early identification;
- Management of an outbreak, including: Declarations and engagement with Outbreak Control Teams, management of possible or confirmed cases, cohorting of residents, management of close contacts, infection prevention and control measures including standard and transmission-based precautions, and management of care equipment, waste, laundry, environmental hygiene and cleaning, communications and support services for staff and residents;
- Care of the dying and recently deceased;
- Monitoring outbreak progress and declaring an outbreak over;
- Hand hygiene, use of and donning and doffing of PPE
- Comprehensive guidance on safely managing admissions, transfers and discharges.

(vii) External IPC and Medical advice and staffing support

(See earlier in this table for a comprehensive overview. The established HSE COVID-19 Response Teams support the prevention, identification, and management of COVID-19 outbreaks across nursing homes and other settings. The teams provide support across a range of nursing and medical care areas, as well as infection prevention and control (IPC). There are currently 23 teams in operation providing support to public, private and voluntary long-term residential facilities. This support includes, but is not limited to: supporting provision of clinical care and be a point of contact with GPs and/or Directors of Nursing during management of COVID-19 outbreak in residential centres; provide infection prevention and control (IPC) guidance to individual facilities/services; provision of staffing as a last resort.

Across all 9 CHOs preparedness plans are in place for HSE provided nursing homes. The capacity issue remains when a large number of staff become COVID-19 positive and in close contact and have to go on leave. Replacing nursing staff is a particular challenge and are replaced through agency and support from hospitals. Continuous efforts are ongoing.

HIQA collates daily, through mandated notifications the number of designated centres with confirmed numbers of COVID-19 residents and staff and suspected numbers of COVID-19 residents and staff. Through engagement with registered providers through inspections, check ins and review of notifications and other information, HIQA informs the Crisis Management Team in each CHO area of actual or potential risk when appropriate. HIQA regularly engages with Community Operations (HSE) to formally discuss ongoing issues and escalate risk as appropriate. This pathway is for the

	purpose of identifying service providers that may require additional external support (HSE) such as advice, PPE, clinical input etc. This support, where possible and appropriate, is typically provided by the HSE COVID-19 response teams.
<p>Establishing procedures for the (re)-admission of LTCF residents recuperating from COVID-19 related symptoms to further prevent the introduction of infection to a facility.</p> <ul style="list-style-type: none"> Assess new and returning residents for symptoms compatible with COVID-19; strongly consider requesting one negative RT-PCR test between 24 and 72 hours before (re-)admission of residents and if testing capacity allows, repeat testing can be considered 3–5 days after admission; in line with hospital discharge criteria request two negative RT-PCR before readmission of hospitalised clinically recovered residents with COVID-19, at least 10 days after onset of symptoms. In cases of severe COVID-19 disease, or cases whose RT-PCR tests remain positive, or in cases of immune suppression of the resident, or when there is insufficient testing capacity, readmission can be considered after 20 days from illness onset with negative RT-PCR results 	<p>(i) HPSC guidance on admissions, transfers and discharges from LTRCF</p> <p>Specific comprehensive guidance on admissions, transfers to and discharges from Long-term care facilities guidance can be found in the HPSC's:</p> <p><i>Interim Public Health, Infection Prevention & Control Guidelines on: Admissions, Transfers to and Discharges from Long Term Residential Care Facilities during the COVID-19 Pandemic</i>²²</p> <p>This document provides public health guidance on a range of issues relating to admissions, transfers and discharges from LTRCs. The following are some key points in the guidance (note: this is not an exhaustive list):</p> <ul style="list-style-type: none"> For people with a diagnosis of COVID-19 infection who are in a RCF or are planning to move into a RCF the period of isolation is 14 days after onset of infection with no fever for the last five of this period; People for admission to a RCF should be tested for COVID-19; <ul style="list-style-type: none"> This is to help identify most of those who have infection, but it will not detect all of those with infection. Testing should be performed within 3 days of planned admission to the RCF; Irrespective of testing all residents should be assessed before admission to ensure they are not known COVID-19 contacts and have no clinical symptoms suggestive of COVID-19; If a person who has not previously been diagnosed with COVID-19 is being transferred from an acute hospital to a RCF, the hospital should arrange for the person to be swabbed in the 3 days before transfer. The person will need to be isolated for 14 days regardless of the test result If a person is being admitted to the RCF from home where possible, the GP should arrange for the person to be swabbed within the 3 days before admission. The person will need to be isolated for 14 days regardless of the test result; If a test pre-admission cannot be arranged, including for urgent admissions, the person should be admitted as planned. The person will need to be isolated for 14 days with full Contact and Droplet Precautions until the result of the test is available. The facility can arrange swabbing after admission; All transfers or new admissions should have a risk assessment, to ensure sufficient resources are available within the RCF to support social distancing and placement of residents; Residents who have not previously had COVID-19 who are transferred or directly admitted to a RCF should be accommodated in a single room (or room with no other residents) for 14 days after arrival and monitored for

²²Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities V6.1 03/11/2020 [accessed 6th December 2020] <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/IPC%20and%20PH%20Outbreak%20Guidance%20RCF.pdf>

	<p>new symptoms consistent with COVID-19 during that time;</p> <ul style="list-style-type: none"> • Any resident transferred (from an acute hospital) to a RCF before the 14 days have elapsed since date of onset of symptoms or date of first positive test (if symptom onset undetermined/asymptomatic), must be isolated with Transmission-based Precautions up to day 14 on return to the RCF. Such transfer should not proceed if the receiving RCF has no other residents with infectious COVID-19 at the time; • In particular existing residents from a RCF who require transfer to hospital from the RCF for assessment or care related to COVID-19 acquired in the RCF should be allowed to transfer back to that RCF following assessment / admission if clinically fit for discharge and risk assessment with the facility determines there is capacity for them to be cared for there with appropriate isolation and where that transfer represents the most appropriate place of care for the resident; <p>(ii) Nursing Homes Expert Panel Recommendations 4.1 and 4.3 <i>Recommendation 4.1</i> of the COVID-19 Nursing Homes Expert Panel Examination of Measures to 2021 report stipulates that all new residents coming into the community or proposed transfers from hospital are tested for COVID-19 prior to admission. <i>Recommendation 4.3</i> states that new residents must be isolated according to HPSC protocol.</p> <p>(iii) Temporary Assistance Payment Scheme See earlier in the table for more detail. This financial support scheme for private and voluntary providers provides for a total of up to €92.5m in funding in 2020 and a total of up to €42m in 2021 – the scheme is in operation until the end of June 2021. As well as providing funding contributing to COVID-19 related costs such as staffing, infection prevention and control and education and training, the Scheme also now provides for a contribution towards the costs of setting aside isolation rooms, applying to those nursing homes that (a) have multi-occupancy rooms, as declared on their latest registration with HIQA and (b) have an occupancy rate that would place the nursing home at risk of being unable to isolate residents either in single rooms, or alone in multi-occupancy rooms.</p>
<p>External visitors, e.g. social visits</p> <ul style="list-style-type: none"> • Establishing risk-based and proportionate infection prevention and control measures that will allow safe visits to residents. Recognising that the social vulnerability in LTRCF residents may be exacerbated when non-pharmaceutical interventions are in place that limit physical personal interactions, allowing external visitors, 	<p>HPSC updated guidance on facilitating safe visits: 30 November 2020</p> <p>It is important that the right to have visitors is balanced with the need to ensure that visitations do not compromise overall resident care or adherence to requisite infection control procedures. The HPSC regularly reviews and updates its COVID-19 Guidance on visits to Long Term Residential Care Facilities (LTRCFs), in consultation with key national stakeholders. The guidance notes that Infection prevention and control (IPC) practice is critical to the safe operation of LTRCFs at all times. As per regulatory requirements, visiting is part of the normal daily functioning of LTRCFs. Therefore, the service provider is responsible for doing all that is practical to support safe visiting. The LTRCF should have the capacity and relevant skill sets within its staffing complement to manage this appropriately.</p>

<p>should be strongly considered.</p> <ul style="list-style-type: none"> • The use of medical face masks should be strongly considered. • Ensure that residents and visitors at the long-term care facility practice appropriate hand hygiene • Symptomatic individuals should not visit LTRCFs. Appropriate health promotion and safety information should be communicated to all patients and their families, staff, contractors and anyone who may enter the LTRCF. • Prior to entering the LTRCF, visitors should ideally be registered with sufficient information in order to assist subsequent contact tracing, if required; LTRCF staff should advise visitors with current symptoms to leave by a route that avoids vulnerable people. However, staff training should also highlight the importance of pre-symptomatic and asymptomatic transmission. • The risk of transmission from other visitors (such as for delivery of supplies and collection of refuse, utility personnel) can be minimised through keeping visits as short as possible; avoiding or minimising entering the LTRCF premises, most particularly common areas. 	<p>LTRCFs are the home environments of individuals residing there and as such the importance of maintaining family connections with loved ones must not be underestimated from a holistic person-centred approach. This guidance document recognises the autonomy of residents in LTRCFs and their right to have or refuse visitors and contact with family members. It aims to support providers in fulfilling their responsibility by giving guidance to management, staff, residents and relatives to balance the risk of COVID-19 while facilitating visiting during these exceptional times.</p> <p>The Registered Provider/Person in Charge has a responsibility to ensure that the autonomy of residents and the right to have visitors is balanced with the need to ensure that visits do not compromise overall resident care or adherence to requisite infection control procedures.</p> <p>Under Regulation 11 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 the person in charge of a nursing home must ensure in so far as is reasonably practicable, visits to a resident are not restricted, unless—</p> <ul style="list-style-type: none"> (i) such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident, or (ii) the resident concerned has requested the restriction of visits. <p>The guidance outlines that restrictions should be applied on the basis of a documented risk assessment that is reviewed regularly in view of the evolving public health situation and new guidance. A risk assessment should take account of the overall care needs, rights and wishes of residents, the vulnerability of the residents, the current incidence of COVID-19 in the surrounding community and the capacity of the LTRCF in terms of buildings, grounds and human resources to manage risks associated with visiting.</p> <p>A range of different measures are in place with regard to visiting subject to the level of the framework of restrictive measures currently in place. Visitors should be made aware of the visiting processes that apply which are symptom and temperature-checking, determination of previous known exposure to COVID-19, and use of correct hand hygiene techniques. In addition, they should be made aware that any visitors with fever or respiratory symptoms will not be admitted.</p> <p>Visitors should be asked if they have COVID-19 or had close contact with a person with COVID-19 / suspected COVID-19 symptoms within the time period as determined by national guidance. Visitors should declare that they have no symptoms and undergo a temperature check before entering the LTRCF. People who have had COVID-19 but for whom the infectious period has passed may visit as for other people. Visitors are required to sign in on entry to the facility (each nursing home is required to maintain a directory of visitors, by law).</p>
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	<p>Under framework level 1 visitors are required to perform hand hygiene and wear a cloth-face covering or a surgical mask during the visit; at level 2 visitors are required to wear a surgical mask throughout the visit. PPE should be provided by the LTRCF if required. Similar is expected to be required for levels 3,4 and 5 noting that additional restrictions apply during the higher levels of the framework.</p> <p>The Health Protection Surveillance Centre (HPSC) updated its guidance to nursing homes on facilitating safe visits on 30 November. The new guidance aims to further support long-term residential care services (including nursing homes) and residents in planning visits across all levels of the framework for restrictive measures in the Government’s Resilience and Recovery 2020-2021: Plan for Living with COVID-19. This guidance balances risks with benefit in line with the disease trajectory in the community, taking into account the need for proportionate IPC measures to allow safe visits. This new guidance outlines an updated definition for ‘critical and compassionate circumstances’, which now provides that, subject to risk assessment in each case, nursing homes residents may receive:</p> <ul style="list-style-type: none"> • up to one visit by one person per week under Levels 3 and 4 of the framework; • up to one visit by one person per two weeks under Level 5; <p>It also notes that every practical effort should be made to accommodate an additional visit on compassionate grounds during the period of a major cultural or religious festival or celebration of particular significance to the resident, such as the Christmas/New Year period.²³</p> <p>The COVID-19 Nursing Homes Expert Panel also made the following relevant recommendations:</p> <ul style="list-style-type: none"> • Management of entry and exit: Examine options for zoning within care homes so different entrances/exits can be used for different parts of the home. This examination should be documented with results and actions incorporated into preparedness plans.
<p>Ensure capacity to mobilise material resources to LTCFs</p> <ul style="list-style-type: none"> • Establishing procedures that ensure rapid access and mobilisation of personal protective equipment to and within the LTCFs. 	<p>(i) HSE provides access to PPE both anticipatory and for outbreaks</p> <p>The HSE has established extensive logistics at national and CHO level providing daily requirements of PPE, free of charge, to all residential care settings and other service areas. Each public, private and voluntary provider has a link to a named person in Public Health with regard to PPE supply. The continued supply of PPE on both a precautionary and an outbreak basis is a key support mechanism and will remain in place for the foreseeable future. In the week ending 8th December 7.9m items of PPE were supplied to residential care settings, representing 46% of all PPE items supplied that week.</p> <p>(ii) Nursing Homes Expert Panel Recommendations 2.8</p>

²³ COVID-19 Guidance on visits to Long Term Residential Care Facilities (LTRCFs) V1.4 24.11.2020 <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Guidance%20on%20visits%20to%20RCF.pdf> [accessed on 6th December 2020]

	<p>Recommendation 2.8 provides that a user-friendly, consistent protocol for ordering and for the ongoing supply of additional COVID-19 related PPE to nursing homes by the HSE needs to be refined. Similar protocols must be put in place for the ordering and supply of other essential COVID-19 management related equipment. These protocols should be kept under review during the pandemic. Each nursing home is responsible for and should have an emergency supply of PPE and other COVID-19 related equipment in the event of a cluster. This should be included in preparedness plans.</p> <p>(iii) Provider obligations</p> <p>It is important to note that each nursing home provider has a legal responsibility with regard to the provision of safe care to their residents and a safe working environment for their staff. In that regard, irrespective of the source of supply of PPE, each provider must ensure that it has sufficient PPE to cover its need, including the need to maintain access to normal supply chains.</p>
<p>D. To minimise the risk of COVID-19 transmission within LCTFs, the following options should be considered:</p>	
<p>Establishing rigorous procedures and practices for managing residents with symptoms of COVID-19, including but not only limited to, access to testing, isolation of patients, awareness by all personnel of the common COVID-19 symptoms, application of infection prevention and control practices and use of personal protective equipment.</p>	<p>(i) Regulation 27: Care and Welfare of Residents in Designated Centres for Older People (Regulations 2013) <i>Regulation 27</i> of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 provides: The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by [HIQA] are implemented by staff. In September 2018, HIQA published “<i>National Standards for infection prevention and control (IPC) in community services</i>”</p> <p>(ii) Nursing Homes Expert Panel Recommendations 2.2 <i>Recommendation 2.2:</i> Each nursing home should adopt a clear IPC strategy including deep clean protocols, for itself which should be incorporated into its preparedness plan. It should be reviewed regularly to ensure consistency with the HSE’s community IPC strategy.</p> <p>(iii) HSE COVID-19 Response Teams (CRTs) The CRTs were established to support Public Health Outbreak teams covering all residential services as well as home support settings. The purpose of the teams is to support the prevention, identification, and management of COVID-19 outbreaks across these services. The teams provide support across a range of nursing and medical care areas, as well as infection prevention and control (IPC).</p> <p>The teams support all residential care facilities/approved centres in their specified catchment area whether they are public, voluntary or private facilities, and across the care groups of older people, disability and mental health. The teams will operate for the duration of the pandemic. 23 COVID Response Teams are currently in operation.</p> <p>(iv) Education, Training, Information and Resources All nursing homes and relevant multidisciplinary teams can access HSELand, the HSE’s online learning and development</p>

portal, containing over 170 eLearning programmes, resources and tools. Relevant eLearning courses available to access include:

- Hand Hygiene for Clinical Staff; Hand Hygiene for non-Clinical Staff;
- Breaking the Chain of Infection;
- Introduction to Infection Prevention and Control;
- Putting on and taking off PPE in community healthcare settings;
- Pronouncement of Death by Registered Nurses in the Context of the Global COVID-19 Pandemic 2020;
- Resource Pack for Registered Nurses and Registered Nurses Returning to Professional Nursing Practice (Older Persons Services) in response to COVID-19 outbreak 2020.

(See section A above for further detail on HSE-provided training)

(v) Guidance

Public health guidance, including for vulnerable groups, is updated regularly and published by the Health Protection Surveillance Centre (HPSC) on its website at:

[<https://www.hpsc.ie/a->

[z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/](https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/) Infection, Prevention and Control Guidance long-term residential care settings guidance

Specific **infection prevention and control guidance** is available and updated regularly by the HPSC for LTRCs:

- Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.

This comprehensive guidance targeted directly at LTRCs provides guidance across a range of key areas including:

- Clinical features of COVID-19, routes and control of transmission, incubation period and environmental survival;
- General measure to prevent an outbreak including: planning, education (staff and residents), physical distancing, controls to prevent inadvertent introduction, surveillance and early identification;
- Management of an outbreak, including: Declarations and engagement with Outbreak Control Teams, management of possible or confirmed cases, cohorting of residents, management of close contacts, infection prevention and control measures including standard and transmission-based precautions, and management of care equipment, waste, laundry, environmental hygiene and cleaning, communications and support services for staff and residents;
- Care of the dying and recently deceased;
- Monitoring outbreak progress and declaring an outbreak over;

	<ul style="list-style-type: none"> ○ Hand hygiene, use of and donning and doffing of PPE ○ Comprehensive guidance on safely managing admissions, transfers and discharges. <p>(vi) Expert Panel and Surveys of Interest</p> <p>See earlier in the table for further information.</p> <p>To identify early progress of nursing homes providers in implementing the Expert Panel’s recommendations. The HSE and NHI conducted surveys of nursing homes under their remit to identify progress on a set of key recommendations/questions. Some of the questions posed and results returned are relevant to this ECDC option, including:</p> <ul style="list-style-type: none"> ● Has your Nursing Home a documented IPC strategy? <ul style="list-style-type: none"> ○ Yes: 100% HSE; 84% private ● Have all staff at your Nursing Home undertaken infection control training? <ul style="list-style-type: none"> ○ Yes: 100% HSE; 93% private ● Has your Nursing Home a documented plan to allow for isolation and cohorting of residents? <ul style="list-style-type: none"> ○ Yes: 100% HSE; 97% private <p>(vi) Health and Information and Quality Authority (HIQA) Assessment and Assurance Frameworks</p> <p>The Chief Inspector developed and published a regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak and a self-assessment in April 2020²⁴. The aim of the framework is to support nursing homes to prepare for an outbreak of COVID-19 and put in place the necessary contingency plans.</p> <p>On 17th September 2020 the Chief Inspector, published a further assurance framework for registered providers for preparedness planning and infection prevention and control measures²⁵. Providers are required to comply with the minimum requirements of the regulations which in the area of infection prevention and control mandate compliance with the National Standards for Infection Prevention and Control in Community Services (2018)²⁶. Therefore, this framework will focus on the national standards to ensure that each designated centre has effective preparedness and contingency plans and infection prevention and control measures in place. Inspections will be carried out as part of this programme where inspectors will ask to see evidence of improvement actions taken by providers to address any deficits arising from their self-assessment under the framework. HIQA also provided education supports through webinars for nursing homes and designated centres for people with disabilities.</p> <p>See earlier in the table for further comprehensive information on the frameworks.</p>
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²⁴ https://www.hiqa.ie/sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf

²⁵ <https://www.hiqa.ie/sites/default/files/2020-09/COVID-19-Assurance-framework-for-registered-providers.pdf>

²⁶ <https://www.hiqa.ie/sites/default/files/2018-09/National-Standards-for-IPC-in-Community-services.pdf>

<p>Minimising forms of personal contact that are known to be a risk for COVID-19 transmission, by for example ensuring physical distancing, universal masking, adequate ventilation, hand washing facilities, as well as adapting how different activities are organised within the facilities.</p>	<p>Care and Welfare of Residents in Designated Centres for Older People (Regulations 2013)</p> <p>(i) <u>Ventilation</u> <i>Regulation 17 (1)</i> of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 provides: The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. <i>Schedule 6, Part 1 (3) n</i> stipulates there should be: ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.</p> <p>(ii) <u>Hand washing facilities</u> <i>Schedule 6, Part 3 (b)</i> states there must be a: sufficient number of toilets, and of wash-basins, baths and showers (including assisted baths and showers, having regard to the dependency of persons in the designated centre) fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection.</p> <p>Health Protection Surveillance Centre (HPSC) suite of guidance</p> <p>(iii) <u>Guidance on prevention and management of COVID-19 outbreaks</u> Public health guidance, including for vulnerable groups, is updated regularly and published by the Health Protection Surveillance Centre (HPSC) on their website at: [https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/]</p> <ul style="list-style-type: none"> • Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.
<p>Environmental cleaning, ventilation and waste management</p> <ul style="list-style-type: none"> • Regular cleaning followed by disinfection is recommended for common areas and resident rooms, in particular of frequently touched surfaces. In addition, ventilation plays a key role for the prevention of respiratory infections in healthcare settings. The minimum number of air exchanges per hour, in accordance with the applicable 	<p>(i) HIQA Assessment and Assurance Frameworks</p> <p>HIQA developed and published a regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak and a self-assessment in April 2020²⁷. The aim of the framework is to support nursing homes to prepare for an outbreak of COVID-19 and put in place the necessary contingency plans.</p> <p>On 17th September 2020 HIQA, published a further assurance framework for registered providers for preparedness planning and infection prevention and control measures²⁸. Providers are required to comply with the minimum requirements of the regulations which in the area of infection prevention and control mandate compliance with the National Standards for Infection Prevention and Control in Community Services (2018)²⁹. Therefore, this framework will focus on the national standards to ensure that each designated centre has effective preparedness and contingency plans and infection prevention and control measures in place. HIQA will undertake inspections as part of this programme where inspectors will ask to see evidence of improvement actions taken by providers to address any deficits</p>

²⁷ https://www.hiqa.ie/sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf

²⁸ <https://www.hiqa.ie/sites/default/files/2020-09/COVID-19-Assurance-framework-for-registered-providers.pdf>

²⁹ <https://www.hiqa.ie/sites/default/files/2018-09/National-Standards-for-IPC-in-Community-services.pdf>

<p>regulations, should be ensured at all times.</p>	<p>arising from their self-assessment under the framework. HIQA will also provide education supports through webinars for nursing homes.</p> <p>See earlier in the table for further comprehensive information on the assessment frameworks.</p> <p>(ii) Health Protection Surveillance Centre (HPSC) suite of guidance <u>Guidance on prevention and management of COVID-19 outbreaks</u> Public health guidance, including for vulnerable groups, is updated regularly and published by the Health Protection Surveillance Centre (HPSC) on their website at: [https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/]</p> <ul style="list-style-type: none"> • Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities. <p>See earlier in the table for further comprehensive information on the guidance.</p>
<p>E. Vaccines: pneumococcal and influenza and future COVID-19 vaccination</p>	
<p>Vaccination of older people aged 65 years and older against pneumococcus and influenza may mitigate the impact of COVID-19 diseases in this population as it may help reduce the occurrence of related hospitalisations.</p>	<p>Nursing Homes Expert Panel Recommendation 2.9 <i>Recommendation 2.9</i> of the COVID-19 Nursing Homes Expert Panel Examination of Measures to 2021 report provides: Influenza vaccine should be prioritised for all residents unless medically contraindicated of all nursing homes once it becomes available and consider making it mandatory for staff. Implementation of this recommendation includes the HSE Flu programme, which is underway. Targeted uptake for 2020 is significantly increased from 2019. The influenza vaccine has been distributed in nursing homes.</p>
<p>Given their direct contact with medically vulnerable people, healthcare workers and staff working in health care facilities should be offered appropriate vaccination against influenza to reduce the risk of infecting vulnerable groups, in addition to protecting themselves.</p>	<p>As at 2 December 2020, approx. 62% of eligible healthcare workers and staff in nursing homes have availed of the influenza vaccine, with 70% of residents in these nursing homes having received the vaccine as well. The general uptake of the influenza vaccine among those aged 65 and over (including nursing home residents) is currently ~67%, based on CSO 2020 population estimates. This means that almost 500,000 people aged 65 and over have received the vaccine in this influenza season thus far, and almost 50,000 healthcare workers have received the vaccine.</p>
<p>Recommend 60+ cohort should be prioritised for Covid-19 vaccination, particularly those residents of LTCF and staff with a national vaccination deployment plan.</p>	<p>The Government recently established the High-Level Task Force on COVID-19 Vaccination. This group is led by the Department of the Taoiseach and will develop a national vaccination plan for the COVID-19 vaccine in Ireland. The Taskforce is working with the HSE and the Department of Health to prepare for the national COVID-19 vaccination programme. The COVID-19 Vaccine Allocation Strategy³⁰ lists the groups of people who will be the first to access a COVID-19 vaccine in Ireland, once a safe and effective vaccine(s) has been authorised. These priority groups include people over the age of 65 living in long-term care facilities, frontline healthcare workers and people aged 70 and over.</p>

³⁰ <https://www.gov.ie/en/publication/39038-provisional-vaccine-allocation-groups/>

	The Strategy has been developed by the National Immunisation Advisory Committee (NIAC) and the Department of Health and approved by Government.						
<p>Among the priority groups to be vaccinated against COVID-19, we indicate the following groups: elderly from 60 years of age and especially those residents in the LTCF, HCWs providing direct care to LTCFs residents, and LTCFs staff in order to minimise the risk of infection to vulnerable persons. National vaccination deployment plans should also have a section on groups to be prioritised for vaccination, under the assumption of initial limited supply.</p>	<p>The Government has agreed the prioritisation process that should apply to the vaccination of the population, based on the advice of national experts on immunisation and endorsed by the NPHE. The COVID-19 Vaccine Allocation Strategy sets out a provisional priority list of groups for vaccination once a safe and effective vaccine(s) has received authorisation from the European Medicines Agency (EMA). The Strategy was developed by the National Immunisation Advisory Committee (NIAC) and Department of Health, endorsed by the National Public Health Emergency Team (NPHE), and approved by Government on 8 December 2020. The strategy prioritises those over the age of 65 living in long-term care facilities, frontline healthcare workers who are in direct patient contact and those aged 70 and over.</p> <p>The Allocation Framework has been developed to consider how to prioritise cohorts is based on (1) ethical principles and (2) epidemiological considerations, and takes account of the current and evolving understanding of distinctive characteristics of COVID-19 disease, its modes of transmission, the groups and individuals most susceptible to infection and the characteristics of the candidate vaccines</p> <p>Four core ethical principles, namely, the moral equality of all people, minimisation of harm, fairness, and reciprocity provide a guide for prioritisation for vaccination. This is a first iteration of the allocation strategy; it will be adapted as more data and evidence emerges over time on vaccine effectiveness and the epidemiology of the disease. Scientists and clinicians will continue to play a key role in determining the ongoing evolution of vaccine prioritisation to ensure their optimum use from a public health perspective. See the table below: Provisional Vaccine Allocation Groups³¹</p> <p><i>Table 4: Provisional Vaccine Allocation Groups</i></p> <table border="1" data-bbox="757 938 1957 1217"> <thead> <tr> <th data-bbox="757 938 1160 978">Group</th> <th data-bbox="1160 938 1563 978">Rationale</th> <th data-bbox="1563 938 1957 978">Ethical Principles</th> </tr> </thead> <tbody> <tr> <td data-bbox="757 978 1160 1217">Adults aged ≥65 years who are residents of long-term care facilities. Consider offering vaccination to all residents and staff on site.</td> <td data-bbox="1160 978 1563 1217">At greatest risk of severe illness and death. In Ireland, in the first wave of COVID-19, 56% of deaths occurred in this setting</td> <td data-bbox="1563 978 1957 1217">In line with the principle of minimising harm, vaccination of this group would protect those at greatest risk of a poor outcome from infection. It adheres to the principle of moral equality and the principle of fairness in recognising the disproportionate burden this group has carried.</td> </tr> </tbody> </table>	Group	Rationale	Ethical Principles	Adults aged ≥65 years who are residents of long-term care facilities. Consider offering vaccination to all residents and staff on site.	At greatest risk of severe illness and death. In Ireland, in the first wave of COVID-19, 56% of deaths occurred in this setting	In line with the principle of minimising harm, vaccination of this group would protect those at greatest risk of a poor outcome from infection. It adheres to the principle of moral equality and the principle of fairness in recognising the disproportionate burden this group has carried.
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³¹ <https://www.gov.ie/en/publication/39038-provisional-vaccine-allocation-groups/>

	Frontline healthcare workers (HCWs)* in direct patient contact roles (including vaccinators) or who risk exposure to bodily fluids or aerosols	At very high or high risk of exposure and/or transmission. In the first wave over 30% cases were in healthcare workers	The principle of minimising harm is realised, as benefit will accrue to healthcare workers and the patients they care for, producing a multiplier effect. Society also has a reciprocity based duty to protect those who bear additional risks to safeguard the welfare of others.
	Aged 70 and older in the following order: 85 and older; 80-84; 75-79; and 70-74.	At higher risk of hospitalisation and death.	The principle of minimising harm, moral equality and fairness are relevant as this group are at greater risk of carrying disproportionate burdens from the pandemic.
	Other HCWs not in direct patient contact	Provide essential health services, protect patients.	Maintenance of healthcare services, minimises harm by preventing injury, illness and death from causes other than COVID, and the principle of reciprocity is upheld.
	Aged 65-69. Prioritise those with medical conditions** which put them at high risk of severe disease	At higher risk of hospitalisation and death	By protecting those at greatest risk of poor outcomes from the disease the principle of minimising harm is upheld.
	Key workers (to be further refined).	Providing services essential to the vaccination programme (e.g. logistical support)	Upholds principle of minimising harm by protecting the continuing functioning of essential services. The principle of reciprocity is upheld.
	Aged 18-64 years with medical conditions** which put them at high risk of severe disease	At higher risk of hospitalisation.	By protecting those at greatest risk of poor outcomes from the disease the principle of minimising harm is upheld.
	Residents of long-term care facilities aged 18-64	High risk of transmission	The principles of moral equality and fairness are applicable, given the higher risk of exposure to infection and the potential vulnerability of some who may not be able to adequately protect their own interests.

	Aged 18-64 years living working in crowded accommodation where self-isolation and social distancing is difficult to maintain	Disadvantaged sociodemographic groups more likely to experience a higher burden of infection.	The principle of moral equality, minimising harm (especially in the context of multi-generational households) and fairness are relevant. Prioritising this group recognises that structural inequalities make some people more vulnerable than others to COVID-19
	Key workers in essential jobs who cannot avoid a high risk of exposure to COVID-19. They include workers in the food supply system, public and commercial transport and other vital services	High risk of exposure as unable to work without physical distancing.	The principle of minimising harm is upheld by reducing societal and economic disruption and the principle of reciprocity recognises the additional risk these groups bear in order to provide essential services
	Those who are essential to education and who face disease exposure - primary and second level school staff, special needs assistants, childcare workers, maintenance workers, school bus drivers etc.	To maintain the opening of fulltime education of all children who have been disproportionately impacted from the pandemic.	Maintaining children's educational and social development and facilitating parents' employment adheres to the principle of minimising harm. The principle of reciprocity is also relevant given the potential additional risk being borne by such groups
	Aged 55-64 years	Based on risk of hospitalisation.	The principles of moral equality, minimising harm and fairness apply.
	Those in occupations important to the functioning of society, e.g., third level institutions, entertainment and goods-producing industries who work in settings where protective measures can be followed without much difficulty	Moderate risk of exposure	The principle of minimising harm is upheld as protecting workers needed to maintain critical infrastructure and other important services will enable social and economic activity. The principle of fairness and moral equality also apply
	Aged 18-54 years who did not have access to the vaccine in prior phases	If evidence demonstrates the vaccine(s) prevent transmission, those aged 18-34 should be prioritised due to their increased level of social contact and role in transmission	The principle of minimising harm is relevant should it become clear that a vaccine can impact on transmission of the virus as this would indirectly protect the most vulnerable in society as well as restore social and economic activity.

	Children, adolescents up to 18 years and pregnant women (to be refined)	If evidence demonstrates safety and efficacy	The principles of moral equality, minimising harm (if vaccines are shown to be safe and effective in these groups) and fairness.	
<p>*Includes health care workers who work in and out of all healthcare settings</p> <p>**Chronic heart disease, including hypertension with cardiac involvement; chronic respiratory disease, including asthma requiring continuous or repeated use of systemic steroids or with previous exacerbations requiring hospital admission; Type 1 and 2 diabetes; chronic neurological disease; chronic kidney disease; body mass index >40; immunosuppression due to disease or treatment; chronic liver disease</p>				