

# **Title: Disability services – preparedness and ongoing response to COVID-19**

**Department of Health and HSE (with input from HIQA)**

**17<sup>th</sup> December 2020**

## **Action required:**

✓ For discussion

✓ For publication

Approved for future publication: YES

## 1. Overview

People receiving disability services are a higher-risk population. The November ECDC 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.

LTRCs are people's homes as well as places where healthcare is provided. NPHET 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. NPHET has been particularly conscious of balancing protective actions with support and compassion and endorsed the paper *"Ethical Considerations Relating to Residential Care Facilities in the context of COVID-19"*.

Nevertheless, through extensive guidance and support to service providers, contingency planning, and a high level of co-operation between HSE, HIQA and service providers, COVID-19 has by and large been successfully managed in this sector. Almost 90% of residential disability centres have never had an outbreak. As of 15<sup>th</sup> December 2020, there were 13 open outbreaks in disability services, and 92% of outbreaks to date were closed.

With approximately 8,300 people living in residential disability care, it is estimated that sadly 16 people to date living in such facilities have died from COVID-19 (0.2% of residents). Two of those deaths occurred in October/November.

### 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 (NPHET) 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 16<sup>th</sup> 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 NPHET 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 have been integral to the continuing evolution of the response to COVID-19.

## 2. Disability service population

### 2.1 Specialist disability services support around 56,000 people

The HSE funds specialist disability services for approximately 56,000 people. This includes services provided to around 29,000 adults and children with intellectual disabilities, as well as to service users with physical, sensory or neurological disabilities, or autism, where the total number involved is not accurately known.

Most of the 635,000 or so people identified in Census 2016 as with a disability or long-term condition are supported through mainstream health and social care services, including services for older people.

## **2.2 Residential care facilities**

Approximately 8,300 people live in residential disability services, of whom around 90% have intellectual disabilities. About 2,000 of these are living in congregated settings (institutions/residential campuses) where ten or more people share the accommodation or location. The remainder are largely in community group homes of typically 4-6 residents, this number has roughly halved since 2011 in line with the policy to transfer residents of these centres to ordinary homes in the community. In the course of 2020, 95 people moved from congregated settings to small-scale housing in the community.

In addition, about 1,300 people aged under 65 live in nursing homes. Some of these are people with disabilities (for example people with acquired brain injuries) for whom this is their long-term home.

The latest HIQA register shows residential disability services (including residential respite) being delivered in around 1,300 registered centres, delivered by over 80 separate service providers, including the HSE.<sup>1</sup> It is estimated that just under 90% of residential centres have not experienced any outbreak, while a small number of centres have experienced more than one outbreak since March.

## **3. Risk factors in disability services**

### **3.1 International evidence**

The European Centre for Disease Control has warned of the higher risk facing those living in residential centres, and the higher the prevalence in the community, the higher the probability of it being imported into these settings. The larger the setting, the greater the risk.<sup>2</sup> Other international evidence suggests that people with intellectual disabilities are at higher risk of dying from COVID-19 than the population at large.<sup>3</sup>

### **3.2 Risk factors**

These are the main risk factors in disability services in relation to COVID-19:

- Residential settings, with a higher risk for congregated settings, but all residential settings presenting an elevated risk
- Governance issues identified by HIQA for some providers, mainly in congregated settings
- High level of underlying health conditions in people requiring specialist disability services
- Difficulties for people with a disability in complying with public health guidance

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<sup>1</sup> A residential campus may contain a number of separate registered centres, e.g. individual houses or groups of houses/apartments on campus that share a Person in Charge so there is not an exact correspondence between outbreak locations reported by HPSC, and registered residential centres

<sup>2</sup> ECDC Rapid Risk Assessment (19 Nov 2020) 'Increase in fatal cases of COVID-19 among long-term care facility residents in the EU/EEA and the UK'.

<sup>3</sup> See for example Landes et al (2020) 'COVID-19 outcomes among people with intellectual and developmental disability living in residential group homes in New York State' in *Disability and Health Journal*, vol 13 Issue 4 (Oct 2020).  
<https://www.sciencedirect.com/science/article/pii/S193665742030100X?via%3Dihub>

- Employment of agency staff, where it occurs, can be a risk factor – consistency is important for residents and for infection control
- Agency staff typically are not paid if they are not available for work.

While disability service providers and most designated disability residential centres have been fairly successful in containing COVID-19, HIQA warn that the risk factors in disability services are significant.

### **3.3 Governance issues**

A significant minority of residential disability centres are characterised by poor governance. In 2019, HIQA found almost half of the congregated settings it inspected were non-compliant with governance standards, and around one in five community residences. Governance failings are strongly associated with poor risk management and other failures of compliance including systems for infection prevention and control.

Regulatory compliance is a prerequisite for securing and maintaining registration with HIQA. Centres are deemed to be compliant, substantially compliant or not compliant. Compliant means the provider and or the person in charge is in full compliance with the relevant regulation. Substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. HIQA has significant powers from seeking improvement plans up to removal of registration. If HIQA finds a provider has an inadequate COVID-19 preparedness plan or is otherwise non-compliant with the regulatory requirements on infection prevention and control, HIQA can require the relevant provider to take action, and to revise its COVID-19 preparedness plan to address these areas, or failing that, can cancel registration.

### **3.4 Scale of health vulnerability**

A recent report from IDS-Tilda, which surveyed over 700 over-40s with an intellectual disability, quantified the prevalence of underlying health conditions that are higher risk factors. This found that 67% of respondents were overweight or obese, 52% had cardio-vascular disease, 29% had epilepsy, 10% had diabetes, and 9% had lung disease. This compares with HPSC figures showing that for all COVID-19 cases for which data were available, 31% had underlying medical conditions.

### **3.5 Sick pay – position of agency staff**

While HSE and s 38 staff (around 70% of all disability service staff) enjoy all employee protections, and s 39 staff would also generally receive sick pay when off work, the state has no oversight of terms and conditions/protections offered by private contractors (of which there are a small number). In all sectors, agency staff may be employed to fill staffing gaps e.g. due to sick leave, and while these may avail of state pandemic payments if they are sick or have to self-isolate, there is the risk of a financial disincentive to staying out of work when it is advised to do so.<sup>4</sup>

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<sup>4</sup> People who have symptoms of COVID-19, are waiting for a test appointment/test results and have symptoms, or have had a positive test result for COVID-19 are advised to self-isolate for a required period after fever or other symptoms have gone. People who are a close contact of a confirmed case of COVID-19 or live with someone who has symptoms of COVID-19 are advised to restrict their movements for 14 days.

## **4. Measures in place**

### **4.1 Suite of supports provided**

A robust series of measures have been put in place to protect disability services from COVID-19 and to respond to outbreaks when they occur. Appendix 1 details the measures taken and in place in disability services in Ireland mapped against the recent recommendations of the ECDC for residential care facilities, and shows that the Irish response is already in line with recommended practice in virtually every respect. The HSE and HIQA report a high level of engagement and co-operation of disability service providers with the statutory authorities and with one another.

#### **4.1.1 HSE supports** to disability services during the pandemic include:

- Provision of PPE to all funded agencies
- Infection Prevention and Control support, advice and training
- Ongoing Public Health advice/support with regard to suspected/positive cases.
- Residential Preparedness Groups
- Round 1 testing of all residential staff in April/May, with a further targeted round of testing in December/January
- COVID-19 Response teams, to assist and support residential services and to oversee and support the reshaping of disability services as a result of COVID-19
- A regular call/forum with all funded agencies to support them throughout the duration of the crisis
- Work with providers around contingency planning, and identifying and preparing isolation facilities
- Help with transport
- Accommodation for staff where required.

#### **4.1.2 HIQA supports**

HIQA's overall regulatory role is to ensure services meet the statutory requirements for registration (and maintenance of registration) which include the requirement to meet HIQA's standards in relation to prevention and control of infections.

Specific measures taken by HIQA to support providers and residents during the current pandemic include:

- A Quality Assurance Framework on infection prevention and control, including a self-assessment tool
- A series of four Webinars on managing infection prevention and control attended by 1,450 people
- HIQA receive statutory notification of any COVID-19 cases of staff or residents in designated residential centres, and contacts the centre on the same day or following day to follow up and check on the arrangements for residents, contingency plans, any staffing issues, any difficulties with Public Health, and escalate to local HSE Crisis Management team if any risks identified
- HIQA have been conducting risk-based inspections, and if non-compliance is identified, providers are required to prepare and implement improvement plans within agreed timeframes to identify shortcomings, and are subject to follow-up inspections to check on delivery

- HIQA plan a set of thematic inspections in 2021 around infection control (Regulation 27), including governance and management, compliance with public health guidance, and staff training, with the initial focus on congregated settings.

## **4.2 Comprehensive set of guidance**

There is a comprehensive set of guidance including guidance from HPSC for residential care settings, specific guidance tailored to disability services from the HSE, and specific guidance in this respect from HIQA.

Since the beginning of the pandemic, the HSE Health Protection and Surveillance Unit (HPSC) have been very proactive in providing infection prevention and control guidance to the population at large. The HSE Disabilities team adapted or created bespoke guidance for the sector arising from issues regarding the rights of disabled people due to restrictions, the specific needs of disabled people etc. These guidance documents were developed following international research and intensive consultation with disabled people and the people who support them. In some instances, legal advice was sought. To date, there are some 39 separate guidance documents, and these include areas such as:

- Contingency planning (for both nursing and non-nursing led services)
- Testing disabled people (including desensitisation programmes, right to refuse etc.)
- Streamlined hospital passport (one-pager to accompany a disabled person should they require hospitalisation)
- Communication – with children, people with ID, people who are hard of hearing/deaf, for hospital clinicians
- End-of life care
- Supporting people in isolation
- Resumption of services – Day Services, Respite Services
- Rights-based guidance (ensuring that people’s rights are balanced with risks).

### **Vaccine guidance in preparation**

Guidance and Easy to Read information is currently under development to ensure that people with disabilities will be provided with sufficient information in accessible formats, and desensitisation programmes where necessary, to be in a position to provide informed consent prior to receiving the COVID-19 vaccine.

## **4.3 Webinars for disability service staff on Guidance**

### **4.3.1 HSE**

The HSE has conducted three infection prevention and control webinars (April, July, October) for disability sector staff, with average audiences of around 500, to discuss all of the most recent guidance in place, discuss scenarios specific to disability services and clarify any perceived inconsistencies between the HPSC general guidance and the Disability Services bespoke guidance.

In addition, this year HSE Disability Operations Quality Improvement Team 3 webinars in November and December in lieu of the National Sharing Day, open to services, staff, people with disabilities and their families. All of the presenters were people with disabilities. Minister Rabbitte spoke at each webinar. The themes of these webinars were:

- Webinar 1 November 12 – The Impact of COVID-19 on Disabled People
- Webinar 2 November 26 – Valuing the Contributions of Disabled People in Society

- Webinar 3 December 3 – Hearing and Responding to the Voices of Disabled People.

Over 800 people attended the webinars and feedback received from the evaluations showed that over 90% of participants felt that the webinars were beneficial. Each webinar was recorded (and signed by Irish Sign Language Interpreters) and will be available on the HSE YouTube Channel.

Finally, the HSE Disability Operations Quality Improvement Team produce a quarterly newsletter which is circulated to over 1,200 staff and includes latest updates and COVID-19 guidance. It also includes guidance on communicating with families.

#### **4.3.2 HIQA**

**HIQA** provided a series of four Webinars in October 2020 on the governance arrangements for service providers to ensure effective infection prevention and control arrangements in residential services. These were attended by 1,450 participants.

#### **4.4 Guidance on Visiting**

Revised Guidance on Visiting in Residential Care Facilities (in line with 5-level Framework) issued in early December includes:

- Reference to separate guidance for own-door and community houses for disability sector
- Reference to supporting residents' particular requirements at time of major cultural or religious celebrations or festivals
- Redefinition of critical and compassionate grounds, and stating a minimum of one visit by one person per week should be permitted to all residents on compassionate grounds
- Explicit statement on residents' access to reading material and other objects.

Following this revised Guidance, the additional specific guidance in relation to residential disability centres has also been updated to incorporate reference to compassionate visits as above, and appropriate provisions around Christmas visits (or for equivalent religious/cultural celebrations in other traditions), to own door, small group homes and congregated disability settings, and is ready for approval. Current guidance on visiting in small group homes and own-door settings (in line with 5-level Framework) is at: <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/COVID-19%20visitations%20to%20residential%20disability%20services.pdf>

#### **4.5 Testing**

Significant effort and focus have been put in place in terms of planning the implementation of programmes relating to COVID-19 testing across disability services. It is important to note that rates of infection and separately levels of mortality associated with COVID-19 relevant to disability residential centres have been and continue to be low. There are two routes to testing either through the GP on a case by case basis, or through Public Health where a determination of specific risk is made requiring mass testing. The general testing protocols apply to disability services, from referral to public health decisions regarding broader testing of staff and residents.

The following is the approach planned for a programme of staff testing in disability centres.

One round of mass testing of staff in disability services was conducted in April and May within disability residential settings. Since then, the application of standard Public Health assessment / guidance for COVID-19 testing has been applied when outbreaks occur.

Notwithstanding the low rates of infection in disabilities, the increased risk pertaining is apparent given increases in numbers with COVID-19 in the general population across the country. Disability residential centres are diverse in range, type and scale; that is, ranging from large congregated settings (of 10 or more people) to small group-home type settings (with 4 or less residents). Some congregated-type locations, often with residents with particular underlying health conditions, are vulnerable to COVID-19.

#### **4.5.1 Process for Planning Staff COVID-19 testing for Staff in Disability Residential Settings**

Community Operations, via the National Oversight Governance Structure, put arrangements in place in October to consult and plan for staff testing in disability residential centres. A preliminary consultation workshop with representatives from Disability Operations, Disability Clinical Programmes Office, Public Health, Community Operations and S38/39 providers met to set out recommendations around implementing an approach to targeted testing in disability settings. This group have recommended a focus on testing of staff who support residents with health-related vulnerabilities and particularly staff in congregated environments where infection prevention and control is a challenge across the numbers supported. Congregated locations are not the only setting type as people with medical complexities can also be supported in smaller community-based residences. Drawing a demarcation on whether people have health vulnerabilities or not is a challenge and will require some local latitude where appropriate. Notwithstanding, HSE have undertaken a desktop review of current settings and the quantum of tests referenced below.

#### **4.5.2 Phased approach to COVID-19 testing for Staff in Disability Residential Settings**

The recommended approach is to focus efforts in terms of a programme of testing through prioritising same across congregate settings where staff are working with vulnerable people and in settings which are less than conducive to managing infection prevention and control (e.g. settings where there are large numbers in very close proximity). Following this focus on congregated locations initially, HSE will then review and assess whether there is a requirement to move to more community based settings. In essence, HSE will work along the following two key phases as outlined here.

- **Phase 1 – December 2020**

Commence Staff COVID-19 testing in one major campus location during December and review approach/ refine the SOP/ model and further roll out our programme from January 2021. The proposed location is Stewarts Care, a S38 provider, a major campus-based registered provider located in CHO 7. Approximately 300 staff will be tested in this centre, focussing on their congregated settings.

- **Phase 2 – January 2021 onwards**

Following the above phase as outlined, the proposal is to test staff at 379 locations that support 2,488 residents. This equates to co-ordinating efforts with approximately 20 large-scale disability residential providers, whilst noting that provision may be made to extend locally where specific health vulnerabilities are identified and based on Public Health guidance/ assessment.



Testing will be conducted by peer testers in-house for the most part. HSE Disabilities have provided the lists of locations to Community Testing and the Standard Operating Procedure is almost finalised to commence Phase 1.

Testing can still occur outside this process as prescribed by a GP for individuals or by Public Health for groups at a specific location.

#### **4.6 Access to isolation facilities**

The HSE Disability Operations team, through the CHOs, has been compiling information on a template with regard to isolation facilities that were available for use in each CHO as part of each organisation's contingency plan. As of 25<sup>th</sup> September, 75 organisations had replied, and at that stage over 400 potential isolation beds had been identified, of which 29 were in use (some of the potentially repurposed isolation facilities that were not needed were not available for their original use due to modifications). When full data is in, the results will be reported to the Senior Officials Group on COVID-19. HSE worked with the regulator to fast track registration of these facilities and received significant cooperation.

### **5. Oversight arrangements**

#### **5.1 Oversight Arrangements (organisational and sectoral), including early warning systems**

A series of oversight arrangements are in place which involve close working relationships between HSE Disability Services at national and local level, HIQA, disability umbrella bodies and individual providers, and rapid response to any outbreaks. The Department of Health has also met with HSE and HIQA in October and December to discuss preparedness in disability services, and the next such meeting is scheduled for January.

#### **5.2 HSE engagement with disability umbrella bodies**

HSE Disabilities engage on a two-weekly basis with the Disability Umbrella Representative Bodies representing the Provider Sector and with Inclusion Ireland representing the voice of the service user. Central to this joint effort is to ensure essential two-way, open communication channels and joint working that delivers agreed measures to assist and support people with a disability, their families and communities during and to do so in a safe and effective manner. There has been an unprecedented level of cooperation and sharing of learning and information between HSE and service providers and between providers themselves, including the HSE during this period. Services have shared templates and tools and worked on groups to develop guidance together. They have where necessary shared staff and provider resources like transport to support the effort. HSE met with CHO on a weekly basis initially and CHOs held in some instances daily meetings including Disability Services, Primary Care, Public Health and particularly the Providers themselves. This facilitated prioritisation of supports, early identification of issues and sharing advice and best practice.

#### **5.3 HIQA engagement**

The HIQA Provider Forum to enable communication between HIQA and representative organisations of service providers, was already in place pre-COVID-19, and normally meets on a quarterly basis. During the height of the pandemic, it met more frequently, sometimes weekly. This forum was very

helpful and supportive in identifying challenges and solutions facing both the Providers and the Regulator.

The standing HSE/HIQA Forum also met more frequently during the pandemic to discuss COVID-19 related issues and was a forum for identifying solutions to problems such as registration, monitoring etc.

(See also 4.1.2 above on HIQA engagement with individual residential centres and follow-up actions where risks identified)

#### **5.4 COVID-19 Response Teams Forum**

The Review of the Operational Guidance and future of COVID-19 Response Teams (CRTs) in Residential Care Units Report (July 2020) evaluated the effectiveness of these teams and recommended a National Network of CRTs be developed. The COVID-19 Response Teams Forum was endorsed by the National Residential Care Monitoring Group on 14 September 2020. The Forum will also contribute to the establishment of a new integrated Community Support Teams (CSTs) on a permanent basis (Expert Panel Report July 2020 - Recommendation 7.1). The purpose of the CRT Forum is to support a more standardised approach to the role of the CRT and to establish a supportive network for sharing experiences and learning. The HSE Disability Services representative participates on this forum to ensure that the Community Support Teams will be inclusive of experts in disability services should the need arise.

## **6. Impact of COVID-19 on services and service users**

### **6.1 Impact on service users**

Residential services continued to operate throughout the pandemic, but day services were closed until August/September, and have re-opened with reduced capacity. Services have explored other ways to support service users including on-line and in-home support. Feedback from service users has shown an increase in stress and loneliness, but also resilience and positive experiences.

#### **6.1.1 Webinar where service users presented their experiences**

A webinar was hosted by the Disability Operations Quality Improvement Team on November 12<sup>th</sup>, 2020 where people with disabilities presented on the impact that COVID-19 had on their lives. This was one of a series of three webinars with nearly 900 attendees. Over nine presentations, some as live or pre-recorded talks; some via the medium of art such as cross stitch, poetry, songs, and dance, people with disabilities described their experiences. One person had been the first in his service to contract COVID-19 and spoke of his experiences in the hospital ICU, how frightened he was, but how reassured he was by the care and support that he received from staff. His message to the audience of disabled people, their families and carers, policy makers and staff, was that if he could survive COVID-19, then they could too.

Other speakers spoke of their fears in terms of their own safety and that of their families during the pandemic. Many of the speakers also showed their resilience and spoke of the new activities that they tried (including sea swimming) which gave them some much-needed relief from stress.

Another positive outcome of the pandemic was that people with disabilities learned to use technology; they spoke about Zoom meetings and the importance of connecting with people during this time when they could not be physically present with each other. These online communities

supported them to reduce social isolation. Presenters also spoke about the ways in which staff supported them to adapt their pre-COVID-19 routines by enabling them to have meaningful days.

### **6.1.2 Research on impact of COVID-19 on older adults with an intellectual disability in Ireland**

A report from Wave 4 of the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing (IDS-TILDA), published on December 3<sup>rd</sup> 2020, identified many of the same experiences as the presenters in the November webinar. Of 739 participants in this wave, 710 completed the COVID-19 survey.

All levels of intellectual disability were represented – 30% had mild ID, 42% moderate ID, and 28% had severe-profound ID. There was a high level of reported pre-existing conditions that are associated with poorer outcomes for COVID-19, with 66% having a history of overweight/obesity and 52% having a history of cardiovascular disease. A total of 443 participants were tested for COVID-19 reporting COVID-19-like symptoms of which 11 tested positive. There were no instances of mortality due to COVID-19 in the sample.

8% of participants moved from their usual home due to COVID-19. This most commonly occurred while waiting for test results, following a period of hospitalisation, or to follow isolation procedures as a precaution, and included where someone relocated to a family home. 79% of participants had a plan to self-isolate and 61% were able to comply with guidelines. 55% of participants reported the same feelings of stress and anxiety that individuals in the webinar in November described – due to not being able to do usual activities (79%); not seeing family (47%) and not seeing friends (45%).

In line with the experiences of people who presented at the webinar, 58% reported some positive aspects to the COVID-19 period including trying new activities (41%), opportunity for more rest (36%) and better relations with staff (26%).

Overall, the report found that in their interviews with people with ID, it was clear that they heard and followed the messages about keeping physical distance, masks, washing hands and monitoring and reporting their symptoms.

“The responsible acts of people with ID were matched by the equally responsible acts of their families when living at home and their service providers when they were living in out of home placements.....Particularly commendable was that there were active plans and strategies for isolation and quarantining, and most people with ID were able to comply with these.”

### **6.1.3 Experience of Digital and Assistive Technology use in Disability Services during COVID-19**

The use of technology has been a distinctive feature of the HSE and its partner Service Providers response to COVID-19 pandemic. In the second quarter of 2020, the National Clinical Programme for People with Disabilities undertook a survey of technology use to learn from the experience of service providers in the sector. The aim was to identify particular difficulties encountered, highlight and share examples of good practice and identify opportunities to strengthen our systemic response across the sector.

The survey comprised nineteen questions and allowed for an open response format. The survey was disseminated electronically through National Disability Operations and cascaded to service provider organisations. Responses were received from 120 different centres providing services to persons with disability throughout Ireland; ranging from large to small service providers; covering both adults

and children's disability services; and including clinical services, day services, education and training programmes, residential and home supports.

A wide range of different technologies were used to facilitate service provision. Service providers were generally very positive about how technology enabled services to continue, to varying degrees, and in some cases, to actually increase their reach. COVID-19 has resulted in improved digital literacy among service users and staff, and it has indicated a capacity for future service enhancement, using technology to augment services that existed prior to COVID-19. Thematic analysis identified a number of issues that emerged from the responses received: these included a sense of connectedness and engagement; the importance of maintaining human interaction; the value of accessibility and family centeredness; the potential for service efficiencies and the needs for personal supports; the frustrations people experience and the barriers and facilitators to overcoming these. The research provides a range of good practices reported by respondents which may be helpful to other service providers in thinking through opportunities for delivering services in a different way.

The survey report, **Right to Connect**, makes a number of specific recommendations. These include investment in training and up-skilling of staff to support the delivery of remote services; investment in technology and its necessary supportive infrastructure; development of national guidance on GDPR, IT security, and governance of virtual health and social care services. The report also recommends the use of structured change processes with a strong co-design element from service users and their families, and recognises and recommends that more work needs to be done to establish why some people with disability have found it difficult to engage with technology. The Irish disability sector functions through a network of different service providers. The enhanced use of technology in the disability sector presents opportunities for more collaborative and integrated planning and delivery of services. Through shared working and learning about the use of technology in our disability services, we can strengthen the benefit to and positive experience of our services by our service users.

## **6.2 Residential services**

Residential service levels were prioritised as a result of COVID-19 and indeed in many instances residents who would have gone to day services in the past now receive their day supports from the home in which they reside. Provision of residential service has continued throughout the pandemic. The ongoing programme to transfer residents of congregated settings to small scale housing in the mainstream community has continued, and 95 such residents have moved to new homes in the community to date in 2020.

Restrictions on visiting are in place, however specific guidance has been issued in relation to disability services, which acknowledges the importance of family visits for residents' wellbeing, and in the light of lower risks in small-scale group homes and in own-door housing, this guidance provides for less restrictive visiting arrangements, following risk assessment in individual cases.

## **6.3 Adult Day Services**

Almost 19,000 are in receipt of disability day service supports at 1,034 locations around the country. These supports are provided by 83 service provider agencies.

All day service locations have reopened since August /September with exception to 7 locations that are currently being used as COVID-19 Isolation/Test centres. In respect of these 7 locations,

replacements are being sourced and in the meantime service users are receiving outreach supports. The capacity in day service locations has been reduced in line with Public Health Guidance. At end of September approximately 4,500 adults that also receive residential services were receiving supports for 24 hour x 7 days weekly or 100% service. The remaining day service users were receiving in excess of 40% service quantum.

Since September €12.5m additional funding has been provided to try and increase capacity to 60% service. €7.5m of this funding is to secure additional posts to enhance the capacity in day service locations. €5m of the funding is to source and make ready additional service locations and to increase the capacity on transport to enable more people attend locations each day. Posts are currently being recruited and buildings are being secured and made ready to enhance the service quantum. Additional transport supports are in place.

In addition, €30m has been provided for 2021 to fund the additional posts employed in 2020 to maintain an increased level of service as we continue to live with COVID-19 restrictions. The full positive impact of the additional funding should be realised in the early months of 2021.

#### **6.4 Children's Disability Services**

Children's Disability Services were stepped down in March 2020 in line with government recommendations to minimise the spread of COVID-19. Through the pandemic, services continued to be provided on the phone/online and also, face to face for some children and families with high prioritised needs, taking all of the required IPC precautions and in line with HSE's Alternative Models of Support document. The temporary reassignment of Special Needs Assistants facilitated the provision of supports to 263 children up to 30<sup>th</sup> June as well as a further 580 children participating in summer programmes during July and August. On July 31<sup>st</sup>, the HSE issued "Interim Guidance on Conducting Assessments in Disability Services" as well as "Guidance to Support Resumption of Children's Disability Services" documentation to the Community Healthcare Organizations. These guidance documents are intended to support clinicians in decision making regarding disability assessments in the context of COVID-19 and secondly to support the return to more normal levels of service provision for children with disabilities and their families. Return of remaining therapy staff from their redeployment to contract tracing to their primary duties is on-going as additional contract tracing staff recruited come on board. As of October 24<sup>th</sup>, the number of therapy and administrative staff normally employed in HSE disability therapy services (including assessment of need and early intervention) deployed to Test and Trace was 167, representing 96.9 whole time equivalent staff. Informal reports from Heads of Disability Services have indicated that this figure has reduced significantly during November / December. The framework for return of staff is set out in <https://www.hse.ie/eng/services/news/newsfeatures/COVID-1919-updates/service-continuity-in-a-COVID-19-environment-a-strategic-framework-for-delivery1.pdf>

#### **6.5 Respite services**

The HSE's *A Safe Return to Health Services* outlines a three phased approach to the return of health and social care services. This plan has ensured that:

- Short-stay residential and emergency/residential respite began to re-open from July to August. In some situations where families were under extreme pressure during the lockdown some services were sustained.
- Activity has increased further in the next two phases, i.e., September – November, and will increase further from December 2020 to February 2021.

The main assumption underpinning this schedule is the level of illness and health service pressure caused by COVID-19. If this increases in later surges, the timelines in this document will change.

At present, centre-based respite facilities are generally providing services at 40 to 60 percent occupancy levels due to necessary precautions to maintain physical distancing and to adhere to infection prevention and control requirements. In a very small number of cases, certain centres remain closed or continue to be used for isolation purposes, subject to the prevailing local incidence of infection, but the HSE continue to work with providers locally to maximise both centre-based and alternative non-residential respite and support option to provide target support, wherever possible.

## 6.6 Personal Assistant and Home Support Services

In preparing for and responding to COVID-19 and to fully align with Public Health guidance as recommended via the NPHET, the HSE and its partner service providers put in place a range of measures, which included the prioritisation of vital Residential and Home Support/Personal Assistant services whilst curtailing or closing certain services such as day services, respite services, and certain clinical & therapeutic supports.

The number of people with disabilities in receipt of Personal Assistant (PA) and Home Support services has remained steady throughout the pandemic. The number of PA hours provided up to end September 2020 (Q3) has exceeded the expected target as a result of additional PA hours being provided in lieu of other services and is on schedule to deliver NSP levels of service by year end. Home Support Services are slightly down on target to date, but not excessively so given the complexity involved in the provision of services due to COVID-19.

In order to support Personal Assistants during the pandemic, the HSE Disability Operations Quality Improvement Office developed infection, prevention and control bespoke guidance for PAs. This was developed in collaboration with Leaders, Personal Assistants and Service Providers and was agreed with the Health Surveillance Protection Centre (HPSC) and was published on the Partner Resources Page on the HSE website under the tab 'HSE Approved Guidance for Disability Services' at: <https://www.hse.ie/eng/services/news/newsfeatures/COVID-1919-updates/partner-resources>

## 7. Data on outbreaks in disability centres

As of midnight, 15 December, HPSC data indicates that COVID-19 outbreaks have been recorded to date in 162 disability centres. 13 outbreaks remain open. In total around 840 people have been infected, and data on healthcare workers who have contracted COVID-19 suggest about 54% of all disability cases have been staff.

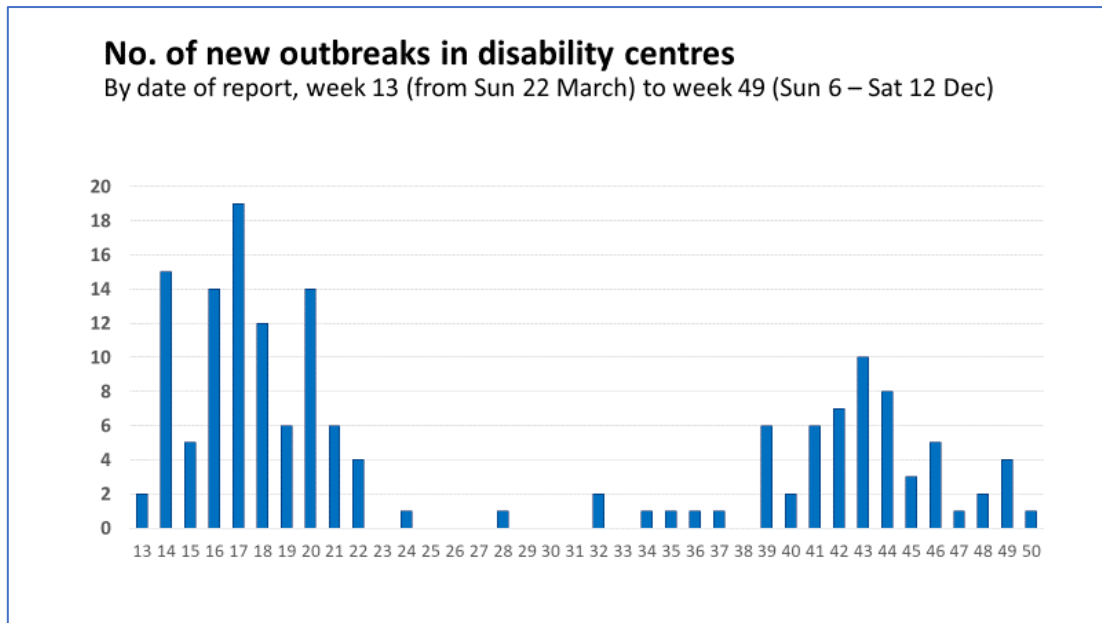
Sadly 17 people have died, 16 of them residents and one person receiving home support services. As with all HPSC data, these are subject to ongoing review and updating. Discrepancies can occur from time to time, or there can be delays in full data relating to a disability outbreak being recorded.

**Table 1: Deaths from COVID-19 in disability services**

Month	In disability residential services	In disability home care service
March	1	
April	12	
May	1	
October	2	1
November	1	

The figure below shows the number of new outbreaks week by week (Sunday to Saturday) in residential disability centres from March 2020 to 12 December, by date reported.

**Chart 1: COVID-19 outbreaks in disability centres**



## Appendix 1: ECDC recommendations and Irish response - Disability

Table showing ECDC recommendations and Ireland's response with respect to disability services

	ECDC recommendations	Ireland's response
<b>1.</b>	<b>Management of long-term care facilities</b>	
<b>1.1</b>	<b>Access to guidelines and information</b>	
<b>(a)</b>	<p><b>Guidance</b> Ensure access to information and resources in the form of guidelines, guidance and procedures on the prevention and control of COVID-19 which will support and ensure all facilities establish safe routines for care.</p>	<p><b>HPSC Guidance on infection, prevention and control for long-term residential care settings</b> Specific infection prevention and control guidance is available and updated regularly by the HPSC for LTRCs. The comprehensive <i>Interim Public Health, Infection Prevention &amp; Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities</i>, targeted directly at LTRCs, provides guidance across a range of key areas including:</p> <ul style="list-style-type: none"> <li>• Clinical features of COVID-19, routes and control of transmission, incubation period and environmental survival</li> <li>• General measure to prevent an outbreak including: planning, education (staff and residents), physical distancing, controls to prevent inadvertent introduction, surveillance and early identification</li> <li>• 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</li> <li>• Care of the dying and recently deceased</li> <li>• Monitoring outbreak progress and declaring an outbreak over</li> <li>• Hand hygiene, use of and donning and doffing of PPE</li> <li>• Comprehensive guidance on safely managing admissions, transfers and discharges</li> </ul>



	<b>ECDC recommendations</b>	<b>Ireland's response</b>
<b>(b)</b>	<b>Guidance for disability services</b>	<p><b>HSE's specific guidance for disability services</b></p> <p>The HSE Disabilities team adapted or created bespoke guidance for the sector arising from issues regarding the rights of disabled people due to restrictions, and the specific needs of people with disabilities. These guidance documents were developed following international research and intensive consultation with disabled people and the people who support them. The HSE has issued 39 separate guidance and resource documents or videos for disability services, service users and families on preventing and managing COVID-19 (including Easy to Read material and Irish Sign Language videos). These resources include:</p> <ul style="list-style-type: none"> <li>• Contingency planning (for both nursing and non-nursing led services)</li> <li>• Guidance on use of personal protective equipment with people with disabilities</li> <li>• Infection prevention and control – guidance for personal assistants</li> <li>• Testing disabled people (including desensitisation programmes, right to refuse etc.)</li> <li>• Streamlined hospital passport (one-pager to accompany a disabled person should they require hospitalisation)</li> <li>• Communication – with children, people with ID, people who are hard of hearing/deaf, for hospital clinicians</li> <li>• End-of life care</li> <li>• Supporting people in isolation</li> <li>• Resumption of services – Day Services, Respite Services</li> <li>• Rights-based guidance (ensuring that people's rights are balanced with risks)</li> </ul> <p><b>HIQA Guidance</b></p> <p>HIQA have developed a guidance and accompanying Self-Assessment Tool for service providers on infection prevention and control planning in their residential services.</p>
<b>(c)</b>	<p><b>Ready access to guidance</b></p> <p>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</p>	<p><b>Public health guidance online</b></p> <p>Public health guidance, including for vulnerable groups, is updated regularly and published by the Health Protection Surveillance Centre (HPSC) on its website at: <a href="https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/">https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/</a></p> <p><b>Disability-specific guidance from the HSE available online</b></p> <p>Disability-specific guidance is available under the tab 'HSE Approved Guidance for Disability Services' at <a href="https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/partner-resources">https://www.hse.ie/eng/services/news/newsfeatures/covid19-updates/partner-resources</a>.</p> <p><b>Database of international guidance, including guidance for residential care facilities</b></p> <p>HIQA have created a database of COVID-19 public health guidance produced by international organisations, which is updated daily, and is a resource to guide NPHE, the Department of Health, HPSC and HSE in developing tailored guidance. <a href="https://www.hiqa.ie/reports-and-publications/health-technology-assessment/covid-19-public-health-guidance-database">https://www.hiqa.ie/reports-and-publications/health-technology-assessment/covid-19-public-health-guidance-database</a></p> <p>HIQA also undertakes ongoing rapid review of guidance for residential care facilities in the context of COVID-19. The review summarises recommendations that have been issued internationally to limit the spread of COVID-19 and protect healthcare workers and residents. The tenth update on this guidance base was published on 13 November 2020.</p>

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
<b>1.2</b>	<b>Access to appropriate equipment</b>	
	<b>Provision of suitable equipment</b> Establishing procedures that ensure rapid access and mobilisation of personal protective equipment to and within LTCFs	The HSE is providing PPE to all funded agencies. 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 24 <sup>h</sup> November 6.6m items of PPE were supplied to residential care settings, representing 37% of all PPE items supplied that week.
<b>1.3</b>	<b>Designated lead person</b>	
<b>(a)</b>	<b>Designated lead person in each facility</b> National authorities to ensure that LTCFs designate within each LTCF who will lead and support the implementation of measures within the facility.	<b>Lead person:</b> S.14 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 provide for the designation of a Person on Charge of each residential centre for people with disabilities. Such a person must also have 3 years management experience in a health and social care area and an appropriate qualification in health or social care management.  In the HIQA Quality Assurance framework around compliance with regulations and standards on infection prevention and control, 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>
<b>(b)</b>	<b>Training</b> Train lead persons, or teams, to ensure the implementation of measures, including occupational safety and health measures and procedures to address IPC measures, supplies and training of staff and residents.	<b>Online training on the guidance</b> Infection prevention and control video resources are available on the HPSC website. Relevant training materials are available to disability service providers on the HSE's online learning and development portal, HSElanD, containing over 170 eLearning programmes, resources and tools. Relevant eLearning courses available to access include: <ul style="list-style-type: none"> <li>• Hand Hygiene for Clinical Staff; Hand Hygiene for non-Clinical Staff</li> <li>• Breaking the Chain of Infection</li> <li>• Introduction to Infection Prevention and Control</li> <li>• Putting on and taking off PPE in community healthcare settings</li> <li>• The HSE has developed and delivered ongoing Antimicrobial Resistance and Infection Control and Community Operations webinars.</li> <li>• HSE Disabilities has also run a series of webinars (April, July, October, December) aimed at disability services staff, with average audiences of around 500, to discuss the most recent guidance in place, including scenarios specific to disability services, and to clarify any perceived inconsistencies between the Health Protection Surveillance Protection Centre (HPSC) general guidance and the Disability Services bespoke guidance. The most recent seminar included a presentation by a service user who had been infected with COVID-19.</li> </ul> HIQA provided a series of four Webinars in October 2020 on the governance arrangements for service providers to ensure effective infection prevention and control arrangements in residential services. These were attended by 1,450 participants.

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
<b>1.4</b>	<b>Registration</b>	
	<p><b>Register of centres, residents and staff</b>            Ensure adequate registration and access to external consultation services for healthcare, in order to safeguard continuity of care. 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 staff that includes contact details</p>	<p><b>Register of long-term care facilities including disability residential centres</b>            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><b>Register of residents and staff</b>            Regulation 19 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Persons (Adults and Children) with Disabilities) Regulations 2013 requires all providers to maintain a directory of residents. The regulations also require that each provider maintain a record of all persons currently and previously employed at the designated disability residential service) including in respect of each person so employed. This record must also include training records.</p>
<b>1.5</b>	<b>Access to external healthcare support</b>	
	<p>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 COVID-19 and enable risk-based, context-specific, implementation of IPC guidance</p>	<p><b>HSE COVID-19 Response Teams (CRTs)</b>            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"> <li>• 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;</li> <li>• provide clinical input into management of outbreaks within Disability or Mental Health services;</li> <li>• provide infection prevention and control (IPC) guidance to individual facilities/services;</li> <li>• advise on further preventative measures that can be implemented;</li> <li>• assessment of staffing levels/governance &amp; management oversight;</li> <li>• assessment of health &amp; welfare of residents through the PIC &amp; Medical Officer/GP, in conjunction with Public Health;</li> <li>• provision of supports to centre/service with outbreak;</li> <li>• monitoring outbreak review and reporting processes;</li> <li>• reporting requirements to the HSE Area Crisis Management Teams (ACMT) and onwards;</li> <li>• where possible, arrange staff resources as a measure of last resort;</li> <li>• escalation of concerns to HIQA where regulatory input or action may need to be considered.</li> </ul>

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
		<p><b>HIQA</b>  HIQA has maintained close monitoring of disability centres throughout the pandemic and where issues have arisen, including any difficulties with access to health services or to public health, HIQA has used an escalation process to ensure that the HSE at national level are made aware of these issues so that they can respond.  HIQA established an Infection Prevention and Control Hub in April 2020 for service providers and staff working in services which provided access to advice on the implementation of public health guidance in individual residential services for people with disabilities.</p>
		<p><b>Surveillance and response to cases in disability service users or staff</b>  The Public Health team have primary responsibility for managing outbreaks in residential services. All outbreaks of COVID-19 must be reported to the regional Medical Officer of Health (MOH) at the HSE's Public Health team at the earliest opportunity. This MOH has the responsibility to investigate and manage the outbreak of COVID-19, and at local level is assisted by HSE public health outbreak control teams (OCT). 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 disability services to implement control measures to reduce the risk to public health.</p>
		<p><b>HIQA follow-up on any cases in residential disability services</b>  In addition, if a resident or staff member in a registered residential disability service is diagnosed with COVID-19, HIQA is informed straight away. That day or the next, they check with the service concerned on and check on the arrangements for residents, contingency plans, any staffing issues, any difficulties with engagement with the Public Health team.</p>
		<p><b>Residents' access to external medical support</b>  <i>Regulation 6 (2)</i> of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Persons with Disabilities) Regulations 2013 provides that the person in charge shall ensure –</p> <ul style="list-style-type: none"> <li>● The resident has a medical practitioner chosen by them or acceptable to them</li> <li>● where the resident agrees to recommended medical treatment, that treatment is facilitated</li> <li>● when a resident requires services provided by allied health professionals, that is provided by either the service or the HSE</li> </ul>

	ECDC recommendations	Ireland's response
<b>2</b>	<b>Testing</b>	
<b>2.1</b>	<b>Access to testing</b>	
	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 among residents or LTCF workers	<p><b>Testing</b> Where an individual associated with a disability services tests positive, the local Public Health team assess the situation and depending on the risk assessment, may recommend that a programme of mass testing of other staff or residents be undertaken, or that individuals may seek testing through their GP on a case by case basis.</p> <p>All residential care facilities for people with disabilities (other than 45 low-support residences) had a round of testing conducted beginning 18<sup>th</sup> May – 1,242 locations in all. Residents and staff were tested in locations with a confirmed or suspected outbreak of COVID-19; in all other locations, staff were tested.</p> <p>A second round of targeted staff testing is being undertaken in December 2020/January 2021, with the initial focus on staff in congregated settings (10 or more residents), to be followed by staff in community residences where there are residents who are medically vulnerable.</p>
<b>2.2</b>	<b>Rapid antigen tests</b>	
	While 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 people in high-risk settings such as LTCFs.	<p><b>PCR-only to date</b> Validation of rapid antigen testing is ongoing within the HSE. Until this work is complete the gold standard of RT-PCR is the recommended test.</p>
<b>3</b>	<b>Minimise introduction of COVID-19</b>	
<b>3.1</b>	<b>Reinforce messages to staff</b>	
	Reinforcing messages on the essential measures for minimising the introduction of COVID-19 infection into to LTCFs by those working there.	<p><b>Support of COVID-19 Response Teams</b> The established HSE COVID-19 Response Teams support the prevention, identification, and management of COVID-19 outbreaks across long-term care 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, providing infection prevention and control (IPC) guidance to individual facilities/services; supporting provision of clinical care and being a point of contact with GPs and/or Directors of Nursing during management of COVID-19 outbreak in residential centres</p>

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
		<p><b>Quality assurance framework on infection prevention and control for RCFs.</b>            In September 2020 HIQA published a further assurance framework for registered providers for preparedness planning and infection prevention and control measures.<sup>5</sup> Providers are required to comply with the National Standards for Infection Prevention and Control in Community Services (2018).<sup>6</sup> The framework includes a self-assessment tool and quality improvement template for providers to use in conjunction with the framework, and it covers</p> <ul style="list-style-type: none"> <li>• infection prevention and control governance and management arrangements</li> <li>• preparedness and contingency plans</li> <li>• staffing arrangements</li> <li>• the knowledge and confidence of staff in care services in implementing infection prevention and control measures</li> <li>• audit and review arrangements</li> </ul> <p>In 2021, HIQA will undertake focused inspections of residential disability services around compliance with infection prevention and control, including governance and staff training arrangements.</p>
		<p><b>Reinforcing messages</b>            See 1.1 above on suite of guidance, and 1.3b on training arrangements.</p> <p><b>Temporary alternative accommodation for healthcare workers living in crowded settings</b>            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 residential care settings. It aims to provide temporary accommodation, where required, for situations such as where the worker lives in a congregated domestic setting</p>
	<p><b>Strong incentives to staff to stay home if ill</b>            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.</p>	<p>Around 70% of disability service staff (c 18,500) are employed on public service terms and conditions which include paid sick leave, facilitating staying at home if they have symptoms or have to self-isolate. In other cases, enhanced COVID-19 rates of Illness Benefit payments facilitate taking necessary time off work.</p>
	<p><b>Examples include</b></p>	
	<p>Defining this occupational group as a priority for <b>testing</b></p>	<p>See 2.1 above on May and December 2020 rounds of staff testing in disability centres.</p>

<sup>5</sup> <https://www.hiqa.ie/sites/default/files/2020-09/COVID-19-Assurance-framework-for-registered-providers.pdf>

<sup>6</sup> <https://www.hiqa.ie/sites/default/files/2018-09/National-Standards-for-IPC-in-Community-services.pdf>

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
	Guarantee <b>financial support and security</b> for all who need to stay home due to suspected or confirmed symptoms	<p><b>Paid sick leave the norm for many staff</b> Most staff in disability services are working in the public sector, in voluntary bodies enjoying public sector pay and conditions (s 38s) or in other voluntary bodies (s 39s). Paid sick leave is standard in public sector and equivalent bodies, and equivalent arrangements to supplement social welfare sick pay may apply in many larger voluntary organisations that compete to recruit similar staff.</p> <p><b>COVID-19 enhanced Illness Benefit</b> If a worker is self-isolating/restricting movements on the instruction of a doctor or the HSE, 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 for a maximum of ten weeks, or, where a person is self-isolating/restricting movements, up to two weeks on the first claim.<sup>7</sup></p>
	Establish mechanisms for <b>quick recruitment</b> /surge of trained staff to avoid a gap in care due to absenteeism	<p>Service providers are required to develop contingency plans for the event of an outbreak, including plans for sourcing replacement staff if staff are ill or self-isolating. Service providers have worked co-operatively with one another around contingency cover. HSE support for registered disability centres has included:</p> <ul style="list-style-type: none"> <li>• Enhanced HSE engagement;</li> <li>• Access to reassigned staff;</li> <li>• Multidisciplinary clinical supports at CHO level through 23 COVID-19 Response Teams</li> <li>• HIQA are informed on the day if a staff member or resident has COVID-19, and they contact the centre within 24 hours to check out the provider's contingency plan and if the provider has access to sufficient staff cover, among other matters.</li> </ul>
	Ensure continuous <b>communication, training and encouragement</b> 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.	See also 1.3b on staff training

<sup>7</sup>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.

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
<b>3.2</b>	<b>Readmission of recuperating residents</b>	
	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.	<b>HPSC guidance on admissions, transfers and discharges from LTRCF</b> Specific comprehensive guidance on admissions, transfers to and discharges from Long-term care facilities guidance can be found in the HPSC's <i>Interim Public Health, Infection Prevention &amp; Control Guidelines on: Admissions, Transfers to and Discharges from Long Term Residential Care Facilities during the COVID-19 Pandemic</i> . <sup>8</sup> 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):
	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	<ul style="list-style-type: none"> <li>• 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;</li> <li>• People for admission to a RCF should be tested for COVID-19;</li> <li>• This is to help identify most of those who have infection, but it will not detect all of those with infection.</li> <li>• Testing should be performed within 3 days of planned admission to the RCF;</li> <li>• 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;</li> <li>• 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</li> <li>• 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;</li> <li>• 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;</li> <li>• 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;</li> <li>• 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;</li> </ul>

<sup>8</sup>Interim 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 6<sup>th</sup> December 2020] <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/IPC%20and%20PH%20Outbreak%20Guidance%20RCF.pdf>



	<b>ECDC recommendations</b>	<b>Ireland's response</b>
		<ul style="list-style-type: none"> <li>• 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;</li> <li>• 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 new symptoms consistent with COVID-19 during that time</li> </ul>
<b>3.3</b>	<b>Safe visiting</b>	
	<p><b>Visiting</b> Establishing risk-based and proportionate infection prevention and control measures that will allow safe visits to residents. Recognising that the social vulnerability in LTCF residents may be exacerbated when non-pharmaceutical interventions are in place that limit physical personal interactions, allowing external visitors, should be strongly considered.</p>	<p><b>HPSC updated guidance on facilitating safe visits to Residential Care Facilities: 30 November 2020</b> 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>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>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 LTRCFs in terms of buildings, grounds and human resources to manage risks associated with visiting.</p>

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
	<ul style="list-style-type: none"> <li>• The use of medical face masks should be strongly considered.</li> <li>• Ensure that residents and visitors at the long-term care facility practice appropriate hand hygiene</li> <li>• Symptomatic individuals should not visit LTCFs. Appropriate health promotion and safety information should be communicated to all patients and their families, staff, contractors and anyone who may enter the LTCF.</li> <li>• Prior to entering the LTCF, visitors should ideally be registered with sufficient information in order to assist subsequent contact tracing, if required; LTCF 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.</li> <li>• 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 LTCF premises, most particularly common areas.</li> </ul>	<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.</p> <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>

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
	Guidance on visiting	<p><b>Specific guidance for disability centres including small-scale community housing and own-door housing</b></p> <p>In addition to general guidance from HPSC on visiting for long-term residential care facilities, specific guidance has been developed for disability services, including separate guidance in respect of small-scale community residences (group homes) typically where 4-6 people live together, and for own-door supported accommodation. The guidance emphasises the importance of visiting for residents' well-being, and to take a balanced approach to risk. Guidance documents provide 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. The guidance has been periodically updated, and it is now aligned with the overarching Government 5-Level framework contained in <i>Resilience and Recovery 2020-2021 - Plan for Living with COVID-19</i>. The generic LRTC guidance now provides, that subject to risk assessments in each case, residents generally can receive 1 visit per week on compassionate grounds at levels 3 and 4, and 1 visit per fortnight at level 5. 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. Less restrictive visiting arrangements, subject to risk assessment, are in place for small-scale group homes. Broadly speaking, the restrictions applying to own-door accommodation are similar to those applying to the community generally. The disability-specific guidance on visiting is currently being updated (mid-December 2020). Current guidance on visiting in small group homes and own-door settings (in line with 5-level Framework) is at: <a href="https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/vulnerablegroupsguidance/COVID-19%20visitations%20to%20residential%20disability%20services.pdf">https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/vulnerablegroupsguidance/COVID-19%20visitations%20to%20residential%20disability%20services.pdf</a></p>
<b>3.4</b>	<b>Rapid mobilisation of PPE</b>	
		See 1.2 above

	ECDC recommendations	Ireland's response
<b>4</b>	<b>Minimise transmission within LCFs</b>	
<b>4.1a</b>	<b>Managing people with symptoms</b>	
	<p>If a resident in a long-term care facility displays clinical signs or symptoms compatible with COVID-19, urgently seek medical assessment to decide on testing and need for possible transfer to an acute care hospital. Staff should be alerted to the broader spectrum of signs and symptoms presented by older people.</p>	<p>The <b>Public Health team</b> have primary responsibility for managing outbreaks in residential services. – see more detail at 1.5 above.</p> <p><b>HSE COVID-19 Response Teams (CRTs) – See more detail under 1.5 above</b></p> <p>The CRTs 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"> <li>• 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;</li> <li>• provide clinical input into management of outbreaks within Disability or Mental Health services;</li> <li>• provision of supports to centre/service with outbreak;</li> <li>• monitoring outbreak review and reporting processes;</li> <li>• reporting requirements to the HSE Area Crisis Management Teams (ACMT) and onwards</li> </ul>

	ECDC recommendations	Ireland's response
	Support to manage outbreaks	<p><b>Detailed guidance</b> on these lines is contained in the guidance on infection control referenced in 1.1a and 1.1b above.</p> <p>The <b>HIQA Quality Assurance Framework on infection prevention and control in residential care facilities</b> provides detailed guidance on the capacity and capability providers should have in place 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 selection of the requirements is outlined below:</p> <p>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;</p> <p>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;</p> <p>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;</p> <p>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.</p> <p>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.</p> <p>The provider will have a system in place to support staff and manage their <b>occupational health</b> 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.</p> <p>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.</p> <p>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>
	Support to manage outbreaks	<p>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>

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
	<p><b>Testing during outbreaks</b> The use of a high performing Rapid Antigen Tests, as described above, can assist in the rapid assessment of the symptomatic person and detection and assessment of a potential ongoing outbreak in the LTCF</p>	<p>PCR tests are standard. Arrangements are made to test the person, and the Public Health team advises what contacts require testing.</p>
<b>4.1b</b>	<b>Awareness of symptoms</b>	
	<p>Ensure that all long-term care facility staff are aware of the residents displaying symptoms compatible with COVID-19, or having tested positive for the disease.</p> <p>Make available easy to understand information detailing IPC precautions throughout the facility.</p>	<p>Specific <b>infection prevention and control guidance</b> is available and updated regularly by the HPSC for LTRCs: <i>Interim Public Health, Infection Prevention &amp; Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities</i>. This comprehensive guidance covers, among other aspects, the clinical features of COVID-19, routes and control of transmission, incubation period and environmental survival</p>
<b>4.1c</b>	<b>Minimising risky contact</b>	
	<p>Residents displaying mild signs or symptoms of COVID-19 and no deterioration of underlying conditions, that do not require hospitalisation, should be isolated in single rooms with a separate bathroom.</p> <p>If there are more than a few cases, consider placing the residents in a separate area or section of the facility with dedicated staff, i.e. staff cohorting.</p> <p>Healthcare and other workers coming into contact with residents who have respiratory infections should be appropriately trained and follow the ECDC guidance (always, medical face mask or FFP2 respirator and eye protection; gown or apron and gloves when there is a risk for contact with body fluids).</p>	<p>The guidance references at 4.1.b covers 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</p>
	<p>Make available easy to understand information detailing IPC precautions throughout the facility.</p>	<p>Easy to Read versions of guidance have been produced for dissemination to residents with intellectual disabilities</p>
<b>4.2</b>	<b>Regular cleaning and air exchange</b>	
		<p>The guidance references at 4.1.b covers management of an outbreak, includes infection prevention and control measures including standard and transmission-based precautions, and management of care equipment, waste, laundry, environmental hygiene and cleaning</p>

	<b>ECDC recommendations</b>	<b>Ireland's response</b>
<b>5</b>	<b>Vaccination</b>	
<b>5.1</b>	<b>Vaccinate residents - flu and pneumococcus</b>	
	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.	Flu vaccine is free to all aged 65+ or living in long-term care homes, and to health care workers. Flu vaccines are being administered in nursing home settings under the flu vaccination plan. The national vaccination plan also recommends over-65s and those in high risk groups, including people with Down Syndrome or chronic neurological disease, for pneumococcus vaccine
<b>5.2</b>	<b>Vaccinate staff - flu and pneumococcus</b>	
	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.	Health care workers can receive the flu vaccine free of charge, and are encouraged to have it.
<b>5.3</b>	<b>Prioritise for COVID-19 vaccinations</b>	
	Recommend 60+ cohort should be prioritised for COVID-19 vaccination, particularly those residents of LTCF and staff with a national vaccination deployment plan.	The Irish Government published its provisional prioritisation list for a COVID-19 vaccination on 8 December 2020. The relevant groups are prioritised in the following order:
	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.	<ol style="list-style-type: none"> <li>1. Adults aged 65 years or over who are residents of long-term care facilities. Consider offering vaccination to all residents and staff on site.</li> <li>2. Frontline healthcare workers in direct patient contact roles or who risk exposure to bodily fluids or aerosols and those providing services essential to the vaccination programme.</li> <li>3. Aged 70 and older in the following order: 85 and older, 80-84, 75-79, 70-74</li> <li>4. Other health care workers not in direct patient contact.</li> <li>5. Aged 65-69. Prioritise those with medical conditions which put them at high risk of severe disease.</li> <li>6. Other key workers (to be further defined)</li> <li>7. Aged 18-64 years with medical conditions** which put them at high risk of severe disease.</li> <li>8. Residents of long-term care facilities aged 18-64</li> </ol>