An Roinn Sláinte
Department of Health

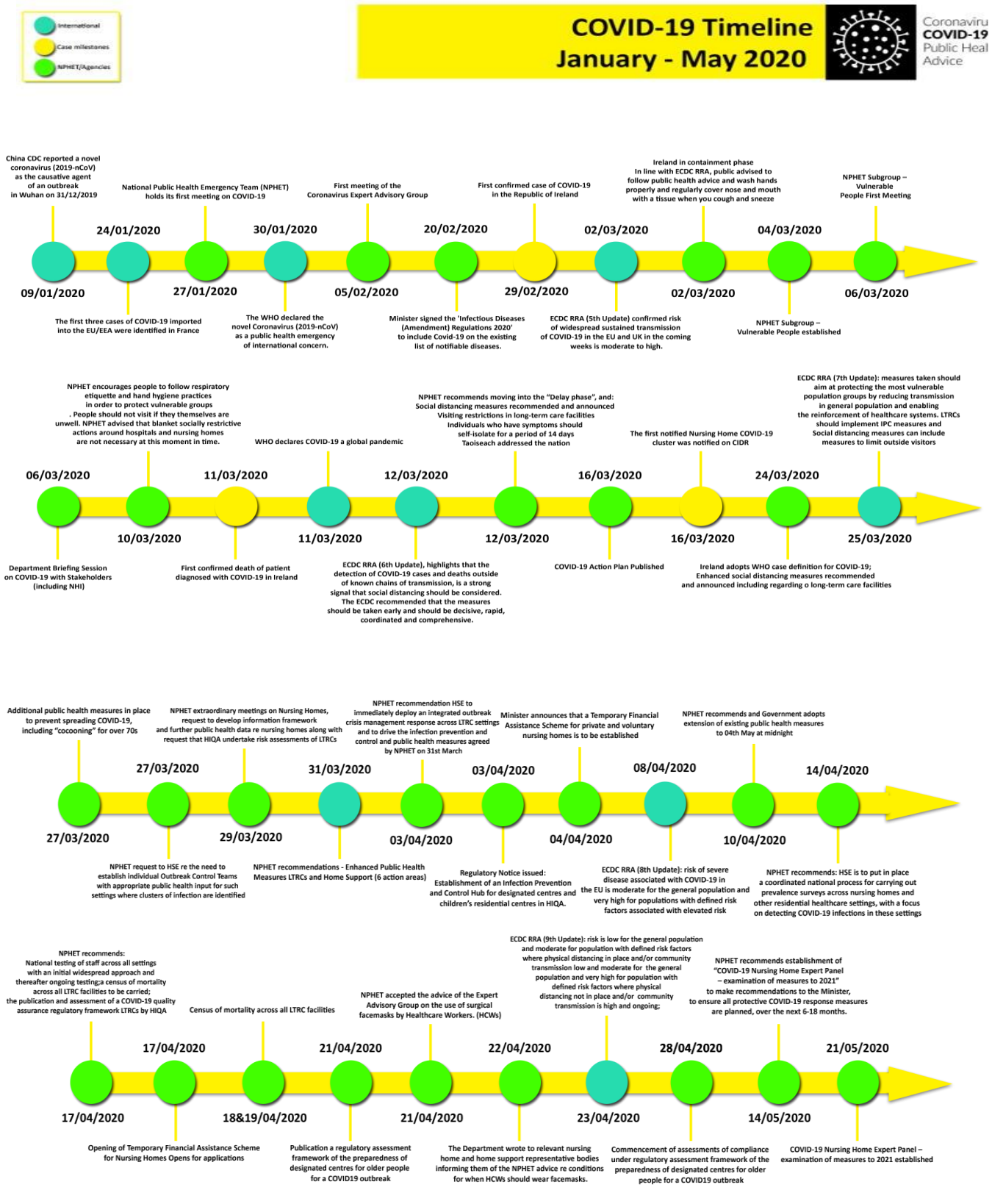
Overview of the Health System Response to date

Long-term residential healthcare settings

NPHET Meeting Paper, 22nd May 2020

Published by the Department of Health 26th May 2020

Contents



Note: *Timeline information represents the information at the time of drafting and may be subject to change*

1. Summary

Introduction

2020 has brought with it the most serious global pandemic in a century – something that was unimaginable a few short months ago. Since COVID-19 emerged first in China in December last, it has spread widely and rapidly around the globe, disregarding borders, time zones, age and race.

As well as being more infectious than first thought, it has been impossible to predict with certainty what its effects will be on any one person infected; some experience no symptoms at all, or are very mildly ill, and for others it is fatal. During January, as COVID-19 just arrived in Europe, the health service and the Government stepped up national public health and emergency responses.

The National Public Health Emergency Team (NPHET) and HSE National Crisis Management Teams for COVID-19 were convened and commenced their work at the end of January within days of confirmation of Europe's first cases in France, as part of the wider whole-of-Government co-ordinated approach. A National Action Plan was published on 16th March 2020, setting out a whole-of-society response and the mobilisation of resources across Government and society to fight the spread of this virus.

The impact of COVID-19 on society in general and those living in long-term residential care (LTRCs) has been considerable. LTRCs are people's homes as well as places where healthcare is provided and the introduction of physical distancing, isolation and restricted contact with family and loved ones has changed the usual dynamic of social interaction. During these times there is a particular 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.

The NPHET approach is public health led in line with data, evidence and best practice as it emerges. Many aspects of this paper are technical in nature and outline the protective and operational actions taken. Terms such as cases, clusters and deaths - these are public health internationally recognised data reference points used throughout this paper. Each of these terms, however, refers to a person who is part of our family, our neighbourhood and circle of friends.

The Department of Health has been notified of 24,315 confirmed cases of COVID-19 and 1,571 deaths in confirmed and probable cases as of 20th May 2020 by the Health Protection Surveillance Centre (HPSC). The first confirmed case in Ireland was identified on 29th February 2020 and the first death related to COVID-19 in Ireland occurred on 11th March 2020.

People living in long term residential care (LTRC) settings are vulnerable populations and have been identified by the World Health Organisation (WHO) to be at a higher risk of being susceptible to infection from COVID-19 and for subsequent adverse outcomes[1]. This is most likely due to their age, the high prevalence of underlying medical conditions and circumstances where high care support with the activities of daily living is required in collective high physical contact environments. There are characteristics of LTRC settings in Ireland, including congregated living environments where the nature

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

of care involves regular carer resident contact, that make them high-risk for Covid-19 outbreak and contagion across residents and staff.

The European Centre for Disease Control (ECDC)[2] in its recent technical report of 19th May recognises that a high proportion of LTRCs across Europe and globally have reported COVID-19 outbreaks, with high rates of morbidity and case fatality in residents and high rates of staff absenteeism.

This paper sets out the challenges and actions taken to support those residents in LTRC settings. LTRC facilities provide long term care and short stay, transitional care and respite support either through the State, section 38's and section 39's or privately[3]. A significant number of these facilities are registered with HIQA or regulated by the Mental Health Commission as approved centres (include LTRC and acute care) for quality, safety and when registered adherence to standards. HIQA and the MHC have implemented on-going risk assessments throughout the pandemic. While the scope of LTRC covers older people, disability and mental health residential care settings, due to the level of impact of COVID-19 both nationally and internationally in nursing homes the primary focus of this paper is on this sector.

Public health led response

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

Prompt, effective public health surveillance and response is critical to the identification and control of outbreaks in healthcare settings. Ireland has a national public health surveillance system, called CIDR (Computerised Infectious Disease Reporting) in place to manage the surveillance and control of infectious diseases in Ireland. Ireland is in a stronger data collection position than a number of other countries as CIDR captures data (cases, clusters and deaths) from both the community as well as acute hospitals and has done so since the commencement of the pandemic.

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

Our approach has been clear and consistent in recording COVID-19 cases and deaths in LTRC settings from the beginning of this pandemic. This places Ireland as one of the very few countries to take a comprehensive whole of country approach and use this data to inform public health actions in a measured, decisive and scientific manner.

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

[3] Acute psychiatric admission units are not considered as part of the mental health LTRC profile

COVID-19 LTRC surveillance information

On 16th March 2020, the HPSC was first notified of clusters in LTRC facilities (two were notified on that day in separate nursing homes with Outbreak Control Teams in place). As of 20th May, the HPSC has reported 463 clusters in LTRCs of which 258 are in nursing homes. These clusters are associated with 6,276 (26% of all cases) and 4,872 (20% of all cases) respectively. Of those cases in LTRCs, 482 were hospitalised and of the cases in nursing homes, 341 were hospitalised. 978 (63%) of all deaths in confirmed and probable cases of COVID-19 are associated with LTRC clusters. Of these 851 deaths are associated with nursing home outbreaks. To date, 38 clusters in LTRCs have been closed; thirteen in nursing homes.

More detailed analysis of cases to May 6th (n=22,203) identifies that:

- The overall incidence rate is 2.39 per 1000 in the general population, and 10.7 per 1000 in those aged over 70 years. Total number of cases in those over 70 years is 5,555. This means that 1% of all people aged 70 years and older in Ireland have been confirmed as having COVID-19.
- The incidence rate among residents of LTRC facilities is approximately 45 times greater than the general population at 133 per 1000 population. Again, this means that 13% of all people in LTRC have been confirmed as having COVID-19.
- If we compare age-specific crude case fatality rates between those in the same age group in LTRCs and those in the general population, they are very similar. For those aged over 70 years the case fatality rate in the general population is 17% and is 21% for those aged over 70 years in LTRCs.
- In summary, those in LTRCs are more likely to contract COVID-19 than those in the same age in the general population, but death rates are similar in both groups.

Analyses of the trajectory of the epidemic among the general population, healthcare workers and LTRC residents has been conducted by the Irish Epidemiological Modelling Advisory Group. Their work shows that the peak number of new confirmed cases in the general population was observed in the last week of March. The peak number of new confirmed cases in healthcare workers occurred after this in mid-April. The rate of increase of new cases among LTRC residents was slower and lagged behind both of these populations. The first outbreak in nursing homes was not identified until the 16th March – four days after the implementation of visiting restrictions (12th March)[4]. Most outbreaks were identified after the 23 March into the first week of April. The peak in numbers of newly confirmed cases seen in LTRC residents in late-April coincides with the implementation of the expanded testing programme of LTRC residents and staff.

COVID-19 impact on LTRC and operational responses

A clinical picture in vulnerable and older populations has emerged that did not meet the case definition as established initially through the WHO. Evidence is emerging that presentation of COVID-19 in LTRC can differ from that of the general population from no temperature to confusion and the pace of progression of disease is much faster, likely due to the age and frailty of older people in such settings. The level of asymptomatic residents has a significant impact on the evolving pattern of COVID-19 in many of these facilities.

As the disease has progressed and new information emerged, a range of enhanced measures for these settings recommended by NPHET on 31st March 2020 and 3rd April 2020 are being implemented. These enhanced measures build on actions already adopted for nursing homes, at the initiation of the

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

relevant Outbreak Control Teams and the existing infection prevention and control advice provided by the HPSC, including general and specific infection prevention measures, specific public health and clinical COVID-19 guidance, social distancing measures, visitor restrictions and cocooning. A substantial package of focused guidance for LTRCs has been published and continues to evolve and be updated in line with new national and international evidence and guidance.

Many LTRCs including nursing homes remained COVID-19 free and had the capacity to manage COVID-19 outbreaks to a level where COVID-19 clusters are now closing. While all LTRC facilities have been affected the most considerable impact seen has been in the nursing home sector. Nursing homes (584; 440 private and voluntary), many of whom operate as single entities of varying size, were significantly challenged, in terms of being able to maintain safe staffing levels and manage enhanced infection prevention measures. Private nursing homes are generally clinically supported by local GPs and therefore do not have a formalised clinical governance relationship in place with the HSE.

The State's responsibility to respond to the public health emergency created the need for the HSE to stand up a structured support system in line with NPHET actions to build sector resilience in light of COVID-19. In addition to public health support, in line with NPHET actions and in order to enable the continuity of service delivery and infection prevention management, substantial support for nursing homes over the last three months has encompassed:

- Enhanced HSE engagement
- Temporary HSE governance arrangements for some non-public nursing homes
- Multidisciplinary clinical supports at CHO level through COVID-19 Response Teams
- Access to supply lines for PPE, Oxygen etc.
- Access to staff from community and acute hospitals
- Suite of focused LTRC guidance
- Temporary financial support scheme
- HIQA Infection Prevention Hub and COVID-19 quality assurance regulatory framework.

International guidance

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

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

Advice from the World Health Organisation and European Centre for Disease Control (ECDC) has been tracked daily and public health and operational changes in LTRCs have been implemented as evidence

has emerged. It was not however until mid to late March 2020 that specific guidance for the LTRC sectors was produced by the WHO and the reported international experience increasingly indicated the significant threat posed to the most vulnerable older people in nursing homes by the rapid spread of COVID-19 in these settings. The serious impact on LTRCs was subsequently identified by ECDC in their 9th rapid risk assessment of 23rd April 2020.

The timeline (Page 2) and summary table in Appendix 4 outline from the first COVID-19 case to date actions taken and how each of these actions if not already in place commenced swiftly and decisively following recommendations from both ECDC and the WHO.

Learning for the future

The very infectious nature of this virus makes it difficult to prevent and control in residential care settings - an experience replicated internationally. ECDC recognises in a special technical report, 19th May, *Surveillance of COVID-19 at long-term care facilities in the EU/EEA,*[5] that the high COVID-19 morbidity and mortality observed among residents in long-term care facilities (LTCF) in EU/EEA countries poses a major challenge for disease prevention and control in such settings. This report outlines a set of multiple factors that may be contributing to spread including asymptomatic staff and residents and atypical COVID-19 clinical presentations or the absence of evident signs or symptoms until the patients' conditions deteriorate.

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

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

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

2. Older People and those living in long-term residential care (LTRC)

Census 2016 showed that over half a million or 587,284 people are over 65 and living at home in the community. Nearly 40,000 currently are living in long term residential care such as nursing homes. One of the important ways to protect our older population has been to reduce the amount of disease present in our community. Enhancing safeguards for vulnerable people from social distancing to cocooning for older people, as recommended in line with the disease trajectory, have been important public health actions.

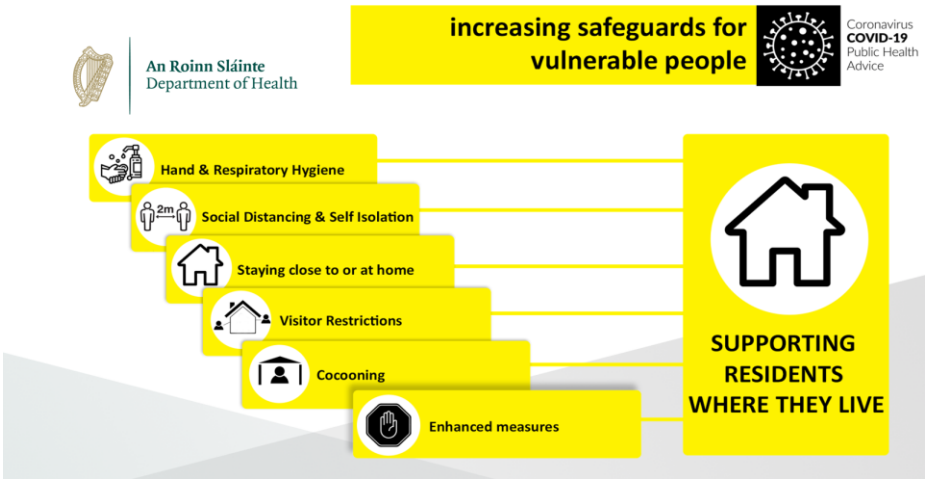


Figure 1: COVID-19 spread – safeguard for vulnerable people

People living in LTRC facilities are vulnerable populations and are at a higher risk of being susceptible to infection from COVID-19, and for subsequent adverse outcomes[6]. There are characteristics of LTRC facilities in Ireland that make them high risk for Covid-19 outbreak and contagion across residents and staff.

These characteristics include:

- Residents by their nature of age or other underlying conditions are at high risk of contracting Covid-19;
- Settings tend to be congregated and residents might be in shared rooms rather than individual rooms;
- High contact environments i.e. significant levels of physical contact and close proximity between care staff and residents, particularly in relation to personal care;
- High level of physical interaction i.e. high numbers of residents, staff, cleaners, caterers, service providers;
- Symptom ascertainment and room isolation can be exceptionally challenging in older residents with neurologic conditions, including dementia;
- Symptoms of COVID-19 are common and might have multiple etiologies in this population;
- A confirmed outbreak will see high levels of staff absenteeism due to sick leave and self-isolation requirements;
- To provide continuity of service absenteeism may result in the need for higher usage of agency/temporary staff, who in turn may be moving between facilities, work in multiple facilities and often share accommodation with each other and with other vulnerable groups,

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

increasing the risk of transmission; these are international phenomenon and not peculiar to Ireland as recognised by the ECDC 19th May 2020 technical report.[7]

- The emerging information on the extent of asymptomatic and pre-symptomatic COVID-19 transmission.

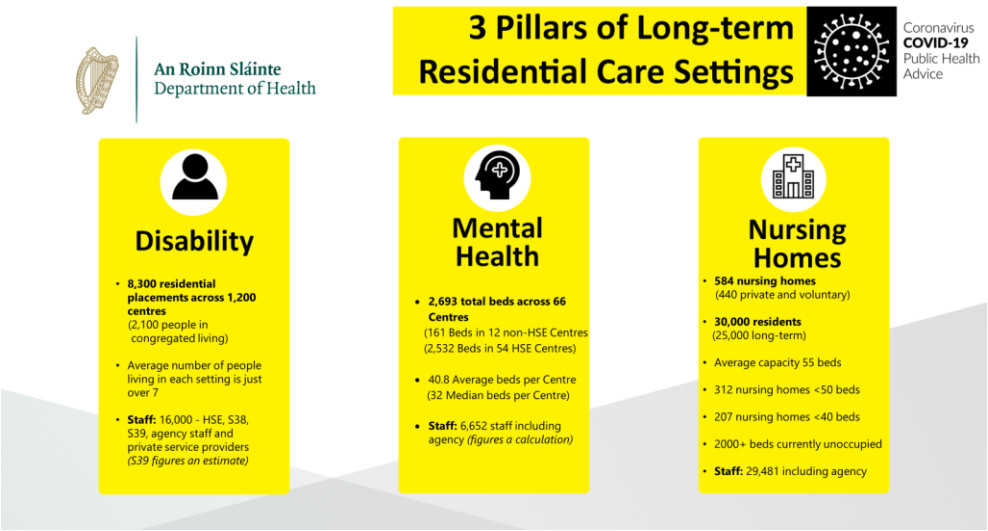


Figure 2: Overview LTRC services

3. Impact of COVID-19 and disease progression in Ireland

The impact of COVID-19 in the LTRC facilities has, like many other countries, been considerable. In recent years[8] the impact of influenza on this sector has been recorded by the HPSC in their weekly and annual reports describing the annual influenza epidemics. In the most recent severe season of 2017/ 2018, 200 influenza outbreaks were reported including 158 influenza outbreaks that season in residential care facilities. However, only 53 deaths were laboratory confirmed to be associated with these outbreaks. Clearly, there are a number of reasons why LTRC have been more severely impacted in this COVID-19 pandemic and these lessons are becoming more evident as epidemiologists and public health experts have learned more about the transmission of this novel virus over the preceding weeks and months.

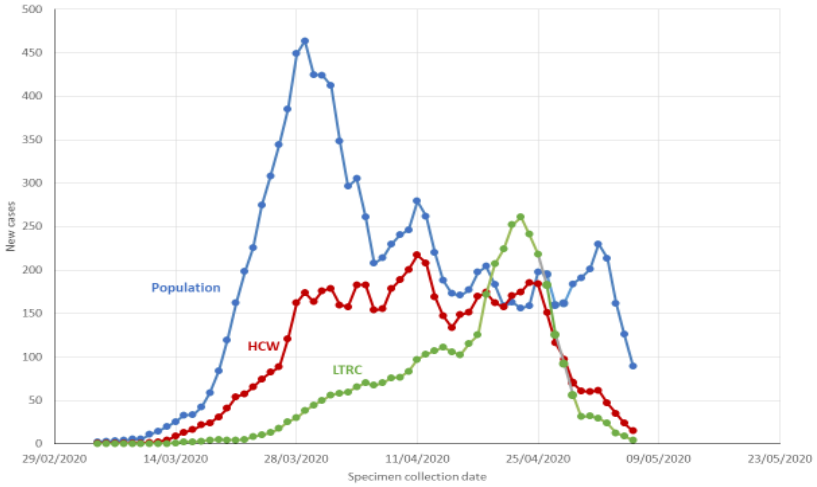
This virus is much more infectious than influenza. A recent review of 12 modelling studies reports the mean basic reproductive number (R_0) for COVID-19 at 3.28, with a median of 2.79.[9] The median R value for the pandemic of influenza H1N1 2009 was 1.46 and for seasonal influenza was 1.28.[10]

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

[7] https://www.ecdc.europa.eu/en/publications-data/surveillance-COVID-19-long-term-care-facilities-EU-EEA
[8] Health Protection Surveillance Centre https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/surveillance/influenzasurveillancereports/seasonsummaries/Influenza%202017-2018%20Annual%20Summary_Final.pdf
[9] Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK – eighth update 8 April2020
[10] Estimates of the reproduction number for seasonal, pandemic, and zoonotic influenza: a systematic review of the literature Matthew Biggerstaff, Simon Cauchemez, Carrie Reed, Manoj Gambhir and Lyn Finelli

Analyses of the trajectory of the epidemic among the general population, healthcare workers and LTRC residents[11] has been conducted by the Irish Epidemiological Modelling Advisory Group. Their work shows that the peak number of new confirmed cases in the general population was observed in the last week of March (Graph 1). The peak number of new confirmed cases in healthcare workers occurred after this in mid-April. The rate of increase of new cases among LTRC residents was slower and lagged behind both of these populations. The peak in numbers of newly confirmed cases seen in LTRC residents in late-April coincides with the implementation of the expanded testing programme of LTRC residents and staff.

Graph 1: Number of new cases detected each day, by specimen collection date, an epidemic curve, for three categories of cases – population, healthcare workers, LTRC



The serious impact on LTRCs was subsequently identified by ECDC in their 9th rapid risk assessment of 23rd April 2020. An emerging picture from the accounts from other jurisdictions are that the virus is likely to have carried unwittingly into facilities by asymptomatic or very mildly symptomatic patients or staff, through no fault of either. Recent testing of all staff in all facilities and all patients in affected facilities will have helped to stop transmission. It remains a major challenge and it will inform our planning as to how best to prevent these importations during the coming months. Reducing the amount of virus in the community will help.

Graph 2 provides a view of the number of COVID-19 outbreaks by date in LTRC settings. The first outbreak was not identified until the 16th March – 4 days after the implementation of visiting restrictions (12th March[12]). In addition, most outbreaks were identified after the 23rd March into the first week of April. Another spike in outbreak identifications coincided with the implementation of the expanded testing programme in the last week of April.

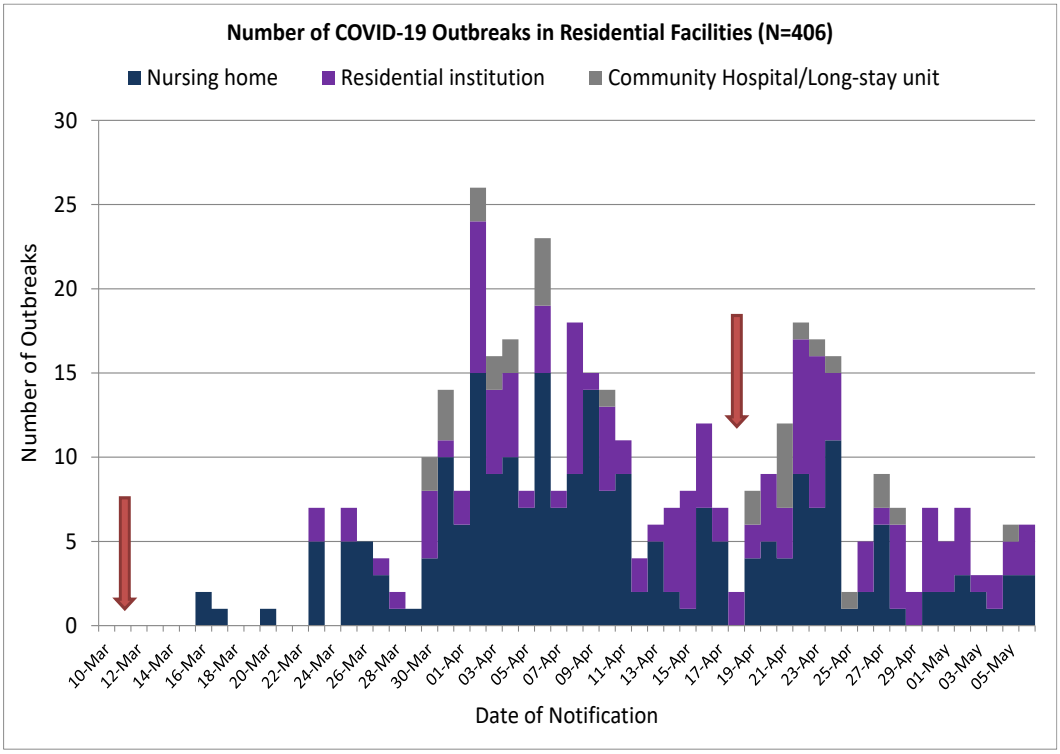
The graph shows the timeline along which new outbreaks in nursing homes, residential institutions and community hospital/long stay units were identified and notified to the HPSC by local Departments of Public Health. The first red arrow corresponds to the time at which the first public health measures,

[11] Isolated cases in LTRC, not associated with an outbreak, are attributed to the general population. LTRC residents described in the above graph reside in settings that have confirmed outbreaks

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

including the restriction of visitors to residential care facilities, were implemented. The second arrow refers to the implementation of the expanded testing programme of residents and staff in residential care facilities.

Graph 2: Number of COVID-19 Outbreaks in LTRC by date



4. COVID-19 Mortality

Excess mortality

Different countries count deaths in different ways and so the data are not always consistent or comparable at an international level. Unlike Ireland, many other countries are not able to report on deaths in nursing homes or in the community and many just report on laboratory confirmed deaths in hospitals. Some countries do not report deaths where COVID-19 may not have been considered to be the main cause of death but rather contributed as a secondary cause. Many countries report completely separately on the registered deaths and are unable to link them with the deaths by place of death such as hospital or nursing home.

In Ireland we can link all these different data streams and provide a breakdown on where these deaths are occurring. It does however mean there can be a lag while all of this work to link data happens and for the notification to reach the HPSC and the Department of Health.

In Ireland, every effort is being made to report on all deaths linked to COVID-19, including:

- all clinicians have been written to, to emphasise to them the importance of death certification and notification of deaths
- outbreak control teams have been asked to ensure that all confirmed or suspected cases in Residential Care Facilities are notified
- a census of mortality in residential care settings has been undertaken (see below)

- Funeral Directors have been written to, to ask them to encourage families to use the online option for death certification and to submit death certification in a timely manner
- the Health Protection Surveillance Centre is monitoring 'all cause' mortality and Ireland is participating in a European network (EuroMOMO) which is monitoring 'all cause' mortality.

Our approach has been clear and consistent to record both probable and all COVID-19 deaths in residential settings. We are now using our increased testing capacity to focus on staff and residents so that we can learn in real time about this virus, ensuring that our actions are informed by evidence of the pandemic. Ireland is one of the few countries to have collected LTRC mortality data from the start. In addition, Ireland reports both lab confirmed and probable deaths.

Mortality Census LTRC

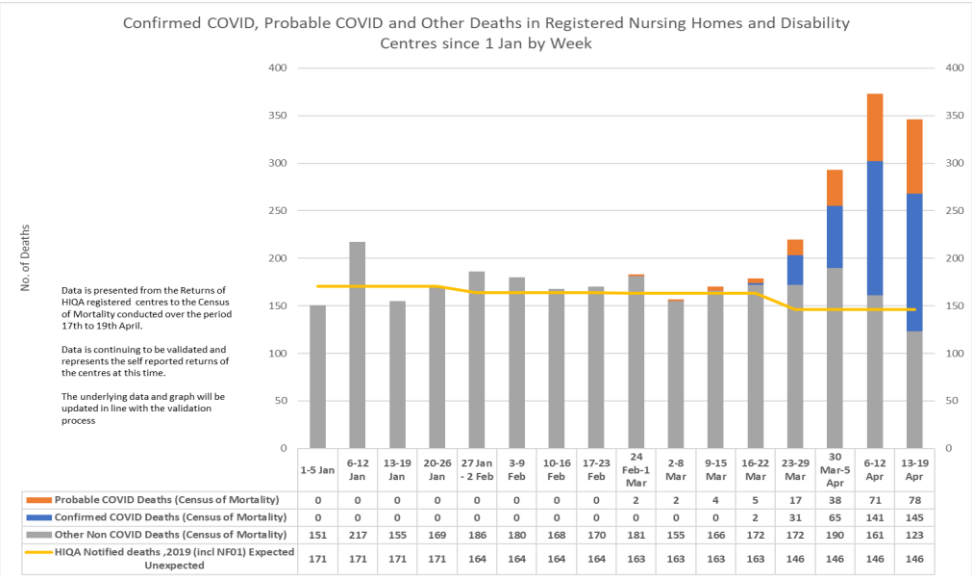
In order to enhance the picture of all mortality in LTRC settings, including lab confirmed and probable deaths, and as per NPHET's actions on 17th April 2020, the Department of Health undertook a census of mortality rates in all registered LTRC settings. This census reported 3,367 total deaths having occurred in LTRCs during the period Jan – 19th April 2020 as set out below.

Table 1: Mortality Census of LTRCs 1st January – 19th April 2020

	COVID-19 Lab confirmed deaths	COVID-19 Probable deaths	Total COVID-19 deaths	All deaths
Nursing Homes	376	209	585	3,243
Disability	8	8	16	73
Mental Health*	10	4	14	51
Total	394	221	615	3,367

Data was compared between the census of mortality and other sources of mortality data including the Health Information and Quality Authority (HIQA) NF02 notifications and Health Protection and Surveillance Centre (HPSC). It demonstrated that the number of cases matched closely between these sources. The data in the graph below would suggest that excess deaths in this period were COVID-19 related.

Graph 3: Mortality Census – LTRC settings January – April 2020



The data indicates an increase in mortality in LTRCs started in mid-March onwards, around the week beginning 16th March 2020. This data provides a snapshot and as the census data is self-reported there will inevitably be some variance between this data and other data sources. The increase in mortality seen here would appear to be attributable to COVID-19 related deaths. Data was also collected on the place of death of residents. Deaths occurred outside of residential centre and in hospitals as follows: 26% for COVID-19 confirmed cases; 5% COVID-19 probable; 15% of all deaths. The current HSE guidance is that people are managed in the facilities where they live unless a transfer to hospital is deemed clinically appropriate and will confer additional benefit.

While the information likely indicates that COVID-19 infection is contributing to mortality in this population during the pandemic, it will ultimately require the outputs of European (and Irish) all-cause mortality surveillance systems to determine the level of excess mortality above what would be expected and particularly in comparison with past severe influenza seasons when excess deaths can reach levels of >1000.

COVID-19 and LTRCs – International Overview Mortality

Official data on numbers of people affected by COVID-19 is not available in many countries. Due to differences in testing availabilities and policies, and to different approaches to recording deaths, international comparisons are difficult.[13] In countries where there have been at least 100 deaths in total and we have official data, the % of COVID-related deaths among care home residents ranges from 24% in Hungary to 82% in Canada.

There have been large numbers of deaths in care homes in Italy, Spain, the United Kingdom and the United States but official data for these countries is either incomplete or difficult to interpret. Another difficulty in comparing data on deaths is that in some countries the data only record the place of death, while others also report deaths in hospital of care home residents. The table below sets out the most recent data from official sources but is caveated with respect to the difficulties in comparing data where there exist differences in testing availabilities and policies, and different approaches to recording deaths, therefore international comparisons are difficult.

[13] Comas-Herrera A, Zalkaín J, Litwin C, Hsu AT, Lane N and Fernández J-L (2020) Mortality associated with COVID-19 outbreaks in care homes: early international evidence. Article in LTCCOVID.org, International Long-Term Care Policy Network, CPEC-LSE, 21 May 2020

Table 2: Number of COVID-19 related or confirmed deaths in the population and in care homes (or among care home residents)

Country	Date	Approach to measuring deaths	Total number deaths linked to COVID-19	Number of deaths of care home residents linked to COVID-19	Number of deaths in care homes	Number of care home resident deaths as % of all COVID-19 deaths	Number of deaths in care homes as % of all COVID-19 deaths
Austria	22/04/2020	Confirmed	510	220		41%	
Australia	18/05/2020	Confirmed	99	29		29%	
Belgium	18/05/2020	Confirmed + Probable	9,080		4,646		51%
Canada	08/05/2020	Confirmed + Probable	4,740	3,890		82%	
Denmark	07/05/2020	Confirmed	506	170		34%	
France	18/05/2020	Confirmed + Probable	28,239	14,363	10,650	51%	38%
Germany[67]	20/05/2020	Confirmed	8,090	3,029		37%	
Hong Kong	20/05/2020	Confirmed	4	0	0	0%	0%
Hungary	11/05/2020	Confirmed	421	100		24%	
Ireland	06/05/2020	Confirmed + Probable	1,375		857	62%	
Israel	29/04/2020	Confirmed	202	65		32%	
Norway	18/05/2020	Confirmed	233		135		58%
Portugal	09/05/2020		1,125	450		40%	
Singapore	03/05/2020	Confirmed	18	2	0	11%	
South Korea	30/04/2020	Confirmed	247	84	0	34%	0%
Spain	10/05/2020	Confirmed + Probable	31,889 (confirmed)		9,642 (confirmed) 16,678 (confirmed + probable)		30% (confirmed)
Sweden	14/05/2020	Confirmed	3,395	1,661		49%	
England & Wales (United Kingdom)	08/05/2020	Probable + Excess deaths	37,375 (probable) 49,470 (excess deaths)	12,526[68] (probable) 25,591 (excess deaths)	9,980 (probable) 21,753 (excess deaths	38% (probable) 52% (excess deaths)	27% (probable) 44% (excess deaths)
Scotland (United Kingdom)	17/05/2020	Probable + Excess deaths	3,546 (probable) 3,946 (excess deaths)		1,623 (probable) 2,006 (excess deaths)		46% (probable) 51% (excess deaths)
United States[69]	20/05/2020	Confirmed	93,163	30,130		41%	

5. COVID-19 Virus Transmission

Transmission of COVID-19 is via small respiratory droplets through sneezing, coughing, or even talking when people interact with each other for some time in close proximity. These droplets can then be inhaled, or they can land on surfaces that others may come into contact with, who can then get infected when they touch their nose, mouth or eyes. The incubation period for COVID-19 (i.e. the time between exposure to the virus and onset of symptoms) is currently estimated to be between one and 14 days).

The environment within our LTRC settings poses unique environmental challenges including congregated settings, with residents living in close quarters with each other thereby making quarantining difficult. The nature of the high personal interaction by staff involves physical interactions and care givers moving from room to room. Nursing homes are established to be people's homes rather than places where advanced and complex healthcare interactions occur.

The very infectious nature of this virus makes it difficult to prevent and control in residential care settings - an experience replicated internationally. In addition, evidence is emerging that presentation of COVID-19 in LTRC can differ from that of the general population from no temperature to confusion and the pace of progression of disease is much faster, likely due to the age and frailty of older people in such settings. Because illness, including COVID-19 infection, in LTRC patients/residents can present atypically, the threshold for considering a possible diagnosis of COVID -19 should be low and even subtle changes in condition should be further evaluated.[14]

[14]Coronavirus-19 in geriatrics and long-term care: an update J Am Geriatr Soc. 2020 Apr 3. doi: 10.1111/jgs.16464. [Epub ahead of print]

ECDC recognises in a special technical report, 19th May, *Surveillance of COVID-19 at long-term care facilities in the EU/EEA*[15] the high COVID-19 morbidity and mortality observed among residents in long-term care facilities (LTCF) in EU/EEA countries poses a major challenge for disease prevention and control in such settings. The presence of atypical clinical presentations in older adults and people with underlying conditions including anorexia, anosmia, apathy, conjunctivitis, diarrhoea, disorientation, lethargy, loss of weight, nausea, rash, respiratory distress, somnolence, stuffed nose or vomiting is noted.

A publication in the US in the Morbidity and Mortality Weekly Report (MMWR) on April 3rd outlined asymptomatic and pre-symptomatic infections in a long-term care facility in Washington. Half of the residents who tested positive were asymptomatic at the time of testing.[16] This means that previously considered highly effective screening measures such as temperature checking, while very useful, will not detect those without symptoms.

The ECDC technical report outlines staff factors that may have contributed to spread of COVID-19 including symptomatic, pre-symptomatic, and asymptomatic case's. Other contributing factors may have been staff working in more than one facility, lack of personal protective equipment (PPE), lack of training and testing and testing being limited to symptomatic individuals. When caregivers become infected with COVID-19, which is difficult to avoid during a pandemic, they will have to remain at home for a full quarantine period which in Ireland led to high levels of staff absenteeism.

Mitigating COVID-19 spread

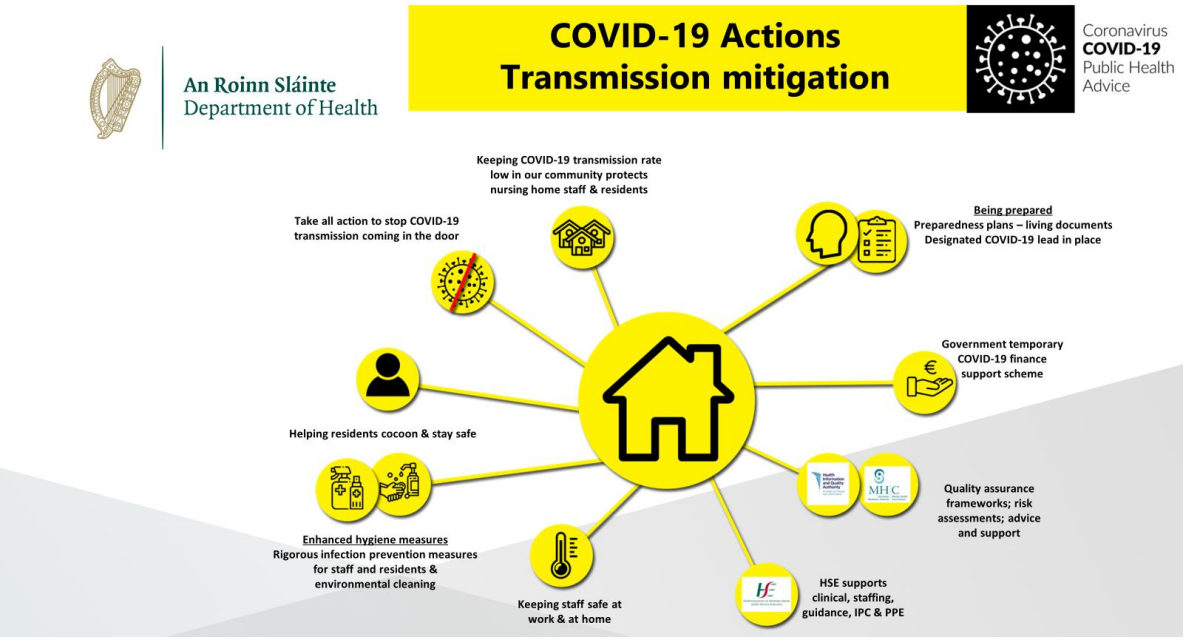


Figure 3: COVID-19 spread – mitigating actions

[15] https://www.ecdc.europa.eu/en/publications-data/surveillance-COVID-19-long-term-care-facilities-EU-EEA
[16] Asymptomatic and Presymptomatic Sars-CoV-" Infections in Residents of a Long-Term Care skilled Nursing Facility – King County, Washington, March 2020 MMWR Morbidity and Mortality Weekly Rept 2020;69: 377-381

Reducing the amount of disease present in our community can help protect our older population, whether living at home or in a LTRC setting. Interrupting transmission is the main goal of public health measures and it is clear from our experience that the scale of effect of interruption of transmission is influenced by a number of factors as presented in figure 3 above. All of the actions taken to mitigate COVID-19 spread are aimed at protecting residents and staff through actions to deter COVID-19 from coming in the nursing home door and if it gets in the door to minimise spread.

Significant enhanced public health measures were set out **31st March 2020** with the aim to interrupt transmission of the disease and prevent onward spread in the nursing home and the community.

The six public health actions agreed are presented in figure 4 and summarised in the box below. Appendix 1 provides a table of the full set of actions and Appendix 2 the HSE's implementation update.

- Strengthened HSE National and Regional Governance Structures
- Transmission Risk Mitigation in suspected or COVID-19 positive settings and staff
- Staff Screening and Prioritisation for COVID-19 Testing
- HSE Provision of PPE and Oxygen
- Training
- Facilities and Homecare Providers – Preparedness planning

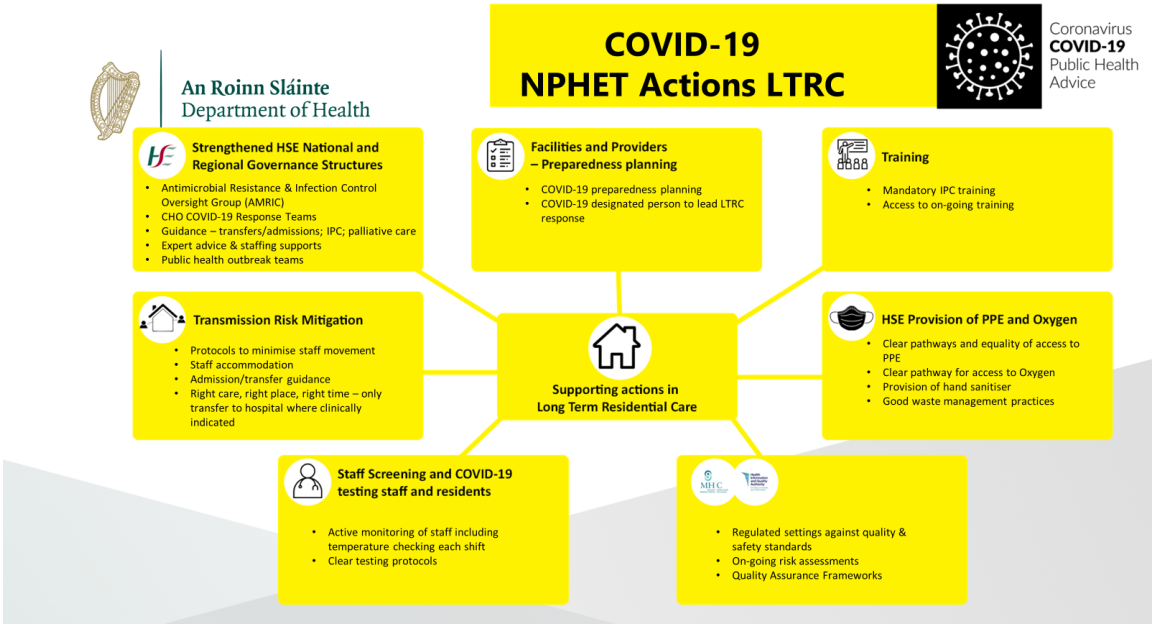
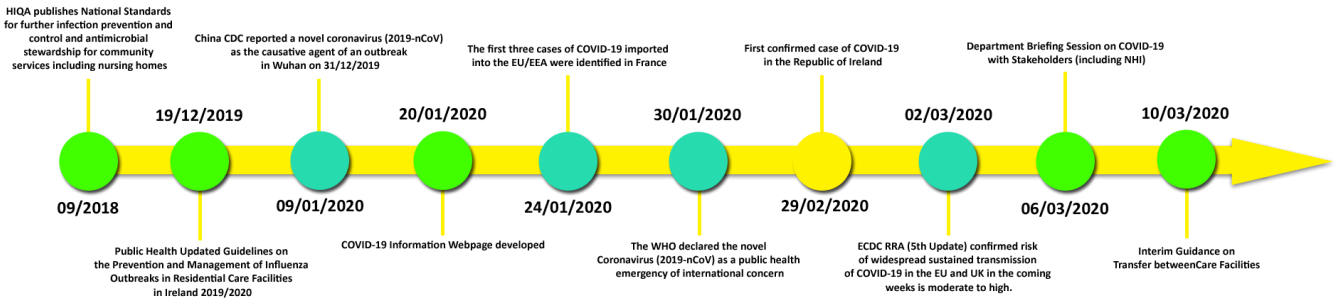
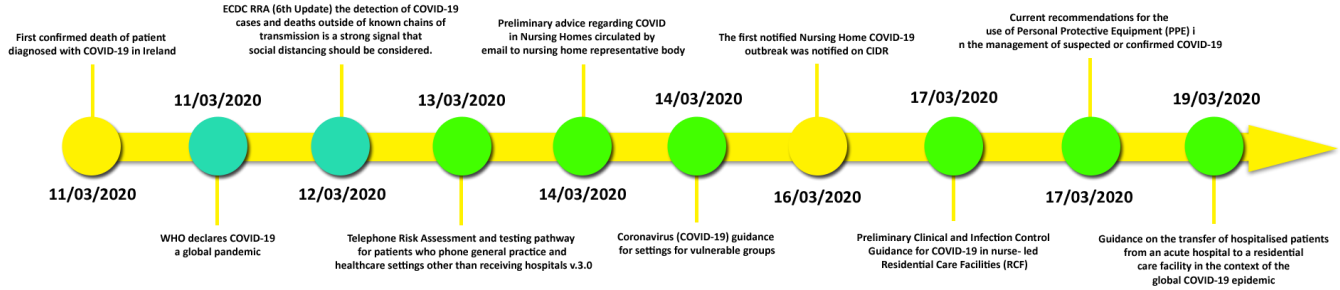


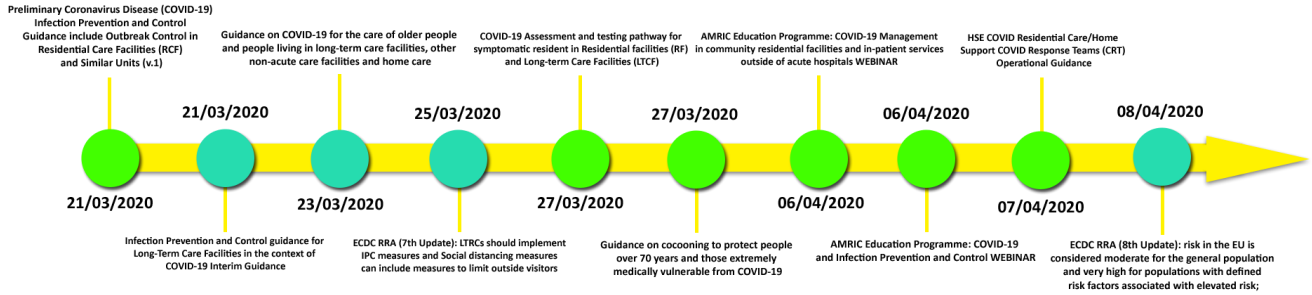
Figure 4: COVID-19 spread – NPHET Actions LTRC

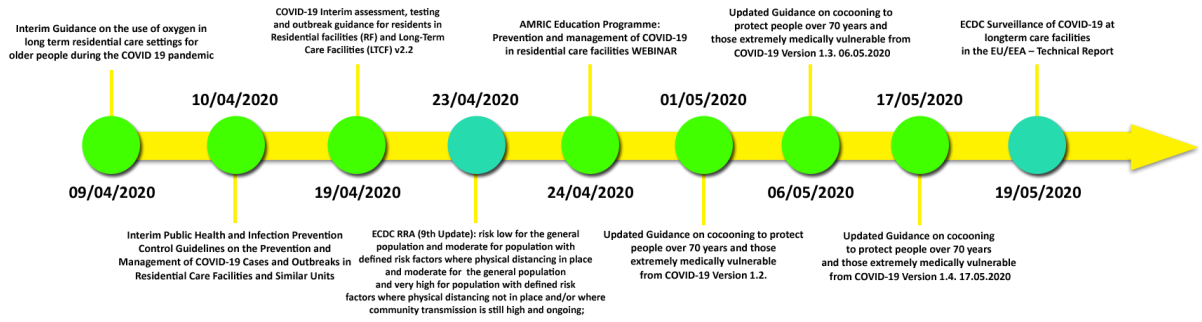
COVID-19 Guidance

A suite of COVID-19 guidance has been developed (Appendix 3). The timeline (page 17) outlines from the date the first COVID-19 case was detected to dates that guidance was developed and updated in line with LTRC infection prevention requirements and recommendations from both ECDC and the WHO.









Note: *Timeline information presented as known information at the time and may be subject to change*

6. Visitor restrictions taken in Nursing Home settings

Visitor restrictions to LTRC settings have been a staple of infection control in many countries. A proportionate response assumes that restrictive measures are justifiable, transparent, flexible and open to review and modification where necessary in individual circumstances and at the point at which the circumstances change for everyone.

LTRCs are people's homes as well as places where healthcare is provided. During these times there is a particular 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. For many in these settings the impact of physical distancing, isolation and restricted contact with family and loved ones is considerable.

It is important that everyone understands why restrictions are implemented and what impact they will have on their interactions. Any changes or updates to these arrangements and the basis for them, should be communicated to residents and their families in a timely fashion. Regular updates about the wellbeing of the resident should be provided to families, e.g. instituting a regular call from the service to families by a person directly involved in the care of the resident. In certain cases, it may be appropriate and important to the wellbeing of the resident to enable a visit or visits, under prescribed conditions e.g. when a resident is at the end of life, or to reduce significant distress or confusion of a resident.

The timing of introduction and level of restrictions varied across countries. Both the WHO and ECDC provided visitor restriction guidance in March. WHO's technical guidance Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 **(21st March[17])** identified that in areas where COVID-19 transmission has been documented, access to visitors in the LTCFs should be restricted and avoided as much as possible.

On **23rd March 2020,** WHO - Guidance on COVID-19 for the care of older people and people living in long-term care facilities, other non-acute care facilities and home care identified that '*Symptomatic visitors should be restricted from visiting the facility. If visitors must visit for a resident's well-being, or for compassionate reasons, and as the next of kin, they should be instructed in respiratory hygiene and on how to wear a mask, perform hand hygiene, and visit the resident directly and exit directly after the visit. They should limit their movement within the facility and come during non-visiting hours when they are less likely to transmit their illness and be provided with necessary PPE'.* [18]

ECDC in its updated risk assessments on **25th March 2020**, 7th Update and **8th April** 2020, 8th Update recommended that social distancing measures can include measures to limit outside visitors to nursing home settings. Table 3 below outlines the summary of visiting measures related to nursing homes for a number of countries.

In the Irish context, on **10th March 2020** NPHET[19] advised that blanket socially restrictive actions around hospitals and nursing homes were not necessary at that moment in time. People were again encouraged to follow respiratory etiquette and hand hygiene practices in order to protect vulnerable groups, including older people and patients with underlying conditions. However, **people should not visit if they themselves are unwell**. At that time there were 34 confirmed cases in Ireland. Further visitor restrictions were recommended by NPHET on **11th March 2020** for implementation on **13th**

[17] https://www.who.int/publications-detail/infection-prevention-and-control-for-long-term-care-facilities-in-the-context-of-covid-19

[18] https://apps.who.int/iris/bitstream/handle/10665/331913/COVID-19-emergency-guidance-ageing-eng.pdf?sequence=1&isAllowed=y

[19] https://www.gov.ie/en/press-release/a4016f-statement-from-the-national-public-health-emergency-team-tuesday-10-/

March 2020[20] for LTRC settings (14 days from first case detected on 29th February). Ireland had 91 cases detected on date of introduction of visitor restrictions and 1819 cases detected 14 days later.

The interventions were made at a time when there was as yet no widespread transmission of COVID-19 in Ireland. The report provided for NPHET from the HPSC on the 11th March 2020 described 35 cases in the country, only 7 of which were reported from the East of the country, initial clusters occurring in the south, mid-west and west of the country.

Table 3: Summary of visiting measures taken in 17 countries/regions relating to Nursing homes addressing the COVID-19 pandemic.

Country	Measure Taken	Date Measure was taken	Days from first detected case	Total detected cases on day of intervention	Total detected cases on day of intervention + 14 days
South Korea	SK strengthens measures to contain outbreak in residential settings for vulnerable people.[13]	07-03-2020	47	6,767	8,897
Belgium	Social Distancing recommendations first introduced, including public message not to visit institutions with vulnerable people[2]	10-03-2020	36	239	3,700
Sweden	Relatives are urged to avoid unnecessary visits to hospitals and elderly homes, and never make a visit if you have respiratory symptoms.[16]	10-03-2020	39	248	2,000
	All private visits to nursing homes outlawed by the government.[17]	1-04-2020	61	4,435	11,445
Ireland	People were encouraged to follow respiratory etiquette and hand hygiene practices in order to protect vulnerable groups, including older people and patients with underlying conditions. People should not visit if they themselves are unwell.	10-03-2020	10		
	Visitor restrictions LTRC unless exceptional circumstances on compassionate grounds	13-03-2020	13	34	1819
Spain	Govt advising to limit visits to nursing homes[14]	11-3-2020	41	2140	39,673
	State of emergency: attendance at care centres to access care only[15]	14-03-2020			
France	All visits to ehpad (nursing homes) and long term care units prohibited [8].	11-03-2020	47	2,269	22,025
Norway	People were requested not to visit others in institutions with vulnerable groups. [12]	12-03-2020	16	277	2900
Northern Ireland	Guidance issued to NI care homes and domiciliary facilities: one adult visitor per day.[11]	12-03-2020	45	52	586
	Shielding which includes extremely medically vulnerable living in residential care	21-03-2020			
	Lockdown	23-03-2020			

[20]Implementation of NPHET recommendations from meeting 11th March were announced by the Taoiseach on 12th March 2020

Canada		13-03-2020	46	152	3555
	Ontario: essential visitors only[3]	13-3-2020			
	Alberta essential visitors only[4]	20-3-2020			
UK	PHE Guidance: Those with symptoms should not visit care homes[5]	13-03-2020	42	590	11658
	PHE Guidance: Shielding which includes extremely medically vulnerable living in residential care[6]	21-03-2020			
	Lockdown	23-03-2020			
	PHE Guidance: Only essential visitors to care homes[7]	15-04-2020			
Germany	All states adopt measures to enforce social distancing [9,10] including imposing restrictions on to visits to hospitals, care facilities, and other similar settings.	16-03-2020	48	4,800	57,300
Australia	Restrictions on entry to aged care facilities[1]	18-03-2020	53	510	4,707
The Netherlands	Institutional homes closed to visitors and anyone not directly involved with the provision of care [18]	20-03-2020	22	2,994	14,697
New Zealand	Alert Level 2 announced: restricted visits to aged residential care[19]	21-3-2020	23	66	824

This is an update to an excerpt from a document entitled 'International Tracker of Government Responses to COVID19' compiled by PSIU. Incidence figures are taken from WHO https://COVID19.who.int/ for consistency. (Note that these may be subject to time lags and revisions. UK data taken from ECDC https://www.ecdc.europa.eu/en/publications-data/download-todays-data-geographic-distribution-COVID-19-cases-worldwide). Incidence data reflects testing strategies and case definitions in each country and therefore numbers are not directly comparable. Updates include addition of details on visitor restrictions in UK, New Zealand, Ontario, Alberta and Spain as well as update of a range of reference sources to government websites.

Sources:

1. https://www.pm.gov.au/media/update-coronavirus-measures
2. https://www.premier.be/fr/Coronavirus-Mesures-supplementaires-prises-lors-du-Conseil-National-de-Securite
3. http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/memos/CMOH_Memo_-_Visitors_COVID-19_March_13_2020.pdf
4. https://open.alberta.ca/dataset/96e5aad9-9981-4593-b015-74484f967a4e/resource/1b1f9b7b-57fa-4f9f-8256-ee223d5878fd/download/health-cmoh-record-fof-decision-cmoh-03-2020.pdf
5. https://www.gov.uk/government/news/new-adult-social-care-guidance-to-protect-the-most-vulnerable-against-COVID-19
6. https://www.gov.uk/government/news/major-new-measures-to-protect-people-at-highest-risk-from-coronavirus
7. https://www.gov.uk/government/collections/coronavirus-COVID-19-social-care-guidance#social-care-guidance
8. http://www.leparisien.fr/societe/coronavirus-les-maisons-de-retraite-en-vase-clos-11-03-2020-8278029.php
9. https://www.bundesregierung.de/breg-de/themen/coronavirus/beschluss-zu-corona-1730292
10. https://www.bundesregierung.de/breg-de/themen/coronavirus/leitlinien-bund-laender-1731000
11. https://www.health-ni.gov.uk/sites/default/files/publications/health/COVID-19-Guidance-Social-Community-Residential-Care.pdf
12 https://web.archive.org/web/20200331115323/https://www.helsedirektoratet.no/nyheter/anbefaler-tiltak-for-a-redusere-antall-reisende-i-rush-tiden
13. https://www.mohw.go.kr/eng/nw/nw0101vw.jsp?PAR_MENU_ID=1007&MENU_ID=100701&page=2&CONT_SEQ=353495
14. https://www.euronews.com/2020/03/11/spain-warns-elderly-to-keep-away-from-grandchildren-as-COVID-19-cases-soar
15. https://www.lamoncloa.gob.es/presidente/intervenciones/Documents/2020/20200314%20%20PG%20Estado%20de%20Alarma.pdf
16. https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/februari/nytt-bekraftat-fall-av-COVID-19/
17. https://www.government.se/articles/2020/04/s-decisions-and-guidelines-in-the-ministry-of-health-and-social-affairs-policy-areas-to-limit-the-spread-of-the-COVID-19-virusny-sida/
18. https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/februari/nytt-bekraftat-fall-av-COVID-19/
19. https://www.health.govt.nz/news-media/media-releases/COVID-19-update-22-march-2020

Figure 5: Summary of visiting measures across countries

7. Testing

From the beginning of testing for COVID-19 nationally, the National Ambulance Service (NAS) had been offering a home-based testing service to all patients who met the case definition criteria set out for COVID-19 by HPSC/NPHET including residential care facilities. As the 'home-based' testing model transitioned towards community-based testing centres a dedicated pathway for LTRC testing was established with NAS.

On the 27th March the case definition was expanded to alert clinicians to the need for a higher index of suspicion being warranted re possible atypical COVID-19 presentations in LTRC facilities and those with immunocompromise. Given the highly infectious nature of COVID-19 in these facilities, and in order to avoid testing delays, LTRC facilities were advised to treat all residents with symptoms as probably COVID-19 positive in facilities where a COVID-19 diagnosis had been confirmed and to avoid further delays in cohorting these residents while awaiting testing.

A clinical picture in vulnerable and older populations has emerged that did not meet the case definition as established initially through the WHO. This had a significant impact on the evolving picture in many of these facilities. The case definition was changed in the HPSC guidance to reflect this change in the clinical picture on 17th April 2020.

On 17th April following a NPHET recommendation the testing of all staff in LTRC facilities was conducted. Over 95,900 tests were completed under the LTRC mass testing programme. Testing has now completed in nursing homes (577 sites) and the overall positivity rate is low (5.5%). All results associated with the mass testing of Nursing Homes have been communicated. HPSC is preparing a report for NPHET on the epidemiology of cases and outbreaks of Covid-19 within residential care facilities in Ireland which provides data and analysis on outbreaks and preliminary results from the mass testing programme. This will help inform and guide future testing strategy for these facilities.

8. Ethical considerations in the context of COVID-19 LTRC facilities

The Department of Health is preparing a paper on "Ethical Considerations Relating to Residential Care Facilities in the context of COVID-19". The paper is for all providers of LTRCs and all staff working in congregated residential care facilities including, but not limited to, healthcare assistants, nurses, clinicians, managers, and visiting GPs. While it is recognised LTRC encompasses a broad group of service providers (the State, voluntary and private), as well as a broad group of clients, each with their own specific needs, as well as diverse care settings, there are a number of common issues arising in LTRC which require ethical consideration. Individuals in LTRC settings have the same human rights as other people to a high standard of care and must be treated with dignity and respect. The guidance seeks to ensure that the interests of vulnerable populations are protected and that public health measures introduced in response to COVID-19 do not disproportionately impact on their rights and liberties.

9. Measures and Timelines

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

Appendix 3 provides a table with key dates and both national and international actions.

While this paper focuses specifically on LTRCs, it is also important to recall the significant and early consideration and preparation undertaken in Ireland generally and in the context of NPHET, prior to the first case of COVID-19 in Ireland and the first confirmed cases in LTRCs. On **24th January 2020** the European Centre for Disease Prevention and Control (ECDC) outlined that the first three cases of COVID-19 imported into the EU/EEA were identified in France. ECDC's communication also noted "*EU/EEA countries should ensure that timely and rigorous infection prevention and control measures (IPC) are applied around people diagnosed with 2019-nCoV*."[21] By the **27th of January 2020** NPHET had been established and held its first meeting. At this meeting NPHET noted that "*the ECDC's risk assessment for the EU / EEA is now 'moderate' but that, subject to appropriate control measures being in place, the risk of onward transmission is rated as 'low*'." At this meeting the HSE briefed NPHET with regard to the HSE's High Consequences Infectious Diseases Group, which had already had several meetings and had produced algorithms / procedures for all key sectors. On **30th January 2020** the HSE circulated guidance and posters on coronavirus to various settings including private nursing homes.

Nursing Homes Ireland through various communique to its members have provided ongoing advice on preparedness, planning and guidance. The Department of Health and the HSE have maintained ongoing engagement and communications with Nursing Homes Ireland and individual nursing homes where issues, such as access to guidance, finance support, staff and PPE as they have been raised have been worked through, managed and progressed.

The ECDC, in its fifth update to its Rapid Risk Assessment (RRA), confirmed the risk of widespread sustained transmission of COVID-19 in the EU and UK in the coming weeks is moderate to high[22] on **2nd March 2020**. On the same day NPHET publicly announced that Ireland remains in a containment phase and the general public are advised to follow public health advice and:

- wash hands properly and regularly
- cover nose and mouth with a tissue when you cough and sneeze

This was in line with the ECDC advice covered in its RRA fifth update, **5th March 2020**.

In advising Government on the introduction of public health measures, particularly during the containment phase, the NPHET was concerned to adopt a strategic and proportionate approach to ensuring that public compliance would be maintained potentially over the longer term, by avoiding adopting stricter measures too early. The advice at that time was for the implementation of containment measures in line with recognised international guidance. During this phase there was limited local transmission and the purpose of the Government-coordinated measures was to prevent further spread of infection by early detection of imported or local cases. There were no reported deaths in Ireland and a small number of confirmed cases in this period. The NPHET press release of **10th March 2020** stated that "*blanket socially restrictive actions around hospitals and nursing homes are not necessary at this moment in time. People are encouraged to follow respiratory etiquette and hand hygiene practices in order to protect vulnerable groups, including older people and patients with underlying conditions. People should not visit if they themselves are unwell*"**.**[23]

Throughout the HSE and HPSC have published and updated COVID-19 guidance (See appendix 3).

[21] https://www.ecdc.europa.eu/en/news-events/novel-coronavirus-three-cases-reported-france
[22] https://www.ecdc.europa.eu/sites/default/files/documents/RRA-outbreak-novel-coronavirus-disease-2019-increase-transmission-globally-COVID-19.pdf
[23] https://www.gov.ie/en/press-release/a4016f-statement-from-the-national-public-health-emergency-team-tuesday-10-/

On **10th March 2020** Interim Guidance on Transfer between Care Facilities was circulated and through HIQA was circulated directly to all LTRC registered centres.

On the **11th March** 2020 the WHO declared COVID-19 a pandemic and the following day the ECDC published its 6th update to the RRA, **12th March 2020**, including new guidance in relation to the implementation of social distancing measures and prevention and control priorities in relation to *inter alia* LTRCs.[24] On the same day as the ECDC update, NPHET recommended that Ireland move to "delay phase" and social distancing measures were recommended and announced, including:

- Visiting restrictions in long-term care facilities;
- Individuals who have symptoms should self-isolate for a period of 14 days;
- Staggered breaks in work and greater remote working etc.

The ECDC RRA noted also "*If health and social institutions are exposed to the virus by health workers or family members with mild infection, the virus could spread quickly in such a setting, in the absence of very early detection and highly effective infection control. The probability of transmission in such settings can be modified by the level of implementation of robust IPC measures and early detection and isolation of introduced cases in patients, residents or staff*".

The Government's COVID-19 Action Plan was published on **16th March 2020** and included key actions relating to the protection of vulnerable groups in community settings, including long-term care settings, through maintenance of existing services and enhanced support actions.

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

On **March 18th 2020,** the NPHET subgroup on Vulnerable People agreed that an urgent short-life working group should be established to examine issues relating to COVID-19 arising in the nursing home sector and to develop proposed measures, including temporary financial support to respond to those issues, where necessary. This interagency working group met on three occasions from the 19th to 26th March and held a consultative engagement with a representative body and with what was, at the time, the first nursing home dealing with confirmed COVID-19 cases. The chair of the working group supported the chair of the Vulnerable Persons Subgroup to develop a paper on LTRC issues for the NPHET meeting on 31st March to ensure timely input to NPHET considerations and to progress a proposal for a temporary assistance payment scheme for private and voluntary nursing homes.

NPHET met on **23rd and 24th March 2020** and across both meetings considered the ECDC's technical document "*Considerations relating to social distancing measures in response to COVID-19 – second update*" published on 23rd March.[25] In line with this document, NPHET recommended enhanced social distancing measures, and specifically in relation to LTRCs recommended "*social distancing measures, in as far as is practicable, is to be ensured between the clients/patients in confined settings, such as long-term care facilities, either for the elderly or persons with special needs*".[26]

[24] https://www.ecdc.europa.eu/sites/default/files/documents/RRA-sixth-update-Outbreak-of-novel-coronavirus-disease-2019-COVID-19.pdf

[25] https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-social-distancing-measuresg-guide-second-update.pdf

[26] https://www.gov.ie/en/collection/691330-national-public-health-emergency-team-COVID-19-coronavirus/#minutes-from-meetings-in-march

On the **24th March 2020** HIQA issued to all designated centres and registered provider's COVID 19 guidance on sector wide preparedness arrangements.

On **25th March 2020**, ECDC published the 7th Update of its RRA[27] which upgraded the risk of "*severe disease associated with COVID-19 for people in the EU/EEA and the UK is currently considered moderate for the general population and very high for older adults and individuals with chronic underlying conditions*." The RRA further stated "*measures taken at this stage should ultimately aim at protecting the most vulnerable population groups from severe illness and fatal outcome by reducing transmission in the general population and enabling the reinforcement of healthcare systems*."

In respect to long-term care facilities, the RRA outlined the following specific measures:

- Long-term care facilities should implement infection prevention and control measures
- Social distancing measures affecting multiple people can include measures to limit outside visitors and limit the contact between the residents of confined settings, such as long-term care facilities;
- Long-term care facilities should implement the baseline options for preparedness for COVID-19 described in an ECDC guidance document, given that the rapidity of an onset of a COVID-19 outbreak may result in insufficient time to implement the necessary infection prevention and control (IPC);
- The ECDC guidance document 'Infection prevention and control for the care of patients with novel coronavirus in healthcare settings – first update' highlights best practices for PPE and options for hospitals and long-term care facilities that have limited access to such materials;
- Testing all cases of acute respiratory infection in hospitals or long-term care facilities in order to guide infection control and PPE use to protect vulnerable persons and healthcare staff; testing of symptomatic healthcare staff, even those with mild symptoms, to guide decisions on exclusion from, and return to, work; the aim is to ensure continued health and social care services;

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

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

Two extraordinary meetings (on **29th and 30th March**) were convened by the Department to further focus on nursing homes – a number of significant considerations and actions arose, including: a requirement for the Health Protection Surveillance Centre (HPSC) to examine additional data in relation to confirmed COVID-19 cases in residential healthcare settings in Ireland; the preparation of a detailed framework of information to support NPHET's focused consideration of the residential care

[27] https://www.ecdc.europa.eu/sites/default/files/documents/RRA-seventh-update-Outbreak-of-coronavirus-disease-COVID-19.pdf

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

On the **30th March 2020** HIQA identified specific designated centres and underlying issues where the registered provider would be challenged to effectively manage this public health emergency. Those at greatest risk were those small providers who did not have access to (a) a group nursing home structure, and (b) a large work force of sufficient scale. The physical premises in which a number of services were provided posed an increased risk associated with multioccupancy rooms, insufficient bathrooms, and minimum day/dining space.

On **31st March 2020**, NPHET considered a specific paper on LTRCs and made a series of recommendations in relation to LTRC facilities comprising six national public health actions (see appendix 1). These actions aim to support the maintenance of residents in LTRCs unless there is clinical or other advantage, and to interrupt transmission of the disease and prevent onward spread in LTRC and the community.

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

The Minister for Health announced, on **4th April 2020**, that he would establish a Temporary Assistance Payment Scheme (TAPS) for private and voluntary Nursing Homes (see next section for further detail).

HIQA issued a regulatory notice to service providers regarding the establishment of the Infection Prevention and Control Hub for designated centres on **6th April 2020** (see next section for further detail).

HSE COVID Residential Care/Home Support COVID Response Teams (CRT) Operational Guidance issued on **7th April 2020**.

ECDC updated risk assessment (8th update): risk of severe disease associated with COVID-19 in the EU/EEA and UK is currently considered moderate for the general population and very high for populations with defined risk factors associated with elevated risk on **8th April 2020**.

On **10th April 2020**, it was agreed at NPHET that there should be continued focus on the long-term residential care sector and to continue to collect, expand and monitor data, with the CRM system data being a critical enabler for this. The NPHET considered that mortality data should be further refined including specifically categorising COVID-19 deaths as suspected or confirmed. Data on identifying place of death; and more timely data on confirmed cases among staff would also be important to get a more complete picture. Given the latest national data and the updated ECDC risk assessment, the NPHET recommended the extension of the current public health measures until midnight on Monday 4th May 2020. There was continued focus on LTRCs at NPHET's meeting on **14th April** where it was agreed that the HSE was to put in place a coordinated national process for carrying out prevalence surveys across nursing homes and other residential healthcare settings, with a particular focus on detecting COVID-19 infections in these settings.

On **17th April** NPHET gave consideration to and endorsed a further set of immediate additional actions focused on long term residential healthcare settings, to further inform and direct the public health response:

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

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

b) national testing of staff across all settings with an initial widespread approach and thereafter ongoing testing, which may include both staff and patients, to be conducted on a rolling basis;

c) the publication and assessment of a COVID-19 quality assurance regulatory framework for LTRCs by HIQA;

d) the implementation of previous recommended actions with enhanced reporting through an expanded 'Nursing Homes/LTRC settings Actions Tracker', which is to include the roll out of the Contact Management (CRM) system.

On **17th April** the Temporary Financial Assistance Scheme for Nursing Homes first opened for applications (see further section below in relation to this Scheme).

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

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

On the **23rd April** the ECDC RRA (9th Update) outlined that risk is low for the general population and moderate for populations with defined risk factors where physical distancing is in place and/or community transmission low and moderate for the general population and very high for population with defined risk factors where physical distancing is not in place and/or community transmission is high and ongoing;

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

At its meeting on **1st May** NPHET continued to advise those aged over 70 years of age and over and the medically vulnerable of the importance of remaining cocooned for their safety. However, should they now wish to leave their homes to engage in exercise and activities outdoors, they should continue to adhere to strict social distancing, keep 2 metres from other people, comply with appropriate guidance regarding maintaining a 'no touch' approach and hand hygiene on returning home. NPHET also accepted a number of Expert Advisory Group measures in relation to Healthcare workers testing and return to work protocols and patients whose illness has resolved, but in whom SARS-CoV-2 RNA remains detectable after 14 days; IPC measures to stay in place for 7 days.

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

Reviews of international evidence

As part of NPHET's consideration the available international evidence and guidance, including from WHO and the ECDC, was considered. HIQA provides a weekly review of public health guidance for residential care facilities. This review notes a range of guidance has been issued internationally to protect residents and staff of LTRCs in the context of COVID-19. The guidance for the most part, includes recommendations on testing, screening, monitoring, isolation, cohorting, social distancing, visitation, environmental cleaning, immunisation, providing care for non-cases, caring for the recently deceased, and governance and leadership. Many similarities exist between guidance documents, including recommendations to monitor staff and residents for new symptoms, to restrict visitation except on compassionate grounds, to isolate suspected and confirmed cases, to cohort symptomatic residents, to regularly clean frequently touched surfaces and to develop outbreak management plans. A summary table is reproduced in Appendix 4. It is noted that the actions undertaken by Ireland are in line with and in some instances beyond the then known actions and guidance internationally in respect of nursing homes.

10. Operational health system supports

Operational Supports

Following the emergence of Covid-19 HSE took a clear decision to include the vulnerable residents of nursing homes, whether private, public or voluntary in the consideration as to how to manage the situation. Since January of this year the HSE has engaged with private nursing homes to assist them and their residents. This has been both nationally, through Nursing Homes Ireland, and locally through individual providers by the Community Healthcare Organisation (CHO) network.

Each CHO Area Crisis Management Team (ACMT) has prioritised the needs of all longterm care residents within their areas and has also offered very significant support to the nursing homes in their areas, particularly those with COVID 19 outbreaks. This has included management support, PPE and other supplies, public health and other clinical inputs, support with sourcing staffing and, in some cases the reassignment of HSE staff to support these facilities.

In addition to preparatory work, the HSE moved from a position whereby the private nursing home sector which is an entirely separate system made of up of individual private entities with a statutory funding stream, regulated by HIQA, to a position whereby the HSE is now providing a significant level of support both nationally and locally in response to the current COVID-19 crisis. This will continue for the duration of the crisis. This included the setting up of a variety of systems to provide immediate practical support such as PPE and Oxygen logistics, to each CHO having COVID-19 Response Teams in place providing information, clinical guidance and support as well as staffing where necessary.

To support designated centres and children's residential centres HIQA has provided a number of supports through an Infection Control Hub, regular HSE meetings and an agreed risk escalation process with the HSE (further details in section 11 of paper).

The Chief Clinical Officer (CCO) convened the National Antimicrobial Resistance and Infection Control (AMRIC) Oversight Group under his Chairmanship to provide oversight and governance in a nationally coordinated fashion to address COVID-19 issues across all healthcare settings.[28]

[28] Membership includes the CCO, National Director Acute Service, National Director Community Operations, National Director of Health Protection and the AMRIC Clinical Lead. In addition, the AMRIC Implementation Team includes AMRIC

The National Community Quality & Patient Safety (QPS) team has been focussed on supporting LTRCs, working through ACMTs dealing not only with current outbreak management but also working with providers who have yet to have an outbreak to take appropriate measures.

Guidance on the set up of COVID Response Teams was issued on 9th April to support all LTRCs within a CHO area and 23 COVID Response Teams are now in place across the 9 CHO areas.

These teams are actively supporting all centres with outbreaks in their area through operational guidance and IPC and Clinical support by Geriatricians etc, and in the most at-risk centres, staff are being deployed or sourced to ensure ongoing safe service delivery. This information is being collated manually at present and as of 4th May of the 400 staff deployed to LTRC approximately 100 relate specifically to private centres across all care groups.

A significant feature of the response required to COVID Outbreaks in LTRCs related to the need to replace staff in a number of centres in significant numbers. This posed a difficulty across the system but with agreements reached with all unions, and building on redeployment methods agreed previously, public to public, redeployment to private nursing homes was agreed on a voluntary basis. Similarly, agreements were reached with voluntary, private and direct home support staff for redeployment and with the necessary indemnity related matters having to be resolved. This allowed for unprecedented transfer of staff across LTRCs, both public and private and by a range of disciplines working in different skill-mix arrangements and across the various settings. The flexibility that these arrangements provided have been highly significant in maintaining safe care, and indeed the ongoing provision of services in some of these centres.

The establishment and provision of accommodation supports for staff who are living in congregated arrangements has been implemented with 2,057 beds occupied per week and with approx. 50% of this utilised by private nursing home staff.

The HSE HR department has worked with the staff agencies to implement the requirement to minimise staff working across centres and guidance has been issued to all providers on this matter, in line with NPHET actions. Further detail on actions implemented by the HSE following NPHET decisions are provided in appendix 2.

Transfers of patients from acute hospitals to LTRCs and the potential for introduction of COVID 19 into facilities

Preliminary guidance with protocols was issued on **10th March** to support the transfers of residents from acute hospital to LTRCs. Where a patient for transfer was identified as a possible close contact of a known COVID-19 positive case, the recommendation was that the person was to be accommodated in a single en-suite room for 14 days after transfer. Patients with possible symptoms of COVID 19 under the case definition were not to be transferred unless a COVID 19 test had been reported as not detected and such patients were to be accommodated in single ensuite room for 14 days following transfer. If a patient was confirmed as COVID 19 positive in an acute hospital facility they were not to transfer to LTRC until they had completed 14 days of isolation and had tested as not detected on 2 swab tests for same. This guidance was circulated to all acute hospitals, CHOs and LTRCs accepting admissions of residents.

In order to ensure sufficient acute hospital capacity to manage the anticipated surge in same, emergency funding was made available to ensure patients who were clinically stable and appropriate for transfer could have their discharge facilitated, while adhering to the guidance as set out above.

Clinical Lead (Chair), senior QPS staff from Acute and Community, Pharmacy, GP representation, Public Health and a surveillance scientist.

There was an emphasis also on ensuring that those patients who had completed their acute medical treatment should be prioritised for such transfers (either with home support or to residential care where this had been approved within local placement forum process) so as to avoid their exposure to the anticipated surge of COVID 19 infections in acute hospitals.

At this stage of the pandemic it is considered that if the protocols set out in the guidance were adhered to, along with the appropriate use of IPC processes within the facilities, the risk of transfer to and subsequent spread of COVID-19 to LTRC facilities would have been low, albeit not impossible given the emerging evidence with regard to asymptomatic and atypical presentations of COVID-19 in some older people. As nursing homes open up to new residents the need for stringent processes and safeguards to prevent infection transfer are very important. This will also need to be balanced by an approach that recognises the critical role that LTRC and nursing homes in particular play in providing a service that cannot be provided elsewhere for older people who require such care and ensuring that a reasonable capacity for flow across services can be maintained.

Palliative Care

The HSE is providing specialist palliative care services during the COVID-19 emergency through its network of hospices and community specialist palliative homecare teams. These services are also playing an important role in providing additional support to non-specialist services, such as nursing homes, in the provision of palliative and end-of-life care during the COVID-19 emergency. In relation to the implementation of the COVID-19 measures recommended by the NPHET, the HSE holds a weekly teleconference with all palliative care services and the alliance of age sector NGOS, which includes Active Retirement Ireland, Age Action, Age & Opportunity, the Alzheimer Society of Ireland, the Irish Hospice Foundation, SAGE, the Irish Senior Citizen's Parliament and Third Age Foundation.

These engagements provide a forum for the HSE to keep those involved in Palliative Care services updated on emerging issues, training and supports and to clarify issues relating to clinical guidance. The teleconferences also enable the HSE to identify and address issues arising within the sector, such as access to PPE, COVID testing of immobile patients and to ensure that appropriate arrangements and supports are in place to ensure continuity and flexibility in the provision of palliative care services.

Consultant-led in-patient palliative care units around the country are providing additional support to non-specialist services, such as nursing homes, in the provision of palliative and end-of-life care. All specialist palliative care services have been asked to establish specific links with nursing homes in their region, particularly where there has been a COVID outbreak. In CHOs where there is a hospice, 24-hour telephone support for generalist services is available, and where there is no hospice, efforts are being made to ensure that hospital-based consultant advice is available.

The National Clinical Programme for Palliative Care (NCPPC) Palliative Care Consultant Advisory Group has developed national guidance, which has been disseminated through webinars, GPs and specialist palliative care services. The guidance aims to assist health care professionals in meeting the palliative care needs of dying patients, including those living in long-term care facilities, such as nursing homes or other community settings.

A series of webinars facilitated by the All Island Institute for Hospice and Palliative Care have been provided for nursing homes and, disability services, with almost 8,000 staff signing up. Topics to date have included 'do not resuscitate' matters, how a palliative care approach to care can support nursing homes during the COVID 19 outbreak, anticipatory prescribing and related issues, and advance care planning.

Temporary Assistance Payment Scheme

On the 4th April 2020 the Minister for Health announced that he was to establish a Temporary Assistance Payment Scheme (TAPS) of up to €72.5m for private and voluntary nursing homes. The core concept of the scheme is that the State will provide additional funding to those nursing homes that require it, to contribute towards support measures associated with COVID-19 preparedness, mitigation and outbreak management. The scheme will operate for a 3-month period.

There are two component parts of the Scheme which are integrated:

- a support payment per month based on the number of residents; and
- enhanced assistance in the event of a nursing home actively managing an outbreak.

Under the standard support component, funding may be provided to each applicant nursing home for COVID-19 related measures and associated expected costs for the month. The maximum level of financial support under the Scheme will be calculated by reference to the number of residents in the nursing home at a specified time.

Where a nursing home has incurred significant further costs or undertaken necessary enhanced actions arising directly from a COVID-19 outbreak, a nursing home may submit a separate business case for enhanced assistance.

There is an overall monthly funding cap, which is the maximum amount that may be paid in respect of each month to a Nursing Home under the Scheme. This amount applies to the aggregate of payments under the Standard Assistance Payment and the Outbreak Assistance Payment. It is equal to the lower of:

- twice the Standard Assistance Payment Cap for the month;
- the amount of €75,000;

The Scheme opened on for applications on 17th April. To date 343 applications have been processed and approximately €8.7m in funding has been paid out. The second component of the Scheme, the Outbreak Assistance Payment is in the final stages of development and applications will open on 22nd May 2020.

11.Regulator Support and Quality Assurance

LTRCs are regulated services where they are required to meet a minimum set of existing regulations/ standards for quality and safety including infection prevention. Regulation and monitoring of standards is either through HIQA for designated older people and those in disability services (since 2009) or the Mental Health Commission (MHC) for mental health services (since 2002). Responsibility for the provision of safe care and service to LTRC residents' rests with the service providers, be that the HSE, s.38s or s.39s, voluntary providers or private providers, who have a duty to ensure continued adherence to the existing regulatory and standards framework. NPHET on 31st March 2020 requested that HIQA and the MHC risk rate all LTRCs settings based on disease progression, environment and staff and liaise with national and regional governance structures and LTRCs as necessary in light of mitigating actions.

HIQA

Many statutory and private nursing homes and disability centres adequately prepared for and managed to contain a COVID 19 outbreak. Many were challenged in the context of the suitability of their premises and their ability to isolate and cohort residents safely. HIQA identified that private nursing homes were more challenged particularly in the context of lower base line staff numbers than

statutory nursing homes, limited formal relationships with the HSE, access to PPE and availability of expertise including on-site medical support.

Under Regulation 27 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, older people and disability providers must ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by HIQA are implemented by staff. This regulation as currently described would not be a predictor of how a home could deal with an outbreak such as COVID-19.

In September 2018, HIQA published *National Standards for further infection prevention and control and antimicrobial stewardship for community services.* These Standards were approved by the Minister for Health under the Health Act 2007, and place a responsibility on all residential services for older people and people with disabilities and all publicly-funded health and social care services in the community to implement the National Standards.

Regulatory compliance is a prerequisite for securing and maintaining registration with HIQA. Nursing homes 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. This finding will have a low risk-rating. Where the non-compliance does not pose a significant risk to the safety, health and welfare of residents using the service, it is risk-rated moderate and the provider must reach compliance within a reasonable time frame. HIQA notes that at the onset of this public health emergency 27% of stationary and private nursing homes were fully compliant with regulations.

Regulatory changes

Inspection process

On the 13th March 2020 the Chief Inspector issued a notice to registered providers advising that routine inspections of designated centres were temporarily suspended while inspections to respond to risk or to register and open new designated centre's or to facilitate increased capacity in centres would continue and where necessary be expedited. The rationale for the temporary suspension of inspections was informed by established public health and regulation principles. The principles and conditions underpinning the decision to temporarily suspend inspections were as follows:

- During the course of any infectious outbreak in advance of COVID-19 it is established practice that HIQA would not routinely inspect in a designated centre
- Avoidance of the inadvertent spread of infection from centre to centre by inspection staff ensuring minimisation of risk to vulnerable residents, centre staff and HIQA staff
- Reducing the burden of inspection at a time when it was recognised that providers were expected to be developing and putting in place their contingency plans
- Communication with regulatory bodies in the four UK jurisdictions and across Europe confirmed that temporary suspension of inspection was common across all similar inspectorate bodies.

In the absence of a routine inspection programme, HIQA established a range of contingencies and measures to ensure ongoing remote assessment of services. At the onset of this pandemic, HIQA developed a quality assessment process whereby all designated centres are formally contacted on a fortnightly basis by an inspector of social services to assess how they are coping, the welfare of the residents, any concerns they have, and any deficits identified in their ability to sustain a safe, high-quality service.

In line with emergent information on provider responses to COVID-19 a further adjustment to the inspection programme was made on 21st April 2020. A contingency planning assessment framework for older people's services was published on 21st April 2020. This framework guided providers to ensure that their contingency plans included consideration of issues that proved challenging to providers who had experienced extensive outbreaks of COVID-19. Onsite and telephone assessment began on 29 April 2020, and to date 153 assessments of compliances have been undertaken by inspectors of social services.

On conclusion of this targeted programme to support providers to ensure all possible action is taken to prepare for an outbreak of COVID-19 in their centres, resources will be directed once again to regulatory compliance inspections required to respond to risk or to facilitate increased capacity in the centres.

Statutory notifications

Under the regulations, designated centres are legally required to notify the Chief Inspector when certain incidents, events, or changes within their centres occur. These are known as statutory notifications and include for instance, the unexpected death of a resident, an outbreak of any notifiable disease, any serious injury and any allegation of abuse.

The Chief Inspector used her discretion to reduce the regulatory burden on providers by reducing the requirement to only notify the Chief Inspector of key incidents. Changes were made to the required notification form for infectious diseases to make it easier for providers to submit only the information required. In addition, changes were also made to the HIQA provider portal to facilitate providers submitting up-to-date figures on suspected and confirmed cases of COVID-19 daily.

On average, 15,000 statutory notifications related to care and welfare of residents are submitted to HIQA each year. These are assessed and risk-rated following prescribed rules that help to determine what (if any) regulatory actions are required in response to the level of risk posed to the resident(s). In addition, the risk rating of notifications contributes to a centre's overall risk profile.

These notifications are an essential component of regulatory oversight of designated centres in the context of COVID-19 as registered providers were legally mandated to notify the Chief Inspector of any outbreak of COVID 19 and the death of any resident as a result of COVID-19. Received notifications are reviewed on a daily basis and centres with increasing numbers of residents with confirmed or suspected COVID 19 were escalated to the HSE for notification to their crisis management teams.

Communication with registered providers and persons in charge

The Inspectorate of Social Services has maintained frequent contact with designated centres throughout the public health emergency. To date, seven regulatory notices between 20th March and 21st April have been issued to registered providers. In summary, these notices have reduced the number of mandatory notifications and have facilitated an easier system to ensure the timely return of data on number of residents and staff with suspected or confirmed cases of COVID-19, and the number of unexpected deaths in each centre. In addition, HIQA has facilitated a one-day turn around registration process to expedite the opening of new residential beds. Furthermore, guidance has been provided identifying the key contingency structures and processes that each provider should have in place to effectively manage a suspected and or confirmed case of COVID-19.

HIQA's unique knowledge of the private nursing homes, in terms of both staffing and environment, has been an important source of information to the HSE in the role it has taken to support this sector. In addition, both the HSE and the Department of Health were facilitated to use HIQA's online

notification system to ensure the timely distribution of key information to the providers of designated centres, including the DOH mortality census questionnaire.

Infection Prevention and Control Hub
To support designated centres and children's residential centres HIQA set up an Infection Prevention and Control Hub providing support to providers and staff via email and phone. To date the hub has responded to 341 designated centres. This support, guidance and or advice includes:

- outbreak preparedness
- outbreak management advice (for example, resident placement, cohorting and special measures where isolations is not possible, transmission and standard precautions)
- understanding HSE advice and its applicability to specific centres
- general support on infection control issues.

Risk escalation
HIQA collates daily, through mandated notifications the number of designated centres with:

- Confirmed numbers of COVID-19 residents and staff
- Suspected numbers of COVID-19 residents and staff.

This in combination with unsolicited information received, solicited information through HIQA's established provider assurance processes and the regulatory history of a provider is risk assessed by Inspectors of Social Services and when appropriate escalated to the HSE and Department of Health. Through engagement with registered providers HIQA escalates actual or potential risk when appropriate to the Crisis Management Team in each CHO area. HIQA meets with Community Operations (HSE) weekly to formally discuss ongoing issues and escalate risk as appropriate

Specific issues escalated to the responsible agencies in relation to suspected or confirmed COVID-19 in designated centres throughout this crisis included requirements for:

- availability of PPE and oxygen including the requirement of base line PPE to be made available in all nursing homes
- requirement for nursing and support staff
- requirement for senior healthcare advice and support, relating to public health, infection control, gerontology and general practice
- improved availability of testing and timely reporting of the results
- improved adherence to public health guidance.

HIQA identified that those providers that had effective preparedness arrangements in place, effectively supported by the public health and crisis management teams in each CHO area, were better prepared to control suspected and or confirmed COVID-19 cases. HIQA issued contingency guidance to providers, and also introduced an ongoing assessment process to establish whether providers of designated centres without COVID-19 have a clear contingency plan in place and know how to seek the external supports that are required to contain an outbreak.

Mental Health Commission (MHC)
Continued Regulation of Mental Health Service Providers
The MHC had been in regular contact with the approved in-patient mental health units since the beginning of March in relation to plans to deal with the virus. From 12th March, it suspended all routine inspections of approved centres until further notice. The publishing of inspection reports was also suspended on this date. While all routine inspections were suspended, MHC retained oversight of approved centres and monitoring continued. The MHC continued to seek assurances from each provider that contingency plans were put in place. They also asked each provider to nominate an

individual to be contacted for updates in relation to the number of suspected and confirmed cases in the approved centre if necessary.

Providers were required to continue to submit Quality and Safety Notifications to the MHC to review and risk rate the information contained in these notifications and follow up with services, as required. MHC continued to implement its registration processes in order to ensure that the Register of Approved Centres remains up to date.

Risk Assessment Activities
In early April, the MHC was requested by the Department of Health to risk-rate all mental health facilities. There are currently 179 services being monitored by the MHC, comprising of 67 in-patient units (services that have always been and continue to be regulated by the MHC), and 112 (unregulated) community residences. Combined, these facilities care for more than 3,800 service users across the country.

The Commission developed a standardised regulatory support framework and is working over the phone with all services to determine their risks in relation to staffing, equipment, premises and specialist support. If risk areas are identified, the Commission escalates those concerns to the Regulatory Management Team, then the HSE, then the Department of Health, as required.

Each week, the MHC's Regulatory Team makes follow-up calls with each service, to confirm the number of suspected and confirmed cases and identifying any issues or concerns within the service. Multiple follow up calls have been undertaken with some services based on the assessed risk. A reassessment against the original COVID-19 risk framework has also been undertaken to examine the extent of mitigations and contingencies put in place by services over the five-week period since early April. On a weekly basis, a summary report is submitted to the Department of Health.

The MHC worked with the Department of Health and the HSE:

- in the drafting of legislation to ensure the continued holding of Mental Health Tribunals. This legislation has ensured that the right of patients to a review of their detention is maintained, while making allowance for limited personal interaction. The MHC issued information notes on the application of this legislation to both providers and patients and has continued to work with both in setting up these tribunals;
- to fast-track the registration of a number of new approved centres. This includes the new centre at Portrane which has been registered, on a temporary basis, to house a number of patients from the Dundrum complex to ensure improved social distancing.

12. Future/strategic considerations

As identified by the WHO, COVID-19 outbreaks will likely continue to be a feature of LTRCs over the coming 6-12 months, which will require on-going support. The public health response to COVID-19 in LTRC remains - preparedness, early recognition, isolation, care and prevention of onward spread. Prompt, effective public health surveillance and response will continue to be critical in the months ahead in order to swiftly identify and control of outbreaks. In line with the progress of the disease LTRCs will continue to deal with the core impacts of COVID-19. While it is encouraging that a substantial number of LTRCs remain COVID-19 free, given the risk profile, LTRCs will continue to be sensitive to the impact of the virus and will need to remain vigilant, particularly in relation to mitigation measures and contingency planning. This will also mean there may be a reduction in the availability of LTRC beds, and without mitigation will increase pressure on hospital capacity.

In respect of the enhanced measures recommended by NPHET, specifically those relating to LTRCs, consideration will need to be given to the changing status of those measures over time, and whether there is a pathway to cessation of measures and/or whether some of those become measures adopted for a longer period of time.

As COVID-19 care continues and non-COVID-19 care increases, guidance will continue to need to be developed to assist providers with how to safely open their centres or part of their centres to allow residents to once again have social contact with their families and friends. Equality, support and guidance is required to assist people with a disability to return to day services, occupation or education.

COVID 19 Response Teams

One of the key aspects of the response has been the establishment of the COVID 19 Response teams. These have reflected a significant level of input from senior clinical expertise with consultant geriatricians, nurses, public health specialists and infection prevention and control specialists working collectively with senior management teams in the CHOs. As well as supporting LTRCs experiencing outbreaks on the ground they have played a critical role in terms of the ability of the CHO to assess and respond to the impact of the outbreaks within a region through joint engagement with CHOs and acute hospitals. Critically this has meant dissemination of early learning from the pandemic experience in LTRCs and ensured coherence between clinical practice advice, public health policy and the mitigating measures being taken at management level. As the country emerges from the initial pandemic wave these structures should evolve into an agreed clinical governance model that supports LTRCs and older people with complex needs at a population level. In particular, in the immediate phase the capability of acute hospitals and communities to effect safe transition into LTRC will reflect the ability of LTRCs to re-open and also provide safe levels of care and follow up through an agreed clinical pathway. The COVID-19 response teams along with the regulatory response from HIQA will play a key role in this.

Consideration should be given to maintaining the HSE established COVID-19 Response Teams as a required support to LTRCs and will need to become a specific service provision ongoing within CHOs and to support older person services in general, similar and in line with specialist teams in the community such as ICPOP. They will need to evolve over the period from Crisis Management Supports to a longer-term specialist clinical support to the Medical Officer/GP function that currently is the service provision by centre. They will still need to work closely with Public Health Outbreak teams and will be more central to the process of admission to Long-Stay Care and residential settings, while also facilitating people to remain in their own homes or return there post-acute care and to increase that specialist service support to primary and social care services.

Anticipated sequelae from RCF outbreaks

It is critical that attention is now paid to the sequelae arising from pandemics outbreaks in the nursing home environment. Long periods of loss of contact with family and friends through extended visiting restrictions have resulted in high levels of reported symptoms of depression and psychological morbidity. This has been added to by the loss of any communal activities over extended periods in facilities with outbreaks and the prolonged disruption of any routine. Psychological sequelae for staff who have coped with prolonged stress and multiple simultaneous bereavements have been described in the context of these outbreaks also.

Weight loss, deterioration in mobility and loss of cognitive function have been noted in a number of COVID-19 survivors with moderate and severe disease and this is having a marked impact in the recovery phase in patients in LTRCs. This will require a dedicated care planning approach that reflects these needs and ensures an appropriate rehabilitative approach with associated multidisciplinary supports should feature as part of any response.

Regulatory oversight

Having regard to the established regulatory framework for LTRCs and recognising the responsibilities and duties that lie at individual LTRC level, regulatory oversight, including through a COVID-19 lens will continue to be an important reassurance and improvement mechanism. Ongoing thematic assessments of regulatory compliance in relation to COVID-19 preparedness are an important initiative and consideration should be given to other relevant focused thematic assessments, such as in relation to end of life care and infection prevention and control measures.

Future considerations

NPHET and relevant State bodies acted quickly and decisively with regard to the recommendation and introduction of a variety of measures for both society in general and specifically for LTRCs. The pandemic and its impact raises questions that require focused and strategic consideration in the future, in particular for older persons, with regard to existing policies, areas of potential new policy development, the model of care for older persons, the configuration of service delivery and delivery models, congregated environments, clinical governance, safe staffing framework and the role of the health services alongside the role of other State bodies and the private sector.

In recognition that there is an expected ongoing COVID-19 impact over the next 6-18 months NPHET has emphasised the importance of real-time learning and a forward-looking approach for nursing homes. Therefore at the meeting 14/05/2020 NPHET recommended the establishment of an expert panel (*COVID-19 Nursing Home Expert Panel – examination of measures to 2021*) which, through examination of national and international measures to COVID-19 as well as international measures and emerging best practice, will make recommendations to the Minister for Health, by the end of June 2020, to ensure all protective COVID-19 response measures are planned, for in light of the expected ongoing COVID-19 risk and impact for nursing homes over the next 6-18 months. This panel will comprise public health, geriatric, nursing and public representation expertise.

Appendix 1 – Enhanced Public Health Measures

Enhanced Public Health Measures for COVID-19 Disease Management Long-term Residential Care (LTRC) and Home Support Services (HSS) NPHET Meetings 31st March 2020 and 3rd April 2020

People living in Long-term Residential Care (LTRC) settings (nursing homes, disability and mental health) and those receiving home support services are vulnerable populations and have been identified by the WHO to be at a higher risk of being susceptible to infection from COVID-19 and for subsequent adverse outcomes. This is most likely due to their age, the high prevalence of underlying medical conditions and circumstances where high care support with the activities of daily living is required in collective high physical contact environments. The response to COVID-19 in LTRC, and for home care services, should be based on preparedness, early recognition, isolation, care and prevention of onward spread.

The public health principles are to:

- Support those receiving home support to continue to live in their own homes unless there is clinical or other advantage
- Support the maintenance of residents in LTRCs unless there is clinical or other advantage
- Interrupt transmission of the disease and prevent onward spread.

Agreed Public Health Actions LTRC Facilities and Home Support Services

No. 1 Strengthened HSE National and Regional Governance Structures	**Home Support**	**LTRC**
• Establish a national and regional (CHO) COVID-19 Infection Prevention and Control (IPC) Teams	**Y**	**Y**
• An IPC Advisor to liaise with each LTRC and homecare provider	**Y**	**Y**
• A local public health led Outbreak Control Team for each outbreak responsible for data capture with support of via CRM system	**Y**	**Y**
• HIQA/MHC to risk rate all LTRC settings based on disease progression, environment and staff and liaise with national and regional governance structures and LTRCs as necessary in light of mitigating actions		**Y**
• Provision of updated guidance (LTRC guidance to include specific admission and transfer guidance)	**Y**	**Y**
• Establish teams (per CHO), building on existing capacity where possible, to provide medical and nursing support	**Y**	**Y**
• Establish capacity and provide for teams of last resort (crisis support team to go into individual LTRC facilities as required) to provide staffing for a short period of time to ensure service continuity		**Y**
• Establish a national protocol in the event of HSS having to be withdrawn e.g. due to a cluster of cases in a local area/lack of staff	**Y**	
• Establish and implement home support ICT system as an enabler to client management and staff rostering, ensuring oversight and management of transmission risk mitigation measures	**Y**	

No. 2 Transmission Risk Mitigation - suspected/COVID-19 positive LTRC/ homecare		
• Agencies and LTRC/home support providers agree protocols and rostering to minimise staff movement across COVID-19 and non-COVID-19 LTRC settings/home support clients	**Y**	**Y**
• HSE to provide support for appropriate alternative residence and transport for staff living in congregated domestic living arrangements involving other LTRC settings/homecare staff	**Y**	**Y**
• Minimise staff movement working across LTRCs		**Y**
• Establish protocol to inform service provider/HSS workers if client has tested positive or if testing has been initiated in the HSE.	**Y**	
• Maintain care in the home for as long as possible, with moving to LTRC facility a last resort.	**Y**	
• Where possible support provision of End of Life care in the home, in line with agreed protocols	**Y**	
No. 3 Staff Screening and Prioritisation for COVID-19 Testing		
• Prioritise LTRC staff/homecare staff for COVID-19 testing	**Y**	**Y**
• Active monitoring of staff for fever, cough and shortness of breath (Temperature checking twice a day)	**Y**	**Y**
No. 4 HSE Provision of PPE and Oxygen		
• Ensure PPE supply to LTRC settings and home support providers	**Y**	**Y**
• Access to oxygen for LTRC settings		**Y**
• Ensure provision of hand sanitiser and adherence to good waste management standards.	**Y**	**Y**
No. 5 Training		
• The HSE and LTRC support access to the provision of training for staff in IPC, use of oxygen, palliative care and end of life care, pronouncement of death		**Y**
• The HSE and home support providers support access to the provision of training for staff in IPC		**Y**
No. 6 Facilities and Homecare Providers – Preparedness planning • Depending on size of LTCF or homecare provider designate a team or at least one full-time staff member as lead for COVID-19 preparedness and response	**Y**	**Y**
• LTRC settings have COVID-19 preparedness plans in place to include planning for cohorting of patients (COVID-19 and non-COVID-19), enhanced IPC, staff training, establishing surge capacity, promoting resident and family communication, promoting advanced healthcare directives		**Y**
• Home support providers to have a COVID-19 preparedness plan in place.	**Y**	

Appendix 2 – Update on HSE implementation of relevant NPHET measures

HSE Update on Specific Actions relating to LTRC from NPHET 6th April, implemented as of 7th May 2020	
No. 1 Strengthened HSE National and Regional Governance Structures	LTRC Update (7th May)
Establish a national and regional (CHO) COVID-19 Infection Prevention and Control (IPC) Teams	National in place and Regional teams being set up and supplemented with additional resources on an ongoing basis
An IPC Advisor to liaise with each LTRC and homecare provider	Included as a requirement in COVID Response Team Document cleared at INOH 9th April. National Training and supports offered to all LTRC settings. Recruitment of ADONs in IPC at CHO level being expedited. Webinars provided and available to all centres.
Provision of updated guidance (LTRC guidance to include specific admission and transfer guidance)	Guidance on Transfer and admission criteria was cleared at INOH 09/03 , currently is now amalgamated into Preliminary RCF Guidance– most recent version 04/05. Being ongoing reviewed
Establish teams (per CHO), building on existing capacity where possible, to provide medical and nursing support	Outlined as a requirement in COVID Response Team Document cleared at INOH 9th April. Webinar provided to all LTRCs on CRTs 23 Teams established across the 9 CHOs with multidisciplinary input from services leads and Public Health. Daily reporting on Outbreaks from PH with input from all CHOs available.
Establish capacity and provide for teams of last resort (crisis support team to go into individual LTRC facilities as required) to provide staffing for a short period of time to ensure service continuity	Outlined as a requirement in COVID Response Team Document cleared at INOH 9th April. Over 400 staff/day being deployed this week. Daily reporting on staff deployed/sourced to LTRC including private, S38/39, Public, across SOP, MH & Disability Centres.
No. 2 Transmission Risk Mitigation - suspected/COVID-19 positive LTRC/ homecare	LTRC Update
Agencies and LTRC/home support providers agree protocols and rostering to minimise staff movement across COVID-19 and non-COVID-19 LTRC settings/home support clients	Guidance Document Cleared at INOH 9th April and issued to the system including agencies.
HSE to provide support for appropriate alternative residence and transport for staff living in congregated domestic living arrangements involving other LTRC settings/homecare staff	Guidance Document Cleared at INOH 9th April, providing a process for accommodation for healthcare workers, across all settings, to avoid congregated living arrangements.
Minimise staff movement working across LTRCs	Addressed by both previous guidance documents above
Active monitoring of staff for fever, cough and shortness of breath (Temperature checking twice a day)	Outlined as a requirement in COVID Response Team Document cleared at INOH 9th April. Process in place in all Res Care centres and supports to Private and Public from Occupational Health
No. 4 HSE Provision of PPE and Oxygen	LTRC Update
Ensure PPE supply to LTRC settings and home support providers	Extensive Logistics in place from National to CHO level providing daily requirements of PPE to all residential care settings and other service areas. Single point of contact in each CHO for Supplies of same.
Access to oxygen for LTRC settings	
Ensure provision of hand sanitiser and adherence to good waste management standards.	
No. 5 Training	LTRC Update
The HSE and LTRC support access to the provision of training for staff in IPC, use of oxygen, palliative care and end of life care, pronouncement of death	A series of Webinars took place open to all Res care centres on IPC, Palliative Care, with approx. 1000 participants. Guidance Documentation issued on Pronouncement of Death and agreement reached with trade unions on its implementation on 5th May.
The HSE and home support providers support access to the provision of training for staff in IPC	A series of Webinars took place open to all Res care centres on IPC Guidance documents on IPC issued and being reviewed on an ongoing basis

No. 6 Facilities and Homecare Providers - Preparedness planning	LTRC Update
Depending on size of LTCF or homecare provider designate a team or at least one full-time staff member as lead for COVID-19 preparedness and response	As part of the CRTs guidance issued on 9th April it was identified that a lead person per CHO be established and all areas have interim leads in place with some progressing the recruitment of a Senior Manager with nursing background for the COVID period. Each Private NH has been made aware of the HSE contact person for their area for Supports and PPE etc. The recent survey from HIQA has identified that Private NHs were aware of the HSE contact services.
LTRC settings have COVID-19 preparedness plans in place to include planning for cohorting of patients (COVID-19 and non-COVID-19), enhanced IPC, staff training, establishing surge capacity, promoting resident and family communication, promoting advanced healthcare directives	As Part of the CRTs guidance issued on 9th April it was identified that part of the work of the teams was to review all Res Centres preparedness plans and this formed work of the CRTs. Also, HIQA provided a framework for all residential services and have been undertaken inspections on this basis and are in constant communication with HSE with information that is provided to CRTs to follow up.

Appendix 3 – Timeline of Actions and Measures

ACTIONS/MEASURES/DECISIONS/MILESTONES		
Measure	**Publisher**	**Date in Place**
HIQA published National Standards for further infection prevention and control and antimicrobial stewardship for community services including nursing homes. These Standards were approved by the Minister for Health under the Health Act 2007, and place a responsibility on all residential services for older people for their implementation.	HIQA	September 2018
China CDC reported a novel coronavirus (2019-nCoV) as the causative agent of an outbreak in Wuhan on 31/12/2019		09/01/2020
The first three cases of COVID-19 imported into the EU/EEA were identified in France	ECDC	24/01/2020
NPHET holds its first meeting on COVID-19	NPHET	27/01/2020
WHO declared the novel Coronavirus (as a public health emergency of international concern.	WHO	30/01/2020
First meeting of the Coronavirus Expert Advisory Group	EAG	05/02/2020
HSE CEO met the chairman and CEO of Nursing Homes Ireland re preparedness	HSE	19/02/2020
Minister signed the 'Infectious Diseases (Amendment) Regulations 2020' to include COVID-19 on the existing list of notifiable diseases.	Minister for Health	20/02/2020
First confirmed case of COVID-19 in the Republic of Ireland		29/02/2020
ECDC RRA (5th Update) confirmed risk of widespread sustained transmission of COVID-19 in the EU and UK in the coming weeks is moderate to high.	ECDC	02/03/2020
Ireland remains in a containment phase In line with ECDC RRA general public are advised to follow public health advice and: • wash hands properly and regularly • cover nose and mouth with a tissue when you cough and sneeze	NPHET	02/03/2020
NPHET Subgroup – Vulnerable People established	NPHET	04/03/2020
NPHET Subgroup – Vulnerable People First Meeting	NPHET	06/03/2020
Department Briefing Session on COVID-19 for stakeholders		06/03/2020

Package of reforms agreed for sick pay, illness benefit and supplementary benefit designed to ensure that employees and the self-employed can abide by medical advice to self-isolate where appropriate	Government	09/03/2020
HSE Actions to support the response to COVID-19 including: • increasing the capacity of the National Ambulance Service • centralised procurement of additional essential equipment, such as Personal Protective Equipment, ventilation equipment, dialysis equipment, portable radiography equipment and additional fleet for community care	HSE	09/03/2020
NPHET encourages people to follow respiratory etiquette and hand hygiene practices in order to protect vulnerable groups. People should not visit if they themselves are unwell. NPHET advised that blanket socially restrictive actions around hospitals and nursing homes are not necessary at this moment in time.	NPHET/Government	10/03/2020
First confirmed death of patient diagnosed with COVID-19 in Ireland		11/03/2020
WHO declares COVID-19 a global pandemic.	WHO	11/03/2020
ECDC RRA (6th Update): the detection of COVID-19 cases and deaths outside of known chains of transmission is a strong signal that social distancing should be considered. Measures should be taken early and should be decisive, rapid, coordinated and comprehensive.	ECDC	12/03/2020
NPHET recommends moving into the "Delay phase", and: • Social distancing measures recommended and announced • Visiting restrictions in long-term care facilities • Individuals who have symptoms should self-isolate for a period of 14 days • Staggered breaks in work and greater remote working etc. Taoiseach addressed the nation	NPHET/Government	12/03/2020
COVID-19 Action Plan Published	Government	16/03/2020
The first notified Nursing Home COVID-19 cluster was notified on CIDR		16/03/2020
NPHET Vulnerable Persons Subgroup established a short-life working to examine	NPHET	18/03/2020

issues relating to COVID-19 arising in the nursing home sector		
Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020 was signed into law providing power to Minister for Health to make regulations prohibiting or restricting the holding of certain events or access to certain premises; to provide for powers for certain medical officers of health to order, the detention of persons who are suspected to be potential sources of infection with COVID-19; and to confer on the Minister for Health the power to designate areas as areas of infection of COVID-19	Oireachtas	21/03/2020
Ireland adopts the WHO case definition for COVID-19; A patient with fever and at least one sign of respiratory disease e.g. cough, shortness of breath Enhanced social distancing measures recommended and announced including specific reference to long-term care facilities	NPHET/Government	24/03/2020
ECDC RRA (7th Update): measures taken should aim at protecting the most vulnerable population groups by reducing transmission in general population and enabling the reinforcement of healthcare systems. LTRCs should implement IPC measures and Social distancing measures can include measures to limit outside visitors	ECDC	25/03/2020
Additional public health measures in place to prevent spreading COVID-19, including "cocooning" for over 70s	NPHET/Government	27/03/2020
NPHET request to HSE re the need for the HSE to establish individual Outbreak Control Teams with appropriate public health input for such settings where clusters of infection are identified	NPHET	27/03/2020
NPHET extraordinary meetings on Nursing Homes, request to develop information framework and further public health data re nursing homes along with a request that HIQA undertake risk assessments of long-term care facilities	NPHET	29/03/2020 and 30/03/2020
NPHET recommendations - Enhanced Public Health Measures for COVID-19 Disease Management in Long-term Residential Care (LTRC) and Home Support (6 action areas)	NPHET	31/03/2020
NPHET recommendation to HSE to immediately deploy an integrated outbreak crisis management response across LTRC settings and to drive the infection prevention	NPHET	03/04/2020

and control and public health measures agreed by NPHET on 31st March		
Regulatory Notice issued: Establishment of an Infection Prevention and Control Hub for designated centres and children's residential centres in HIQA. The aim being to provide a direct line of contact for providers and staff of social care services to offer guidance and support. This Hub will work closely with the HSE and Tusla and, when appropriate, will escalate high-risk centres for their attention.	HIQA	03/04/2020
Minister announces that a Temporary Financial Assistance Scheme for private and voluntary nursing homes is to be established	Minister for Health	04/04/2020
HSE COVID Residential Care/Home Support COVID Response Teams (CRT) Operational Guidance issued	HSE	07/04/2020
ECDC RRA (8th Update): risk of severe disease associated with COVID-19 in the EU is moderate for the general population and very high for populations with defined risk factors associated with elevated risk;	ECDC	08/04/2020
NPHET recommends and Government adopts extension of existing public health measures to 04th May at midnight	NPHET	10/04/2020
NPHET recommends and Minister adopts that: HSE is to put in place a coordinated national process for carrying out prevalence surveys across nursing homes and other residential healthcare settings, with a particular focus on detecting COVID-19 infections in these settings, using approaches such as pooled PCR tests randomised samples taken at these sites, in accordance with the recommendations of the ECDC	NPHET/Government	14/04/2020
NPHET recommends and Minister adopted that: • National testing of staff across all settings with an initial widespread approach and thereafter ongoing testing, which may include both staff and patients, to be conducted on a rolling basis; • a census of mortality across all LTRC facilities to be carried out this weekend to cover all deaths, COVID-19 and non-COVID-19 since 1 January 2020, regardless of where the death occurred;	NPHET/Government	17/04/2020

• the publication and assessment of a COVID-19 quality assurance regulatory framework LTRCs by HIQA • the implementation of previous recommended actions with enhanced reporting through an expanded "Nursing Homes/LTRC settings Actions Tracker", which is to include the roll out of the Contact Management (CRM)System		
Opening of Temporary Financial Assistance Scheme for Nursing Homes Opens for applications	NTPF/HSE/DoH	17/04/2020
Census of mortality across all LTRC facilities	DoH/HIQA	18&19/04/2020
Publication of a regulatory assessment framework of the preparedness of designated centres for older people for a COVID19 outbreak	HIQA	21/04/2020
NPHET accepted the advice of the Expert Advisory Group on the use of surgical facemasks by Healthcare Workers. (HCWs)	NPHET	21/04/2020
The Department wrote to relevant nursing home and home support representative bodies informing them of the NPHET advice re conditions for when HCWs should wear facemasks.	DoH	22/04/2020
ECDC RRA (9th Update): risk is low for the general population and moderate for population with defined risk factors where physical distancing in place and/or community transmission low and moderate for the general population and very high for population with defined risk factors where physical distancing not in place and/or community transmission is high and ongoing;	ECDC	23/04/2020
Commencement of assessments of compliance under regulatory assessment framework of the preparedness of designated centres for older people for a COVID19 outbreak	HIQA	28/04/2020
NPHET recommendations: continue to advise those aged over 70 years of age and over and the medically vulnerable of the importance of remaining cocooned for their safety, however, should they now wish to leave their homes to engage in exercise and activities outdoors, they should continue to adhere to strict social distancing, keep 2 metres from other people, comply with appropriate guidance regarding maintaining	NPHET	01/05/2020

a 'no touch' approach and hand hygiene on returning home. NPHET also accepted a number of Expert Advisory Group measures in relation to: • Healthcare workers testing and return to work protocols • Patients whose illness has resolved, but in whom SARS-CoV-2 RNA remains detectable after 14 days, IPC measures to stay in place for 7 days The NPHET recommends the removal of the requirement to fall into a priority group from the current case definition (last updated on 24th April 2020). The target date for implementation is from 6th May 2020 or such further date that is deemed more operationally feasible and agreed with the HSE in the interim		
NPHET recommendation on the establishment of an expert panel (COVID-19 Nursing Home Expert Panel – examination of measures to 2021) which, through examination of national and international measures to COVID-19 as well as international measures and emerging best practice, will make recommendations to the Minister for Health, by the end of June 2020, to ensure all protective COVID-19 response measures are planned, for in light of the expected ongoing COVID-19 risk and impact for nursing homes over the next 6-18 months.	NPHET	14/05/2020
Surveillance of COVID-19 at long-term care facilities in the EU/EEA	ECDC 19	19/05/2020
COVID-19 Nursing Home Expert Panel – examination of measures to 2021 established	Minister	21/05/2020

GUIDANCE AND SUPPORT TOOLS		
Measure	**Publisher**	**Date Published/Circulated**
HIQA publishes National Standards for further infection prevention and control and antimicrobial stewardship for community services including nursing homes	HIQA	September 2018
Public Health Guidelines on the Prevention and Management of Influenza Outbreaks in Residential Care Facilities in Ireland 2019/2020	HPSC	19/12/2019
COVID-19 Information Webpage developed	HPSC	20/01/2020
Department Briefing Session on COVID-19 with Stakeholders	DoH	06/03/2020
Interim Guidance on Transfer between Care Facilities	HSE	10/03/2020
COVID-19 Telephone Risk Assessment and testing pathway for patients who phone general practice and healthcare settings other than receiving hospitals v.3.0	HPSC	13/03/2020
Preliminary advice regarding COVID in Nursing Homes circulated by email to nursing home representative body	HSE	14/03/2020
Coronavirus (COVID-19) guidance for settings for vulnerable groups	HPSC	14/03/2020
Preliminary Clinical and Infection Control Guidance for COVID-19 in nurse- led Residential Care Facilities (RCF)	HSE	17/03/2020
Current recommendations for the use of Personal Protective Equipment (PPE) in the management of suspected or confirmed COVID-19	HPSC	17/03/2020
Guidance on the transfer of hospitalised patients from an acute hospital to a residential care facility in the context of the global COVID-19 epidemic	HPSC	19/03/2020
Preliminary Coronavirus Disease (COVID-19) Infection Prevention and Control Guidance include Outbreak Control in Residential Care Facilities (RCF) and Similar Units (v.1)	HPSC	21/03/2020
Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 Interim Guidance	WHO	21/03/2020
Guidance on COVID-19 for the care of older people and people living in long-term care facilities, other non-acute care facilities and home care	WHO	23/03/2020

COVID-19 Assessment and testing pathway for symptomatic resident in Residential facilities (RF) and Long-term Care Facilities (LTCF)	HPSC	27/03/2020
Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19	HPSC	27/03/2020
AMRIC Education Programme: COVID-19 Management in community residential facilities and in-patient services outside of acute hospitals WEBINAR[29]	HPSC	06/04/2020
AMRIC Education Programme: COVID-19 and Infection Prevention and Control WEBINAR	HPSC	06/04/2020
HSE COVID Residential Care/Home Support COVID Response Teams (CRT) Operational Guidance	HSE	07/04/2020
Interim Guidance on the use of oxygen in long term residential care settings for older people during the COVID 19 pandemic	HSE	09/04/2020
Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units	HSE	10/04/2020
COVID-19 Interim assessment, testing and outbreak guidance for residents in Residential facilities (RF) and Long-Term Care Facilities (LTCF) v.2.2	HPSC	19/04/2020
AMRIC Education Programme: Prevention and management of COVID-19 in residential care facilities WEBINAR	HPSC	24/04/2020
Updated Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19 Version 1.2. 01.05.2020	HPSC	01/05/2020
Updated Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19 Version 1.3. 06.05.2020	HPSC	06/05/2020
Updated Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19 Version 1.4. 17.05.2020	HPSC	17/05/2020
ECDC Surveillance of COVID-19 at longterm care facilities in the EU/EEA – Technical Report	ECDC	19/05/2020

[29] https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/webinarresourcesforipc/

Appendix 4 – Summary Table HIQA weekly review of public health guidance LTRC

From: Rapid review of public health guidance for residential facilities, HIQA 21 May 2020

	Australia, ICEG[6] (includes CDNA[7])	Canada[9]	United States of America, CDC[10, 11, 14]	Ireland, HPSC[20, 41]	Scotland, HPS[26]	Hong Kong[19]	UK[23, 24] (includes PHE[25])	New Zealand[31, 33, 38] (includes HQSCNZ[35])	The WHO[34]
Testing	Residents with new respiratory symptoms and asymptomatic contacts	No guidance	No guidance	All residents and staff where a case has been confirmed, all staff where there is no case	All residents and staff where there is an outbreak (plus additional scenario based testing strategies)	No guidance	Patients in critical care or requiring hospitalization for pneumonia, ARDS or flu like illness and where there has been an outbreak	Residents with new respiratory symptoms, staff should be tested in the community as a high priority group	No guidance
Screening	All entrants	All entrants	All entrants	Staff	No guidance	Staff and visitors	No guidance	No guidance	All entrants
Screening checks	Contact, travel, symptoms	Contact and symptoms	Temperature and symptoms	Temperature and symptoms	No guidance	Temperature	No guidance	No guidance	Temperature (staff), symptoms and risk (visitors)
Monitoring of residents	Daily (close contacts only)	✓	Daily	Twice daily	Daily	Daily (twice daily for new admissions)	Twice daily	Daily	Twice daily
Monitoring of staff	No guidance	Twice daily for exposed staff who are not unwell	Throughout the day	Twice daily	No guidance	No guidance	Daily	Daily	No guidance
14 day isolation of confirmed and suspected cases	✓	No guidance	✓	✓	✓	No guidance	✓	✓	✓

	Australia, ICEG[6] (includes CDNA[7])	Canada[9]	United States of America, CDC[10, 11, 14]	Ireland, HPSC[20, 41]	Scotland, HPS[26]	Hong Kong[19]	UK[23, 24] (includes PHE[25])	New Zealand[31, 33, 38] (includes HQSCNZ[35])	The WHO[34]
Cohorting of residents	Same diagnosed virus	Confirmed cases	Confirmed cases	Suspected or confirmed cases	Suspected or confirmed cases	No guidance	Suspected or confirmed cases	Suspected or confirmed cases	Suspected or confirmed cases
Cohorting of staff	Care for confirmed cases	Care for suspected or confirmed cases	Care for confirmed cases	COVID-19 cohort areas and non-COVID-19 areas	Care for confirmed cases	Work with 'same group of residents'	'symptomatic or asymptomatic residents'	'residents in isolation'	No guidance
Communal dining	No guidance	Cancel if suspected or confirmed cases in RCF	Cancel	Cancel if social distancing not possible	No guidance	Stagger	No guidance	No guidance	Stagger, cancel if social distancing not possible
Group activities	Cancel if outbreak occurs in RCF	Cancel if social distancing not possible	No guidance	Cancel if social distancing not possible	Cancel if outbreak occurs in RCF	Cancel if social distancing not possible	Cancel if social distancing not possible	Cancel if outbreak occurs in RCF	No guidance
Visitation restrictions	Visits only on compassionate grounds	Visits only on compassionate grounds	Visits only on compassionate grounds	Visits only on compassionate grounds	Visits only on compassionate grounds	Visits only on compassionate grounds	Visits only on compassionate grounds	Family only	Visits only on compassionate grounds
Facemasks for staff	Within 1-2m of confirmed or suspected cases	While in the RCF	While in the RCF	Within 1-2m of residents or other staff	Within two metres of residents	While in the RCF	Within two metres of residents	Within 1-2m of confirmed or suspected cases	Within 1-2m of confirmed or suspected cases
Facemasks for residents	If symptomatic resident leaves room	During transfer	If resident leaves room	Confirmed and suspected cases in shared spaces	No guidance	All residents	Symptomatic residents during transfer between rooms	If symptomatic resident leaves room	Confirmed and suspected cases
Facemasks for visitors	Room of suspected or confirmed cases	✓	✓	Room of suspected or confirmed cases	Local risk assessment'	✓	No guidance provided	As directed by staff	No guidance provided

	Australia, ICEG[6] (includes CDNA[7])	Canada[9]	United States of America, CDC[10, 11, 14]	Ireland, HPSC[20, 41]	Scotland, HPS[26]	Hong Kong[19]	UK[23, 24] (includes PHE[25])	New Zealand[31, 33, 38] (includes HQSCNZ[35])	The WHO[34]
Cleaning of frequently touched surfaces	Twice daily	Twice daily	Regularly	Twice daily	Twice daily	Twice daily	No guidance provided	Twice daily (if an outbreak occurs)	Twice daily
Immunisation	Influenza for staff, visitors and residents	No guidance	No guidance	Influenza for residents and staff	No guidance	No guidance	No guidance	Influenza for all staff and residents	Influenza and pneumococcal for employees and staff
Use of nebulisers for non-cases	Avoid	No guidance	No guidance	No guidance	Does not require aerosol generating procedure PPE	No guidance	No guidance	Avoid	No guidance
Care of recently deceased	Routine practice, continue IPC precautions, use leak-proof bag	Routine practice, continue IPC precautions	No guidance	Routine practice, continue IPC precautions, inner lining not needed, face mask for deceased resident, family advised not to kiss but can touch	Routine practice, continue IPC precautions, no requirement for a body bag	No guidance	Routine practice, continue IPC precautions, non-essential contact should be avoided.	No guidance	No guidance
Develop policies and plans	Outbreak management, staff shortages, supplies, sick leave, point of contact	Supplies, communication	Outbreak management, staff shortages, supplies, compliance, sick leave, communication, point of contact	Outbreak management, supplies, communication	Outbreak management, staff shortages	No guidance	Follow influenza outbreak management plans	Outbreak management, staff shortages, supplies, sick leave, point of contact	Compliance, point of contact

	Australia, ICEG[6] (includes CDNA[7])	Canada[9]	United States of America, CDC[10, 11, 14]	Ireland, HPSC[20, 41]	Scotland, HPS[26]	Hong Kong[19]	UK[23, 24] (includes PHE[25])	New Zealand[31, 33, 38] (includes HQSCNZ[35])	The WHO[34]
Provide training for staff	✓	✓	✓	✓	✓	No guidance	No guidance	✓	No guidance

*Excludes PALTC as it is a non-governmental agency, PHA as their guidance is primarily based on PHE and UK guidance, CMS as the CDC guidance is considered the primary guidance for the United States, NSW guidance because the Australian Government Department of Health guidance is considered the primary guidance for Australia and the ECDC guidance as only select elements are applicable to LTRCs.