Submission to the Special Committee on Covid-19 Response

Congregated Settings – Nursing Homes

25 June 2020

1.0 Introduction

1.1 The Irish Nurses and Midwives Organisation (INMO) wishes to thank the Oireachtas Special Committee on Covid-19 response, for this opportunity to submit on the important matter of the impact of COVID-19 on congregated settings - nursing homes.

1.2 The main issues we will concentrate on are:

- Key challenges during the COVID-19 pandemic
- Delivery of nursing home care
- Recruitment and retention of nursing staff
- Covid-19 infection rates in health care workers and the role of occupational health
- Safeguarding residents

2.0 Key Challenges during the COVID-19 Pandemic

2.1 There have been ongoing problems in our current nursing home care settings which have been compounded by the pandemic. 943 deaths are associated with nursing home clusters (Department of Health, 2020).

2.2 Factors that exposed the system's vulnerabilities include:

- Competition between clinical governance and financial restraints
- Nursing and other health care worker HCW shortages
- Access issues
- Outsourcing of 80% of care delivery by the public sector with no resulting follow up governance or supportive oversight for care of the older person service.
- The emerging trend of corporate and international financial institutions taking ownership of large parts of the sector.

2.3 Infection prevention and control (IPC) preparedness was impeded, in our view, in the private nursing home sector by the absence of a specific link to the public health system and a dearth of appropriately qualified clinical IPC experts available on site.

2.4 Possible factors include:

- **Patient Transfers -** From January – May 2020, 4,073 patients were approved for transfer from acute hospitals to private nursing homes. During March and April 1,680 patients were transferred from acute hospitals to the private sector (Bowers, 2020).
- **HSE Guidelines -** Confusion existed in respect of mandatory isolation, daily staff temperature testing and visitor restrictions resulting in different approaches in different locations.
- **PPE supplies -** Already low stocks led to a rapid and massive shortfall in this sector.
- **Clinical Resources -** Shortages of vital resources such as oxygen and fluids were publicly reported by nursing homeowners (HIQA, 2020).
- **Healthcare workers (HCWs) and residents' testing -** Delays in testing were compounded by long waiting times for results, delayed diagnosis and implementation of preventative measures. Derogation was provided to managers requesting that staff who were identified as close contacts could attend work if they were asymptomatic. This proved a mistake considering subsequent evidence regarding asymptomatic transmission.
- **Use of Facemasks by HCWs -** Delays in issuing a national request to wear facemasks in all health care settings unnecessarily exposed HCWs to higher levels of infection.

- **Staffing Levels -** Inadequate staffing numbers with included senior nursing IPC expertise (HIQA, 2020).

3.0 Delivery of Nursing Home Care

3.1 In moving forward and reopening the nursing home sector, there must be key consideration given to how nursing home care is delivered. Public health services must be responsible for the delivery of nursing home care to ensure that it is equitable and accessible. The current system is no longer sustainable and impedes the provision of an integrated health service.

3.2 Any changes to nursing home care in Ireland must reflect the Sláintecare report's call for a single-tiered universal health care model, one which supports integrated care, is person-centred and provides quality excellence. The Sláintecare Report clearly states that there must be an end to the *"over-reliance on market mechanisms to deliver new health care services by the expansion of public nursing homes and homecare"* (Houses of the Oireachtas, 2017, p. 80).

3.3 Congregated settings pose clear challenges in the face of COVID-19. It is essential that robust home care packages are developed, thus allowing people to stay in their homes for as long as possible. New models including public service provision "own door assisted living" must now be examined and developed.

3.4 There must be appropriate authoritative clinical governance, accountability of providers and coordination across the nursing home sector.

4.0 Recruitment and Retention of Nursing Staff

4.1 The recruitment and retention problem which has long existed in the nursing home sector was further compounded by the pandemic. A comprehensive workforce plan is required in the care of the older person services, which must include:

- The extension of the Framework for Safe Nurse Staffing and Skill Mix, a dependency-based model of determining staffing. This is government policy for the acute hospital sector and has proven to save money, improve patient outcomes, increase retention of nurses. which underpins safety and improved outcomes for patients.
- Not adopting this model, results in, inferior older person's care which is currently based on a cost of care model. This puts cost before care and clearly this cannot be tolerated in a modern society that cares and respects its growing elderly population.
- Post registration gerontology nursing higher diploma courses. Incentivising older person nursing as a career choice is imperative to the long-term ability to provide person centred care.
- The ceasing of registered nurse substitution, which has been used as a cost saving measure within the sector. This practice is contrary to evidence on nurse led care and staffing which is link to improved patient outcomes and must therefore cease.

4.2 Recruitment and retention problems within the private nursing home sector are linked with pay and conditions and welfare at work. Nurses and midwives working in private nursing homes must be afforded the right to collective bargaining. The human right to join a union and bargain collectively for fair pay and fair conditions of employment is critical to a fairer workplace.

4.3 It is the only way to ensure employees enjoy bargaining power on a par with the employer. Furthermore, the role of a professional trade union provides a level of protected openness to

staff which promotes transparency and early warnings necessary for promotion of the safeguarding rights of residents.

Optimising the scope of practice and role of the nurse in care of the older person.

4.4 Any new model for care must include nursing at its core, maximising the contribution of the profession in the provision of care excellence. Clinical care provision must be nurse-led/delegated. This is essential given that this is a complex phenomenon incorporating skills and expertise from many domains (Phelan, et al 2016). For example, the sharing of tasks - which formed part of the Haddington Road Agreement - enhances patient care by ensuring early and timely intervention in the correct setting and not requiring transfer to the ED Department as is currently the case. Providing care to a patient in their residence decreases patient morbidly as well as decreasing the workload of an already over stretched ambulance and acute hospital service.

4.5 All nurses and midwives must be facilitated to fully utilise advanced skills, providing services such as IV antibiotics, IV fluid therapy and other interventions on site. A recent example of such an expansion is the provision of guidelines on the pronouncement of death by a registered nurse as part of the COVID-19 public health response. This expansion of the role of the nurse was agreed by the INMO in 2017 but not actioned by the HSE. Further expansion is required. Removing practice barriers at local and national level is key to the nursing profession reaching its full potential, working within its full scope of practice beyond COVID-19 (Rosa, et al. 2020).

5.0 Covid-19 Infection Rates in Health Care Workers and the role of Occupational Health

5.1 There is considerable evidence identifying high infection rates amongst healthcare workers globally. The Irish evidence identifies a real challenge in terms of the number of healthcare workers infected with the virus. Recent HPSC figures (15th June 2020) show that of the 8,180 infected HCWs:

- 32.9% are nurses.
- 66.7% were acquired in a healthcare setting
- 21.5% of cases are associated with nursing homes (HPSC, 2020).

5.2 A national occupational health policy which strengthens infection control advice and protocols must be agreed. These must be applied across all of the health service, including the nursing home sector and include:

- Protective protocols for self-isolation of healthcare workers combined with human resource staff replacement policies
- Regular schedule of risk assessment for healthcare workers
- Strict implementation of the return to work protocol and appointment of worker representatives in accordance with this protocol in all areas of healthcare
- Surveillance protocols for healthcare workers
- Adequate PPE protocols
- Protocols for the routine monitoring and recording of infectious illnesses, including recovery or death of healthcare workers
- Protocols to monitor stress, burnout or mental health issues arising in healthcare workers
- Practical onsite psychological supports for health care workers
- Policy to combat social discrimination of healthcare workers providing care to COVID-19 patients

- Adequate rest periods for healthcare workers
- Provision of adequate childcare for healthcare workers

5.3 A national occupational health policy on testing and contact tracing must also be established. This policy should span the whole health service, including the nursing home sector. This policy should include mandatory routine testing and temperature checks for all healthcare workers alongside access to occupational health services and advice whether working in a private or public facility.

6.0 Safeguarding Residents

6.1 Protective measures must ensure the residents of nursing homes are put at the centre of care and that care is not solely driven by finances. As the country reopens it is essential that the nursing home sector can continue to operate. However, to mitigate a new surge in COVID-19, a number of measures must be put in place:

- The extension of the Framework for Safe Nurse Staffing and Skill Mix.
- Essential planning for any future surge in COVID-19 which must include increased capacity and resources, involving senior nursing expertise at development stage.
- High priority on supply and use of PPE across all nursing homes must continue.
- Establish a national strategy of testing and contact tracing as we enter a new phase of the pandemic, which must span the entire health service including public, private and voluntary settings. This strategy must build on best practice evidence available on testing systems that worked well e.g. prison services.
- The testing and tracing system must have national governance but include local teams who will establish and create the link between the public health service and private nursing homes.
- Daily Routine testing and temperature checks of residents, staff and visitors.
- Clear policies and enforcement around infection control, led by appropriately qualified IPC nurse, guiding practices including patient discharge from hospital to nursing home and visiting arrangements.

7.0 Actions

1. Community clinical supports in the community and financial supports must be developed to allow those who want care in their own home, have a real option and alternative to Residential care.

2. In residential care staffing and skill mix must be determined by residents needs and dependency levels as determined by an appropriate clinical based tool which values the transitional nature of older person care.

3. Nursing in older are must become a worthwhile career choice for nurses by allowing the maximum use of clinical skills, the promotion of gerontology as a specialism and the appointment of ANP specialists in, for example, infection prevention and control.

4. The 80% private for profit model with a concentration on cost of care must cease. A variation of section 38 of the Health Act should be used to underwrite the conditions of employment in that part of the sector currently described as private.
5. In the interest of staff and clients the funding in the sector must be contingent on the right to collective bargaining for all staff categories.

8.0 References

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