

**MSF**

Agosto de 2020

## **TOO LITTLE, TOO LATE:**

**The unacceptable neglect of the elderly in care homes during the COVID-19 epidemic in Spain**



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Médecins Sans Frontières/Doctors Without Borders (MSF) is a medical humanitarian organisation that provides assistance to victims of natural or manmade disasters and armed conflicts, without any discrimination based on origin, gender, religion, philosophy or politics.

Among its most common interventions is the response to epidemics in complex contexts, where the lack of human and material resources, security and training are added challenges to the detection, control and treatment of the disease, as well as to the protection of patients.

Detecting, tracking, protecting and treating are the basic key elements that the organisation applies in any response to epidemics and they are also applicable to COVID-19: early detection, contact tracing, isolation of positive cases and quarantine of possible secondary cases are the actions that have to be applied so that this unacceptable situation is not repeated.

## SUMMARY

The situation experienced in elderly care homes during the COVID-19 epidemic in Spain **should never happen again**. The lessons learned and the lives lost should provoke **profound change**. The risk that elderly people living in care homes will be affected again has not subsided; we must be prepared to reduce suffering and limit mortality as much as possible

**The excessive mortality during this crisis points to structural and systemic problems in relation to the Spanish care home model.** It highlights in particular the need to improve the medical care that should be provided to those who live in these centres, whether public, private or subsidised. The logic of the current care home model responds more to the conditions of the service provider than to the social and health needs of the elderly. This has had a serious direct impact on their health and mortality: it is estimated that the number of elderly people who died in care homes (27,359 between 6 April and 20 June, according to the Ministry of Health) represents 69% of all those who died from COVID-19 throughout Spain.

The COVID-19 response revealed the **lack of capacity and assistance given to this group both in primary care services and in the hospital system**. During the peak of the epidemic, this model left many care homes without viable options adapted to their needs, and many felt "abandoned, without the possibility of hospital referrals and without adequate primary care assistance".

In the first moment of the crisis, the response focused on the collapse of the health system, in hospital emergency services and ICUs, which reached the point of refusing patient referrals from care homes. These **had to assume de facto a responsibility for which they were not prepared, equipped, or protected**, with disastrous consequences for residents, staff and management teams, and a direct impact on the high mortality.

**It is necessary to develop contingency plans** for possible new outbreaks of COVID-19 or similar epidemics, to **ensure early warning and immediate response in care homes**. The plan must include measures aimed at the well-being and quality of life of the elderly. Special attention should be given to infection prevention and control (IPC) and the different elements of dignified care, such as last goodbyes, professional comfort care, and visits or contacts with family members.

### MSF response

**On 19 March, MSF began supporting care homes** with onsite teams made up of health and logistics personnel. Our teams lacked experience with this new virus, but the experience of 50 years working in epidemics with innovative and emergency strategies enabled us to solve the challenges that this pandemic posed for us to work in Spain. MSF focused on easing the burden on staff that were overworked, disoriented, misinformed and devoid of protective equipment.

The organisation supported the staff of **almost 500 care homes**, in the areas of: patient separation by cohorts; design of materials, pathways and protocols for segregation adapted to the situation; awareness and training on infection protection and control; use of personal protective equipment (PPE) adapted to the needs; training, contingency plans and evaluations of facilities; and provided PPE donations when necessary.

As a medical humanitarian organisation, MSF included in its response the most humane and ethical dimension: dignified treatment and care, and the reinforcement of patient autonomy.

## Dialogue with the authorities

From the beginning of its response, MSF communicated, in addition to offers of collaboration, a series of specific requests to the highest authorities. It is worth mentioning those carried out during the first days of the state of alarm to the Spanish president, Pedro Sánchez, to the Minister of Health, Salvador Illa, and to ministries and departments in the different autonomous communities. In these communications, once the care home activities started, **MSF advocated for an initial collaboration and proposed concrete measures for change**, stating the challenges and proposing the solutions detailed in this report.

The key messages and difficulties transmitted in this dialogue with the authorities were, essentially: the lack of transparent information, leadership and clear and determined actions; deficiencies in infection prevention and control; lack of capacity building and primary care programmes, as well as timely hospital referral from care homes; the shortage of PPE in care homes and of adequate protocols and training for their use; the lack of clarity in the protocols for end-of-life care and family goodbyes, with the difficulties that the latter caused; the need to improve the treatment, care and dignity of patients; inefficiency and delays in diagnostic strategies; and the lack of available and trained human resources.

## The care home model

Care homes had a structural lack of resources and healthcare supervision and no contingency plan. This combination made it **unfeasible that they could respond to the epidemic**. They lacked the healthcare resources, which had a direct impact on the health of residents, when facilities designed for a social (housing) service were handed the responsibility of providing an emergency life-or-death health service. This led to neglected medical care, high mortality, and a decline in the quality of social care. **Many elderly people died isolated and alone**.

Whatever management and governance model is adopted, it must be translated into a regulatory framework that adequately protects the elderly. The functional deficiencies detected, with their dramatic cost in lives and suffering, must be radically remedied.

## Challenges

During its intervention in nearly 500 care homes in various autonomous communities, MSF encountered the following challenges:

1. **Lack of preparedness and contingency plans**, aggravated by the lack of coordination and multiplicity of interlocutors, among them social services and health departments, town and city councils, primary care services, public health services, and boards of foundations and managers of private and religious centres.
2. **Reduced leeway to implement isolation, quarantine and distance measures**, especially due to the inadequate infrastructure and space to achieve effective isolation, and to the high occupancy.
3. **Lack of training in the use of PPE for personnel** not accustomed to using these elements. In addition to being insufficient, the PPE, which arrived late, was not always adapted to the needs of care homes.

4. **Lack of organisation, management and human resources for the implementation of contagion control measures.** With the increasing number of casualties and without an alternative recruitment strategy, the remaining staff had to take on other quasi-medical tasks (without precise instructions or knowledge), which did not form part of their social work duties.
5. **Limitations of diagnostic tests and lack of ability to act on results** and respond once positive cases have been identified.
6. **Denial of referrals to hospital services** for hundreds of elderly people, forcing care homes to keep positive patients with a very serious prognosis, thus facilitating the rapid spread of the virus, affecting other residents and staff. This directly impacted the quality of care of residents and, in many cases, probably contributed to or was the cause of death.

**MSF considers that alternatives should have been proposed with the available means and resources**, facilitating referrals to social health centres, hospital extensions, “comfort” or medically-equipped hotels or private hospitals, since, in all these places, there were free places even during the peak of the epidemic.

The reality that the MSF teams observed is that healthcare was left to care home staff, who are not equipped for it. The most vulnerable population was left in the hands of the well-intentioned people who cared for them, who faced alone the enormous challenge, at times, of saving their lives or accompanying them in death.

7. **Isolation to the detriment of health and dignified care**, with strict measures (due to the uncertainty generated by asymptomatic cases and the scarcity and unreliability of diagnostic tests), which in many cases were indiscriminate and disproportionate and had a serious impact on residents' health.
8. **Lack of protocol for palliative and end-of-life care, last goodbyes and visits**, partly due to the lack or insufficient number of experienced staff at care homes to provide this care, and partly to the difficulties of primary care in the most acute moment of the crisis.
9. **Lack of psychosocial care for residents, staff and families.**

## Conclusions and recommendations

The report offers a series of conclusions and recommendations that can be consulted in detail on the following pages.

During its intervention, MSF was able to verify that, **due to the profile of people living in care homes**, many of them fragile and with multiple pathologies, keeping those who fell ill in closed spaces and without adequate medical and psychological care increased infection, accelerated mortality and **produced undignified and inhumane situations**.

**Priority was not given to hospital referrals** or preferential channels so that infected people could be transferred to other centres or hospitals. And the care homes, places for coexistence and care but not for medical treatment, **had to provide care for which they were not prepared**. Care homes lack the resources, infrastructure, training and responsibility for medical care and there was also no immediate, adequate and life-saving response, coordinated with health and care services.

**Infection prevention and control capacity, which is essential in an epidemic, was also lacking.** One of the consequences was the isolation of residents, sometimes indiscriminately, and the restriction or denial of last goodbyes, visits or personal mobility, which also had serious physical and psychosocial consequences for the elderly.

We were also able to verify the **lack of protection measures and adapted, timely training with clear protocols for use** that protect staff and residents. Meanwhile, professional profiles were poorly developed in terms of skills and training, and staff off work due to infections were not replaced quickly enough and in sufficient numbers.

Finally, among the conclusions, MSF includes the **institutional lack of coordination and strategies**. The authorities prioritised the care response in hospitals, which neglected the elderly in care homes, despite being the most vulnerable group with the highest mortality.

Our presence in the homes and our proximity to the affected people, together with our experience in epidemic situations, has allowed us to identify a series of lessons learned, which we have incorporated into the recommendations that we detail at the end of this report.

**The recommendations are addressed to: the central and autonomous governments; companies, foundations and private or public-private entities that manage or subcontract the management of care homes; the Spanish public prosecutor and competent regional prosecutors; the ombudsman and his counterparts in the autonomous communities; and professional associations and unions.**

With a view to protecting elderly people living in care homes, alleviating their suffering and improving emergency preparedness and response related to a possible second outbreak of COVID-19, or outbreaks of other infectious diseases in the future, MSF considers it essential to **develop contingency plans easily adaptable to each care home**. These plans must include passive and active surveillance systems that detail the alert threshold, availability of protection and hygiene material (with a purchasing channel already established), teams formed to supervise and support epidemic prevention and control measures, as well as detailed access protocols for visits or suppliers of care homes on alert, referrals to hospitals and primary care, access to palliative care and access to quality and timely diagnoses. Plans for the segregation of areas and pathways, hygiene measures and the correct and rational use of PPE in care homes are also essential, in addition to psychosocial support for the residents, family members and staff of these centres. All of this must be accompanied by continuous training programmes.

MSF recommends that the required **ratios of trained personnel that guarantee dignified and adequate care for the elderly, including palliative and comfort care** be ensured in care homes. Of course, the provision of protective materials and consumables, as well as reserve stocks, must also be ensured.

Regarding **infection detection, surveillance and control**, MSF recommends, among other measures, having **professionals trained in this field** to advise, train and supervise healthcare personnel. For this, it will be essential to appoint and train an IPC supervisor, define protocols in the event of a new outbreak, and give more budgetary and training attention to this issue.

In any case, a principle of **balance between isolation, quarantine and coexistence** must be established, and it must be ensured that segregation measures also respond to the socialisation needs (both psychosocial and physical) of elderly people and prioritise their health at all times in a comprehensive way.

For this, MSF recommends **ensuring certain flexibility in the occupancy of the centres**, especially in the most critical periods, so that the segregation of areas can be carried out. In cases where it is not feasible to have individual rooms, a preventive space must be assigned that is at least available for periods of risk. At all times, **it must be ensured that physical isolation does not lead to social isolation** and MSF considers it important to maintain services aimed at the care and well-being of residents, such as educational activities, social work, hairdressing or physiotherapy.

It is also crucial that there be a physical space and schedule for **family visits, and protocols for last goodbyes** that guarantee that, in crisis situations, the elderly can, if necessary, **face the end of their lives in the most dignified and accompanied way possible**.

**Psychosocial support mechanisms** are also essential. MSF recommends a minimum package of measures, both for staff and residents as well as for their families, that are free, confidential and easily accessible.

Finally, MSF's recommendations include the need to **collect, systemise, publish and analyse data**, so it can serve as an adequate alert and response mechanism, both preventive and proactive.

With this report, MSF aims to help **prevent a recurrence of the unacceptable situation of abandonment and neglect** of the health and care needs of the most vulnerable people, the elderly, as well as the lack of protection for the most exposed people, care home staff. **Healthcare for the elderly and the protection of those who care for them are not an option: they are a medical, ethical, social and regulatory obligation.**



*Photo 1 - Olmo Calvo*



## 1. CONTEXT AND MSF INTERVENTION

This report describes the activities and lessons learned by MSF teams in their support of elderly people in care homes in Spain during the COVID-19 epidemic. The purpose of the document is to share MSF's experience in the crisis and provide a series of recommendations aimed at causing changes in the current response and in preparing for new outbreaks of COVID-19 or other infectious diseases. All this is done in order to reduce mortality in care homes and ensure that the people who live in these centres receive dignified and quality care and that the personnel who take care of them are guaranteed adequate protection.

### 1. Context and origin of the intervention

The arrival of the COVID-19 pandemic in Spain placed us at an exceptional moment in recent history and confronted us with a huge challenge in terms of public health. Spanish society, as was the case in the rest of the European countries, experienced an unexpected situation: an unknown epidemic that quickly spread to everyone's surprise and disbelief and a lack of data, agility, preparation and response from both international and regional organisations, such as the central government and the different regional governments. This confusion also affected MSF.

The challenges and difficulties were enormous both for the government and for society, and also for the MSF teams. The dilemmas faced and the options assumed often translated into difficult decisions and the effort made by all parties, and in particular by the staff of care homes, the elderly and their families, must be recognised.

COVID-19 proved to be a contagious disease in which there was no clinical experience, treatment or vaccine, that was spread rapidly even by asymptomatic people, and had a long incubation period. The response to this virus should be that of **a humanitarian emergency** in which, in a short period of time, the same event has a fatal impact on a large number of people and challenges the health system and the community. Unlike other environments where MSF is used to working, Spain has major health resources, although it lacks solid contingency plans, adequate strength and investment in public health and epidemiological surveillance. The lack of preparedness and coordination, as well as the improvisation and initial paralysis in the response, led in some autonomous communities to the overwhelming of essential emergency and ICU services and the collapse of the hospital network.

The strategy of prioritising the hospital network without detecting in time that the most vulnerable people were in care homes meant that these strategies also failed when it came to protecting the elderly. **The people most vulnerable and affected by COVID-19 were failed and abandoned.** Many care home managers and their staff, healthcare teams and caregivers were negligently left to their fate, not only in their role of caring for the elderly, but even when having to seek healthcare in extreme life-or-death situations (since, without oxygen, a critically ill COVID-19 patient generally fails to survive). The care homes had to **assume de facto a responsibility for which they were not prepared, equipped or protected, with disastrous consequences** for residents, staff, managers and family members.

We share here the lessons learned during the intervention of the MSF teams, which, as mentioned earlier, also lacked experience with this disease and were learning in real time how to face the countless challenges that this pandemic posed at different levels. Our goal is to help **prevent a repeat of the unacceptable situation of abandonment and neglect of the health and care needs of the most vulnerable people, the elderly, as well as the lack of protection for the**

**most exposed people, care home staff. Healthcare for the elderly and the protection of those who care for them are not an option: they are a medical, ethical, social and regulatory obligation, both at the local and regional level, as well as at the state level.**

#### Introduction to the MSF intervention

In mid-March, after analysing the situation, MSF offered its direct collaboration to the competent authorities. Almost immediately, a call from a care home management consultant alerted us to the situation in these centres. Assuming its responsibility in line with its almost 50 years of proven experience in complex health crises (many of them linked to epidemic episodes), and in view of the collapse suffered by the system in the first weeks, MSF decided to concentrate its initial effort on proposing and executing solutions for the decongestion of hospital emergency services, the supply of oxygen and the maintenance of the referral systems in the two autonomous communities with the highest number of infected and deceased people in hospitals: Catalonia and Madrid. It became immediately evident that the most vulnerable group was the elderly living in care homes. **On 19 March, we began this support with onsite teams** in some of the most affected care homes in Catalonia and, from that moment on, our framework of action was also extended to other communities and we multiplied the teams and care provided.



*Photo 2 - Olmo Calvo*

## Chronology of MSF's intervention in Spain

<b>13.03.20</b>	MSF's Emergency Unit decides to start an intervention in Spain.	<b>01.04.20</b>	5,088 elderly care homes contacted so far to offer them free and confidential support, which can be provided in person or virtually.
<b>14.03.20</b>	We publicly announce our availability and offer our support.	<b>04.04.20</b>	We make the first visits to care homes in the communities of Madrid, Castilla-La Mancha and Castilla y León.
<b>15.03.20</b>	The Ministry of Health asks MSF for support to expand hospital capacity in the Corredor de Henares region of Madrid.	<b>09.04.20</b>	Together with Amnesty International, we publish an open letter to the Spanish government, asking for more protection for health personnel.  We start support activities for care homes in Andalusia.
<b>16.03.20</b>	Care home managers ask MSF for support in Barcelona.	<b>18.04.20</b>	As of this date, we forward to the decision-making bodies of the government our practical recommendations and proposals for operational solutions.
<b>17.03.20</b>	We start activities in Catalonia, in the extension to the Hospital Sant Andreu de Manresa, and we assess the situation at the hospitals in the Corredor de Henares region.	<b>08.05.20</b>	Following the response of the Ministry of Health, MSF insists on the need for a mobilisation plan for care homes that is "effective and proportional to the needs" and which guarantees "quality care and dignified treatment", as well as human resources and protective materials for primary geriatric care
<b>19.03.20</b>	We start activities in care homes in Barcelona.	<b>15.05.20</b>	We inform the relevant authorities that our activities in Spain will end on 22 May, while offering the resources available on the web portal and a telephone number for urgent requests.
<b>21.03.20</b>	We send a letter to the president of the Spanish government, Pedro Sánchez, to request an urgent meeting in which to propose solutions, in light of "the exceptional situation and the overwhelming of health facilities".	<b>19.05.20</b>	Together with eight health organisations, including the Spanish Society of Geriatric and Gerontological Nursing, we publish an open letter to the Spanish government and the autonomous communities addressing the protection of health and care home staff.
<b>22.03.20</b>	We start activities in Madrid supporting the extension of the Severo Ochoa University Hospital in Leganés.	<b>25.05.20</b>	We announce the closure of our programmes in Spain and begin to send personnel and material to other countries, such as Yemen and Peru.
<b>23.03.20</b>	In Barcelona, we collaborate in setting up the extensions to the Vall d'Hebron and Santa Creu i Sant Pau hospitals.	<b>31.05.20</b>	We officially close the intervention, although we leave a small contingency team in charge of monitoring the situation and we keep the website open.
<b>27.03.20</b>	We launch the specialised website <a href="http://www.msfcovid19.org">www.msfcovid19.org</a> , aimed at health authorities, healthcare managers, and health and care staff caring for the elderly.  We start to give support to care homes in the Basque Country.	<b>02.06.20</b>	Together with Amnesty International, we meet with spokespersons for the Health Commissions of the Congress of Deputies and the Senate, to expand on the requests made in early April and May and request a contingency plan appropriate to possible outbreaks, with special attention to care homes.

- 29.03.20** In a communication to the Ministry of Health, we ask that the patient referral system between the most affected and the least affected places be strengthened.
- 30.03.20** We hold our first online seminar, 'Patient circuits in health and social health centres', attended by 122 people.

MSF also provided onsite assistance, with technical advice and training, in other types of residential care homes, such as those for dependent persons and for minors, responding to requests from the government or from the centres themselves. Although most of the recommendations outlined here can easily be applied to the circumstances of these centres, they are not the specific subject of this report, which focuses on care homes for the elderly as the main source of morbidity and mortality during the pandemic.

In this effort, we witnessed the main obstacles faced by most of the centres, while we collected the testimonies of the people who, both from the government and from the centres themselves, had to seek **urgent, imperfect solutions in a complicated and exhausting situation**. This onsite work and proximity to affected people, together with our experience in epidemics, allowed us to extract a series of lessons that, translated into recommendations, are the final objective of this report (and have been positively valued by care home managers and staff).

## 1.2 Objective, strategy and justification of the intervention in care homes

The purpose of MSF's intervention in care homes was to improve infection prevention and control to reduce transmission and thereby reduce mortality. To this end, the goal was to protect residents and staff from the virus, with best practices, without undermining the dignity of care, and provide useful solutions. To do this, MSF aimed to **alleviate the burden of staff that were overwhelmed, disoriented, misinformed and lacked protective equipment**. Thus, we decided to directly support care home staff in the following areas:

- Separation of patients by cohorts.
- Design of materials, pathways and protocols for segregation adapted to the situation.
- Awareness-raising and training on infection prevention and control (IPC).
- Use of personal protective equipment (PPE) adapted to the needs.
- Training, contingency plans and evaluation of facilities.
- Donation of PPE.

The **strategy** consisted of working directly in care homes and for this we coordinated with the regional social services and health managers of the autonomous communities, district and city councils, the managers of public and private care homes, and with the families of residents. MSF set up seven mobile teams, with several sub-teams made up of at least one health profile and one logistics profile, sometimes accompanied by a coordinator and/or a psychologist. In coordination with the management teams of the care homes, the modus operandi consisted of identifying challenges and agreeing on and implementing measures with an immediate impact on the protection and access to health of residents and staff.

Given the diversity and technical complexity of some spaces and the difficulties for an urgent response for which there was not always scientific evidence, MSF created several working groups to accompany and complete the intervention from a more specialised perspective<sup>1</sup> and from an ethical perspective, always in a transparent way and agreed with the care homes. Almost a hundred MSF people worked for two and a half months on this response.

MSF had two options: to serve a few care homes, and pour all its effort into them, or to try to reach as many centres as possible. MSF decided to reach as many homes as possible, since identifying the most exposed and vulnerable was impossible, in light of the urgency of the situation and the lack of precise data and time. Therefore, from the beginning, a specific website (<https://msfcovid19.org>) was developed for the authorities, and health and care managers and professionals, in order to increase the impact of our action. A mobile application<sup>2</sup> was also developed to facilitate the consultation of information.

Our organisation decided to take a step forward and work in our home society and with the elderly, a context far removed from our usual social mission. This allowed us not only to learn about COVID-19 and transfer that knowledge to other countries, but also to learn to work in a new environment (care homes) and with a population that is not usual in our projects (since we work mainly in places

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<sup>1</sup> Spaces and Infection Control Group, made up of profiles specialised in hospital management and space management (architect) and two logistics specialists with experience in major epidemics of cholera and Ebola; Rapid Diagnostic Test Group, made up of specialists who reviewed changes in diagnostic tools and strategies; Mental Health and Psychosocial Support Group, to offer guidance on emotional support; and the Palliative Care Group, aimed at gathering information from various professional fields to feed the reflection of the teams faced with this reality in care homes.

<sup>2</sup> Available as a smartphone app for Android (<https://play.google.com/store/apps/details?id=appappmsfCOVID19org.wpapp>) and iOS (<https://apps.apple.com/es/app/COVID-19-f%C3%B3rma-te-e-inf%C3%B3rma-te/id1518790380>).

with a very reduced life expectancy, contrary to the situation in Spain). Therefore, we have gained sensitivity towards the specific needs of elderly people and this broadens our humanitarian mission, to encompass actions that not only save lives, but also give dignity to a group with different physical, social and psychological needs and capacities.

In the technical field, we developed tools for decision-making adapted to care homes, which we have already extrapolated to other contexts. We also developed very pragmatic recommendations, with which we continue to advocate to the authorities and those responsible to contribute to bringing about change in the preparations for a new outbreak or similar infectious scenario. We see that these recommendations are beginning to be implemented little by little in various autonomous communities.

Our work has been valued positively, for having provided **practical, creative solutions adapted to each care home visited, as well as for having provided emotional support to management teams, staff and families**, at a time when they felt neglected by the system. For the staff and managers of the centres, the feeling of helplessness and loneliness when responding to an urgent and unknown situation, which put their own life at risk, was very difficult to cope with. These people showed an enormous commitment to such a human and professional challenge and in very adverse conditions. Without exception, the presence of the MSF teams served to alleviate fear and frustration at the lack of means, support and specific and adapted instructions, and above all the pain over the deaths. The pressure reached very high peaks and the work sessions with our teams began by facilitating a space for emotional relief, in which many people cried, lamented the impossibility of being able to do everything and shared the suffering of helplessly witnessing the deterioration and death of residents they had sometimes known for years.

The COVID-19 crisis should serve as a wake-up call for the design of humanitarian programmes that take into account the age of the people served. The UN Department of Economic and Social Affairs estimates that the number of elderly people worldwide will double to more than 1.5 billion by 2050. This will undoubtedly increase the need to care for them in humanitarian crises.



Photo 3 - Olmo Calvo

### 1.3 Activities of MSF teams

In two months of intervention, MSF supported 486 care homes. In 89% of the cases, the activities involved the direct presence of our teams and, in 11%, the collaboration was remote, with technical evaluations of the facilities done via Skype, Zoom or telephone.

During this period, we visited or supported 200 care homes in Catalonia, 114 in Castilla y León, 79 in the Community of Madrid, 17 in Andalusia and 10 in Castilla-La Mancha. In other autonomous communities, such as La Rioja, Aragón, Valencia and Galicia, we provided support by telephone or via quick consultations to all the centres that requested it.

- As of 1 April 2020, MSF had contacted and offered free and confidential technical support, both onsite and online, to 5,088 care homes throughout Spain.



- In total, 435 onsite and 51 virtual visits were made, in addition to almost 800 interactions, which included phone calls, training and follow-up. We also donated PPE to 57 care homes.
- As of 22 June, the work in care homes represented 78% of the interactions carried out by MSF during its intervention in Spain (which also included support to hospitals to expand their capacities).<sup>3</sup>

Additionally, we advised on the use of protective equipment, on guidelines and protocols to maximise hygiene and prevent contagion, and on establishing pathways and isolation areas based on the presence of positive or suspected cases. We consolidated these practices with training sessions given both to care home and government staff, and to other entities that provided their support and backing, for example regional health managers, district councils, primary care centres, public health services, as well as firefighter, Red Cross and civil defence teams.

FIGURA 3. NÚMERO DE RESIDENCIAS APOYADAS POR MSF

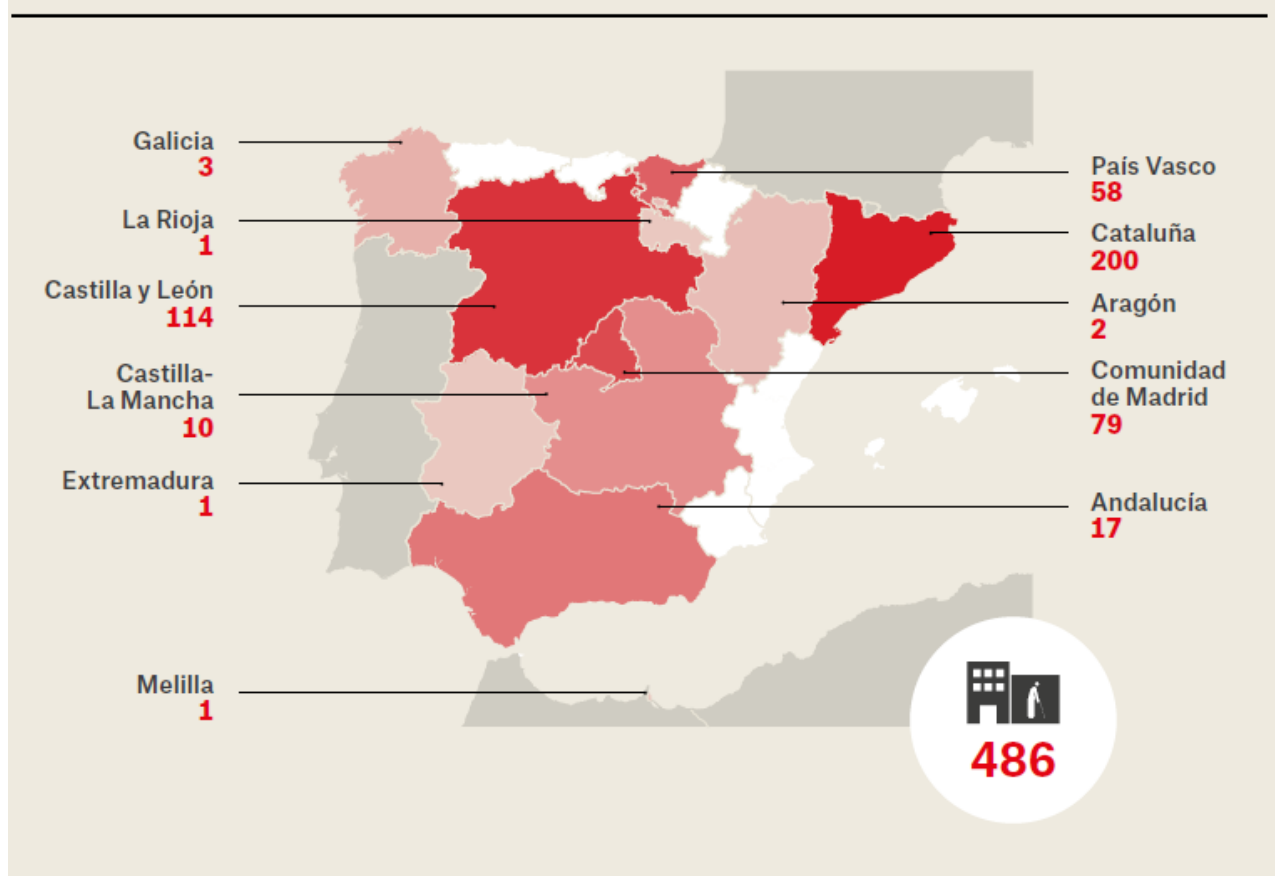


Figure 1 - Care homes that received MSF support between March and May 2020

In addition to the open channels for enquiries and requests for assistance and material, and the professional support website, MSF organised webinars for training and the sharing of experiences, as well as support and guidance for family members, in which tools and technical guidelines with practical solutions were shared. By the end of July, the website had received almost 76,000 visits

<sup>3</sup> Detailed information on MSF's response in Spain can be found in the report 'Our response to COVID-19 in Spain. Accountability report'. Available at: <https://www.msf.es/sites/default/files/documents/informe-intervencion-covid-msf-en-espana.pdf>.

and more than 9,500 people had participated in one of the 38 online seminars organised. This website is also used in many Spanish-speaking countries and **remains open for anyone interested to access the published documentation and training.**

In addition to the technical dimension, the MSF teams addressed the most humane and ethical dimension: **dignified treatment and care** and the reinforcement of patients' autonomy. We supported care home staff in facilitating residents' mobility (when possible and strictly respecting the protection measures), as well as in **facilitating telephone or video calls with their families or face-to-face visits** (already in the de-escalation phase).<sup>4</sup> We helped establish friendly pathways that enable these encounters without breaking the protection regulations. Where appropriate, we also provided assistance in the end-of-life and comfort protocols, providing information and support, in particular, for last goodbyes.

#### 1.4 Methodology: testimonies and primary and secondary sources

This report is based on the collaboration and testimonies of people directly affected by the situation: care home residents, staff and managers, family members, regional health authorities, primary care and specialist medical personnel, nursing staff, social workers, education staff, public health personnel, gerontologists, psychologists and psychiatrists, as well as palliative care, funeral services, cleaning and laundry staff, as well as register office staff, fire brigades and political leaders. We have contacted several of these people again during the drafting of this report to update, corroborate and complete some aspects or testimonies.

With regard to documentary sources, we inventoried and analysed the rules governing care homes in the different autonomous communities, in particular the protocols that affect the response in case of infections, visits, mobility and final goodbyes at the end of a patient's life.<sup>5</sup>

For the chapter on secondary sources of information and analysis, we consulted: the reports of the Daily Mortality Monitoring System (MoMo), the Centre for the Coordination of Health Alerts and Emergencies (CCAES) and the National Public Health Surveillance Network (RENAVE); the daily bulletins of the Ministry of Health; data from the Carlos III Health Institute; and the reports of the autonomous communities. The websites of professional associations, trade unions and care home associations were also taken into account, as well as information from the national and international press and the few but apt recommendations and analyses of organisations and specialised publications, such as the World Health Organization (WHO), the European Union, the European Centre for Disease Prevention and Control (ECDC), its US counterpart (Centers for Disease Control and Prevention, CDC), The Lancet, the London School of Economics (LSE) and the Center for Clinical Standards and Quality / Quality, Safety & Oversight Group (CMS).

The situations described here were collected in the reports of the MSF teams, after visiting almost 500 care homes and interacting with another 800. Far from being anecdotal, **they confirm a pattern in which, in a generalised way, we can observe the same difficulties and behaviours.**

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<sup>4</sup> Guide for the opening of care homes in the United States, with details applicable to the Spanish care home context. Center for Clinical Standards and Quality / Quality, Safety & Oversight Group. Available at: <https://www.cms.gov/files/document/qso-20-30-nh.pdf>. Consulted on 13.07.2020.

<sup>5</sup> 'Residency Regulations Summary', prepared by the Spanish Society of Geriatrics and Gerontology (SEGG). Reviewed on 17.06.2020. Available at: <https://www.segg.es/> y [https://www.segg.es/media/descargas/Cuadro\\_resumen\\_SEGG\\_Normativa\\_Residencias\\_Rev\\_18mayo2020.pdf](https://www.segg.es/media/descargas/Cuadro_resumen_SEGG_Normativa_Residencias_Rev_18mayo2020.pdf). Consulted 13.08.2020

Others: <https://www.inforesidencias.com/contenidos/reglamentacion>. See comparison of staff ratios, beds and licences at: <https://www.inforesidencias.com/contenidos/reglamentacion/nacional/cuadro-comparativo-en-tre-normativas-sobre-residencias-geriatricas-en-espa-a>.



(In fact, for this analysis, we have avoided particular situations that, no matter how harsh, did not reflect the general situation.)

We also used the information collected in the MSF interventions in elderly care homes in France, Italy and Belgium, to compare and contrast experiences and recommendations. In this process, we came to the conclusion that the challenges faced were very similar and the practical response of our organisation was the same. In the four countries, our political advocacy actions were and are aimed at causing a change in the elements and criteria that directly affect the provision of quality healthcare for the elderly in care homes.

#### Terminological scope and confidentiality

For the purposes of scope, this report considers care home staff to include all care, health, cleaning, laundry, kitchen and maintenance, education and social work staff, as well as the specialised personnel who interact and participate in the activities that take place in an elderly care home. In the same way, in the absence of an official or consensual definition, the concept of "elderly care home" is used in its most generous sense, from apartments with reduced capacity to large facilities, be they public, private, subsidised or mixed care homes, or social health centres. We will refer to adults over 65 years of age as "elderly" and "vulnerable" in view of their great exposure to the virus, due to the structure of the care homes (oriented towards coexistence) and the habitual existence of previous pathologies. In other words, age alone is not a criterion of vulnerability or frailty. The autonomy of the elderly must be considered and they must participate and be consulted.

To protect the right to privacy and confidentiality, MSF has modified the names associated with the testimonies, with express consent in all cases, and has chosen to use generic geographic references (without thereby distorting the content).

#### Limitations

Regarding the limitations, we must point out that the MSF teams did not participate directly in the clinical management of patients, apart from some exceptions of an urgent nature, when the life of the person was at stake. Therefore, our data is based on observation and direct testimony and not on medical data or records. Thus, this report reflects what we have seen, done and learned, as well as our recommendations based on such actions.

This report therefore refers to quantitative data, extracted from official sources (mentioned above), whose interpretation is limited by the diversity of criteria, definitions and data collection methods, which prevents rigorous comparisons. Nevertheless, it was and is important to share public data on the number of infected and deceased people, even if imperfectly, in order to alert those responsible **to the magnitude of the impact on the health of the elderly of the decisions that have been taken during the pandemic** and to get their attention and a commensurate allocation of resources. MSF teams used the sources available at all times, together with the individual testimonies collected, to alert the authorities and care home managers and stress the need for changes.

Today, the availability of data, the discrepancy between the sources and the fragmented interpretation of the information make it even more difficult to analyse the impact of the pandemic on care homes in Spain, and we consider that it deserves its own section.

#### Lack of information to assess the magnitude and severity of the situation

Suffice it to say that, with the care home sector being the hardest hit by the health crisis caused by the pandemic, the central government has not yet published definitive cumulative data on the number of deaths. The figure for care homes, as of 22 July, ranged from 19,645 people who were deduced from the data provided by the autonomous communities,<sup>6</sup> to between 27,359 and 32,843 reported on different occasions by the Ministry of Health, the communities themselves and other publications.<sup>7</sup>

The data on deaths is the most relevant and the most difficult to obtain rigorously. There are three main approaches to recording COVID-19-related deaths. It is important to consider each of these approaches when generating the information necessary to measure the impact of the epidemic. They are as follows:

- Deaths of people with a positive PCR test result.
- Deaths of people with suspected COVID-19.
- Deaths in a greater number than usual for a given date and place.

On 23 March, via Order SND / 275/2020,<sup>8</sup> the Ministry of Health asked regional governments to send the data of people who died in hospitals with a positive PCR test result and with symptoms compatible with COVID-19. But **it was not until 16 April** (Order SND / 352/2020), **after the peak of the epidemic and with more than 5,000 deaths in care homes** (such as in the Community of Madrid), when the **autonomous communities were required to submit a form with the number of deaths** in care homes. This new data collection order was not accompanied by an efficient and agreed mechanism between the regional governments to carry out a rigorous work; rather, there were complaints about how complex and bureaucratic the forms were at a time of urgency and scarce resources. By 7 July, there were still several autonomous communities that had not delivered any data to the Ministry; others had only done it once.

The lack of systemisation and documentary clarity and the change in protocols and case definitions at the central level prevent data and results from being comparable. While some autonomous communities distinguish between deaths diagnosed by PCR test and those symptomatic but without diagnostic confirmation, other communities do not establish such differentiation. In addition, some communities have included in this statistic the deaths of the elderly in centres for people with disabilities or mental illness. The exchange of information and official sources leads to situations so absurd that, in Catalonia for example, the mortality rate in elderly care homes of the regional government, the Generalitat, (obtained from funeral services data) doubles the figure managed by the Ministry of Health.<sup>9</sup>

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<sup>6</sup> <https://www.rtve.es/noticias/20200721/radiografia-del-coronavirus-residencias-ancianos-espana/2011609.shtml>. Consulted on 22.07.2020.

<sup>7</sup> <https://elpais.com/sociedad/2020-07-07/el-gobierno-cifra-en-27359-el-numero-de-fallecidos-en-residencias-aunque-no-lo-hace-publico-porque-cuestiona-los-datos-de-las-comunidades.html> (consulted on 06.07.2020) and <https://www.lainformacion.com/asuntos-sociales/residencias-muertes-espana-sanidad-COVID/2809726/> (consulted on 14.07.2020).

<sup>8</sup> Order SND / 275/2020, of 23 March, on the submission of information from autonomous communities to the Ministry of Health, an order that changed the data collection criteria. The Order establishes that only cases confirmed by PCR will be collected in the daily report issued by the CCAES, both for deceased and infected persons; but even at that time, not all hospitals, and even fewer primary care centres or care homes, had PCR tests at their disposal. Available at: <https://www.boe.es/boe/dias/2020/03/24/pdfs/BOE-A-2020-4010.pdf>. Consulted on 10.06.2020.

<sup>9</sup> [https://cronicaglobal.elespanol.com/vida/generalitat-reconoce-ahora-casi-doble-muertos-por-coronavirus-en-cataluna\\_338616\\_102.html](https://cronicaglobal.elespanol.com/vida/generalitat-reconoce-ahora-casi-doble-muertos-por-coronavirus-en-cataluna_338616_102.html) (consulted on 10.06.2020) and <https://elpais.com/sociedad/2020-04-15/cataluna-cambia-la-forma-de-contar-casos-y-hace-aflorar-3242-fallecidos-mas-con-coronavirus.html> (consulted on 11.07.2020).

At the international level, there are no adapted criteria in the absence of diagnostic tests.<sup>10</sup> The new International Classification of Diseases, in its Tenth Revision (ICD-10),<sup>11</sup> applies the emergency code "U07.1" in the coding for COVID-19 mortality, with confirmation only by laboratory test. However, at the beginning of the epidemic, there were no means of diagnosis available in care homes and asymptomatic people in these centres reached very high numbers: 69.7% of residents who had tested positive and 55.8% of staff, according to a study carried out in Barcelona.<sup>12</sup> The case definition should have been adapted to the available diagnostic means and, in any case, these redefinitions also contributed to the discrepancy in the figures.



Photo 4 - Vincenzo Livieri

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<sup>10</sup> <https://ltcCOVID.org/2020/04/12/mortality-associated-with-COVID-19-outbreaks-in-care-homes-early-international-evidence/>. Consulted on 11.07.2020.

<sup>11</sup> <https://icd.who.int/browse10/2019/en#/U07.1>. Consulted on 11.07.2020

<sup>12</sup> [https://wwwnc.cdc.gov/eid/article/26/9/20-2603\\_article](https://wwwnc.cdc.gov/eid/article/26/9/20-2603_article). For this study, 5,869 samples were obtained (3,214 from residents and 2,655 from staff); 23.9% of residents (768) and 15.2% of staff (403) tested positive for COVID-19. Among those who tested positive (and for those with information on symptoms), 69.7% of the residents and 55.8% of the staff were asymptomatic.

Official websites are a clear example of discrepancies in data and criteria, as can be seen in the following box.

**Data on deaths according to various public sources (although dates and criteria are not comparable, the discrepancy in figures is demonstrated):**

**1. Ministry of Health.** 'Update No. 161', of 14 July, establishes the total number of deaths in Spain (all age groups and regardless of the place of death, whether in hospitals or care homes) at **28,406 people**.<sup>13</sup>

**2. Ministry of Health.** On 7 July, it reports that at least **27,359 people died** in care homes between 6 April and 20 June.

The count excludes the dates of the peak and highest mortality, does not specify causes of death and leaves out one autonomous community. The figure represents 7.1% of the total number of care home residents in Spain and, far from dispelling doubts, opens a gap of more than 5,000 deaths, since not even the department led by Salvador Illa endorses the quality of a number that could fluctuate up to **32,843 deaths**.<sup>14</sup>

**3. Autonomous communities.** According to the data offered on 13 July by RTVE, which in turn cites data provided by the autonomous communities, the number of fatalities that the coronavirus had caused in the nearly 5,400 elderly care homes in Spain stands at **19,634**.

**4. National Institute of Statistics (INE) and Civil Registries (excess mortality).** According to the INE data received from the Civil Registries, the number of people who died between 1 January and 24 May amounted to 225,930, **an increase of 24.1% (43,945 more people)** compared to the same period in 2019. Mortality soared in Spain in the worst week of the health crisis, with an increase of 155%. According to data as of **27 July**, excess mortality from all causes at the national level, from 13 March to 22 May, was 58%. This excess was concentrated in those over 74 years of age (**67%**), followed by the 65-74 age group (**47%**).<sup>15</sup>

**5. Ministry of Inclusion, Social Security and Migrations.** In May 2020, 38,508 fewer state pensions were paid than in April; it is the **highest decrease in the last 15 years**. Between January and May, the number of cancelled pensions (which are largely due to the death of the pensioner) grew to 205,638, 17.5% more than in the same period of the previous year.

Regarding the collection of data, and not just of deaths, the ECDC<sup>16</sup> created a specific model for COVID-19, defined as "reliable, accessible, sustainable, transparent, comparable and interoperable", which the Spanish authorities are still assessing to adapt the current model.

<sup>13</sup> Ministry of Health, 'Update nº 161'. Available at:

[https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov-China/documentos/Actualizacion\\_161\\_COVID-19.pdf](https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov-China/documentos/Actualizacion_161_COVID-19.pdf). Consulted on 14.07.2020.

<sup>14</sup> <https://www.lainformacion.com/asuntos-sociales/residencias-muertes-espana-sanidad-COVID/2809726/>. Consulted on 14.07.2020.

<sup>15</sup> [https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/MoMo/Documents/informesMoMo2020/MoMo\\_Situacion%20a%2019%20de%20julio\\_CNE.pdf](https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/MoMo/Documents/informesMoMo2020/MoMo_Situacion%20a%2019%20de%20julio_CNE.pdf). Consulted on 27.07.2020.

<sup>16</sup> European Center for Disease Prevention and Control. Surveillance of SARS-COV-2 in long-term care facilities in the EU/EEA, 19 May 2020. Stockholm: ECDC; 2020. <https://www.ecdc.europa.eu/en/publications-data/surveillance-COVID-19-long-term-care-facilities-EU-EEA> Pages 8-10. Data reporting. Available only in English.

Therefore, as of the date of this report, any rigorous and differentiated balance of people who died in hospitals or care homes is inaccurate. Nor can we distinguish, from among those who died in care homes, those who did so directly from COVID-19 or from other pathologies without having been referred to primary care or hospitals. The estimate is close to **30,000 deaths in care homes**.

## 1.5 MSF's advocacy work

From the beginning of its intervention, MSF made, in addition to collaboration proposals, a series of specific requests to the highest authorities.<sup>17</sup> Of note are those made during the first days of the declaration of the state of alarm to the president of the Government of Spain, Pedro Sánchez, the Minister of Health, Salvador Illa, and to ministries in the different autonomous communities. In these communications, MSF advocated for initial collaboration and proposed concrete measures for change once the activities in care homes started, stating the challenges and proposing solutions (as we will see in the following sections).

The key messages and difficulties outlined in the communication with the authorities were the following:

- Lack of transparent information, leadership and clear and determined actions to tackle the outbreak in care homes.
- Deficiencies in infection prevention and control and the need for a professional profile that assumes the supervision of these tasks.
- Lack of increased capacity and reinforcement of primary care programmes.
- Lack of timely hospital referrals.
- Insufficient personal protective equipment, protocols and adequate training for its use.
- Lack of clarity in end-of-life and last goodbye protocols, and manifest difficulties in last goodbyes with family members.
- Need for improvement in the treatment, care and dignity of patients.
- Inefficiency and delays in diagnostic strategies.
- Lack of available human resources with appropriate training.

On 29 March, MSF wrote directly to the Minister of Health asking him to, among other measures, "execute a procedure and clear criteria for referrals and counter-referrals between the most affected and the least affected places."

On 9 April, MSF published, in collaboration with Amnesty International, a letter entitled 'It is here and it is now', a key piece to which the government responded in detail in May. Following up, MSF sent a second letter (when the mortality of the elderly needed more attention and resources) to the **Ministry of Health and the Health Commission of the Congress of Deputies**, as well as to other key interlocutors: **the president's offices and health departments of the autonomous communities**. It was also disseminated among **professional associations of medicine, nursing, social education and health technicians**, and among **care home associations, unions, private care home owners, family member groups and funeral homes**, to get feedback and, where appropriate, adapt MSF activities in its support to care homes. We received a response from various public administrations and we worked bilaterally to monitor the evolution and progress.

On 8 May, MSF insisted by letter to the **Ministry of Health** on the need for "an effective staff mobilisation plan proportional to the residents' needs for quality care and dignified treatment in personal resources and protection materials, as well as the provision of the necessary resources for

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<sup>17</sup> All these letters can be consulted.



geriatric management in primary care.” On 19 May, these same requests were repeated in a joint open letter with several professional health associations, including the Spanish Society of Geriatric and Gerontological Nursing (SEEGG).<sup>18</sup>

On 2 June, and as a follow-up to all the aforementioned initiatives, MSF held a meeting with **spokespersons for the Health Commissions of the Congress of Deputies and the Senate**. The meeting expanded on the requests made at the beginning of April and May, focusing the requests on the evaluation of the impact and the establishment of an adequate contingency plan that would prepare the health system for possible outbreaks, with special attention to care homes.

During the epidemic, we also transferred our observations and practical recommendations to the **CCAES** (18 April, 1 May and 22 June), with the aim of sharing them in the meetings that the coordination centre held with the health minister and the president of the government.

Finally, on 15 May, we sent a letter to the **Ministry of Health and to all health departments and other relevant stakeholders** to inform them of the end of MSF's direct support intervention (on 22 May), while facilitating access to available resources on the web and a telephone number for urgent requests for assistance and materials.

At the end of July, as a follow-up to bilateral talks, we delivered a joint note with the lessons learned from MSF's work in **Belgium, Portugal and Spain** to various key figures and institutions of the **European Union**. In this communication, we asked for a contingency plan for care homes, which should be accompanied by a clear allocation of resources to strengthen health systems in primary and hospital care.



Photo 5 - Olmo Calvo

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<sup>18</sup> Association of Community Nursing, General Council of Nursing, Federation of Community Nursing and Primary Care Associations, Collegiate Medical Organisation, Spanish Society of Geriatric and Gerontological Nursing, Spanish Society of Primary Care Physicians, Spanish Society of Family and Community Medicine and Spanish Society of General and Family Physicians.

## 2. THE ELDERLY IN CARE HOMES AND THEIR VULNERABILITY TO THE EPIDEMIC

### 2.1 Profile of residents: vulnerability and high mortality

Elderly people living in care homes are in especially vulnerable to COVID-19 for various reasons:

- They generally have multiple pathologies, comorbidities and chronic diseases, which weaken their state of health and their resistance to infection.
- Their close proximity and the community dynamics facilitate the spread of viruses.
- Personal care tasks, especially if residents have some degree of dependency, require close physical contact. Activities such as washing the body, dressing, feeding or helping in the bathroom facilitate contagion.
- Staff in charge of these tasks continually enter and exit the facility and often work in several places, due to job insecurity, which increases the possibility of them contracting the virus and spreading it to different centres.

Another very important factor to take into account is that elderly care homes are not conceived in Spain as social health centres and therefore those who live in them **remain in the National Health System in the same way as any other person residing in their own home**, which includes access to health facilities (health centres, specialists and hospitals) and home care, that is, in the care home itself, by primary care teams. Care homes **are homes, where the purpose is coexistence and to ensure basic care, not the cure of diseases or emergency medical assistance or hospital care**. For this reason, the staff is not generally trained in medical care.

The COVID-19 situation has revealed that there were no adequate response mechanisms in care homes to address the vulnerability or fragility of the elderly, which translated into high mortality and made this population **the most affected by COVID-19, and also the most abandoned**.

**At the first moment of the crisis, the response focused on the collapse of the health system, in hospital emergency services and ICUs, which reached the point of refusing referrals from care homes.** These were not provided with the necessary resources to counteract this vulnerability and there were no clear instructions in terms of segregation of areas, disinfection measures, protection, diagnostic strategies and access to health, not even when care homes were placed under the responsibility and management of the health departments of the autonomous communities.

### 2.2 The care home model in Spain

The high death rate that COVID-19 has caused in care homes reveals that a good part of the difficulties during the crisis were linked to structural deficiencies, as well as job insecurity and cuts in the sector that have been well documented. For MSF, the debate is not about changing one model for another, or whether care homes should pass to the National Health System or should continue to be part of social services, or whether their management should continue to be decentralised in the autonomous communities, or whether the model should be public or private. For MSF, the debate should be on how to **ensure that elderly people and their health and care needs are put at the centre of the model**.

Whichever management and governance model is adopted, it must translate into a regulatory framework that adequately protects this group. The functional deficiencies detected, with their dramatic cost in lives and suffering, must be radically remedied. The requirements and obligations taken on and met by those who assume responsibility for the care of these people should be up to the challenges that this crisis has shown. This situation must not be repeated.

## 2.3 Impact on health

Care homes had a **structural deficit in resources and sanitary supervision and no contingency plan**. This combination made the response to the epidemic unviable. They lacked health and care resources, which had a direct impact on the health of the residents, when the **responsibility for emergency life-or-death health services fell to facilities designed for social situations (housing or residential care)**. This led to insufficient medical care, high mortality, and a decline in the quality of social care. **Many elderly people died isolated and alone, to the point that, in some cases, they were found dead in their rooms after several hours or even days.**

"The potential lack of efficiency translates not only into a decline in people's health and quality of life, but also into an increase in cost, since we do not adequately attend to the post-acute and chronic phases, producing inabilities, recurrences and exacerbations that could be avoided."  
Alberto Giménez, president of the Economy and Health Foundation.<sup>19</sup>

To avoid this impact, greater cohesion of social and health services and greater coordination, supervision and support of the public health system via primary care centres are necessary, in order to guarantee medical assistance and dignified care wherever it is necessary: in the home, outpatient clinic, ambulance, primary care centre, care home, social health centre, hospital, medically-equipped hotel, "comfort hotel", sports pavilion, etc.

## 2.4 Competences during the state of alarm: the role of the autonomous communities

The responsibility for care homes corresponds to the 17 autonomous communities. The model is therefore diverse and open to the discretion of each competent autonomous body. In addition, we must add the alteration due to the declaration of the state of alarm.<sup>20</sup> The regional and local powers were not directly modified, but their ordinary exercise was partially affected, since the central government's measures during the state of alarm could cover any matter. Specifically, the powers over care homes correspond to the Department of Social Affairs of each autonomous community. The governance structure of care homes in Spain is made up of different levels and elements of social services, which are managed separately from the national health system, with responsibility being distributed vertically among the national, regional, provincial and municipal administrations. During the state of alarm, Order SND/265/2020,<sup>21</sup> which came into force on 23 March, transferred the powers from the departments of social affairs to the departments of health. In some autonomous communities, such as Catalonia, this status dependent on the health department lasted beyond the end of the state of alarm.

## 2.5 Care home regime

As a result of this fragmentation and multiplicity of parties involved, care homes and their services are governed and managed by a combination of service providers and public and private (for-profit and non-profit) entities, always connected to the national health system. This segmentation generates important challenges when it comes to harmonising and supervising the quality of the services provided, resulting in the responsibility for inspection being diffuse and social and health

<sup>19</sup> <http://isanidad.com/100778/que-significa-sociosanitario-consenso-de-50-expertos-de-la-fundacion-economia-y-salud/>. Consulted on 16.06.2020.

<sup>20</sup> Royal decree 463/2020, of 14 March, which declares the state of alarm.

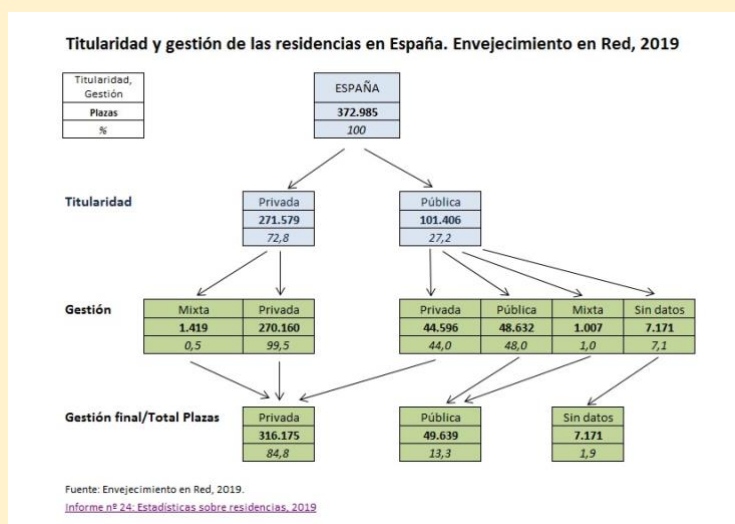
<sup>21</sup> Order SND/265/2020, of 19 March, which allows the autonomous governments to intervene in the management of public or private care homes. The order establishes that it will be possible to "modify the provision of services of medical, nursing or other health personnel linked to elderly care homes and other social and health centres." In its section 7, it empowers the autonomous region governments to "issue the resolutions, provisions and interpretative instructions that, in the specific sphere of their action, are necessary".



resources being managed in an uncoordinated manner. With regard to the link between private companies and publicly-owned services, there are two types of agreements with the public administrations responsible for the powers: the subsidised model (public money finances the use of places in private care homes) and the concession model (management of public centres is transferred to private companies).<sup>22</sup>

The care home sector is increasingly dominated by private for-profit providers. Among the many family members we were in contact with, among other sources, there is widespread concern over the decline in quality standards as a result of efforts to reduce costs and generate expected profit margins. Public sector facilities managed by private providers face the same problems.

According to the latest CISC data available, there are 5,417 elderly care homes in Spain, with a total of 372,985 places.<sup>23</sup> Of these, 72.8% are **privately owned** (271,579 places, a figure that includes the 49,832 in private non-profit organisations); the rest are publicly owned (27.2%, that is, 101,406 places). In terms of management of places, 84.8% of all care home places are **managed by private companies**.<sup>24</sup>



Currently, there are no decisive studies that allow a comparison of the impact of mortality in the different models of public or private management,<sup>25</sup> nor between the models with centralised management or with fully or partially transferred powers.

MSF considers that, in the face of an emergency such as COVID-19, it would be recommendable to have **a system based on caring for the most vulnerable people, wherever necessary, with innovative and emergency-focused strategies, although initially they may be imperfect; it is the intervention criterion that most reduces mortality and best controls, protects and prevents infection.**

<sup>22</sup> A specific and relevant example is represented by the leading multinational in the care home sector in Spain, DomusVi, which has agreements with 82 autonomous region and municipal public administrations and with provincial councils. See: [https://www.infolibre.es/noticias/politica/2020/04/13/82\\_administraciones\\_alimentan\\_con\\_dinero\\_publico\\_expansion\\_multi\\_nacional\\_las\\_residencias\\_domusvi\\_105819\\_1012.html](https://www.infolibre.es/noticias/politica/2020/04/13/82_administraciones_alimentan_con_dinero_publico_expansion_multi_nacional_las_residencias_domusvi_105819_1012.html). Consulted on 14.04.2020.

<sup>23</sup> <http://envejecimiento.csic.es/documentos/documentos/enred-estadisticasresidencias2019.pdf>. Consulted on 05.08.2020.

<sup>24</sup> <http://envejecimientoenred.es/quien-gestiona-las-residencias-en-espana/> and <http://envejecimientoenred.es/quien-gestiona-las-residencias-en-espana/>. Consulted on 05.08.2020.

<sup>25</sup> Of the 486 care homes that MSF visited or supported, 16% are publicly managed and 84% privately managed.

### 3. SUMMARY OF DIFFICULTIES ENCOUNTERED AND MSF'S RESPONSE

"When we woke up, the virus was already here," says Domingo, accentuating the syllables as he pronounces this sentence, as he would perhaps do with his students during his days not so long ago as a high school teacher. We appreciate the allusion to the famous Monterroso short story and I let him know: "This bug hides better than a dinosaur," I tell him, looking for the spark of pride that appears in someone's eyes when you acknowledge their ingenuity. But the only thing we see in his eyes is a dull sadness. He turns his face, gazes at the empty bed of the roommate with whom he will no longer play cards, and shakes his head in stupor. "I don't know how nobody realised before."

Testimony of a member of the MSF teams that provided onsite support in care homes.

Without intending to, Domingo summed up in two sentences the feeling of perplexity that we found in the almost 500 care homes we supported in Spain. If we knew that this virus was very contagious and preyed on older people, why have we taken so long to protect them? What went wrong? What can we do so that it doesn't happen again?

#### 3.1 Lack of preparedness and contingency plans

The epidemic situation in Spain revealed the importance of contingency plans, which anticipate epidemic scenarios and adequate operational responses. In the case of care homes, this lack of preparedness<sup>26</sup> had a devastating effect. According to Ministry of Health estimates available and yet to be confirmed, the number of deaths in care homes ranges **between 27,359 and 32,843**.

The least serious scenario that the Ministry of Health has offered puts the fatalities at 27,359. Of the total, 9,003 cases (32.9%) were diagnosed as COVID-19, while in 9,830 cases (35.9%) symptoms attributable to the virus were detected, although it was not confirmed. The rest of the deaths in these centres (31.2%) were attributed to other causes, understood to include cases related to other diseases that were not treated due to lack of care, lack of hospital referral or due to the disruption in the prescribed administration of medication.<sup>27</sup>

The negative impact of this lack of preparedness increases when the answer also depends on a multiplicity of interlocutors, as has already been explained in the section dedicated to the management of care homes in Spain: social services and health departments, district and city councils, primary care services, public health services, boards of foundations and managers of private and religious care homes. All these parties must work in a coordinated manner and with a common strategy, discussed and agreed upon beforehand, in which each one's roles and responsibilities are well defined. The **complexity of the models** (public, subsidised, private, foundations and religious) only increases this need for preparedness, since **fragmentation favours bottlenecks and delay in the decision-making process**.

**The lack of understanding** between the public administrations governed by different political parties and the mistrust between the government bodies responsible for the legislation, supervision and control of care homes, as well as the budgetary dependence on the state or family members **counted for more, on occasions, than giving an effective and immediate response to the**

<sup>26</sup> [https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov-China/documentos/COVID\\_19\\_Estrategia\\_vigilancia\\_y\\_control\\_e\\_indicadores.pdf](https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov-China/documentos/COVID_19_Estrategia_vigilancia_y_control_e_indicadores.pdf). Consulted on 07.07.2020.

<sup>27</sup> <https://www.lainformacion.com/asuntos-sociales/residencias-muertes-espana-sanidad-COVID/2809726/>. Consulted on 07.07.2020.

**identified needs.** The business volume of the private sector which, as we have seen, corresponds to 72.8% in Spain,<sup>28</sup> further complicates the tasks of surveillance, coordination and supervision by the authorities and exerts commercial pressure on the procedures, which in many aspects leads to a lack of definition, as well as to the defencelessness of residents and family members when there is a lack of adequate healthcare.

We observed, for example, a lack of criteria and agility to determine the closure of care homes to visitors and suppliers, as an isolation mechanism against the virus, while there were no adequate protection materials, resources and protocols, and this occurred both in publicly and privately managed care homes. Despite the fact that at the end of February some care homes were proposing this measure, they were not able to assume this sense of preparedness. The lack of legislation and the fear of the legal consequences of unilateral decisions caused many managers, paralysed and overwhelmed by the circumstances, to wait for other parties to assume responsibility.

Miguel, regional manager of social services in one of the most affected autonomous communities, explained the following to MSF, without hiding his regret:

“There were two care homes here that wanted to close to visitors in the last week of February and the first of March, when cases were already becoming known. ‘Impossible,’ I told them, ‘there is no legal protection for what you are proposing. We’ll be inundated with complaints from the relatives.’ Ten days later, all the regional governments had followed the same path following the state of alarm decree, but the virus was already in many of the centres. I don’t know if it would have helped, but I can’t stop thinking about what we could have avoided if these decisions had been made before, when we could already see what was coming our way.”

The absence of contingency plans does not only affect the moment of identifying when a crisis is being faced, but also the way to navigate it, as well as the de-escalation phase and the measures to promote recovery and preparedness for a possible new outbreak.

**This lack of planning invites chaos in a crisis situation:** lack of medical care and the possibility of patient referrals to hospitals; lack of definition of the role that primary care and public health services should play; lack of solutions to manage cases in need of medical, palliative and end-of-life care; neglect of the human aspects of confinement; difficulties in the supply of protection and hygiene materials; multiplication of protocols from different areas not very applicable to the reality of care homes; deficiencies in specific training; absence of plans to cover staff absences; lack of strategies for the prevention of contagion; uncertainty in leadership and responsibilities between the different authorities and entities; poor reliability of diagnostic tools and strategies (which arrived with a long delay); and finally, the fact that care homes were not taken into consideration when it was time to propose de-escalation plans and it was decided to keep the elderly in isolation or quarantine, who in some cases had already been 70 days without any external contact.

➤ After this learning process, MSF developed a contingency plan model adapted to care homes, which outlines the elements that need preparation, coordination and pre-positioning.<sup>29</sup>

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<sup>28</sup> April 2019 data from the CSIC and the CCHS. Available at: <http://envejecimiento.csic.es/estadisticas/indicadores/residencias/index.html>. Consulted on 07.07.2020.  
<sup>29</sup> [https://msfCOVID\\_19.org/plan-de-contingencia-para-residencias/](https://msfCOVID_19.org/plan-de-contingencia-para-residencias/)

### 3.2 Reduced leeway to implement isolation, quarantine and distance measures

**In the absence of the proper protection equipment and protocols, diagnostic capacity, personnel and specific training**, the closure of care homes to visitors and suppliers serves, if at all, to mitigate the risk, since the staff continue to enter and exit the premises, with the danger of outside infection. Therefore, detailed effort must be put into internal protocols. It should be decided in advance how to isolate people with confirmed infection and quarantine<sup>30</sup> suspected cases, as well as what to do with people who have not been affected. Functional pathways must be maintained in isolated areas without falling into cross contamination, all of this ensuring maximum respect for the dignity and quality of care for those who live in these spaces of coexistence, in short, their homes. As Elena Estrada, MSF's humanitarian affairs adviser, points out, **"confinement should not be done at the expense of the physical and cognitive faculties of the elderly, but according to them."**

In this sense, the MSF teams detected two main difficulties for the implementation of the segregation and isolation measures: the inadequate infrastructure and spaces, and the high occupancy at the care homes.

#### Inadequate infrastructure and spaces

The testimony of one of the medical coordinators of the MSF teams in the support response in Catalonia summarises what we observed in each of the territories in which we worked with teams on the ground:

"The buildings and the distribution of spaces in elderly care homes do not favour infection prevention and control measures. There is no type of care home designed in terms of infection prevention. No two care homes are the same. They are all different in terms of access, distribution of rooms and of common areas, kitchen and laundry services, changing rooms, natural ventilation circuits, with access to outdoor areas or, on the contrary, completely closed buildings. In each centre, we have faced a puzzle to recommend and implement the most appropriate segregation measures and pathways, and on many occasions we have had to choose the lesser evil in order to come up with something functional."

In fact, these puzzles were sometimes so complex that in some care homes our onsite teams were unable to find appropriate solutions, and we requested the building plans to develop detailed proposals with the help of another technical team consisting of architects and specialists in infection control and in hygiene and sanitation.

#### High care home occupancy at the time of the crisis

The need to separate residents into cohorts based on symptoms (and as long as there were no reliable diagnostic tests) clashed with the fact that most care homes were almost at 100% capacity at the beginning of the crisis. This created a lot of difficulties for the zoning strategy. The resistance of many care homes to its implementation came from the extra workload for the staff, already overwhelmed and decimated by mass sick leaves, when having to carry out extra tasks in disinfection, transfer of residents and signage, but above all due to the uncertainty generated by using spaces that could already be contaminated to separate the elderly without this bringing an obvious benefit, since insecurity persisted regarding the management of asymptomatic cases and of

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<sup>30</sup> To understand the difference between isolation, quarantine and social distancing, see: <https://academic.oup.com/jtm/article/27/2/taaa020/5735321>. Consulted on 03.07.2020.

people with other diseases. We now know that up to 70% of residents and 55% of staff could have been asymptomatic, according to a study carried out in Barcelona.<sup>31</sup>

Andrés, a fire chief who led the disinfection and zoning support work in collaboration with MSF, sometimes faced this resistance from care home managers:

“They sighed a little when we told them that we were going to do the deep disinfection of walls, floors, cabinets and beds, because they did not see how they could dedicate themselves to this with so many personnel on leave and so many things to do in such critical moments. This mental barrier diminished when they felt that they were not going to be alone in that task, but the fear of moving people, with all their belongings, from one place to another, to create clean and dirty areas persisted. They often preferred that the elderly, while there were no reliable test results, were kept locked in their rooms, instead of regrouping them into zones, for fear of losing control and that the whole building would become contaminated. The result was appalling: a succession of closed doors, sometimes locked, and people banging and begging to get out. It was horrible.”

- The segregation measures implemented, discussed and developed with the MSF teams and the care homes visited, are also available on the website [msfcovid19.org](https://msfcovid19.org), with various practical protocols.<sup>32</sup>

### 3.3 Lack of training in the use of PPE

The lack of supply of PPE during the months of March and April and the need to use home-made alternatives – the so-called “substandard” ones, made by individuals or by groups organised spontaneously to help hospitals and care homes – are sufficiently discussed and documented, and it is not necessary to highlight them in this report.

However, the availability of PPE was not sufficient to effectively mitigate virus transmission. On the contrary, the misuse of protective equipment easily becomes a vector of contagion between staff and residents. During the donning and doffing of gowns, coveralls, gloves, face shields and masks is when there is the greatest risk of contamination. However, the supplies that were arriving little by little were not accompanied by instructions and training activities for the staff, who are not accustomed to using these elements, as they include laundry and cleaning staff, social workers, etc. The user guides and protocols that arrived by email proved to be insufficient and there was no time to read them or even to learn of their existence. In addition, the PPE that arrived were not always adapted to the needs in care homes, especially coveralls, for which the removal procedure is very complex and therefore they are more susceptible to causing contagion.

The response from Alba, director of a care home in Castilla y León, summarises the justification of most care home managers when we asked about the lack of protocols that we observed during the first weeks of the crisis:

“Honestly, I don't have time to read all the emails I'm bombarded with. I have a lot of staff on leave, family members are calling constantly and I have to prepare two or three reports every

<sup>31</sup> [https://wwwnc.cdc.gov/eid/article/26/9/20-2603\\_article](https://wwwnc.cdc.gov/eid/article/26/9/20-2603_article). See note 16.

<sup>32</sup> <https://msfCOVID-19.org/?s=sectorizaci%C3%B3n>.

day with the same information for the different authorities. Furthermore, when I have had the opportunity to read the messages, I find contradictory recommendations and protocols. It is totally confusing and, meanwhile, the residents are falling ill and someone has to take care of them. We are handling medical care that we have not done before and no one is coming here to help. We are doing what we can, but someone should come here who knows what this is all about.”

This is how Laura, a nursing assistant at one of the private care homes that received MSF support, described it:

“We are used, for good or bad, to working with protective materials such as gloves and masks, but in care homes there are many people who do not know how to use them. The caregivers, the maintenance and cleaning staff or the kitchen staff are extremely absent-minded and in the end it's chaos. Some go everywhere overprotected, without differentiating which area they are in, taking the contamination from one place to another, and others go uncovered, without worrying about protecting themselves because it is very uncomfortable, and, 'what the hell, it's all infected ', they tell you. I have done what I could to sensitise everyone, standardise use, so that the care taken by one shift is not spoiled by the other, and above all so that they can put it on and take it off in the right place and in the right way. But someone should have come here to do this work in an expert and methodical way. Here and in all the care homes, because the same thing is happening to my colleagues in other centres. But in our case, with the power that this company has, it is incredible that they have not bothered to give training. They left the boxes with the materials and then, learn by yourselves. It was only when you came that people could learn to use it.”

The lack of specific training focused on infection prevention and control and the use of protective equipment does not concern only care home staff, but also the primary healthcare personnel who participated in the care of residents. One of the errors witnessed throughout our support interventions was the deficient use of PPE by health professionals who provided care in different care homes. This misuse due to lack of protocols and adequate training, consisting above all of overprotecting themselves without respecting zones and pathways or the guidelines for removing PPE, has become one of the main vectors of contagion from one care home to another. We saw medical personnel arriving already dressed in the coverall in their car, entering a care home, doing the rounds of symptomatic residents, and leaving for another care home without changing their PPE.

Luis, a primary care doctor at a health centre who we found giving support in one of the care homes visited, lamented the lack of reflection and training in the face of a virus that was new to everyone:

“We have been carried away by courage and the desire to help without being prepared. You had to go because the situation was catastrophic and the doctors of the care homes or health centres were on sick leave. And so you went, with the best of goodwill, putting in many hours and always afraid, but you went. In some places the doctors did not want to go to the care homes, but in many others they did, because they had to be there. Now, I have no doubt that we have played an active role in transmitting the virus. It was assumed that we, by our profession, knew how to use all this, but it is not like that. It is not the same to put on a pair of gloves with each patient or a mask from time to time, than to have to make visits to homes and care homes with all the equipment that you have to put on, take off and discard several times a day. In the health centres, we have lacked a person responsible for biological risks,



someone who would make sure that we had the equipment and were trained in its use, and who could give us security in what we were doing.”

- MSF created training sheets and organised numerous online seminars on the use of PPE. This was the topic that raised the most doubts and to which we dedicated the most materials (which included creative alternatives in case of shortage<sup>33</sup>), while we insisted to the authorities about the need to provide materials and protocols adapted to reality.



Photo 6 - Anna Surinyach

### 3.4 Lack of organisation, management and human resources for contagion control measures

During this epidemic, it became clear that, to offer healthcare<sup>34</sup> and not just social care in care homes, there must be adequate human resources both in number (ratios<sup>35</sup>) and suitably qualified, to guarantee adequate care. Medical care continues to correspond to primary care centres or hospitals. So much so that the courts ordered some communities to immediately provide medical personnel to care homes.<sup>36</sup> In the event of a crisis, unskilled staff could be hired who, with basic training, could be delegated a series of specific tasks. The US CDC has developed strategies in this

<sup>33</sup> <https://msfCOVID-19.org/epi-material-modo-empleo/> and <https://msfCOVID-19.org/como-fabricarse-unas-mangas-de-plastico-protectoras/>. Consulted on 09.07.2020.

<sup>34</sup> According to the WHO, healthcare encompasses all goods and services designed to promote health, including "preventive, curative and palliative interventions, whether directed at individuals or populations". See also 'Declaration of Human Rights', article 25.1. Available at: <https://www.un.org/es/universal-declaration-human-rights/>. Consulted on 09.07.2020.

<sup>35</sup> Comparison of ratios of staff, beds and licences by autonomous communities <https://www.inforesidencias.com/contenidos/reglamentacion/nacional/cuadro-comparativo-en-tre-normativas-sobre-residencias-geriatricas-en-espa-a>. Consulted on 14.07.2020.

<sup>36</sup> The Administrative Disputes Chamber of the Superior Court of Justice of Madrid, in its records of 21 and 27 April 2020, adopted extremely precautionary measures, an unprecedented ruling, ordering the Ministry of Health of the Community of Madrid to immediately provide elderly care homes with the necessary health personnel, as well as the necessary means to develop diagnostic tests and to comply, precisely, with the provisions of Order SND/265/2020, of 19 March.

regard,<sup>37</sup> applicable in Spain, such as employing student volunteers or training community members to take on specific tasks, guided by a trained and experienced person. MSF frequently uses this practice of delegation of tasks in the health field in contexts where resources are lacking and in times of acute crisis. In this area, MSF developed specific support materials.<sup>38</sup> This solution must not entail the validation of incorrect or abusive practices or the abandonment of responsibilities, and must follow, above all, the principle of "do no harm".

The criteria for the mandatory presence of medical and nursing personnel during certain hours of the day, depending on the number of residents and their degree of dependency,<sup>39</sup> also varies according to the autonomous community. When reviewing the regulations of the 17 autonomous communities,<sup>40</sup> it is found that there is no express obligation in any of them to have nursing staff during the night shift,<sup>41</sup> which indicates the eminently social character of care homes. The high cost of these services has meant that only private care homes belonging to large groups include a more or less extensive portfolio of onsite medical services among their services. This has allowed them to charge more for each place, generating long waiting lists for public care homes with medical or nursing care 24 hours a day. The shortage of experienced personnel is exacerbated by precarious working conditions, as well as the perception that the work is low-skilled; so much so that migrant workers make up a large proportion of the workforce,<sup>42</sup> because the conditions are far from attractive for the national market.

"The current staff ratios in the regulations are insufficient, especially in the ratios of geriatric nursing assistants and, additionally, for a good interdisciplinary approach, it is necessary to incorporate in all the regulations (currently they are only included in less than 10 of the 17 communities) ratios for the presence of professional profiles in the following areas: social education, nursing, physiotherapy, medicine, psychology, occupational therapy and social work, among others."

Spanish Society of Geriatrics and Gerontology<sup>43</sup>

The fact that most care homes closed late and that the means of protection did not arrive in time made it impossible to act in a preventive manner. Many care homes had to organise themselves without basic knowledge about the measures to prevent infection and isolate cases. The only alternative cannot be to lock up staff and residents, as was done in some care homes, indefinitely, until the threat passes. To make things worse, **the increasing number of staff on leave, without an alternative recruitment strategy to maintain or even increase human resource ratios, forced the remaining staff to take on other tasks without receiving precise instructions.** There were many sick leaves among managers and the staff most qualified to assume organisational tasks, and those who did not become ill were quickly overstretched and forced to multiply their functions, often losing sight of the essential tasks of management, supervision and

<sup>37</sup> 'Strategies to Mitigate Healthcare Personnel Staffing Shortages'. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>.

<sup>38</sup> <https://msfCOVID-19.org/wp-content/uploads/2020/04/CV042-ORG-Modelo-respuesta-COVID-19-en-residencias-presentaci%C3%B3n-30042020-V1-ok.pdf>.

<sup>39</sup> The Barthel index or scale, used by health professionals, allows the functional assessment of the autonomy of a patient and his/her rehabilitation. See: [http://scielo.isciii.es/scielo.php?script=sci\\_arttext&pid=S1135-57271997000200004](http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1135-57271997000200004).

<sup>40</sup> The Catalan government has committed to having nursing staff on the night shift in care homes with more than 60 residents, according to the statements made regarding care homes in the Catalan Parliament on 7 July 2020.

<sup>41</sup> SEGG and others. See note 5.

<sup>42</sup> 'Facts and Figures on Healthy Ageing and Long-term Care' (various authors) is one of the few reports in this regard. Cited by the WHO in: <https://www.euro.who.int/publications/detail/403>. Consulted on 18.06.2020.

<sup>43</sup> SEGG and others. See note 5.



coordination of the rest of the staff. The patient-caregiver ratio also impacts on adherence to treatment (which many residents receive for their chronic diseases), given the supply problems at the centres and the lack of human resources to ensure regular intake and prescriptions.

The lack of key personnel did not enable management and staff to follow up on the information received from different channels or to respond to families' requests for information, nor even to their own psychosocial support needs. All this also made it difficult to humanise the confinements of residents and the implementation of **measures that preserve coexistence, quality of care, basic routines of mobility and sociability** and, ultimately, dignity. Decisions that were sometimes obvious to those of us who came from outside were beyond the reach of those working in conditions of stress, anguish, bewilderment, and strain from the feeling of not managing to do everything that had to be done. The novelty of the virus and the complexity of many care homes made supervision necessary, which was beyond the reach of the vast majority of public and private managers, and therefore of their staff.

Isabel, the director of a care home belonging to a religious community to which MSF lent its support, expressed the frustration experienced in many care homes due to their ignorance about the steps to take and inability to take control of the situation:

“At the beginning of March, when this challenge arrived at the global level, we already saw that the threat was upon us and we decided to restrict visits. This was complicated, because there was not yet an awareness of the risk and it took a lot for both residents and families to assume it. At the end of March, we had the first case. This fact marked a before and after. From then on it snowballed. I was trying to stay in control, but it was not possible, the virus was taking over. I requested support from the Andalusian government. They told me someone would come. And so the days went by. Easter arrived and I was working 12 to 14 hours a day. But I could not control the situation, the virus controlled us. I was kind of in shock, stuck. Some people came from the Public Health inspection, the UME,<sup>44</sup> Civil Defence, and they disinfected, and they gave us information, but the situation did not improve. I improvised and invented how to do things. We have a very participatory system, but I asked myself every day: 'Will what we are doing be okay?'”

Government support and supervision have been deficient. The social services or public health workers who were assigned to monitor the affected care homes did not have the knowledge or training to give effective support for the problems that were appearing in the centres. Despite the interest and good intentions of many of them, their work could not go beyond collecting data for reports and insisting on instructions that they themselves sometimes did not understand. The prohibition of meetings and training as part of the measures taken by the government to limit contagion forced them to prepare themselves on their own, which resulted in unequal support that was lacking criteria, was fruitless and in many cases non-existent and generated more bewilderment.

Beatriz, a social worker in one of the regional offices of the Department of Social Services, explained the following to the MSF team that was supporting some care homes:

“We haven't stopped making visits. There are very few of us for all the affected care homes and the situation is becoming more and more serious. But as for help, what you would call real help, we can do nothing more than remind them in each place of the instructions that they

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<sup>44</sup> Military Emergency Unit.

must follow and listen to their complaints. I have the same information that they have in the files and in the protocols sent; nobody has taught us anything, I'm unable to know if they are doing it right. I don't know anything about pathways or zones, I don't even know how I'm supposed to put on the PPE. From what you just said here, I put it on wrong. I've learned more in two hours of visiting with you than in everything I have read since this nightmare began. I believe that now I will be more useful; I will be able to see if something is not being done right or is not being done, but I don't think I can guide them properly if I find myself in a disastrous situation. We are not prepared for this. We fill out our report, we serve as an escape valve in those centres where we have managed to have a relationship of trust (because in others they see us only as inspection visits), and we make follow-up calls. But I'm always left with the feeling that we should be able to do more. I saw a movie yesterday where a man is drowning, they can't rescue him, and it made me want to cry.”

- The materials on vector control developed by MSF after these experiences, based on the control of infections of other diseases, are available on our specialised website,<sup>45</sup> along with a specific sheet on the delegation of tasks accompanied by close supervision.

MSF tried various staff recruitment strategies and even some provincial alliances with regional employment services, but the results were not satisfactory. One of MSF's key recommendations, also recommended by the CDC for COVID-19 cases,<sup>46</sup> is to include an infection prevention and control person in care homes and primary care centres, due to the breadth of necessary activities.

### 3.5 Limitations of diagnostic tests and lack of ability to act on results

Based on the experience accumulated by MSF in responding to epidemics, we know that the use of diagnostic tests is always recommended under two premises: that their results are reliable and that there is the capacity to implement the measures derived from such results, such as the transfer of some residents to other centres. However, it has been verified that neither of the assumptions has been present in the strategy for diagnosis and response to the identification of positive cases, which has had consequences both for the resulting lack of credibility and trust in the system, as well as for the state of health of people affected by the disease. In fact, when diagnosing without the proper decision algorithm, without adequate PPE, and universal precautions, the risk of cross infection increases.

#### The theory and the practice

**Order SND/265/2020, of 19 March,**<sup>47</sup> among others, addresses measures for the diagnosis, monitoring and referral of sick people. For these purposes, it provides that, “whenever it is available, the confirmatory diagnostic test should be performed in cases that present symptoms of acute

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<sup>45</sup> <https://msfCOVID19.org/webinar-valoracion-y-apoyo-en-prevencion-y-control-de-la-infeccion-en-residencias-de-mayores/>

<sup>46</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>. “Facilities should assign at least one person with IPC training, to ensure on-site management of COVID-19 prevention and response activities, due to the breadth of activities that are the responsibility of an IPC programme, and that include the development of policies and procedures, infection surveillance, competency-based training of health personnel and verification of compliance with recommended practices.” Only available in English.

<sup>47</sup> On the adoption of measures related to elderly care homes and social and health centres, in the face of the health crisis caused by COVID-19.

respiratory infection to confirm possible COVID-19 infection.” To do this, it establishes that **“care home staff should contact the assigned primary care centre, which will act in coordination with the care home physician, if this resource is available”** and that, **“if referral criteria to a health centre are met, the procedure established for that purpose will be activated.”** However, in practice, on many occasions the MSF teams witnessed that there was no possibility of carrying out these diagnostic tests, or of effectively isolating people, due to ignorance of the IPC measures. In addition, in the case of care homes, a doctor may or may not be available, by the hour or on some days, and this may or may not be coordinated with the corresponding health centre. During the peak of the epidemic, generally no doctor could go to the care homes.

The low reliability of the diagnostic tests (distributed after weeks of waiting) and the lack of suitability for the decisions that had to be made meant in many centres a stop to the zoning activities that we tried to implement to protect residents without symptoms of the disease. **The delay in communicating the results of the most reliable tests (PCR) generated confusion** among staff who had to reorganise spaces and segregation, creating a vicious cycle of work overload, inability to manage IPC and worsening care for the elderly. There have been cases of 80% false positives, which caused a large workload in moving rooms and floors, thus increasing the feeling that blind measures were being taken that put at risk the health of residents and staff who did not know what to expect and felt that their effort to establish an effective isolation setup was useless.

The delay in getting the results of the PCR tests also contributed to the ineffectiveness of the protocols, since the people tested had to be isolated until the arrival of the diagnosis, to prevent them from becoming infected after the test was performed, something that very few care homes managed to carry out. **This delay also contributed to the fact that the treatment of other important pathologies was postponed or underestimated**, with the consequent damage to the health of many people. This impact has yet to be assessed. In certain care homes, the percentage of infected people was so high that a strategy of separating “clean care homes” from “COVID care homes” was not feasible, as there was no extra capacity to transfer residents to other locations. Systematic testing requires nursing staff, to the detriment of other tasks such as clinical management of patients, palliative care, etc.

Some of the (few) rejections that MSF has received of its offer of collaboration in care homes were motivated precisely by the lack of reliability of the diagnostic tests. This is how the director of a company that manages four care homes in the same province answered us:

“We have been talking about it with the team and we have decided to consider the four care homes as already contaminated, so it is not necessary for you to come to work in the segregation of areas. We will continue with room isolation until there are reliable tests. So if there are any residents who are not yet infected, perhaps we can protect them. If we start to move and mix them according to the tests that have been done, they will all end up infected, because we are now seeing in the press that the tests do not work. The ones that have just been withdrawn are the same ones that we were used here. How can we trust what they say? We have been demanding the tests for two weeks and, when they finally arrive, they are too few, insufficient to also test the staff, and they also give false results. As if we did not have enough on our hands with all the obstacles that are being put in our way to treat those that are already sick.”

The obstacles mentioned referred precisely to the blocking of hospital referrals for residents with hospital criteria (cases in need of urgent medical assistance).

### 3.6 Denial of referrals to hospital services: negligence or omission of the duty of assistance?

#### Resident healthcare before and during COVID-19: hospitalisation

Healthcare for the elderly depends on the health system of each autonomous community. If specialised (medical) care is needed, they should be referred – like anyone else – to the National Health System. **Law 16/2003, on Cohesion and Quality of the National Health System**,<sup>48</sup> details the health benefits and emergency criteria, with a clear reference to hospital care, and is complemented by the provisions of Law 33/2011, on General Public Health, which clearly establishes age non-discrimination.<sup>49</sup> In those care homes where there is medical care, this does not replace the health system, but rather complements it, as part of the catalogue of extra services that the care home offers.

Doctors, directors of primary care centres, internists, ICU nurses and experts in palliative care and ethics consulted by MSF all agree that the transfer to hospital of elderly people in very serious condition, with a basic situation of fragility and lack of autonomy, is sometimes not in the best interest of the patient. What's more, hospitalisation can create other complications, especially in people with cognitive impairment. However, **a viable alternative to non-hospitalisation should be offered and COVID-19 should be no exception.** Denying hospital referral without offering an adequate viable alternative could incur an omission of the duty of assistance, which several courts are currently studying.

#### Hospital referrals and their alternative: testimonials

Between the end of March and the beginning of April, hundreds of residents were denied their request to access emergency services and hospital admission, their access restricted depending on the autonomous community and stage of the epidemic. With no alternative, care homes were forced to keep positive patients with a very serious prognosis.

According to government data, **between 27,000 and 33,000** people died in care homes, many of them without being transferred to a hospital. The latest report from the National Epidemiological Surveillance Network, from the end of May, indicated that **44%** of the elderly who were infected in care homes were never referred to a hospital and died in their centres.<sup>50</sup> This practice also implies a **perverse progression**: we are not talking about the health of an individual, but about a matter of public health, the health of an entire group, which not only affected patients with COVID-19, but also patients with other pathologies and their caregivers. In this situation, the virus spread rapidly and affected residents and staff, who, without adequate means to protect themselves, became ill, leaving the workforce depleted. Meanwhile, elderly people without symptoms of COVID-19 and in good health should have been transferred to medically-equipped hotels, to free the care homes, in

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<sup>48</sup> Available at: <https://www.boe.es/eli/es/l/2003/05/28/16/con>. In its article 3, the Law establishes that "all persons with Spanish nationality and foreign persons who have established their residence in Spanish territory are holders of the right to health protection and healthcare." This right is reflected in the Catalogue of Benefits of the National Health System. Consulted on 04.07.2020.

<sup>49</sup> Article 6.1. Available at: <https://www.boe.es/eli/es/l/2011/10/04/33/con>. Consulted on 04.07.2020.

<sup>50</sup> Includes a comparison of hospital admissions and deaths by age (page 9). Available at: <https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/Documents/INEORMES/Informes%20COVID-19/Informe%20n%C2%BA%2032.%20Situaci%C3%B3n%20de%20COVID-19%20en%20Espa%C3%B1a%20a%2021%20de%20mayo%20de%202020.pdf#search=RENAVE%20informe%20mayo%202020>. Consulted on 17.07.2020.

order to prevent more infections. The unacceptable result was the very high number of infections and deaths in undignified circumstances.

## DATA

Between March and May 2020, the number of people who died in care homes was equivalent to **69% of the total** officially notified by the Ministry of Health.<sup>51</sup> According to the MoMo, the **excess mortality** was concentrated in those older than 74 years (**67%**), followed by the 65 to 74 age group (47%).<sup>52</sup> More recent data point to higher percentages, since Catalonia and Madrid already exceeded 10,000 deaths in care homes in June.

**In Catalonia,\*** as of 7 July and according to figures from the Generalitat (Catalan government) reported in the press,<sup>53</sup> of the 3,891 total deaths, **2,797 (71.9%) occurred in care homes** and 1,094 in hospitals (28.1%). In 21 centres, 90% or more of the deaths occurred in the care home itself. In six care homes, with a total of 101 deaths, there was not a single transfer. In the 16 centres managed by the Generalitat, only 27 of the 183 people that died were hospitalised. And of the 142 care homes with 10 or more deaths, only in 15 of them was the number of deaths less than 50.

*\* Note: as of 17 July, 4,119 people had died in care homes, but the details have not been disclosed. This represents more than 72% of the total number of deaths in Catalonia, according to the register of regional funeral homes.*

The **Community of Madrid** has not yet published such detailed data. Since the pandemic began, in the 710 care homes in the community a total of 5,984 people have died with COVID-19 or compatible symptoms. Of the total, 1,253 deaths correspond to cases confirmed by PCR and the rest to cases with compatible symptoms.<sup>54</sup>

The population most vulnerable to COVID-19, upon being denied hospitalisation was relegated to the care of care home staff, who, as we have seen, despite their commitment, had neither the responsibility nor the means nor the knowledge to attend to their medical needs. This had a direct impact on the quality and care of residents and, in many cases, probably contributed to or was the cause of death.

In the care homes visited by the MSF teams, testimonies were collected from managers and staff, who lamented the refusal of health centre medical personnel to accept patients from care homes, or how the emergency services refused to send ambulances if the call came from a care home, despite the fact that the person for whom help was requested met the necessary clinical criteria, such as severe respiratory distress.

Alejandro, a nurse in one of these care homes, explained these difficulties to our team:

“In our case, we were able to care for some patients who, under normal circumstances, would have been referred without problems. There is a medical service here and we have an oxygen

<sup>51</sup> See: <https://www.rtve.es/noticias/20200707/radiografia-del-coronavirus-residencias-ancianos-espana/2011609.shtml>. Data as of 7 July 2020.

<sup>52</sup> [https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/MoMo/Documentos/informesMoMo2020/MoMo\\_Situacion%20a%2019%20de%20julio\\_CNE.pdf](https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/MoMo/Documentos/informesMoMo2020/MoMo_Situacion%20a%2019%20de%20julio_CNE.pdf). Consulted on 27.07.2020.

<sup>53</sup> [https://www.infolibre.es/noticias/politica/2020/07/08/2\\_797\\_mayores\\_murieron\\_marzo\\_abril\\_residencias\\_cataluna\\_sin\\_ser\\_trasladados\\_hospital\\_108573\\_1012.html](https://www.infolibre.es/noticias/politica/2020/07/08/2_797_mayores_murieron_marzo_abril_residencias_cataluna_sin_ser_trasladados_hospital_108573_1012.html)

<sup>54</sup> <https://www.rtve.es/noticias/20200707/radiografia-del-coronavirus-residencias-ancianos-espana/2011609.shtml>. Consulted on 17.07.2020.

facility, so an effort was made while it was possible, because they had already told us that the hospital was not admitting cases from care homes, due to lack of beds. But there came a time when we started talking about the risk to life, and not always related to COVID. Here the patients are elderly and a complication in their chronic diseases is a threat. An attempt was made to refer two residents for whom we no longer had the means, but the hospital confirmed that they would not be admitted. I know that our doctor insisted on the urgency of these referrals, but they made it clear to him that no care home cases were being admitted. Simply put, the reasons for requesting the referral did not matter. Both patients died here within two days, and frankly, it didn't have to be that way. Both could have recovered."

Magdalena, the exhausted manager of a small rural care home who is also a nurse, explained the following to the MSF team, when we went to help with the segregation of areas at the centre:

"I've been doing shift after shift for two days, because there is no one else who can take care of the residents that they will not let me send to the hospital, and I can't take it anymore. Yesterday one died and tonight another will die if I don't stay, but I have to rest to be able to continue managing all this: half of the workforce is on sick leave, family members are calling non-stop and there are a lot of protocols to implement. Here it is very difficult to hire health personnel; nobody wants to come to work in such a remote place. I managed to get a nurse friend to give me a hand, but the hospital has claimed all those who were in the reserve pool and I have been left alone again. The mayor is looking, but I can tell you that he will only find people and volunteers for cleaning, nothing for healthcare. I have called the entire province. At the hospital, they have set up a 'COVID team' for the care homes, but there are only three people and they have not come here. Nor do I think they will do much, as here in this care home they will find many cases and they will not prescribe referrals. But at least they could guide me with the treatments and procedures. I'll stay tonight, of course, and the other nights when it is needed. After all, I'm a nurse. This is vocational, and even more so when you work with elderly people. But here alone I can't do much. Even if I stay, they will continue to die."

Many people died without an individualised clinical diagnosis or management alternative agreed with the family and clinicians. Even in cases with a referral diagnosis (in some private and religious care homes that had medical personnel), the referral was denied, alleging "hospital collapse". In some cases, referrals were limited to one person per day.

Luisa, a social worker at a care home that MSF teams visited up to four times due to the high mortality rate among its residents, answered the question about hospital referrals in this way:

"You called the referral hospital and they said: 'I'm sorry, today we can only admit one person from care homes. You choose.' Even so, the ambulance did not come to pick them up and they died in a few hours or days."

These same MSF teams indicate that the centres visited, without exception, lacked not only the equipment and the necessary medical and emotional training, but also the required number of people and basic protective materials. What we saw is that hospital referrals were not guaranteed, but neither was an alternative, nor the informed consent of the patient about the practices that should be carried out, **nor respect for their autonomy and dignity, nor their last wishes, nor a final goodbye to their families.** Many died alone, dehydrated, in agony (from respiratory distress) and without palliative care. All this led MSF to publish a press release and an opinion article, to

defend the idea that elderly people should receive medical care regardless of their place of residence.

“Care homes, in this context, must be an essential part of the health system. Adequate medical care must be provided in them and the hospital referral of patients who need it must be ensured. If this is not happening, if these groups have been excluded from the system due to its overload, it must be corrected immediately, explained transparently to society and all the necessary resources must be applied to correct this error. Normalising this would be unacceptable under any premise. The most vulnerable are not the first to be excluded: they are the ones who need the most protection”.  
David Noguera, president of MSF Spain, in an article published on 7 April 2020 in *elDiario.es*.<sup>55</sup>

### Triage and viable alternatives: what was done to give patients an alternative with the best possible healthcare in care homes?

As happens with any other person who uses public health, the elderly living in care homes are subject to clinical criteria for admission to ICUs and other hospital services. In a situation with emergency services overwhelmed, such as that experienced in various parts of the country during the most acute stages of the epidemic, these clinical admission criteria become even more relevant to ensure that the existing means are put at the service of patients with a better recovery prognosis. Each case must be evaluated individually, with exclusively clinical, psychological and social criteria. **The prioritisation criteria must be objective, ethical and transparent, applied equitably and made public if necessary.**

Faced with COVID-19, the triage process was activated <sup>56</sup> whereby medical staff prioritised cases above all for emergency and ICU admissions.<sup>57</sup> Medical humanitarian organisations accustomed to working in emergencies and humanitarian crises, such as MSF, are well aware of the triage process, which forces us to make difficult decisions and often confronts us with ethical dilemmas.

In Spain, and apart from the limitations in ICU beds, **alternatives should have been proposed with the available resources**, proceeding to referrals to hospitals, social health centres, hospital extensions, “comfort” or medically-equipped hotels, or private hospitals, since, in all these places, there were free places even during the weeks of the epidemiological peak. In some of the autonomous communities that developed protocols to restrict referrals, residents who had private insurance were referred to private hospitals, since there were beds and resources available, as an alternative to letting them die in the care home.<sup>58</sup>

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<sup>55</sup> [https://www.eldiario.es/opinion/tribuna-abierta/soledad-virus\\_129\\_1210868.html](https://www.eldiario.es/opinion/tribuna-abierta/soledad-virus_129_1210868.html).

<sup>56</sup> Triage is a process that allows clinical risk management to be able to properly and safely manage patient flows when demand and clinical needs exceed resources. ‘Triage: a fundamental tool for emergencies’. Available at: [http://scielo.isciii.es/scielo.php?script=sci\\_arttext&pid=S1137-66272010000200008](http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1137-66272010000200008).

<sup>57</sup> ‘Contingency plan for intensive care services in the face of the COVID-19 pandemic, prepared by the Spanish Society of Intensive and Critical Care Medicine and Coronary Units. Chapter 6 is about how to do triage. Available at: <https://semicyuc.org/wp-content/uploads/2020/03/Plan-Contingencia-COVID-19.pdf>.

<sup>58</sup> <https://elpais.com/espana/madrid/2020-06-10/los-mayores-con-seguro-privado-pudieron-ser-trasladados-de-residencias-a-hospitales-en-madrid.html>, [https://www.eldiario.es/madrid/comunidad-madrid-ancianos-trasladados-hospital\\_1\\_6025890.html](https://www.eldiario.es/madrid/comunidad-madrid-ancianos-trasladados-hospital_1_6025890.html) y <https://www.publico.es/sociedad/COVID-19-mayores-seguro-privado-enfermos-COVID-19-llevados-residencias-hospitales-madrid.html>.



Resources **must be mobilised** in the less affected autonomous communities. Also, in several communities, there are alternatives to conventional hospitalisation <sup>59</sup> and/or primary care rapid response teams that can be activated, in order to guarantee collaboration with the geriatric services of hospitals. **All this must be prepared for a possible second wave. There is no excuse.**

The reality that the MSF teams observed is that **healthcare was left in the hands of the staff of care homes**, who are in no way equipped and in many cases lacked **oxygen therapy, ventilators or intravenous antibiotics**, elements that are necessary for some COVID -19 patients.<sup>60</sup> They even lacked protective equipment, but above all they lacked health personnel in a ratio proportional to the needs and with the appropriate experience and training. All these resources were prioritised for hospitals, to the detriment of care homes and the most vulnerable population, which **was left in the hands of the well-intentioned people who cared for them**, left alone to face an enormous challenge, which at times was to save their lives or accompany them in death.

### Positioning of the WHO and MSF

The WHO warned, in a report on the COVID-19 crisis in Europe, that "several countries in the region have issued guidelines that prevent the access of elderly people to hospital care", measures that "are not recommended in cases where the care home does not offer basic clinical standards of care". The report goes on to say that "adequate and appropriate access to medical care must be ensured, both in referrals to hospital and in their homes and in primary care," and indicates that, in the case of acute infection, such as COVID-19, monitoring oxygen saturation and early oxygen supplementation by mask or nasal cannula are recommended if oxygen drops below 95%. In this sense, the WHO points out that "if the services and facilities of the care homes cannot provide this treatment to the patient with dyspnea, then a location should be offered where it can be provided." **"Failure to do so implies denying these people access to care,"** it stresses. "Cases of elderly people being denied care (i.e. counselling, oxygen, saturation monitoring, or access to hospitals or critical care) because of their age or vulnerability are of concern and this is not recommended."<sup>61</sup>

For MSF, the priority is that elderly people receive the medical care they need<sup>62</sup> and to ensure that their needs in terms of care, health and dignity are placed at the centre of all public policy, and also in practice, to prepare so that these events are not repeated. The denial of hospitalisation was perhaps, in individual diagnosed cases, appropriate to the triage during the peak of the epidemic, but, as it was not accompanied by any viable alternative, it resulted in high mortality, probably avoidable in many cases.

The proposal to "medically equip care homes" during the epidemic (as the only urgent and exceptional way of response) was more a promise than a reality. However, going forward, it is **important to distinguish between providing care homes with resources** (oxygen and perhaps extra nursing staff or increasing primary care visits) **and inpatient care** (24-hour nursing care and doctor on call, quick and easy access to complementary tests such as laboratory tests and X-rays,

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<sup>59</sup> <https://www.elsevier.es/es-revista-medicina-clinica-2-articulo-alternativas-hospitalizacion-convencional-medicina-interna-13074393?code=65WZ9X21AjKquQcCa3JYglDyPfNULF&newsletter=true>. Consulted on 27.07.2020.

<sup>60</sup> "Care homes have never tried to fulfil this function, nor do they have the staff or the spaces of a hospital. They are big houses where many people live." Lourdes Bermejo, vice-president of SEGG.

<sup>61</sup> 'Strengthening the health system response to COVID-19: preventing and managing the SARS-COV-2 pandemic across long-term care services in the WHO European Region' (29 May 2020). Copenhagen: WHO Regional Office for Europe; 2020. Licence: CCBY-NC-SA 3.0 IGO. Available at: <https://apps.who.int/iris/bitstream/handle/10665/333067/WHO-EURO-2020-804-40539-54460-eng.pdf?sequence=1&isAllowed=y>.

<sup>62</sup> On the fundamental rights of patients, see: [https://www.semfy.es/wp-content/uploads/2016/07/23\\_01.pdf](https://www.semfy.es/wp-content/uploads/2016/07/23_01.pdf)



capacity for urgent assistance and cardiopulmonary resuscitation if necessary, etc.). **Medically equipping care homes should not prevent or replace proper referrals to hospitals** or any other viable alternative that ensures quality care and respects the dignity of the patient.

### 3.7 Isolation to the detriment of health and dignified care

Ignorance and fear marked the months of the epidemic in care homes, leaving group activities, coexistence routines and the social dimension that these centres offer the people who inhabit them reduced to strict compliance with isolation, for more than 90 days in some cases and without defining a time limit.

Especially in the first weeks of the epidemic, **the physical, cognitive and emotional needs of isolated people were not taken into account**, which put their health in danger in all other aspects that were not related to the spread of the virus. In the field of mental health, for example, there are studies that indicate that 30% of the elderly living in care homes have symptoms of depression or anxiety. Of these, 30% could be diagnosed with clinical depression or anxiety.<sup>63</sup> If we include dementia, up to 80% of the elderly in care homes would have a diagnosable mental or neurological disease.<sup>64</sup> It is therefore beyond doubt that fear and uncertainty (prolonged due to isolation), loneliness and the breakdown of routines that give them a sense of control had an impact on the states of depression and anxiety common to the residents of these centres.

In many cases, the strict isolation measures were taken **indiscriminately, simply in case of doubt, due to the uncertainty generated by asymptomatic cases and due to the scarcity and limited credibility of diagnostic tests**. But above all, and especially during the first weeks, the cause was the **ignorance of the segregation and pathways strategies**, which would have allowed maintaining the desirable social dimension in some limited areas of the centres. A particularly serious aspect is that, following this lack of logic, people who were neither sick nor likely to have the virus were isolated, and who ended up being equally affected in their physical and mental health due to the disproportionate confinement measures.

The quick way to isolate, without considering coexistence and dignified care, consisted of keeping residents in their rooms, denying all possibility of going out into the corridors and common areas. Cases considered COVID-19 positive cases, either due to symptoms or diagnosis, were marked on the doors so that the staff who had to attend them were aware of the need to use the assigned protection measures there. The corridors thus became a succession of closed doors, some of them locked to contain the most fractious or difficult people due to their cognitive state, or who did not understand what was happening and rebelled. In some places, these people spent several weeks like this and we have been told about cases of residents with a death wish who stopped eating and taking medication, which was found hidden after their death.

The response must be humanised: accompany and dignify. **It is necessary to communicate in an understandable way**, but above all with special attention to the peculiarities of advanced age and its generalised cognitive deterioration. The circumstances and the reason for isolation and the prohibition of visits should be explained, in understandable language, as these people are asked to

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<sup>63</sup> Dozeman et al. *Depression and Anxiety, an Indicated Prevention (DIP) Protocol in Homes for the Elderly: Feasibility and (Cost) Effectiveness of a Stepped Care Programme BMC Geriatr.* 2007 Mar 8;7:6. doi: 10.1186/1471-2318-7-6. Also in Creighton et al. *J Affect Disord.* 2018 Feb;227:416-423. *The Prevalence, Reporting, and Treatment of Anxiety Among Older Adults in Nursing Homes and Other Residential Aged Care Facilities.* DOI: 10.1016/j.jad.2017.11.029.

<sup>64</sup> Bartels et al. *Psychiatr Serv* 2002 Nov;53(11):1390-6. *Models of Mental Health Services in Nursing Homes: A Review of the Literature.* DOI: 10.1176/Atención Primaria.ps.53.11.1390.

change their behaviour, to distance themselves from other people, to remain in isolation, to stop seeing their relatives, to communicate only via mobile phones and tablets, and in general to change their routines.

Carmen, the director of a small family-run care home, related one of these cases, when we asked her about the impact of these isolation measures on the elderly that she knows so well:

"We started by isolating everyone in their rooms, as recommended, to avoid contagion. We didn't know how long this was going to last and we saw right away that there were residents who weren't going to be able to manage it. Eugenia, for example, stopped eating and moving; she passed the hours staring out the window. There were other residents who complained and tried to get out of their rooms, and the truth is that it has been very painful to have to keep them locked up. In Eugenia's case, I was afraid that she would let herself die and I began to take her out every day for a while, to see if she would regain her will to live. And she started eating, she started to get better, until one day the primary care people came just when we had her out, and they told me that I was being irresponsible and putting everyone in danger. I had no choice but to return her to her room. They made me feel really bad. She stopped eating again and within a few days she died. I'm not saying that she would not die anyway, but I am clear that she did not want to go through this. When the primary care team came back and I told them that she had died from being locked up again, they said: "Don't tell us that." They were quite upset. The same thing has happened to all of us. We were so scared by the virus that we have not thought of anything other than isolating as much as possible, without thinking about what this meant for them."

### **3.8 Lack of protocol for palliative and end-of-life care, final goodbyes and visits**

During our presence in numerous care homes, we verified the lack of clarity and implementation of protocols dedicated to the treatment of comfort, sedation and palliative care for terminally ill people who had not been referred to hospitals or other facilities during the epidemic. This was partly due to the lack of experienced staff in the centres to provide this care, and partly to the difficulties of primary care staff in responding to the demands during the most acute moments of the health crisis. Sometimes it was also due to lack of medication. The care of these cases turned out to be very deficient and the responsibility fell on people who did not have the knowledge or the adequate preparation for these sensitive situations, being themselves in a situation of hopelessness and despair.

In Spain, not all communities have regulated the right to a dignified death that includes palliative care: only nine of the 17 autonomous communities have done so.<sup>65</sup> This is still a debate in Spanish society that is closely linked to models and quality of care. However, palliative care is an essential service that must be integrated and maintained as a regular part of medical care. No one in need of palliative or end-of-life care<sup>66</sup> should be abandoned or neglected. For this, it is necessary to increase the capacity for palliative care in care homes, which implies involving staff who are not familiar with these methods, ensuring quality standards<sup>67</sup> and training staff to act based on informed, inclusive and autonomous decisions of patients or, if necessary, their families.

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<sup>65</sup> <https://derechoamorrir.org/2020/04/15/COVID-19-listado-de-iniciativas-para-facilitar-el-acompanamiento-al-final-de-la-vida/>. Consulted on 10.07.2020.

<sup>66</sup> Both palliative care and care for terminally ill patients provide welfare. But palliative care can begin at the time of diagnosis and at the same time as treatment. End-of-life care begins after treatment for the disease is suspended and when it is confirmed that the person will not survive.

<sup>67</sup> See note 68.

According to the WHO guidelines for COVID-19, palliative care is integrated with curative care: “All people should have the right to die with dignity and access to palliative care if all other measures have been taken to provide quality care, including oxygen therapy”. However, during the epidemic, the volume of palliative care provided declined markedly; a study carried out in a Spanish hospital (and referenced by the WHO) indicated a 50% reduction in admissions for palliative care.<sup>68</sup>

These are, according to the WHO, the key actions in terms of palliative care necessary during a COVID-19 epidemic:

- Ensure national and regional policies, programmes and guidelines to support the provision of palliative care.
- Review palliative care in care homes in the context of COVID-19.
- Incorporate training in palliative care and basic skills for staff that are not already familiar with this area and determine who may need such skills.
- Ensure that elderly people receiving palliative and end-of-life care, as well as their loved ones, continue to receive psychological and spiritual support.
- Include data on palliative care in care homes as part of the minimum national data and reports.
- Ensure quality standards and train staff based on informed, inclusive and autonomous decisions.

Natalia, who runs a small private care home where everyone knows each other, told us about one of the experiences that impressed her most. When she spoke, she was with a co-worker and they both broke down in tears:

“One day the palliative care team arrived from the health department and gave the first sedation injection to one of the residents who was in a very serious condition and we had not been able to refer to the hospital. Before leaving, they left another two injections ready for me to give at the times that they indicated. I looked at the syringes and knew that I couldn't do it, no matter how simple they said it was. It wasn't because of the injection itself, but because of what it meant. Nobody has prepared me for a situation like that, much less for me to do it. I never gave her the injections and the fact is that Ana ended up recovering and we still have her here with us. She is very old and very weak, but she is still here. We have had other cases that were sedated by the palliative care team to avoid suffering. Maybe there were many, now we won't know. But that they left us the responsibility of doing it is something that I could never have overcome.”

(After contacting her again to prepare this report, Natalia confirmed that Ana was still alive.)

Some of the deficiencies related to palliative care in the toughest days of the epidemic, as reported by nursing home staff and families, are as follows:

- Lack of protocols for the treatment of pain, hydration and changes in posture (prevention of bedsores and pressure ulcers). The limitation of primary care services prevented these services from being established as quickly as desired, given the rapid deterioration of patients within a few hours.

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<sup>68</sup> <https://www.euro.who.int/en/countries/spain/publications/providing-palliative-care-during-the-covid-19-pandemic-experiences-from-spain-2020> y [https://www.euro.who.int/data/assets/pdf\\_file/0008/445553/palliative-care-COVID-19.pdf](https://www.euro.who.int/data/assets/pdf_file/0008/445553/palliative-care-COVID-19.pdf). Consulted on 12.07.2020.

- Lack of oxygen supply, a fundamental part of the treatment, since dyspnea and low saturation are very common symptoms in COVID-19. Care homes usually use oxygen concentrators with a maximum flow of 5 or 10 litres per minute, which is insufficient for patients with high demand, such as those affected by COVID-19. The logistics associated with this supply were absent in many centres during the first weeks and only care homes with medical services with piped oxygen installations were able to cope with this shortage.

### Visits and last goodbyes

The lack of definition of the competent authorities regarding the possibility of organising farewell visits for residents who were facing their last hours of life greatly weighed on the reluctance of care homes to take this step. The legislation was ambiguous enough to allow the responsibility for any errors to fall on the management of the centres, who mostly opted for a rigid and restrictive stance, limiting last goodbyes to video calls (and even this option was not very common). Those who did dare to offer the possibility of a face-to-face farewell visit did so secretly and with fear of suffering a sanction or recrimination, not to mention the fear of complaints in the event that a family member was infected during the visit. We are even aware that, anticipating the complaints of some relatives, care was taken to choose who was offered this possibility and who was not, which counts as discriminatory treatment, caused by the feeling of helplessness.

Javier is a nurse at an elderly care home and managed the centre when both the director and the governess were on sick leave. In response to MSF's question about the dilemma of last goodbyes with family members, he answered:

"It was hard for me to understand when the director told us that she had ordered some tablets for the question of last goodbyes. We were already making video calls to contact relatives, using our own phones, because most of the residents have very basic phones, and the tablets made me feel that we were normalising this, that we were giving up this very important human part. Three residents had already died with no company other than ours, and it seemed to me that the tablets were like a patch, that you had to be able to organise things differently. Later, when I was in charge of everything because she and the governess were on leave, I spoke with my co-workers to see if they would agree to allow a relative of Isidro, a man who was in palliative care, to come and say goodbye. They were afraid and they refused. "We are getting sick," they told me. "How are we going to prevent family members from getting sick?" At that moment it seemed to me that we were making a mistake and I got quite angry, but seeing now how complaints are pouring in everywhere, I think we did the only thing we could do, because we had to face the consequences alone. Sorry to say it, but there are people with very bad intentions and if they can blame you, they will. It doesn't matter that you are trying to help them. If something goes wrong, you take the blame".

- In response to the demands of families, MSF created very detailed recommendations and an algorithm to facilitate last goodbyes, applicable to visits when they are allowed.<sup>69</sup>

<sup>69</sup> [https://msfCOVID\\_19.org/despedidas-de-familiares-en-residencias-diagrama-de-toma-de-decision/](https://msfCOVID_19.org/despedidas-de-familiares-en-residencias-diagrama-de-toma-de-decision/)

### 3.9 Lack of psychosocial care for residents and staff

The rupture that a contagious situation implies in a care home is difficult to measure if the operation and routines of these centres are not known. The dynamics of a care home are oriented to favour coexistence and contact through activities and regular practices that serve to safeguard the social dimension of these centres and the lives of the residents. Common areas, group activities and workshops seek to reduce isolation. Visits to and from the centre serve to preserve family and emotional bonds and are specific to each resident. The confinement situation meant the immediate prohibition of all these practices, limiting each resident to a restricted space and isolated from the rest, without the guidance and support of routines established in many cases for years, and with the cancellation of their regular contact with the outside world.

For the residents, this situation occurred without more emotional support than that provided by the centre's staff, also overwhelmed by the reality. In general, **we encountered many elderly people that did not understand what was happening**, who found themselves being cared for by people unknown to them or that they did not recognise due to the PPE, and they couldn't understand the reasons for all the changes. It is a situation that exacerbates disorientation and cognitive impairment and is compounded by being locked up and without physical contact with other people.

One of the MSF team members explained it in this way:

"From day one, we realised that, to help in the care homes, the first thing would be to get the staff out of the tunnel in which they were stuck. They worked tirelessly, with the feeling of being behind with everything, insecure about what they were doing and hurt by the little recognition they felt from society. 'They only remember us when there is a complaint about abuse, but when it comes to applauding the heroes of the pandemic, we are not even mentioned,' they told us in more than one centre. We have found many people doubling shifts because someone was on sick leave, assuming tasks that were not theirs and suffering because of the situation of residents, with whom many have ties that go beyond their work commitment. They are emotional bonds, built over years working for their well-being, and in some way they consider themselves family. You also saw the fear for their families, the fear of returning home after spending all day in a contaminated environment. Unlike health personnel, more accustomed to extreme situations, a good part of care home staff found themselves overnight in the middle of a nightmare in which people could die if things were done wrong, and they did not have support. The moment you gave them the opportunity to lift their heads up from what they were doing and talk about what they were experiencing, they would fall apart. So you had to let them get out their frustrations, and they cried and apologised for what we could point to as ineffective or incorrect. And only then, when they had already got things out and you showed them appreciation for their efforts and successes, could you begin to build something. But this emotional relief has been anecdotal and has reached few centres; the vast majority of care homes have not had someone to listen to them. And the worst may be yet to come, when the tension of the day to day decreases and they have the opportunity to relive what they have been through. We know this well in the world of humanitarian emergencies. While you are in full swing, the very excitement of the moment carries you along, but when you go home and relax, all the bad things come out. It is what is commonly known as 'post-traumatic stress'."

**We found hardly any care homes that had access to a psychosocial support service during the weeks of the health crisis.** Moreover, where helplines had been provided by institutions or business groups, there was a lot of mistrust about using them, given the fear of the lack of confidentiality when expressing complaints, frustrations and talking things through with services provided by those who could be perceived as responsible for the situation, and who were still their employers.

During the epidemic, emotional and mental health was largely ignored by the authorities or by the large groups that run private establishments. MSF identified this need<sup>70</sup> and organised webinars providing tools and proposing intervention models. We also conducted many interviews with residents and staff in which we talked about emotional containment and support. In the final phases of its intervention, MSF included psychological and social support activities, which resulted in a package of emotional support tools that can be easily implemented.<sup>71</sup>

### **3.10 Representative case study of a care home during the COVID-19 epidemic**

This case illustrates the evolution of the virus once inside the care home and the efforts made by the staff, management and the MSF team. It is a true case; the data is real and illustrates what happened in many other care homes. **The critical points detected in the care home were:**

1. The initial situation of the care home was fragile, with little training in infection prevention and control.
2. A first screening with low-sensitivity rapid tests further increased the false sense of security. After the first confirmed case of COVID-19, the whole care home was not managed as a source of infection. PCR tests showed a high degree of contagion among residents and the crisis broke out.
3. Despite the evidence of the high degree of contamination at the care home, the tests for staff were carried out too late, which increased the risk of transmission.
4. Once implemented, the separate zones and pathways were not adequately respected.
5. Except for MSF, there was no organisation that provided support in IPC.
6. When the care home became overwhelmed, there was no effective transfer strategy. The referral hospital did not have the capacity to receive patients that the care home needed to refer.
7. An increase in capacity both in hospital referrals and transfers to 'COVID+' (affected) and 'COVID-' (unaffected) care homes was not carried out due to lack of technical solutions and the investment and cost involved.
8. Making the care home supposedly medically equipped meant that people whose clinical condition required hospital admission received inadequate and very deficient healthcare at the care home.
9. Adequate palliative care was not provided to residents at the end of their lives.
10. This whole situation had a great impact on the mental health of residents, families and staff.

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<sup>70</sup> On 2 April, MSF organised the online seminar "How to give bad news and how to take care of your mental health," given by Cristina Carreño, the organisation's mental health specialist. The seminar tried to reinforce the advisability of "asking for help" and offered basic tools to deliver bad news. MSF also advocated for the creation of "comfort pavilions" for mental health and palliative care, as shown in the model released on 17 April. Webinar available at: <https://msfCOVID-19.org/?s=webinar+cristina+carre%C3%B1o>.

<sup>71</sup> <https://msfCOVID-19.org/paquete-de-recursos-en-salud-mental-y-apoyo-psicosocial/> and <https://msfCOVID-19.org/guia-de-apoyo-psicosocial-para-la-desescalada/>.



## CHRONOLOGICAL EVOLUTION

16 April

- SITUATION:
  - 173 residents
  - **1 COVID case confirmed by PCR (15 April)**
- ACCUMULATED DEATHS\*: 0
- TESTS: screening of all residents with rapid serological test. All residents tested negative in the rapid test, including the case confirmed by PCR (possible false negatives).
- HR (total staff: 129): 17 on sick leave
- OBSERVATIONS: absence of isolation (only the resident confirmed by PCR), absence of zones and pathways, shortage of PPE, lack of nursing staff.
- MSF ACTIVITIES: first visit. Zoning is carried out, pathways are defined and basic training in IPC is offered.
- CRISIS COMMITTEE: creation of the regional committee for care homes (in which MSF participates).

21-22  
April

- SITUATION:
  - 172 residents
  - **45 confirmed COVID cases**
  - 120 tests pending results
- SYMPTOMATIC CASES: 21 (2 of them in palliative care)
- ACCUMULATED DEATHS: 1
- REFERRALS: 25 patients, to two hospitals in the area (with social health capacity).
- TESTS: mass PCR tests on all residents (in several batches).
- MSF ACTIVITIES: monitoring of the IPC and lobbying in the Crisis Committee so that all staff are tested.

25-26  
April

- SITUATION:
  - 142 residents
  - 135 confirmed COVID cases
  - 7 negative cases
- SYMPTOMATIC CASES: 30
- ACCUMULATED DEATHS: 5
- TESTS: PCRs need be repeated due to possible contamination in the laboratory.
- HR: 30 on sick leave (mostly nursing and geriatric care staff).
- HEALTHCARE: primary care support Monday to Friday; in the afternoon and at night; there is no medical assistance (except in emergency, handled by the nearest health centre, 12 km away).
- MSF ACTIVITIES: reinforcement of zoning, pathways and IPC, in addition to donation of PPE.
- CRISIS COMMITTEE: proposal to medically equip the care home with oxygen (assessment by emergency medical services); it is disregarded because the installation is outdated.

29 April

- SITUATION:
  - 141 residents
  - **136 confirmed COVID cases**
- SYMPTOMATIC CASES: 30
- ACCUMULATED DEATHS: 6
- HEALTHCARE: increase from one to **three primary care teams**, from Monday to Friday during the day.
- OBSERVATIONS: difficulty for primary care teams to respect the zones and pathways.
- MSF ACTIVITIES: support for the attempt to reinforce the human resources at the care home; reinforcement of zoning and IPC measures; advocacy with the management of the centre to isolate and create zones for negative cases; and lobbying activities related to referrals, dignified care, testing, PPE, visits and last goodbyes, and HR ratios, with various entities involved (Crisis Committee, primary and hospital care services in the area, Department of Health, etc.).

3-5 May

- SITUATION
  - 124 residents
  - 117 positive cases\*\*
  - 7 negative cases
- ACCUMULATED DEATHS: 18.
- REFERRALS: **23** (18 to hospital and 5 to COVID+ care home).
- TESTS: it is decided to **repeat the PCR tests** for all residents.
- HEALTHCARE: the number of experienced nursing staff is increased, with a daily presence, as a key point of contact to coordinate care and the home care team. The primary care teams are maintained.
- MSF ACTIVITIES: lobbying of the Department of Health so that all staff are tested.
- CRISIS COMMITTEE: It is proposed to establish zones according to severity (and create a palliative care floor), but it is finally rejected; disinfection is scheduled by the fire department; the proposal to create an extension at the referral hospital is rejected.

9 May

- SITUATION:
  - 98 residents
  - **88 confirmed COVID cases**
- SYMPTOMATIC CASES: 8 (2 patients in palliative care)
- ACCUMULATED DEATHS: **30**
- HEALTHCARE: **psychological** care for residents, promotion of visits for end-of-life accompaniment and last goodbyes with one family member. The two patients in palliative care receive prompt assistance.
- TESTS: start of **PCR tests on staff**.
- MSF ACTIVITIES: monitoring and material donations (a shortage of gloves is detected in the regional platform).

- SITUATION:
  - 94 residents
  - 47 confirmed COVID cases
  - 47 negative cases\*\*\*
- ACCUMULATED DEATHS: **32**
- TESTS: second PCR tests are performed.
- HR: PCR tests done; as of 24 May, according to data from the care home director's office, 129 tests were carried out, with 91 negative and 38 positive results.
- OBSERVATIONS: disinfection by firefighters (on 13 May) and zoning indicated by MSF and public health services.
- MSF ACTIVITIES: reestablishment of zones is carried out based on the results of the second PCR tests. **MSF's last visit.**

\* From 15 March.

\*\* Invalid test results are suspected.

\*\*\* 40 tested negative after overcoming the disease and 7 had remained negative from the beginning.

## 4. CONCLUSIONS

As of 21 July, “the number of fatalities that the coronavirus has caused in Spanish care homes – whether public, subsidised or private – with COVID-19 or similar symptoms stands at 19,645, according to data provided by the autonomous communities. Thus, **deaths in care homes would be equivalent to 69.1%** of the total officially notified by the Ministry of Health. Although the ministry has not announced the number of deaths in these centres, an internal document shared with the autonomous communities to which RTVE.es has had access estimates that there are at least 27,359 deceased.”<sup>72</sup>

**The situation experienced in care homes during the COVID-19 epidemic should never be repeated. Lessons learned and lives lost should provoke profound change. The danger of elderly people living in care homes being affected again has not subsided. In the event of a second wave or new outbreak, there is no excuse not to be prepared, or to be able to reduce suffering and limit mortality as much as possible.**

Excessive mortality during this crisis points to structural and systemic problems in relation to the Spanish care home model, and highlights in particular the need to improve the medical care that must be provided to those who live in these centres, whether public, private or subsidised. The logic of the current care home model responds more to the conditions of the service provider than to the social and health needs of the elderly. This has had a serious direct impact on their health and mortality. It is estimated that elderly people who died in care homes represent **69.1%** of the total number of people who died in Spain.<sup>73</sup> MSF believes that the debate is not about whether care homes should pass to the National Health System, if they should continue to be part of social services, if responsibility for them should continue to be decentralised in the autonomous communities, if the model should be public or private, or whether or not care was provided at a specific hospital; what matters is that elderly people, like everyone else, have access to quality health care, with dignified care, regardless of where they are. However, the response to COVID-19 revealed the lack of resources, capacity and assistance to this group in both primary care services and the hospital system. During the peak of the epidemic, this model left many care homes without viable options, and many felt “abandoned, without the possibility of hospital referrals and without adequate primary care assistance”.

There is a need to develop contingency plans for possible new outbreaks of COVID-19 or similar epidemics, to ensure early warning and immediate response, since, in the case of this disease and in very vulnerable patients like the elderly, deterioration is sometimes a matter of hours. The plan must be accompanied by measures aimed at the well-being and quality of life of the elderly, as the main focus and with an ethical background. Infection prevention and control and the different elements of dignified care deserve special attention, such as last goodbyes, professional comfort care and visits or contact with family members.

By way of conclusion, we list below the elements that, from MSF's experience and after collaborating with nearly 500 care homes, have a more serious impact on the health, quality and dignified treatment of the elderly. These 10 conclusions contain the dysfunctional areas and minimum elements that must be corrected to avoid a repetition of the situation experienced.

<sup>72</sup> <https://www.rtve.es/noticias/20200721/radiografia-del-coronavirus-residencias-ancianos-espana/2011609.shtm>.

Consulted on 22.07.2020.

<sup>73</sup> *Idem*.

### **Profile of residents: put them at the centre of attention**

1. Due to the large concentration of frail elderly people, with multiple pathologies, in closed places and with physical proximity, keeping sick and critical people in care homes without adequate medical attention multiplied infections, accelerated mortality and produced undignified and inhumane situations. Referrals or preferential channels were not prioritised so that infected persons were transferred to other centres, hospitals or social health centres, nor were residents considered as the focus of any measure that was adopted, according to their needs.

### **Medical care: improve both the primary care and hospital response**

2. Care homes, for the most part, are places for coexistence and care, not for cures or medical treatments; their objective is social care for the people who live there. They therefore lack the resources, infrastructure, training or responsibility for medical care. However, without such resources, they were forced to respond to a health crisis. The rest of pathologies were also affected by the lack of adequate and timely medical attention, which increased the risk of mortality, pain and fear in care homes.

3. There was no immediate, adequate and life-saving response, coordinated with health and social care services, particularly during the epidemic peak. Effective assistance from the health system was lacking.

4. Given the restrictive criterion applied to hospital referrals in the autonomous communities, with higher mortality in elderly people, no viable alternative was proposed and endowed with resources to care for them in another place or in the same care homes, leaving residents dying, without the proper medical attention, without being able to say goodbye to their families, without referral or compassionate treatment at the end of their lives.

### **Infection prevention and control: implement training and protocols**

5. The capacity in infection prevention and control (including the isolation of contacts and suspected cases) was deficient, as well as the handling of cases to avoid them worsening, whether or not they were COVID-19 cases. Care homes had little IPC culture and did not have personnel in charge of training and supervising this aspect.

6. The restriction or denial of last goodbyes, visits or mobility generated by isolation also had physical and psychosocial consequences that were not sufficiently considered or addressed.

### **Protection and training of human resources: adapt and provide training**

7. Professional profiles are poorly developed in terms of skills and training, and working conditions are very precarious. Staff on sick leave were not replaced quickly enough and in sufficient numbers, at a time when a greater quantity of trained and agile staff were needed. Without a sufficient workforce, the rest was unfeasible. The caregiving and cleaning staff were key and were not reinforced in time.

8. There was a lack of protection measures and adapted, timely training with clear protocols for use that would help protect staff and residents.

### **Lack of coordination and strategies: more leadership and coordination**

9. Showing institutional lack of coordination and lack of leadership, the authorities prioritised the care response in hospitals, neglecting the elderly in care homes, despite them being the most vulnerable group with the highest mortality.

10. It is necessary to develop a system of quality and ethical indicators oriented towards the impact on the well-being and quality of life of the elderly in care homes.

In short, measures must be taken that **revolve around the care and health needs of the elderly, with better social and health services provided by primary care and emergency services,**

including dignified care wherever it is necessary (in the home, outpatient clinic, ambulance, primary care centre, care home, social health centre, hospital, medically-equipped hotel, etc.).

## 5. RECOMMENDATIONS

Throughout its COVID-19 intervention in Spain, MSF developed a series of pragmatic responses to the difficulties encountered in the nearly 500 care homes that we supported. They are lessons learned, the objective of which is to ensure that the response to new outbreaks is not conditioned by the political or business agenda, profit or opportunity, but rather by the needs of the elderly. Therefore, we are not talking about structural recommendations or changes in the model (which are not the subject of MSF's work), but rather the impact that the current model has on the health of this group.<sup>74</sup> **We advocate putting elderly people at the centre of any decision or public policy that is developed in response to this situation to ensure that what happened is not repeated, dignifying the treatment and care that this group receives, and reinforcing their autonomy as patients or highly vulnerable group.**

These are the main recommendations:

1. Prepare contingency plans that can be easily adapted to each care home.
2. Establish policies and mechanisms for effective detection, surveillance and control in environments such as care homes. Guarantee access to PPE and training on its use for staff and residents.
3. Ensure the capacity for zoning in care homes, respecting the dignity and care of the elderly and protecting staff.
4. Establish mechanisms to take care of the mental and emotional health of residents, staff and families.
5. Accompany all of this with the collection, systemisation, publication and analysis of data, to improve decision-making.

**We address both the central government and the autonomous, provincial and municipal governments**, as those responsible for transferring, developing, supervising and providing resources for the COVID-19 prevention and response policy for care homes. **It is their duty to ensure action beyond the fight for responsibility, transferred or full, over health and social welfare.** The measures and protocols must have as their main and only objective the well-being and dignified care of the elderly living together in care homes, their home, and the protection of the people who work taking care of them. These measures must be expedited, in light of the worrying and incipient climate of relaxation after the de-escalation.

**The measures recommended here are generic. Detailed information, as well as the technical sheets developed by MSF, are available on our specialised website <https://msfcovid19.org> and in mobile applications developed for Android (<https://play.google.com/store/apps/details?id=appappmsfcovid19org.wpapp>) and iOS (<https://apps.apple.com/es/app/COVID-19-f%C3%B3rmate-e-inf%C3%B3rmate/id1518790380>).**

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<sup>74</sup> The recommendations follow the 10 goals to prevent and manage COVID-19 in care homes established by the WHO: 'Ten policy objectives to prevent and manage the COVID-19 pandemic across LTC services'. WHO 'Strengthening the health system response to COVID-19: preventing and managing the COVID-19 pandemic across long-term care services in the WHO European Region' (29 May 2020). Copenhagen: WHO Regional Office for Europe; 2020. Licence: CC BY-NC-SA 3.0 IGO.

## 1. DEVELOP CONTINGENCY PLANS EASILY ADAPTABLE TO EACH CARE HOME <sup>75</sup>

(All these measures refer to emergency preparedness and response.)

### Spanish government and autonomous region governments:

Within the framework of their health and political competencies, they must propose and guarantee the resources for a contingency plan (with special attention and detail to infectious diseases of mandatory declaration) and an urgent response that includes:

- Applicable passive and active surveillance systems that detail the alert threshold.
- Availability of protection and hygiene material, with an established procurement channel.
- Teams formed to supervise and support epidemic prevention and control measures.
- Protocols (which must be known and accessible by all care home staff and dictated by the competent authority in particular with regard to visits and farewells and mobility as fundamental rights)<sup>76</sup> in relation to:
  - Access to the centre once the alert situation (isolation or preventive quarantine) has been decreed: visits, last goodbyes, mobility, suppliers, etc.
  - Referrals to hospitals and primary care services.
  - Access to palliative care services based on informed decisions in coordination with primary care.
  - Access to quality and timely diagnostics.
- A plan for:
  - Zoning, pathways, hygiene measures and correct and rationalised use of PPE.
  - Psychosocial support for residents, family members and staff of the centres.
  - Hiring and training of additional staff (with previous estimates established).
- Continuous training programmes with an emphasis on models and simulations.
- Type III biological waste management protocol adapted to care homes.
- Territorial de-escalation plan and return to preventive surveillance.
- System of quality indicators and results aimed at having an impact on the well-being and quality of life of the elderly, which makes their needs a priority and includes medical, ethical and scientific advice.

These contingency plans will be the framework to be **developed by care homes, always guided, accompanied and supervised at the territorial level**, ensuring that **the elderly and their health and care needs are put at the centre of attention**. The plan must include the provision of resources (financial, human and material) by the autonomous regions for the strengthening of health systems, both in primary and hospital care. **It must include dynamic evaluation criteria**. As far as possible, best practices should be adopted.

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<sup>75</sup> Model prepared by MSF, downloadable from [msfCOVID-19.org](https://msfCOVID-19.org). Technical sheet available at: <https://msfCOVID-19.org/wp-content/uploads/2020/05/CV055-ORG-Plan-de-contingencia-residencias-de-personas-mayores-20200519-V1-ok.pdf>.

<sup>76</sup> These rights cannot be derogated by a residence manager or a private company but only by the competent authority as it is the case for the rest of the citizens.



## **Foundations, companies, corporate groups, employers and private or public-private entities that directly manage, subcontract or own care homes:**

Each elderly care home, regardless of its management model or ownership, will have to prepare its contingency plan, which should detail a series of questions developed in other MSF documents already referenced, with special emphasis on these two key elements:

### **Human and material resources**

- Ensure a staff-resident ratio that guarantees dignified and adequate care.
- Guarantee that sick leaves are covered, revising upwards the ratios of direct care personnel.
- Ensure availability of rapid response human resource teams, with training in geriatrics or gerontology, as well as other key personnel, such as cleaning, laundry and cooking.
- Include in the personnel selection criteria the necessary knowledge in each category for the work assigned in the contingency plan.
- In case of emergency, be able to hire non-qualified personnel if they are given basic training in the tasks of their role in the event of a COVID-19 outbreak, always under close supervision.
- Ensure a supply of protection materials and consumables, including reserve stocks, identification of suppliers and purchasing capacity (with its corresponding budget forecast), as well as practical training for use.

### **Quality healthcare including palliative and comfort care**

- Be familiar with the protocols for referrals to primary and hospital care and, where appropriate, comfort care in the care home.
- Ensure and safeguard the last wishes of residents.
- Incorporate basic skills and competencies in palliative care in the profiles of the personnel that provide care in care homes.
- Inform residents and family members in particular about the protocols at the centre regarding referrals, end-of-life care, visits, last goodbyes and diagnostic tests.
- Appoint one or more persons for contact with the families, who will also communicate the possibility of last goodbyes or visits.

**All this must be done in coordination with the relevant regional and state entities in terms of monitoring, development, supervision and evaluation of contingency plans, taking into account the different levels of responsibility and competences.**

## **National public prosecutor and competent territorial prosecutors:**

- Establish actions to guarantee access to medical care for people living in care homes, and in particular, the protocols for hospital referrals.
- In their role as guarantors and supervisors, give instructions for carrying out visits, establishing a routine and supervision both by motion of the party and ex officio.
- In their judicial function, handle the proceedings to resolve the more than 200 complaints filed by family members and residents, with priority to those related to denial of medical care.

## **Parliamentary groups and especially the Health Commissions of the Congress of Deputies and the Senate, and regional parliaments:**

- Follow up on contingency plans, asking the competent authorities for transparent accountability and the publication of the plans and measures adopted, in order to provide them with a budget. For this, the regular appearance of the national health minister and, where appropriate, the ministers of the autonomous communities could be requested. But also of the management entities, associations of residents or family members, or the elderly business groups and associations of care homes.

### **Ombudsman and its counterparts in the autonomous communities:**

- Include in its annual report the situation of the elderly in care homes, reinforcing the focus on dignified healthcare and putting residents at the centre of all measures to be adopted.
- When making recommendations to the central and regional governments in its annual or ad hoc report, take into account those contained in this report.
- Reinforce the right to visits and last goodbyes, in line with what has already been recommended by the ombudsman.<sup>77</sup>
- Check the necessary elements for dignified treatment and care, including referral protocols and isolation measures compatible with the dignity and physical and mental health of staff and residents.

### **Professional associations and unions in the sector:**

- Ensure that, in the contingency plans and in practice, the people who are registered or affiliated, and other workers, have received adequate training for the emergency response, including an agile personnel selection strategy free from bureaucracy (to fast track regularisation and accreditation of qualifications or registration with Social Security).

## **2. ESTABLISH MECHANISMS FOR THE DETECTION, SURVEILLANCE AND CONTROL OF INFECTION,<sup>78</sup> INCLUDING THE PROVISION OF PPE AND TRAINING FOR ITS USE**

### **Spanish government and autonomous region governments:**

Within the framework of their health and social policy competencies, and in coordination with the relevant regional public health ministries and departments, but especially with primary care centres, they must:

- Consult with entities in the sector to learn about the practical challenges to control contagion, paying special attention to existing needs (materials, training, personnel, etc.).
- Have professionals trained in infection prevention and control available to advise, train and supervise healthcare personnel; designate and train an IPC oversight figure.
- Develop protocols for a possible new outbreak (zoning, pathways, supplies, visits, last goodbyes, etc.).
- Establish a crisis committee, in order to create a space for coordination, impetus and monitoring, in close coordination with those responsible for IPC in each care home.
- Give greater budgetary and training attention to detection, surveillance and control, providing primary care centres with resources and funds.
- Establish self-assessment tools, with practical indicators that serve to regularly monitor the centre's preparedness and response capacity for detection, surveillance and control.
- Guarantee the quality and sufficient quantity of protective material and adequate training in its use, establishing training programmes that include periodic practice exercises and simulations.

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<sup>77</sup> The ombudsman, Fernández Marugán, urged authorities "to adopt protocols that allow for last goodbyes with at least one member of the family, in order to have a death process that is as humane and dignified as possible, complying with public health requirements," and recommended "the provision in care homes of adequate healthcare to patients with COVID-19 without indication for hospitalisation, in order to obtain adequate medical and nursing support." Statements on 15 June 2020, in his first appearance before Congress after the COVID-19 crisis to present the reports corresponding to the years 2018 and 2019.

<sup>78</sup> The measures recommended here are generic. More detailed information is available at <https://msfCOVID-19.org/>.

**Foundations, companies, corporate groups, trade associations and private or public-private entities that directly manage, subcontract or own care homes:**

**In coordination with the corresponding primary care centre** and the prevention unit or designated entity in each autonomous community:

- Identify and train in each centre a reference person or persons for prevention, hygiene and infection control. Special attention should be paid to the training of cleaning and laundry staff.
- Ensure that, in carrying out this task, they have all the necessary means of protection, as well as the required diagnostic and therapeutic resources.
- Establish a pre-positioned stock of protection and hygiene materials. Identify a procurement and supply channel, with suppliers and distribution deadlines.

**National public prosecutor (FGE) and competent territorial prosecutors:**

- Ensure an accessible mechanism so that residents, staff and family members can present any complaints they may have about the lack of surveillance and control, of protection material, or of dignity and quality of medical care.

**Ombudsman and its counterparts in the autonomous communities:**

- In the exercise of its power to visit care homes, gather information on the detection, control and surveillance mechanisms and their indicators, warning of possible failures, gaps or good practices, and make them public both in its annual report and in monographs, if necessary.

**Professional associations and unions:**

- Ensure that a sufficient number of people receive training in infection prevention and control, in particular cleaning and laundry personnel.

**3. ENSURE THE CAPACITY FOR ESTABLISHING ZONES IN CARE HOMES, RESPECTING THE DIGNITY AND CARE OF THE ELDERLY**

A principle of balance between isolation, quarantine and coexistence must be established, ensuring that the zoning measures also respond to the socialisation needs, both psychosocial and physical, of the resident population, and prioritising the overall health of the residents at all times.

**Spanish government and autonomous region governments:**

Within the framework of its health and social policy competencies, and in coordination with the relevant ministries:

- Ensure some flexibility in care home occupancy, especially in the most critical periods, so that zones can be established. In cases where it is not feasible to have individual rooms, a preventive space must be identified that is at least available for periods of risk.
- Ensure that physical isolation does not lead to social isolation, establishing thresholds that determine when and how to begin or cancel the isolation of residents and facilitating mobility within the care home.

**Foundations, companies, corporate groups, trade associations and private or public-private entities that directly manage, subcontract or own care homes:**

- Incorporate safety measures in physical distancing, the use of a mask and hand and respiratory hygiene, in order to have common areas with adequate disinfection and hygiene, so that segregation does not mean limiting the person's living space to the one room. Thus their mobility and coexistence routines can be preserved. Disinfection and hygiene circuits, schedules and routines must be put at the service of this objective (with disinfection after each use).
- Improve access to the laundry, kitchen, deliveries, evacuation and waste areas, as well as toilets or water points and changing rooms, so that personnel entering and leaving the building do not have to pass through administrative and residential areas when not necessary.
- Maintain services for the care and well-being of residents, such as educational activities, social work, chiropodist, hairdressing or physiotherapy.
- Create a physical space and a schedule for family visits, governed by a protocol. An end-of-life and last goodbyes protocol will be implemented. In both cases, a discharge of responsibility document in case of contagion will be included for the resident as well as for the relative.

#### **4. ESTABLISH PSYCHOSOCIAL SUPPORT MECHANISMS**

**Spanish government and autonomous region governments:**

Within the framework of their health and social policy competencies and in coordination with the corresponding departments, they must:

- Ensure that care homes have access to support services for mental and emotional health, establishing a minimum package of measures (both for staff and residents as well as for family members) that are free, confidential and easily accessible.
- Ensure that contingency plans and response to epidemics and other disasters include the mental health needs of residents, family members and care home staff.

**Foundations, companies, corporate groups, trade associations and private or public-private entities that directly manage, subcontract or own care homes:**

- Ensure residents and staff have access to mental healthcare services.

#### **5. COLLECT, SYSTEMISE, PUBLISH AND ANALYSE DATA**

This is a cross-cutting recommendation (and a cornerstone for the rest of the recommendations) closely related to the epidemiological data surveillance system.

**Spanish government:**

- Improve the data collection and analysis systems, so that they serve as an appropriate alert and response mechanism (preventive and proactive).
- Ensure a smooth data collection and processing mechanism between the autonomous communities and the central government.
- Update and unify the currently differing regulatory requirements that care homes must meet to be able to operate.