Responding to the Global Crisis in Care Homes – MSF Briefing Paper

August 2020

The COVID-19 pandemic has disproportionately impacted older people living in long term care facilities. In many countries, most COVID-19 deaths have been amongst residents of care homes, often accounting for more than third to as high as 80% of total deaths, according to national figures.[1]

Despite the vulnerability of older residents to COVID-19, care homes have been deprioritized in the global and many national responses to the pandemic. Residents and staff of long term care facilities for older people, as well as those that accommodate people living with disabilities, bore the brunt of the crisis without significant reinforcement, resources or support.

Issues related to access to COVID-19 testing and treatment, and shortages in essential resources such as protective equipment and staff, affected the physical and mental health of older people residing in care homes; as did the lack of continued access to health services and the impact of isolation measures.

As the crisis in care homes continues in many parts of the world, concrete actions must be taken to tackle the physical and mental health implications of COVID-19 on residents and staff of care homes. This paper summarises Médecins Sans Frontières (MSF) key reflections from our interventions in care homes around the world and presents recommendations to prevent and mitigate the consequences of COVID-19.

Médecins Sans Frontières/ Doctors without Borders response in Care Homes:

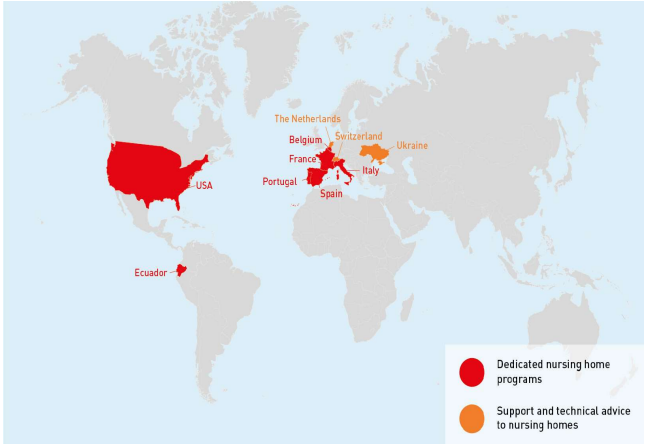
Since March, MSF intervened in 10 countries in Europe, South America and North America to respond the global humanitarian crisis in care homes.

MSF deployed mobile nursing teams who visited care homes to provide on-site technical expertise and guidance in infection prevention and control. This was targeted and adapted to each care home with individualised assessments and tailored recommendations to each care home's specific circumstances. MSF staff followed up with in-person visits to help ensure recommendations would be implemented.

General IPC (Infection Prevention and Control) and COVID-19 specific learning tools such as posters, on-line videos, training courses, and webinars on subjects such as IPC measures, testing and psycho-social support were also made available and disseminated.

Some care homes that needed additional support were provided with one-on-one coaching. MSF teams embedded themselves within these care homes to provide more hands-on capacity building and support to staff and management. A psychologist or social worker frequently accompanied the MSF mobile team to support mental health and wellness amongst the staff. MSF offered care home staff individual debriefings, group sessions and psychological first aid on stress, grief and coping mechanisms. This support enabled them to deal with extremely difficult situations and to gain greater confidence in dealing with the risks and mitigating the human costs of the pandemic. We recommend the creation of similar mobile teams that can be deployed rapidly and in response to requests for help from care homes.

Additionally, MSF extended its technical support to health authorities and long-term care facilities through an online resource and technical support platform called PEAC which has been implemented in Europe, and Central and South America. The PEAC provides distance support to facilities to help coach structures in IPC and organisation of care.



To address the urgent situation in care homes, MSF makes the following **recommendations**:

Care homes should be prioritised in all stages of national and global COVID-19 response and recovery plans

- COVID-19 responses should be people-centred and be implemented in a humane, dignified way that includes the voices of older people and staff within care homes. It should be grounded in a public health approach aimed at early detection and rapid mitigation of transmission, aided by field epidemiology and infection control measures.
- Care homes must be included in specific national contingency, response and recovery plans. This requires collaboration and information sharing system between sectors and sub-national policy levels to ensure coordination of response.
- Guidance and protocols need to be adapted and complemented with practical and direct on-site support.

Ensure care homes have the staff and resources, including health staff and equipment, to respond to COVID-19 and provide quality care services

- Ensure adequate supply of PPE in facilities to protect staff from infection, as well as other basic hygiene equipment and supplies.
- Practical training sessions with simulations in areas of infection prevention, hygiene, organization of care and psychosocial support should be organized for all care home staff, including kitchen and logistics support staff, and volunteers.
- Establish rosters and secure staff to provide surge capacity to support long term services.
- Regular testing of staff and residents is recommended to detect infectious people as early as possible. Increased and accelerated testing capacity can help care homes monitor the situation and base decisions for increased IPC or individual isolation or cohorting on test results.

Ensure continuity of care and essential services for people living in care homes, including prevention, treatment, rehabilitation and palliation

- Ensure access to primary health care through sufficient visits of general practitioners, and virtual consultations considering the needs of older people.
- Establish clear medical referral protocols and care pathways for residents with suspected or confirmed COVID-19 as well as non-COVID-19 to access primary, secondary and tertiary health services. The referral guidance needs to be improved to avoid misplaced reluctance to provide adequate clinical care and/or to avoid putting informal pressure on residents or their families. There should be no selection bias based on age or disease in such protocols.
- Ensure that palliative care plans are applied through a person-centered approach and therapeutic plans are updated. Staff should be trained in providing palliative care and communication on end-of-life, including facilitation of last visits.

Increased mental healthcare for staff, residents and relatives

- Psychological care and consultations should be considered essential services for care homes, especially during periods of isolation. Residents, their families and staff should have access to mental health support.
- Staff in care homes, as well as external mental health workers and healthcare workers should be trained in psychological first aid (PFA) and trauma informed response.
- Reduce isolation of residents and mitigate implications on mental health through the establishment of visiting policies that balance IPC measures with facilitating social contact. Recruit and train volunteers, as well as other key external providers in IPC to help provide social interaction.

Care homes were vulnerable to Covid-19 but they were not prioritised in the national and global response to the pandemic

In many countries where MSF intervened, care homes were poorly prepared to respond to an infectious disease outbreak of this magnitude. In the COVID-19 response, the priority has been to maintain hospital capacity at all costs to cope with an influx of patients and avoid the oversaturation of hospitals. Meanwhile, nursing homes were left behind. This inattention contributed to the spread of the virus in care homes.

Many of the care homes visited by MSF faced similar difficulties and stumbling blocks, namely: a lack of preparation and contingency planning for this type of emergency, a lack of access to adequate resources including staff and essential equipment, insufficient access to testing and treatment, and a lack of direct support to facilities.

A lack of clarity in coordination and crisis management at local, national and regional levels contributed to confusion, disorganisation and lack of tangible support to care homes struggling to address the overwhelming needs of residents. Difficulties were exacerbated by the multiplicity of recommendations, protocols and guidelines issued by health authorities, regulatory bodies, corporate groups as well as other stakeholders. Protocols were often difficult to adapt to the reality of the care homes and staff struggled to implement recommendations without adequate training, resources or tools.

Care homes lacked the resources to respond to COVID-19 and provide and provide quality care services

Care homes visited by MSF mobile teams often lacked the knowledge and tools required for hygiene management, and infection prevention and control measures, which are the best measures to mitigate the transmission of COVID-19. Shortages of PPE and a lack of knowledge and training about its proper usage left residents and staff vulnerable to infection. In the worse off centres visited by MSF, care home staff were seen wearing improvised PPE such as trash can liners and rain ponchos as protective gowns.

Many facilities lacked the knowledge and resources required for proper hygiene management, and infection prevention and control measures (IPC). Some care homes visited by MSF lack the proper cleaning supplies, often reusing supplies such as sponges and rags on multiple surfaces. Non-clinical staff, especially those in support services such as cleaning, kitchen and laundry staff were often not trained in COVID-19 transmission modalities and the rationale behind prevention measures.

"What we saw was an acute crisis triggered by COVID-19 on top of an ongoing chronic crisis and neglect of our care homes. MSF intervenes in moments of acute crisis where we can help; care home residents were some of the most exposed to COVID-19 but were also among the least protected. Despite the risks being well-documented, care homes were left to fend for themselves without protective equipment and without the training. Staff told us that they were overwhelmed and confused, drowning in guidance and regulations but with no on-the-ground support. Through providing direct and in-person support MSF teams were able to support teams to understand the basics of infection prevention and control, but more importantly, we were also able to reinforce and empower teams. Saying you're not alone, we're not here to punish you, we're here to be in support with you is indirectly providing its own mental health benefits."

Heather Pagano, COVID-19 Emergency Coordinator USA Michigan Care Home Intervention

Organisation of care and cohorting in facilities was also very difficult to implement in care homes. Facilities often lack access to testing required for monitoring and surveillance, often lacking the resources, knowledge, and space to appropriately isolate residents. In early stages of the pandemic many countries prioritised testing capacity for hospitals. Without access to testing, facilities cannot properly conduct surveillance or organize care and cohort or isolate suspected COVID-19 cases.

Even though care home staff were on the frontline in the fight against the pandemic, they received little recognition. Staff shortages and high rate of absenteeism, due to fear or sick leave, exacerbated an already fragile situation. There was a lack of investment in staff expertise and capacity building, for both clinical and non-clinical staff, as well as a lack of adequate on-site and proactive psychosocial support.

COVID-19 impacted access to essential health services for people living in care homes

"Care homes became make-shift hospitals but without the equipment, material, staff and expertise to provide complex medical care. The possibility to refer patients from care homes to external medical services, most notably hospitals, decreased significantly. In Belgium, amongst a third of the care homes we visited told us not even all their emergency calls got an adequate answer and the number of visits by general practitioners to care homes decreased by half. That's worrying, because it had a clear impact of the quality of care for the residents."

Stéphanie Goublomme, COVID-19 Emergency Coordinator Belgium Care Home Intervention

In several of the countries MSF intervened, there was reduction of visits from general practitioners and external medical services to care homes during the surge of COVID-19, impacting continuity of care for residents. At the initial stages of the crisis, criteria to accept medical referrals from care homes to hospitals became more restrictive. Consequently, care homes were forced to provide more complicated medical support to residents, if it is required. However, not all care homes were equipped with the necessary staff, expertise, drugs, oxygen or equipment to provide intensive or palliative care.

In many countries, deaths disproportionately occurred within long term care facilities. For example, in Belgium between March and June 9,731 people died from COVID-19.[2] Half of deaths occurred in care homes. In Spain, more than 27.359 people died in care homes between 6 April and 20 June; approximately 68.8% of deaths were attributed to suspected or confirmed COVID-19. Meanwhile, 31.2 % of the deaths were related to other causes[3].

The COVID crisis has immense impacts on the mental health of residents and staff

Long term care facilities' staff have not received adequate support during this crisis. Consequently, staff and residents have suffered from an increase in mental health distress.

Residents have been isolated in facilities, often with little to no social interaction, resulting in increased psychological stress, dejection, depressive symptoms, suicidal thoughts and other mental health difficulties. Containment and isolation measures should be applied in a dignified way, consider the individual needs of older people, and residents should be engaged and informed of health information.

Elimination of visits and recreational activities may be disruptive and traumatic experiences for older residents. Whilst social interaction was replaced with video-calls and other tools, this was often not sufficient or difficult to use for some residents.

"We started by isolating everyone in their rooms as recommended to avoid contagions. But of course, we didn't know how long this was going to last, and right away we saw that there were residents who were not going to be able to bear it. The truth is that it has been very painful to have to keep residents locked up without them understanding why. Eugenia, for example, stopped eating and moving, spending hours looking out the window. I started taking her out every day and she started to get better. The Primary Health Care Center staff came, they told me she must return to her room. She stopped eating again, and after a few days she died. I do not say that she would not die anyway, but I am clear that she did not want to go through all this."*

Carmen, staff member of care home in Spain*

Staff were under incredible pressure to mitigate the human and health consequences of the epidemic among this highly vulnerable and fragile population. In several care homes, staff witnessed the decline in health and the death of residents, accompanied by fears for their own health and that of their family members who were at risk due to their work exposure. Despite their essential role on the frontlines of the pandemic, care home staff faced growing devaluation and stigmatisation of their sector. Consequently, staff regularly expressed sadness, anger, frustration, guilt, fear, and helplessness.

[1] Salcher-Konrad M, Jhass A, Naci H, Tan M, El-Tawil Y, Comas-Herrera A., COVID-19 related mortality and spread of disease in long-term care: a living systematic review of emerging evidence.

[2] Sciensano, data available 26 June 2020; https://covid-19.sciensano.be/fr/COVID-19-situation-epidemiologique

[3] Maria P, 7 July 2020; https://www.lainformacion.com/asuntos-sociales/residencias-muertes-espana-sanidad-COVID/2809726/

* Name changed

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