



## **Too little, too late**

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

# Summary

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# Executive summary

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The current care home model had a direct impact on health and mortality during the COVID-19 pandemic

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Care homes had to assume a responsibility for medical care, for which they were not prepared

## CONTEXT

The situation experienced in nursing homes during COVID-19 must never happen again. Lessons learned and lives lost should bring about profound change. The risk that older people living in nursing homes will be impacted again has not subsided; we must be prepared 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 model of nursing homes. In particular, it highlights the need to improve the medical care that must be provided to those who live in these centres, be they public, private or state-subsidised. The logic of the current nursing home model meets the needs of the service provider more than 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 nursing homes (27,359 between 6 April and 20 June, according to the Health Ministry) represent 69.1% of all people who died from COVID-19 throughout Spain.

The response to COVID-19 revealed the lack of capacity and aid for this group in both the primary care services and the hospital system. During the peak of the epidemic, this model did not leave viable options or options that were adapted to many nursing homes; in their own words, "they were abandoned without the possibility of hospital referral and without adequate primary care assistance."

In the first moment of the crisis, the focus of the response was centred on the collapse of the health system; in the emergency services and ICUs of hospitals, reaching the point of hindering referrals. The nursing homes had to assume a de facto responsibility for which they were neither prepared, nor equipped nor protected, with disastrous consequences for residents, workers, management teams and a direct impact on high mortality.

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 in nursing homes. The plan must be accompanied by measures aimed at the well-being and quality of life of the elderly. Special attention needs to be given to the prevention and control of infections and the different elements of dignified care, such as farewells, professional comfort care and visits or contacts with family members.

## MSF'S RESPONSE

### MSF supported almost 500 care homes

On March 19, Doctors without Borders (MSF) began the work of supporting nursing homes with face-to-face teams made up of health and logistics personnel. The teams lacked experience with this new virus; but the experience of 50 years working in epidemics with innovative and emergency strategies allowed them to solve the challenges that this pandemic posed for the organisation in its work in Spain. The teams focused on relieving the burden of the staff, which were overworked, disoriented, misinformed and lacking in protective materials. MSF's teams provided support to staff from almost 500 nursing homes in:

- Separation of patients by cohorts.
- Design of materials, circuits and protocols for subdivision adapted to the situation.
- Awareness-raising and training on infection protection and control.
- Use of protective equipment adapted to need.
- Training; contingency plans; structure evaluations.
- Providing material when necessary.

As a humanitarian medical organisation, the teams included in their response the most human and ethical dimension: dignified treatment and care, and the strengthening of patient independence.



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MSF offered its collaboration and proposed numerous concrete measures to the relevant authorities

## COMMUNICATION WITH THE AUTHORITIES

From the beginning of its response, MSF shared, in addition to offers of collaboration, a series of specific requests to the highest authorities. It is worth highlighting those were carried out during the first days of the declaration of the state of emergency for the President of the Government of Spain, the Minister of Health, and the councillors and delegates of the different autonomous communities. In these communications, MSF advocated for initial collaboration and proposed concrete measures for change once the activities in nursing homes began, stating the challenges and proposing solutions that are laid out in the report. The key messages and difficulties expressed in the dialogue with the authorities were the following:

- Lack of transparent information, leadership and clear and determined actions.
- Deficiencies in infection prevention and control. Need for the figure of an IPC supervisor.
- Lack of increased capacity and strengthening of primary care programs.
- Lack of timely hospital referral.
- Insufficient individual protective equipment, protocols and adequate training for its use.
- Lack of clarity in end-of-life and farewell protocols.
- Clear difficulties in farewells with relatives.
- Necessary improvement in patient treatment, care and dignity.
- Inefficient and late diagnosis strategies.
- Lack of available and trained human resources.

## RESIDENTIAL MODEL

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System failures caused many elderly people to die alone

The nursing homes had a structural deficit of resources and sanitary supervision and no contingency plan. This combination made it unfeasible to respond to the epidemic. They lacked health and care resources, which had a direct impact on the health of the residents, when the responsibility for an emergency health resource, life or death fell on structures designed for social situations (housing/residence). This led to medical care being neglected, high mortality and a decrease in the quality of social care. Many older people died isolated and alone.

Whichever management and governance model is adopted, it must be translated into a regulatory framework that adequately protects this group. The deficiencies detected in the operation, with their dramatic cost in lives and suffering, must be radically corrected.

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There were no contingency plans and there was a great lack of coordination on the part of all those responsible

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The PPE arrived late, was insufficient and was not accompanied by training in its use

## CHALLENGES

During MSF's intervention in more than 500 nursing homes in different communities of the country, MSF has encountered the following challenges:

- 1. Lack of forward planning and contingency plans:** the negative impact of this lack of forward planning increases when the response also depends on a multiplicity of actors: Departments of Social and Health Services, Provincial Councils, Town Halls, primary care services, public health services, trustees of foundations and management of private centres and religious centres.
- 2. Reduced room for manoeuvre to implement isolation, quarantine and distancing measures:** two major difficulties were detected in executing subdivision and isolation measures: inadequate infrastructure and spaces, and high occupancy.
- 3. Lack of training in the use of PPE:** the protective supplies were not accompanied by training activities for the personnel, who were not accustomed to using these items. The user guides and protocols that arrived by email proved insufficient and there was no time to read them or even to know of their existence. Furthermore, the PPE that arrived were not always adapted to the needs of residences.
- 4. Lack of organisation, direction and human resources in contagion control measures:** the increasing number of personnel on leave, without an alternative recruitment strategy to maintain or even increase human resource ratios, forced the remaining personnel to assume other tasks without receiving precise instructions.
- 5. Limitations of diagnostic tests and lack of capacity to act on the results:** the use of diagnostic tests is always recommended under two premises: that their results are reliable and that there is the ability to implement appropriate measures. However, it has been found that none of the assumptions were present in the diagnosis and response strategy to identify positive cases.
- 6. Denial of referrals to hospital departments:** Between the end of March and the beginning of April, hundreds of residents saw their request for access to emergency services and hospital admissions denied, according to autonomous communities and days of evolution of the epidemic. Without an alternative, the nursing homes were forced to keep positive patients with a very severe prognosis. In this situation, the virus spread rapidly, affecting residents and workers who, without adequate means to protect themselves, became ill, reducing the workforce that despite their commitment, had neither the responsibility nor the means nor the knowledge to attend to their medical needs. This directly impacted the quality and care of residents and, in many cases, probably contributed to or was the cause of death.

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Medical care was left in the hands of care homes, which were not equipped for it

Alternatives had to be proposed with the available means and resources, proceeding to referrals to social health centres, hospital extensions, hotels re-purposed for palliative care or otherwise or private hospitals, since, in all these places, there were free places even during the weeks of the epidemiological peak. In some of the communities that developed protocols to de facto restrict referrals, residents with private insurance were referred to private hospitals, since there were beds and resources available as an alternative to letting them die in the nursing home.

The reality observed by the MSF teams is that health care was left in the hands of the staff of the nursing homes, which are in no way equipped. The most vulnerable population was left at the mercy of the good intentions of the people who cared for them, alone in the face of an enormous challenge, which was sometimes to save their lives or accompany them in death. This directly impacted the quality and care of residents and, in many cases, likely contributed to or caused preventable deaths.

- 7. Isolation to the detriment of health and dignified care:** 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.
- 8. Lack of protocol for palliative care, end of life, farewells and visits:** the lack of clarity and execution of protocols dedicated to comfort treatment, sedation and palliative care for people in terminal condition who had not been referred to hospitals or other structures during the epidemic. This was due in part to the lack of experienced personnel in the centres to provide this care and in part due to the difficulties of primary care personnel responding to the demands of the most acute moments of the health crisis; sometimes it was also due to lack of medication.
- 9. Lack of psychosocial care for residents and staff:** MSF teams barely found nursing homes that had access to a psychosocial support service during the weeks of the health crisis.

# Conclusions

The ten conclusions of the report, which refer to different areas, contain the minimum failings and elements that must be corrected to avoid a repetition of the situation experienced.

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Keeping sick and critical people in care homes without adequate medical care increased infection

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

1. Due to the high concentration of frail elderly, with multiple pathologies, in closed places and with physical closeness, keeping sick and critical people in the nursing homes without adequate medical care multiplied the infections, accelerated mortality and produced shameful and inhumane situations. Referrals or preferential circuits transferring infected people to other centres or hospitals were not prioritized.

## **Medical care: improving the response from primary and hospital care**

2. The nursing homes, in their majority, are places for communal living and care, not for cures or medical treatments; its objective is social care for the people who live there. They therefore lack the resources, infrastructure, training or responsibility for medical care.
3. There was no immediate, adequate and life-saving response, coordinated with healthcare and assistance services, particularly during the epidemic peak.
4. Given the restrictive criterion applied to hospital referral in autonomous communities with higher mortality of the elderly, no viable alternative was proposed and endowed with resources to care for them.

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The health system failed to provide effective assistance

## **Infection prevention and control: training and recording**

5. The capacity in the prevention and control of infections (including the isolation of contacts and suspected cases) was deficient, as well as the management of cases to avoid their aggravation, whether or not they were COVID-19 cases. The residences had little knowledge of IPC and also did not have personnel in charge of training and supervising this aspect.
6. The restriction or denial of farewells, visits or mobility caused by isolation also had physical and psychosocial consequences.



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Staff on sick leave were not replaced at the proper rate

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The competent authorities showed a lack of coordination and leadership

### **Protection and training of human resources: adapting and training**

7. Professional profiles are poorly developed in terms of skills and training, and working conditions are very precarious. Sick leave was not replaced at the appropriate rate and ratio.
8. There was a lack of protection measures and adapted, timely training and with clear use protocols that protected personnel and residents.

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

9. Showing institutional lack of coordination and lack of leadership, the Administrations prioritised the healthcare response in hospitals, which left behind the elderly in the nursing homes, even though they were 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 nursing homes.

# Recommendations

This face-to-face work and proximity to those affected, together with the experience in epidemic situations, has allowed us to identify a series of lessons learned translated into recommendations.

These are the five main recommendations:

## 1. PREPARE CONTINGENCY PLANS THAT ARE EASILY ADAPTABLE TO EACH RESIDENCE

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Both the central and the autonomous region governments must propose and guarantee the resources for a contingency plan

**The Spanish government and the autonomous governments must propose and ensure there are adequate resources for a contingency plan:**

These contingency plans will be the framework to be developed by each residence, always guided, accompanied and supervised at the local level, ensuring that the elderly and their health and care needs are put at the centre of attention. The plan must include a provision of resources (financial, human and material) by the autonomous communities for strengthening health systems, both primary care and hospital.

**Foundations, companies, corporate groups, employers, private or public participation entities, that directly manage, subcontract or own nursing homes:**

Each centre for the elderly, regardless of its management model or ownership, will have to prepare its contingency plan with special emphasis on these two key elements:

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Sufficient appropriately qualified personnel must be ensured to guarantee dignified and adequate care

**Human and material resources:** Ensuring a staff ratio that guarantees proper and dignified care. Guaranteeing that the losses are covered, reviewing upwards the ratios of direct care personnel, as well as other key personnel, such as cleaning and laundry. Ensuring a supply of protective and consumable materials, including reserve storage, supplier identification and purchasing capacity, as well as practical use training.

**Quality healthcare including palliative or comfort care:** Know the protocols for referral to primary and hospital care and, where appropriate, comfort care in the residence. Ensuring and safeguarding last wishes. Incorporating a training curriculum in palliative care and basic skills.



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## 2. ESTABLISHING MECHANISMS FOR INFECTION DETECTION, MONITORING AND CONTROL

### Spanish Government and Autonomous Governments:

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It is crucial to allocate the necessary budget and training for detection, surveillance and control

- Consulting with the agencies in the sector to know the practical challenges for contagion control, paying special attention to the existing needs (materials, training, personnel, etc.).
- Identifying and training an infection prevention and control (IPC) oversight figure.
- Greater attention to budget and training in detection, monitoring and control, providing primary care centres with resources and a budget.
- Guaranteeing the good quality and adequate quantity of protection material and adequate training on its use.

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Training in IPC should also include cleaning and laundry staff

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A good balance must be established between isolation, quarantine and coexistence, and between physical and mental health

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MSF recommends care homes try to ensure that zone segregation does not mean limiting the residents' living space

**Foundations, companies, corporate groups, employers, private or public participation bodies, in coordination with the primary care centre:**

- Identifying and training a person or persons of reference in prevention, hygiene and infection control in each centre. Special attention should be paid to training cleaning and laundry personnel.
- Ensuring that, in carrying out this work, they have all the necessary protection measures, as well as the required diagnostic and therapeutic resources.
- Establishing a pre-positioned *stock* of protection and hygiene materials.

**3. ENSURING THE CAPACITY OF SUBDIVISION IN THE RESIDENCES WHILE RESPECTING THE DIGNITY AND CARE OF THE ELDERLY**

A principle of balance must be established between isolation, quarantine and communal living, ensuring that the subdivision measures also respond to the need for socialisation, both psychosocial and physical, of the resident population, and prioritising at all times the comprehensive health of the residents.

**Spanish Government and Autonomous Governments:**

- Ensuring some flexibility in the occupancy of the centres. 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.
- Ensuring that physical isolation does not lead to social isolation.

**Foundations, companies or public or private bodies, or employers, that manage or own the nursing homes:**

- Incorporating security measures, so that subdivision does not mean limiting the person's living space to the room and thus preserving their mobility and communal routines.
- Maintaining services for the care and well-being of residents, such as educational, social work, hairdressing or physical therapy activities. Creating a physical space and a schedule for family visits, governed by protocol.
- An end-of-life farewell protocol will be implemented.

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Mental health support services for residents, staff and families must be ensured

#### **4. ESTABLISHING PSYCHOSOCIAL SUPPORT MECHANISMS**

##### **Spanish Government and Autonomous Governments:**

- Ensuring that nursing homes have access to support services for mental and emotional health, establishing a minimum package of measures.
- Ensuring that contingency and response plans for epidemics and other disasters include the mental health needs of residents, family members, and residential staff.

##### **Foundations, companies or public or private bodies that manage or own the nursing homes:**

- Ensuring residents and staff have access to mental health care services.

#### **5. COLLECT, STANDARDISE, PUBLISH AND ANALYSE THE DATA**

- Improving the data collection and analysis systems, so that they serve as an appropriate alert and response mechanism (preventive and proactive) standardised between the Autonomous Communities and the central government.

**Médecins Sans Frontières/Doctors Without Borders (MSF)** is a medical humanitarian organisation that helps victims of natural or man-made 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.

The basic elements of any response to epidemics are also applicable to **COVID-19**: early detection, contact tracing, isolation of positive cases and quarantine of possible secondary cases are the actions to be applied so that this unacceptable situation is not repeated in our elderly care homes.