



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

Regulation of  
Health and Social  
Care Services

# The impact of COVID-19 on nursing homes in Ireland

July 2020

*Safer Better Care*



## About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- Setting standards for health and social care services — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- Regulating social care services — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- Regulating health services — Regulating medical exposure to ionising radiation.
- Monitoring services — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- Health technology assessment — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- Health information — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- National Care Experience Programme — Carrying out national service user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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## A message from the Chief Inspector of Social Services and Director of Regulation



*Mary Dunning, Chief Inspector of Social Services and Director of Regulation*

The global COVID-19 pandemic has completely transformed how we live and relate to one another. It has caused fear, anxiety and confusion. This is especially true for the most vulnerable in our society, including people living in residential centre settings, such as nursing homes. Our sympathies go to all those who have lost a loved one or friend as a result of the virus

The first confirmed case of COVID-19 in a nursing home in Ireland was reported on 13 March 2020, which was quite early in the evolution of the virus in this country. It soon became apparent that the presentation of the virus in older people was different to that of the general population, with many residents showing no symptoms or indeed displaying symptoms that were inconsistent with the case definition for the virus. This made the detection of the virus in nursing homes particularly difficult.

This overview report focuses on the experiences of nursing homes in Ireland in the context of the COVID-19 pandemic, including:

- how they were impacted
- how residents and their families experienced the pandemic, and
- the efforts of staff and management to keep people safe.

Many nursing homes in Ireland have been fortunate not to have an outbreak of COVID-19 to date. This has been achieved by the collective effort of management, staff, residents and their families. Advice and support were available from the Department of Health, local public health officials, crisis management teams in the Health Service Executive (HSE) and the Infection Prevention and Control Hub in the Health Information and Quality Authority (HIQA).

From the start of the emergency, our inspectors maintained regular contact with nursing home providers and managers of these centres, monitoring their ability to manage an outbreak. We directed them to additional supports and, when necessary, escalated to the HSE issues that providers and managers were reporting to us, such as access to personal protective equipment (PPE), COVID-19 testing and communication of test results.

Nursing home providers and staff in designated centres were required to take in and understand frequently-changing national guidance on the management of COVID-19. They were often challenged by the scarcity of PPE across the health sector and the unavailability of staff due to self-quarantine and self-isolation requirements due to the initial limitations regarding access to testing and confirmation of results. We found that some providers did not have comprehensive contingency plans in place in the event of such an outbreak.

Thankfully, many of the issues encountered by providers in March 2020 had been resolved by the time of preparing this overview report. However, greater clarity is required for the sector on a rolling testing programme for staff. In addition, the public health emergency has thrown into sharp relief the need for all nursing homes to meet new physical environment regulations aimed at providing residents with more living space, dignity, comfort and safety, which are due to come into effect from the end of 2021.

Throughout COVID-19, we continued to regulate nursing homes. While we initially suspended inspections on a temporary basis to prevent our inspectors inadvertently spreading the virus from centre to centre, we continued to assess information received about centres and prepare for the full resumption of inspections. This report describes the findings of our contingency assessment and risk inspection programmes. This story, however, would be incomplete without drawing attention to the human impact of this disease. Therefore, this report also reflects the experiences of residents, their families and staff, as reported to us.

Our inspectors spoke with many residents, relatives and staff working in centres, including some who have been bereaved due to COVID-19. I am very conscious that between March and July 2020, residents and their families made significant sacrifices due to visiting restrictions and having to minimise contact with each other. Their courage, resilience and adherence to public health guidance has undoubtedly helped to prevent further spread of the virus in nursing homes. It did, however, result in social isolation and loneliness for these residents. While many of us in wider society are enjoying the benefits of a relaxation of the public health restrictions, many residents in nursing homes continue to feel isolated and somewhat left behind. With this in mind, there may be merit in providing more detailed, local epidemiological data to nursing home providers with a view to allowing them more discretion in how they manage visits and access to their centres.

Many older people living in nursing homes sadly died as a result of COVID-19. While the death of a loved one is always painful, COVID-19 measures added to the distress felt by families as many of our social customs ceased, such as having family with the person at the end of their life and the holding of a wake and funeral. This loss was also deeply felt by residents who lost friends and companions they had grown to

know while living there. Many members of staff who our inspectors met and spoke to are deeply traumatised by COVID-19.

Ireland, like many other countries, went through an unprecedented ordeal during the spring and summer of 2020. Our collective efforts have successfully flattened the curve of infection and the transmission of the virus. However, in the absence of an effective treatment or vaccine, the coronavirus remains a significant and ongoing threat to society. There is still a great deal of uncertainty regarding possible treatments and vaccines for COVID-19. Older people are especially vulnerable and we must remain vigilant and continue to adhere to the advice of public health experts.

In time, we can reflect on this pandemic and learn the national lessons of its impact on nursing homes. HIQA will contribute to this discussion with a view to charting a way forward for health and social care services and how they are regulated and supported in the future. In the meantime, we will continue to work closely with everyone involved in providing residential care to older people in Ireland to help ensure that residents are safeguarded and that their quality of life is restored and enhanced for the future.

Mary Dunnion

Chief Inspector of Social Services and Director of Regulation

## About this report

This report outlines the range of measures taken by the Chief Inspector of Social Services in response to the outbreak<sup>1</sup> of COVID-19 in nursing homes in Ireland.

HIQA is the independent regulatory body for nursing homes in Ireland. From the onset of this national public health emergency, HIQA has maintained regulatory oversight of the health and social care services under its legal remit.

This has been conducted through monitoring information about services, carrying out inspections and supporting health and social care services. During the emergency, we have also endeavoured to ensure that the voices of residents and families continue to be heard. Our regulatory oversight has included:

- contacting nursing homes by telephone every two weeks as part of our quality assurance programme
- assessments of nursing homes on contingency planning and preparedness for an outbreak of COVID-19
- processing applications by nursing home providers to renew their registration or register new centres, and
- carrying out risk inspections of nursing homes.

Support for the sector has included:

- publishing regulatory information notices to keep providers up to date on how we are regulating services
- preparing and publishing guidance and self-assessments for providers to assess how prepared they were for COVID-19
- operating an Infection Prevention and Control Hub to give providers information on managing COVID-19
- focusing the work of our Information Handling Centre on engaging with people who contacted us with concerns.

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<sup>1</sup> In line with guidelines from the Health Protection and Surveillance Centre, an outbreak or cluster is defined as follows:

- two or more cases of laboratory confirmed COVID-19 infection regardless of symptom status. This includes cases with symptoms and cases who are asymptomatic.  
**OR**
- two or more cases of illness with symptoms consistent with COVID-19 infection (in line with the COVID-19 case definition), and at least one person is a confirmed case of COVID-19.

HIQA has also used the information it holds about centres to support the Department of Health, the National Public Health Emergency Team (NPHE) and the HSE in terms of timely exchange of relevant information on regulated residential centres.

## Introduction – COVID-19 in nursing homes

At the time of this report, there were 576 registered nursing homes in Ireland, with approximately 32,000 residential places. Nursing homes are operated by a mixture of private and voluntary bodies, and the HSE. Private entities are by far the largest providers in the sector, managing 8 out of 10 beds nationally (80%). While the average number of beds in nursing homes nationally is just over 56, they range in size from as little as nine beds to the largest centre which has 184 beds.

There is considerable variation in the type of nursing home accommodation available across the country. Many of the newer nursing homes provide single en-suite bedrooms and have ample communal and outdoor spaces for residents. Some of the older facilities — many operated by the HSE — rely on multi-occupancy rooms (where residents share bedrooms and share toilet and bathroom facilities) where there is limited communal day space.

### HIQA's regulatory response to COVID-19

HIQA has been represented on NPHE since it was established in late January 2020. NPHE was tasked with coordinating the response to COVID-19 and providing advice on public health matters to Government. As the first number of positive tests for COVID-19 were confirmed in Ireland, HIQA continually monitored the situation in residential centres for which it has regulatory oversight: nursing homes, residential disability services and certain children's services.

As the pandemic progressed and the number of cases increased, the Chief Inspector decided on 13 March 2020 to temporarily suspend all routine regulatory and monitoring inspections in these services with immediate effect. This decision was necessary in order to prevent potential further spread of the virus by inspectors pending greater public health clarity about the nature and spread of the virus.

The Chief Inspector undertook a number of initiatives at this time in relation to nursing homes in order to ensure the safety and welfare of residents and to support service providers in keeping people safe. They include the following approaches:

- A quality assurance process was set up, whereby all nursing homes were phoned on a fortnightly basis by an inspector of social services. These calls were to assess the welfare of the residents, how nursing homes were coping, any concerns they had and any deficiencies identified in their ability to sustain a safe, high-quality service. From 25 March 2020 until the time of writing this report, 2,851 such phone calls were made to nursing homes by inspectors.

- New registration applications were prioritised to facilitate the swift opening of new residential placements.
- An 'Infection Prevention and Control Hub' support service was set up by the Chief Inspector. The Hub, staffed by inspectors with experience in infection prevention and control, acted as a source of immediate advice and support for centres that had queries on COVID-19 outbreak prevention and management.
- Eight regulatory information notices were issued to registered providers between 20 March and 26 June 2020. These were aimed at enhancing the flow of notifications that providers are required to make to the Chief Inspector. This has enabled the timely return of data on the number of residents and staff with suspected or confirmed cases of COVID-19, and the number of deaths in each centre.
- There has been regular liaison between the Chief Inspector and the Department of Health and the HSE regarding ongoing issues in services and the escalation of risk.
- The Chief Inspector has carried out a programme of inspections to assess the preparedness and contingency planning for COVID-19 outbreaks in those nursing homes that had not yet had a suspected or confirmed case of the disease.
- The Chief Inspector has also carried out a separate targeted programme of risk-based inspections focusing on those nursing homes that were most impacted by COVID-19.

## COVID-19

The newly discovered coronavirus that causes COVID-19 is an especially difficult one to manage from an infection prevention and control perspective, particularly in the context of residential care for older persons. This cannot be overstated in evaluating this issue, and it is due to a number of factors that have emerged or been further emphasised during the current pandemic.

The virus is highly infectious, with people commonly carrying it and spreading it without displaying any symptoms themselves. The extent of both of these properties was not known at the start of the outbreak. These factors makes it especially hard to keep COVID-19 out of nursing homes when it is circulating in the community, even in spite of visitor restrictions. Therefore, inward transmission into nursing homes by staff is a key likely source of its introduction to these settings.

Compared to the general population, it appears to present differently in older people who may often be unable to verbalise symptoms. Furthermore, the mortality rate is especially high in frail older people relative to the rest of the population, meaning people living in a congregated setting such as a nursing home are particularly vulnerable.

The fact that it displays a myriad of symptoms, or indeed none at all, makes ready access to testing a key requirement. Such access is a given in the hospital setting in managing outbreaks, for example, but it was not in place at the onset of the COVID-19 outbreak in nursing homes.

### **How the COVID-19 pandemic evolved in nursing homes**

The first case of COVID-19 in the Republic of Ireland was confirmed on 29 February 2020. NPHET had been preparing for this eventuality for a number of weeks and had been issuing guidance and advice to a range of interested parties. Nursing Homes Ireland, a representative body for providers of almost 400 private nursing homes, decided to restrict nursing home visits to its member centres from 6 March 2020.

The Chief Inspector continued to closely monitor the progression of the pandemic through inspections, statutory notifications submitted by nursing home providers regarding infectious disease outbreaks and deaths, and through information and concerns received from staff or members of the public. In order to limit the potential spread of the disease and to protect the health and safety of inspection staff, a decision was taken on 13 March 2020 to temporarily suspend all routine inspections.

Like everyone else in society, the nursing home sector had never experienced a modern pandemic before. While many nursing homes would have experienced disease outbreaks such as the norovirus or influenza, such experiences did not prepare them for what is required during COVID-19. Equally, while nursing homes provide nursing care, they are predominantly based on the social care model. Therefore, the staff in these settings would not have the same knowledge and experience of infection prevention and control as staff in the acute care sector, nor would they have access to the same expertise in this area.

As the disease evolved, and affected both staff and residents, there were a number of areas of concern that impacted on the capacity of a number of nursing home providers to effectively keep residents safe in the event of an outbreak of COVID-19. The concerns of the Chief Inspector related to:

- the absence of clinical governance in most nursing homes
- staffing levels, especially to enable staffing to be organised to care for residents in separate, self-contained groups

- maintaining staffing levels in the event of sudden and unplanned absences
- the availability of resources such as PPE, access to specialist expertise and support
- the layout of centres and their ability to separate the location of healthy and ill residents or isolate residents as required
- the history of non-compliance with relevant key regulations, such as governance and management, premises, personal possessions and infection prevention and control.

In the absence of formal relationships between the HSE and private nursing homes, HIQA identified how critical it was for nursing home staff to be able to avail of the HSE's public health expertise, guidance and community support during the COVID-19 pandemic. The specific areas of concern and risk were listed in correspondence from the Chief Inspector to the Department of Health on 13 March 2020.

Throughout the subsequent weeks, inspectors of social services maintained close contact with all nursing homes. There were 2,851 such phone interactions by inspectors to managers or staff in nursing homes from 25 March 2020 until the time of preparing this report. In addition, providers were required to notify the Chief Inspector of any suspected or confirmed cases of COVID-19 in their centres. It was through these interactions that inspectors were able to determine where nursing homes were struggling, for example, in relation to access to equipment such as PPE or advice. HIQA escalated all risks to the HSE for their support.

A feature of the response to the pandemic was the necessity for frequent updates to national guidance for infection, prevention and control in residential settings. The Health Protection Surveillance Centre (HPSC) of the HSE developed *Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities*.

Regular updating of official national guidance was necessary in the context of rapidly-evolving information and directions from NPHET and the Government. As the extent of the potential risk and impact of the disease in residential care facilities emerged, the guidance was updated with targeted and specific advice for providers of services. The guidance provided by the HPSC was of critical importance in supporting and guiding centres to manage the risk posed by COVID-19. The guidance gave providers a framework to assess and review their preparedness to both withstand and respond to outbreaks of COVID-19 in critical areas including:

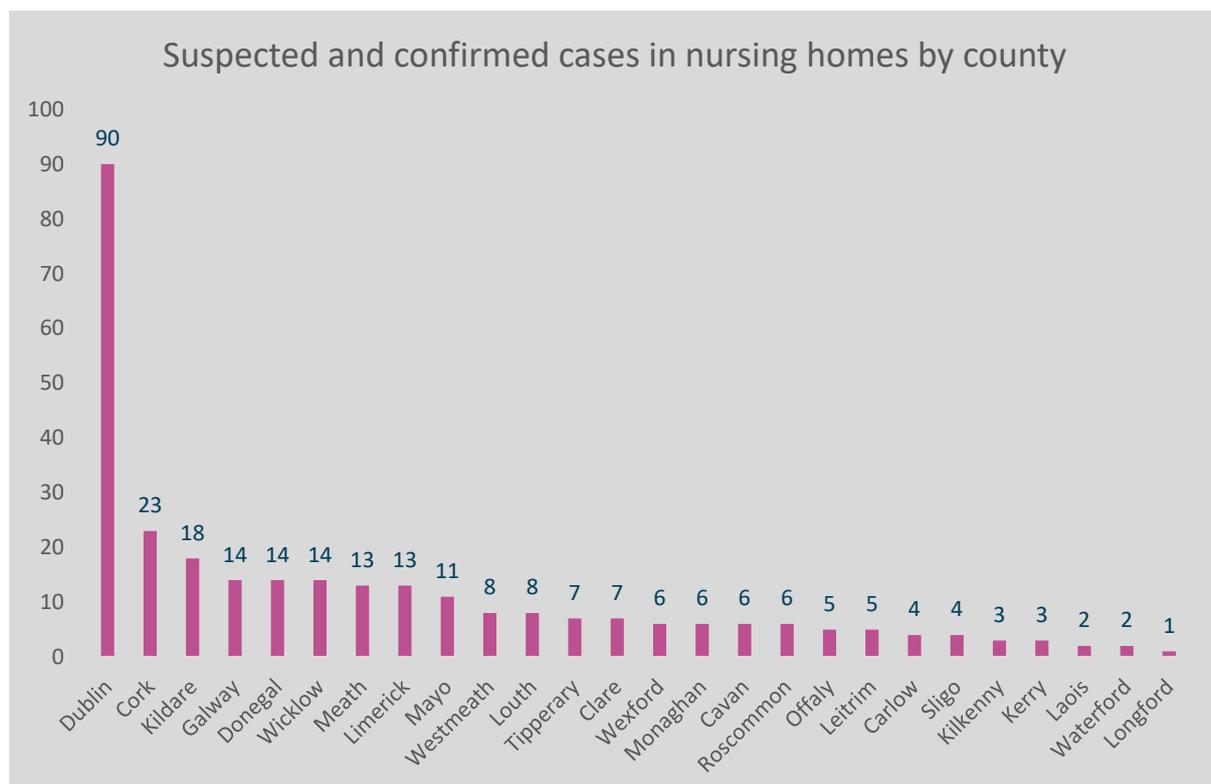
- staffing arrangements
- the application of standard precautions to limit the spread of infection

- testing
- use of PPE
- isolation arrangements during an outbreak.

Between 30 March 2020 and 3 July 2020, there were 11 revisions to HPSC guidance. This required management in nursing homes to quickly take in and understand these updates, and to ensure that all staff were aware of the changes. They were also required to enable the implementation of the changes throughout their service.

As outlined above, nursing home providers are required to notify the Chief Inspector of any outbreak of infectious disease in their centres. These notifications were important indicators of possible risk to residents and staff in terms of the outbreak and spread of COVID-19 during the course of the pandemic. The first notification to the Chief Inspector of a suspected or confirmed outbreak of COVID-19 in a nursing home in Ireland was received on 13 March 2020. At the time of writing this report, half of centres (51%) had reported a confirmed case or cases of COVID-19, while 9% of centres had reported a suspected case. Forty per cent of centres had reported no outbreak. It should also be noted that the geographic distribution of COVID-19 cases in nursing homes nationally was broadly consistent with that of the general population. Figure 1 below illustrates the distribution of cases throughout the country as of 30 June 2020.

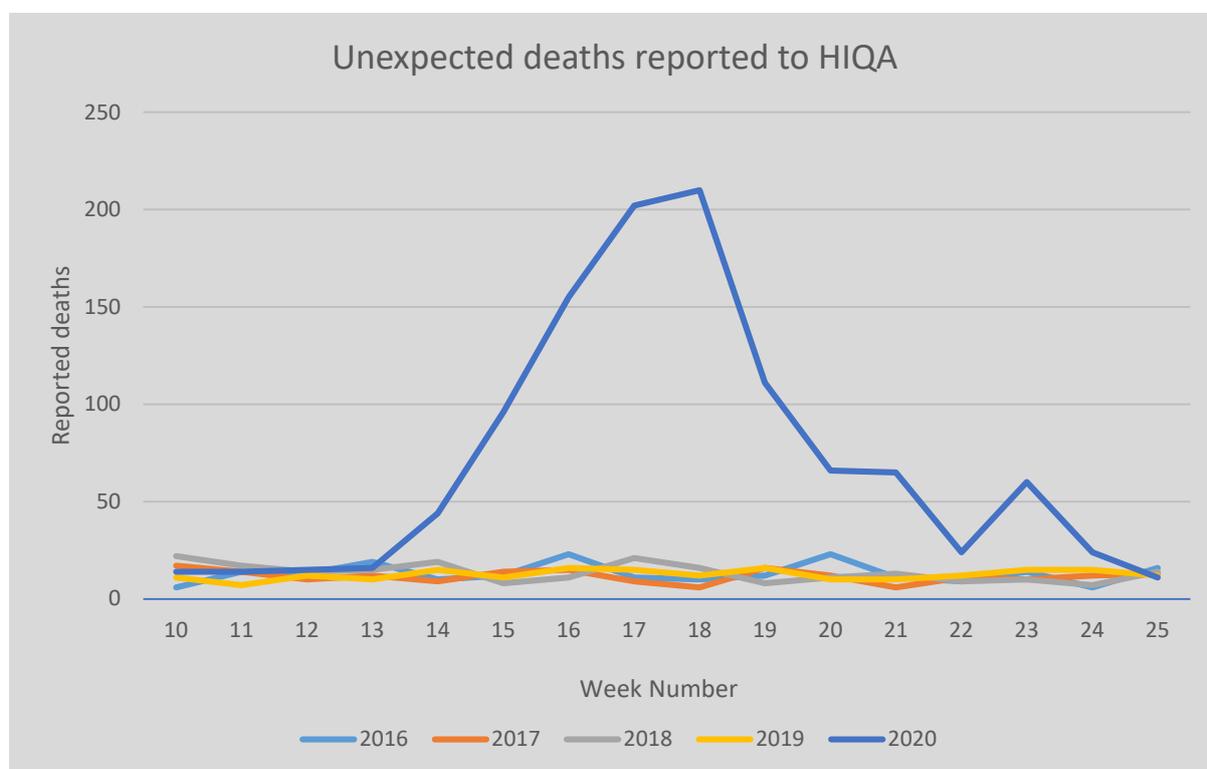
**Figure 1. Suspected and confirmed cases in nursing homes by county as of 30 June 2020**



The changing presentation of the disease, its rate of spread and the vulnerability of our older generation had a very significant and devastating impact on residents in nursing homes. The virus appears to present unusually in older people and can often progress rapidly in centres as many residents also have additional underlying health conditions. Sadly, the mortality rate has been especially high in frail older people, not just in nursing homes but right across the entire population.

Nursing home providers are required to inform the Chief Inspector about unexpected deaths in their centres. A review of the number of deaths reported to the Chief Inspector in 2020 compared to previous years shows a significant increase. It is not possible for HIQA to validate that the increase in reported deaths were directly related to COVID-19; the HPSC is the organisation responsible for validating these figures. However, what the graph below illustrates is the devastating impact of COVID-19 in nursing homes. Behind these statistics are people who have died, as well as families, nursing home residents and members of staff struggling to come to terms with the loss of a loved one or friend. This was at a time when visiting was restricted to nursing homes and, therefore, time spent with residents at end of life was not what it would have been pre-COVID-19.

**Figure 2. Number of unexpected deaths in nursing homes compared with data from the preceding four years**



## Nursing home compliance assessments

The priority of the Chief inspector during the COVID-19 pandemic has at all times been the safety and wellbeing of people living in nursing homes. Under the Health Act 2007, as amended, the registered provider is responsible and accountable for the quality of care and safety of residents in designated centres. To support registered providers and designated centres during this public health emergency, supports and resources have been made available by the HSE at different times during the pandemic. These include:

- crisis management teams in each HSE Community Health Organisation (CHO) area, including infection prevention and control specialists
- access to PPE for staff working in designated centres
- the provision of public health advice
- voluntary re-deployment of staff to designated centres
- access to testing and results
- access to specialist medical input such as gerontology.

In addition, support for providers and staff was available from HIQA through HIQA's Infection Prevention and Control Hub and from inspection staff.

In addition, HIQA developed and published a *Regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak* and a self-assessment in April 2020. The framework reflected the HPSC's guidance on residential care facilities. These assessments were aimed exclusively at assisting those nursing homes that were as yet free from COVID-19.

Preventing and preparing for COVID-19 is, however, not simply a matter of good infection prevention and control practices. There are other important factors which are equally important in response to a pandemic, and these include:

- good governance which is proactive and has contingency plans in place
- clear communication with residents and their families, and staff
- updated staff training
- measures to address the individual wellbeing of residents in light of the social isolation they are likely to experience due to restrictions on visiting and activities.

Therefore, the regulatory assessment framework reviewed a range of regulations that took account of these matters. These included, among others, regulations on staffing, training, communication, governance and management, risk management, and infection prevention and control.

The aim of the framework was to support nursing homes to prepare for an outbreak of COVID-19 and put in place the necessary contingency plans. Providers were asked to assess:

- their preparedness to manage an outbreak of COVID-19 in the key areas of governance, leadership and management, and those regulations covering quality and safety
- their knowledge of the resources available to support residents and staff in preparing for and managing an outbreak
- the efforts made by them to access specialist clinical advice in providing safe care for residents
- the systems in place to ensure the centre is a safe place for residents.

Inspectors then set about validating the provider's own self-assessment of compliance against specified regulations. This was done through an interview with senior management of the centre, and by verifying evidence by a review of documentation and observation in the nursing home (where appropriate).

Inspectors gave advance notice of the visit to the nursing home so as to allow the provider and staff to prepare for the visit in a safe manner. As the on-site assessment of compliance took place during a national public health emergency, inspectors of social services took all necessary precautions in line with HPSC advice. This included:

- the observation of physical distancing at all times throughout the on-site assessment
- inspectors not entering areas occupied by residents
- the monitoring of symptoms of COVID-19 in inspectors, including checking temperature prior to entering a centre
- a declaration by the inspector to the person in charge of the nursing home that they have no symptoms of illness or a raised temperature
- the observation of good hand hygiene at all times
- compliance with good cough and sneeze etiquette by inspectors at all times
- the use of PPE in line with HPSC guidance
- compliance with any additional measures that registered providers have in place in individual centres, as appropriate.

Furthermore, inspectors of social services were familiar with *Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units*, published by the HPSC.

## Judgment descriptors

The Chief Inspector makes judgments on whether the registered provider or person in charge is compliant, substantially compliant or not compliant with the regulations associated with the findings. The table below shows the judgment compliance levels — which are termed ‘judgment descriptors’ — that were used for this regulatory assessment framework. These judgment descriptors were used by providers when undertaking their own self-assessment and also by inspectors during their on-site assessment.

**Table 1. Judgment descriptors**

Compliant	Substantially compliant	Not compliant
<p>This means the provider and or the person in charge has taken the necessary steps to prepare for an outbreak of COVID-19.</p>	<p>This means that the provider or person in charge has most of the elements of an effective contingency plan but some action is required.</p>	<p>This means that the provider has not taken the necessary steps to prepare for an outbreak of COVID-19. In the absence of this preparation and contingency planning, residents are at risk. Urgent action is required by the provider.</p>

## Main findings

In general, inspectors found a good level of compliance across the nursing homes where the contingency arrangements were assessed. Where regulatory non-compliance was identified, the relevant provider was required to take action and revise its COVID-19 preparedness plan to address these areas.

Table 2 below sets out the percentage compliance identified for the 15 regulations included in the *Regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak* and the self-assessment conducted by providers.

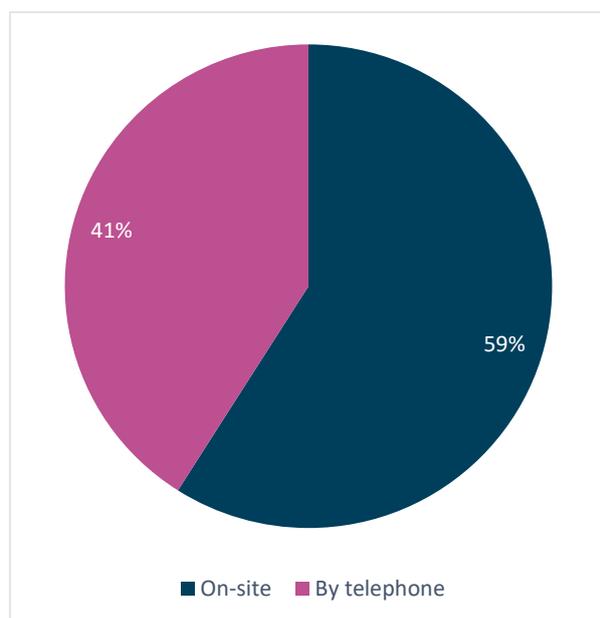
**Table 2. Percentage of compliance with regulations in regulatory assessment framework**

Regulations	Compliant	Substantially compliant	Not compliant
Regulation 10: Communication difficulties	99%	0%	1%
Regulation 11: Visits	99%	1%	0%
Regulation 14: Persons in charge	99%	1%	0%
Regulation 15: Staffing	91%	3%	6%
Regulation 16: Training and staff development	95%	1%	4%
Regulation 23: Governance and management	88%	5%	7%
Regulation 26: Risk management	96%	2%	2%
Regulation 27: Infection control	94%	3%	4%
Regulation 31: Notification of incidents	97%	1%	3%
Regulation 4: Written policies and procedures	95%	1%	4%
Regulation 5: Individual assessment and care plan	96%	1%	3%
Regulation 6: Health care	99%	0%	1%
Regulation 7: Managing behaviour that is challenging	97%	1%	2%
Regulation 8: Protection	98%	0%	2%
Regulation 9: Residents' rights	98%	1%	1%
<b>Grand total</b>	<b>96%</b>	<b>1%</b>	<b>3%</b>

There were a total of 189 compliance assessments carried out in 189 nursing homes free of COVID-19 between 29 April and 26 May 2020. The assessment programme concluded on 26 May 2020 when a decision was made to recommence risk inspections of nursing homes.

In total, inspectors made 2,826 assessments of compliance with regulations, averaging approximately 15 regulations assessed in each nursing home.

**Figure 3. Type of assessment**



In general, a good level of compliance was found across the nursing homes assessed. Of the 189 nursing homes, 142 (75%) were found to be fully compliant with all of the regulations assessed. There were 13 nursing homes (7%) where one or more regulation was found to be not compliant. In particular, it is a concern that there were four nursing homes that were not compliant with more than 20% of the regulations assessed. As a result, these homes will continue to be closely monitored by the Chief Inspector to ensure that they address the issues identified.

Overall, this represents a high level of compliance with the assessment programme and is testament to the diligence and contingency planning undertaken by the vast majority of nursing home providers and their staff.

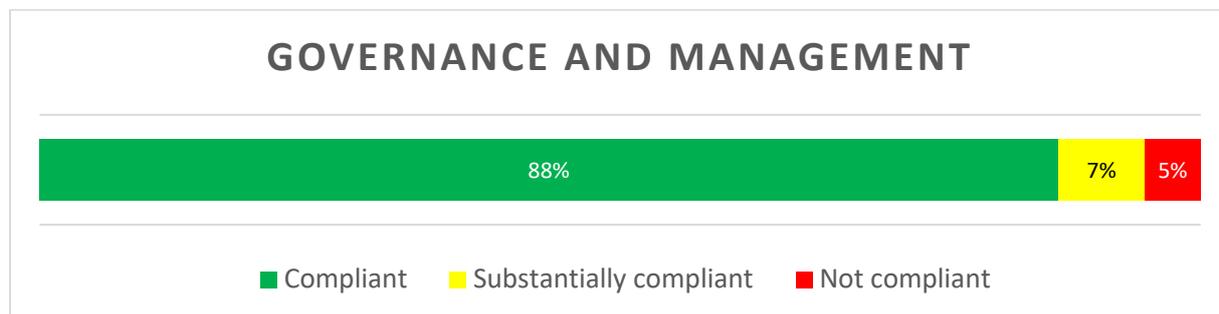
The three regulations with the highest level of non-compliance were Regulation 3: Governance and management; Regulation 15: Staffing; and Regulation 27: Infection control. These will be discussed in more detail in the next section of the report.

While overall there were good levels of compliance with the regulatory assessment framework, there were areas that required providers to take action to ensure that their contingency plans were resourced and well thought out in the event of an outbreak occurring. These areas of concern included governance and management, staffing, and infection prevention and control. The following section describes the key findings in more detail.

### **Governance and management**

The regulation on governance and management requires that nursing home providers have sufficient resources along with a clearly defined, effective management system to ensure care is safe, appropriate, consistent and effectively monitored. Effective governance, leadership and management is key to the quality and safety of care in the normal running of a nursing home. However, during COVID-19 it is vital that the registered provider has governance structures and operational arrangements for the timely detection and response to COVID-19.

**Figure 4. Governance and management findings**



There were many good examples of nursing homes that had engaged in comprehensive contingency planning in the event that there was a COVID-19 outbreak in their centre. Inspectors found good practice in terms of identifying sufficient numbers of replacement staff on stand-by should they be required. Most nursing homes were in regular contact with local public health officials and had made plans for compartmentalising their centres should an outbreak materialise. Some had even taken the approach of zoning their centres in order to limit the circulation of any potential outbreak, as illustrated in one inspection report:

The centre has been divided into zones, each with its own entrance and exit. Staff have a changing and toileting area in each zone. Staff do not mix with staff from other zones. Staff do not leave their zone at any time throughout their shifts. Meals are delivered to each zone throughout the day.

Most nursing homes had sourced a supply of vital equipment such as PPE, oxygen, medicines and hand hygiene products. Some nursing home providers had demonstrated an innovative approach to addressing contingencies, as shown in this inspection finding:

....the provider has been in contact with a local hotel, which is currently closed, to secure agreements that in the event their kitchens and staff are incapacitated, that the hotel will be able to supply a full catering service to the centre.

Notwithstanding the above, the governance and management regulation had the highest level of non-compliance across this programme of compliance assessments, a rate of 5%. This equates to nine centres where the inspector formed the view that the governance and management of the centre was ill-prepared for the outbreak of COVID-19 in the nursing home.

One area of concern related to the failure of some registered providers to have appropriate contingencies in place in the event that the person in charge (the

effective manager of the centre) were to fall ill or be required to self-isolate or self-quarantine.

In another nursing home, an inspector found that "...if the person in charge was to be absent, there were no contingency arrangements or measures in place to ensure effective management of the centre and safe, appropriate and consistent delivery of care to residents".

It is the Chief Inspector's experience that impact of the outbreaks of COVID-19 in nursing homes was exacerbated by the absence of senior management on site, as a result of contracting the virus themselves. As such, it was alarming that some registered providers had failed to demonstrate sufficient preparation for such an eventuality.

Inspectors also found non-compliances in the context of arrangements for isolating and cohorting (separating well and unwell) residents in the event that an outbreak of COVID-19 was suspected or confirmed. While most nursing homes had devised such plans, some would not have been effective in the event that a significant number of residents became infected, as illustrated in this finding:

The provider and person in charge had made plans for cohorting residents in the event of an outbreak; however, as the centre was fully occupied, the plan would not be effective in the event of six or seven residents becoming symptomatic due to the multi-occupancy nature of the bedrooms.

Other nursing homes that were not compliant with this regulation were found to have insufficient communication and liaison with local public health officials in their respective HSE Community Health Organisations. For example, one inspector reported:

While aware of the process for escalating an outbreak of infection to the crisis management team in the HSE and aware of relevant contact numbers, the provider has not made contact with them to alert them of their vulnerabilities.

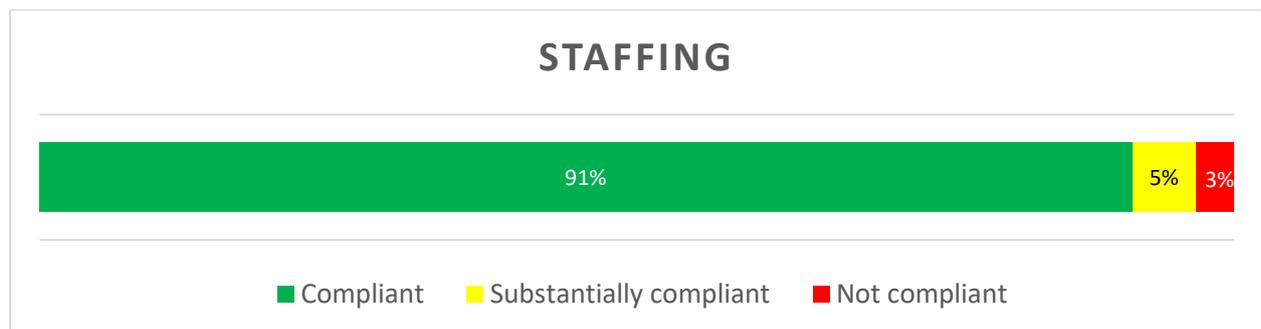
The person in charge was not clear in relation to who she or her staff should contact for resources in the event of an outbreak of COVID infection.

Other issues identified by inspectors in the context of governance and management included: review of policies and procedures; access to resources; provision of testing; and behavioural support plans.

## Staffing

The regulation governing staffing requires nursing homes to have sufficient numbers and skill-mix of staff in order to meet the assessed needs of the residents. However, the regulation does not set out minimum staffing requirements, nor does it offer guidance on how staffing levels should be determined.

**Figure 5. Staffing findings**



Inspectors found that the vast majority of nursing homes were staffed by people who were committed to keeping residents safe. Many staff had agreed to work additional hours and made themselves available on stand-by should the need arise. For example, one inspector reported: "All staff have been surveyed in relation to their willingness to increase their hours, particularly staff that do not currently work full-time."

Most nursing homes had sufficient numbers of registered nurses, care assistants, cleaning and catering staff on their roster to manage in the event of an outbreak of COVID-19. A significant number of centres had made provision for staff to work in assigned zones in order to limit their movement around the centre. Staff were adequately supervised in terms of their own health with regular temperature checks and screening for symptoms of COVID-19. In one centre, it was reported:

There was a screening and reporting process in place to ensure that symptomatic staff did not come on duty. Neither did staff come on duty if they were living with persons working in another healthcare setting that was affected by COVID-19.

Six nursing homes were found to be not compliant with this regulation, representing 3% of all centres inspected. A recurring theme in this context was an insufficient number of staff on duty. For example, in one centre, the inspector wrote that "...the person in charge told the inspector that seven nurses had left to cocoon due to COVID-19 and a few other care staff had resigned from the centre. She said she was trying to manage the centre with minimum staffing at the moment. She only had a skeleton workforce and did not have any relief staff available."

Other nursing homes had insufficient numbers of staff rostered at night. This was a risk in terms of managing the needs of all residents and ensuring effective supervision of all areas of the nursing home. Low staff numbers also meant that some staff were required to circulate in and out of all resident areas, thereby placing residents at risk of cross infection should an outbreak occur. In one centre, the inspector noted:

At night time there is only one nurse on duty responsible for the administration of medications and in charge of the centre. This staffing complement is a risk to resident care. The nurse has direct contact with all residents.

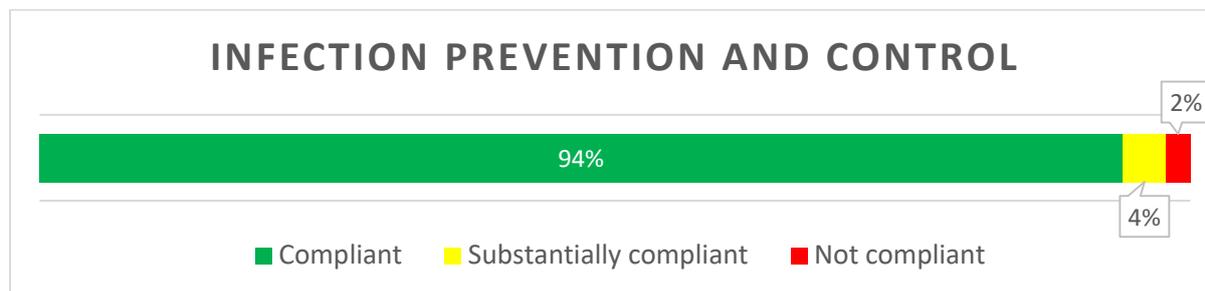
Inspectors also found issues relating to Garda vetting for relief staff and a failure to make arrangements with regard to agency staff availability.

### **Infection prevention and control**

It is the opinion of the Chief Inspector that the current regulation on infection prevention and control in nursing homes are not commensurate with what is required to respond and manage a COVID 19 outbreak. Nursing homes would have experienced outbreaks such as norovirus (known as the winter vomiting bug) or influenza; however, these outbreaks would not have prepared them for an event such as COVID-19. The infection prevention and control regulation requires that registered providers of nursing homes 'ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff'.

Effective infection prevention and control is an important aspect of nursing home management at all times. Nursing homes are required to be vigilant in terms of monitoring residents for any sign of common infections such as Methicillin-Resistant *Staphylococcus aureus* (MRSA), winter vomiting bug or influenza. The COVID-19 pandemic has heightened awareness around infection prevention and control and resulted in nursing homes taking additional measures to keep residents safe. Inspectors looked for evidence that nursing homes had implemented the HPSC's guidance on infection prevention and control in residential care facilities. In addition, inspectors assessed whether there were effective cleaning practices in place, suitable equipment for staff and proper management of laundry and waste.

**Figure 6. Infection prevention and control findings**



In general, inspectors found a high level of compliance with this regulation with almost 98% of nursing homes either compliant or substantially compliant. Increased cleaning programmes had been introduced and these were being audited. Hand hygiene products were readily available and visitors that were permitted entry were asked to clean their hands regularly. During one on-site visit, the inspector was asked to use the supplied alcohol gel when entering and leaving the centre and the room they were working in.

Some nursing home providers had also increased their supply of other equipment so as to avoid cross contamination, such as using additional hoist slings. Adequate facilities were a cause for concern in some centres that were found to be non-compliant with this regulation. In one assessed centre, the inspector reported:

There were limited showering facilities in the centre. In one wing of the centre, there were two showers shared between 10 residents, and in another area, the person in charge told the inspector that 14 people share one shower room.

The above scenario would have presented a significant infection prevention and control challenge had an outbreak of COVID-19 occurred in this nursing home. This underscores the fact that some nursing homes continue to operate with facilities that require extensive remodelling in order to meet new requirements on premises which will be introduced in 2021<sup>2</sup>.

Inspectors also found issues relating to contingencies for laundry facilities. Many nursing homes process their own laundry on site. One assessed nursing home had not made adequate plans in the event that staff working there were unavailable to do laundry. It was suggested to the inspector that they “might ask a neighbour or a member of the local community to do the laundry”. Any use of untrained people to manage laundry for vulnerable residents in such high-risk circumstances would have been highly inappropriate.

<sup>2</sup> In 2016, the Minister of Health extended the deadline by which nursing homes have to make certain specific improvements to the physical infrastructure in centres until the end of 2021.

## Risk inspections

As noted above, HIQA made the decision on 13 March 2020 to temporarily suspend all routine inspections. Inspectors continued to monitor centres as detailed earlier in this report. During March, April and May 2020, an increasing number of nursing homes developed outbreaks of COVID-19 (in total 60% of nursing homes reported either confirmed or suspected outbreaks).

Increasingly, the Chief Inspector had some concerns around a number of nursing homes and how the providers were managing outbreaks of COVID-19 in those centres. Therefore, risk inspections resumed in late May 2020 and focused primarily on those centres that had reported confirmed cases of COVID-19. Between 27 May 2020 and the time of writing this report, a total of 44 such inspections had taken place.

The initial priority was to inspect centres that had had significant outbreaks. Key findings from these inspections include:

- Governance and management structures in some centres were still not sufficient to withstand an initial or even a second wave of an outbreak.
- Baseline staffing levels had not increased, even in those centres where there had been significant outbreaks; where additional staffing resources had been provided they were removed as soon as was feasible.
- Infection prevention and control knowledge and competence commensurate with a pandemic was not available in centres, leading to an ongoing reliance on public health and HSE resources.
- Centres had access to PPE and other key consumables earlier in the pandemic, but there was confusion with regard to who was responsible for ongoing supply of such equipment.
- In the absence of an integrated care records system (a record that includes nursing, medical and other health professional input and treatment plans), it was difficult to follow the resident's care journey. This was especially evident where residents either transferred to or from the acute services. It was not always clear what information was given to the acute service or what information was given to the nursing home when a resident returned to the service or when a resident was reviewed by a doctor.

The Chief Inspector was sufficiently concerned regarding the management and systems in place to keep residents safe in one nursing home and sought a court order for an emergency closure order, which was granted by a district court on 30 May 2020. Reports for all of the nursing homes visited during these risk inspections will be published in due course.

As outlined above, many of the risk inspections undertaken by inspectors were of nursing homes that were known to have had COVID-19 outbreaks. Inspectors were keen to speak with residents and their relatives or friends, as well as staff and management, so that they could assess how the nursing home had managed the outbreak and the impact that COVID-19 had on the lived experiences of residents, their families and staff. They were also interested to learn of any measures which had been successfully implemented by a provider to guard against or manage any future outbreaks. HIQA staff adopted the same infection prevention and control measures outlined earlier in this report while carrying out risk inspections of nursing homes.

The following information represents preliminary findings from the risk inspections, as many of the reports were still being prepared at the time of writing this overview report. However, they are broadly reflective of what was found by inspectors in nursing homes across the country. Overall, the findings from these inspections are mixed. Certainly, the levels of non-compliance are considerably higher when compared to the findings of the contingency planning and preparedness self-assessments described earlier in this overview report.

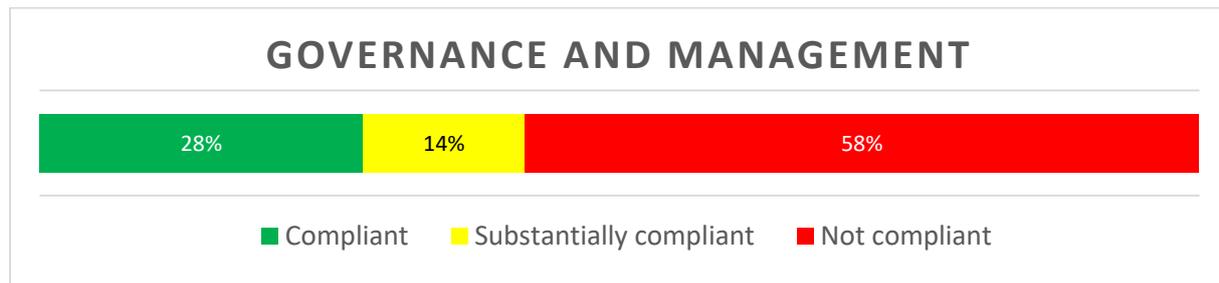
None of the nursing homes inspected were found to be fully compliant with the regulations inspected against. Five nursing homes were found to be mostly compliant, where inspectors assessed compliance with the regulations as being either compliant or substantially compliant. The remaining 39 nursing homes were judged to be not compliant with one or more regulation assessed.

It is a concern that 11 nursing homes were found to be not compliant with at least one in three of the regulations inspected. The following sections outline the regulations that had the highest level of non-compliance and are a significant concern in the context of COVID-19.

## **Governance and management findings**

The governance and management regulation acts as an important indicator of how well a nursing home is run. If a nursing home performs poorly under this regulation, then it is often the case that outcomes for residents are negatively impacted. Nearly six out of 10 nursing homes (58%) inspected were found to be not compliant with this regulation.

**Figure 7. Governance and management findings**

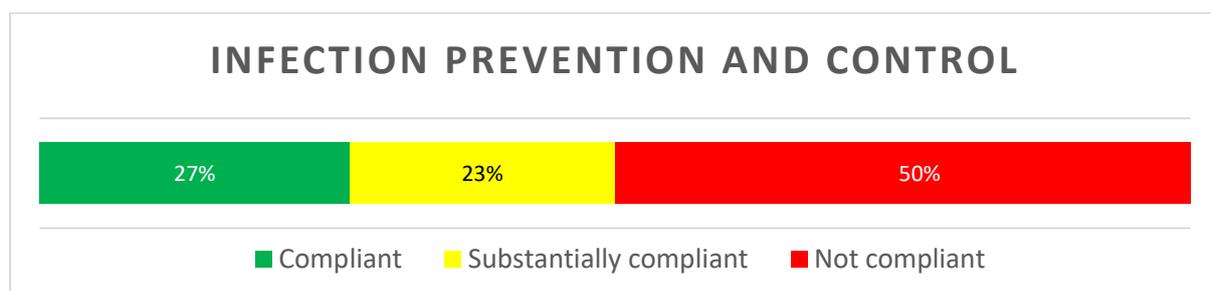


The high rate of non-compliance with this regulation indicates that these nursing homes were ill-equipped to manage the challenges presented by COVID-19. Inspectors found examples of poor contingency planning, a failure to identify replacement staff, and a lack of effective communication and supervision between staff and management. It was also found that some nursing homes had not taken sufficient account of public health guidance in their policies and practices. It is acknowledged that preventing an outbreak of COVID-19 was extremely difficult for many nursing homes. However, the failures in compliance with the governance and management regulations in some centres may, in the opinion of the Chief Inspector, may have contributed to more severe outbreaks than may otherwise have been the case.

### Infection prevention and control findings

The rate of non-compliance with this regulation was 50% across all nursing homes inspected, which was an obvious concern in the context of COVID-19.

**Figure 8. Infection prevention and control findings**



Inspectors found instances of routine infection prevention and control measures not being followed. For example, one nursing home had left bedroom doors open for residents that had tested positive for COVID-19. In another nursing home, staff were observed caring for residents in close proximity without using surgical masks in line with HSE guidance. There were also issues with incomplete documentation and records relating to infection prevention and control. For example, temperature checks on staff were not being documented in some nursing homes.

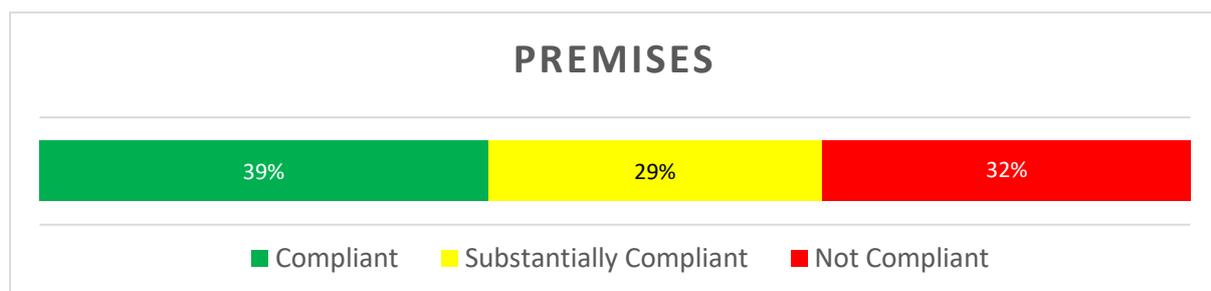
Proper cleaning and sanitary practices were also hampered in some centres by inadequacies associated with the layout of the physical premises.

Some nursing homes were also challenged in their efforts to maintain proper infection prevention and control standards due to staff shortages, as many staff were affected by COVID-19 themselves. There were also some instances of nursing homes that were not carrying out infection prevention and control audits. This is partly due to the fact that most nursing homes do not have specialist nurses on hand with expertise in infection prevention and control.

## Premises findings

Inspectors also reviewed the suitability of the physical environment and how it enables the nursing home to meet the needs of the residents. This regulation had a non-compliance rate of 32%.

**Figure 9. Premises findings**



In recent years, the Chief Inspector has consistently drawn attention to inadequate premises in a significant number of nursing homes in Ireland. This is a result of outdated premises where residents are required to share bedrooms and bathrooms, thus compromising the effectiveness of infection prevention and control in a centre, and the privacy and dignity of residents. Premises such as these proved particularly problematic in the context of managing COVID-19. The close proximity of residents made it very difficult to adhere to physical distancing requirements and created difficulties with implementing proper infection prevention and control practices to help counter COVID-19.

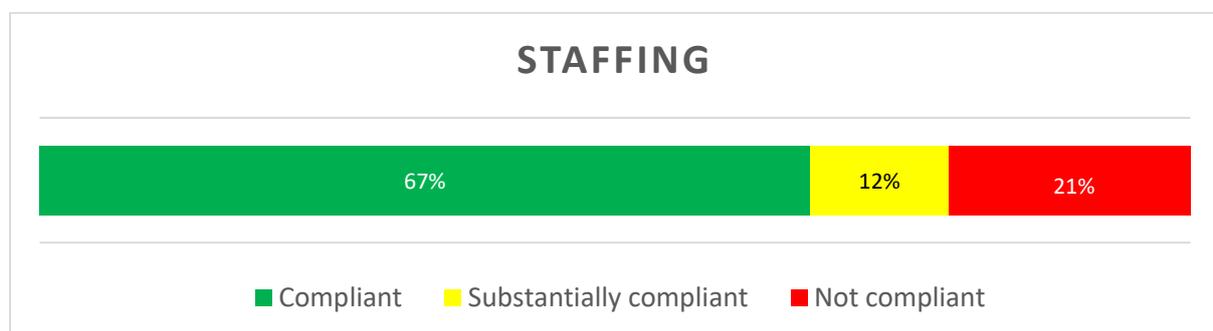
Some nursing homes had inadequate access to outdoor spaces which limited the ability of by-now socially isolated residents to enjoy different environments. Some nursing homes lacked sufficient storage space for equipment such as hoists and wheelchairs. As a consequence, these were kept in hallways and presented a trip hazard to residents, in addition to presenting a cluttered appearance. Many nursing homes have plans in place to address issues related to their premises. The Minister for Health has set a December 2021 deadline for improved living arrangements in nursing homes in Ireland. However, it remains a significant challenge — particularly

in light of the COVID-19 pandemic — to sufficiently remodel these nursing homes in advance of the deadline.

## Staffing findings

Having adequate staffing levels and skill-mix to meet the assessed needs of residents is always important in the context of a nursing home. It is critically important in the context of the outbreak of an infectious disease where staff are likely to fall ill and may be difficult to replace. Inspectors found a rate of 21% non-compliance with this regulation.

**Figure 10. Staffing findings**

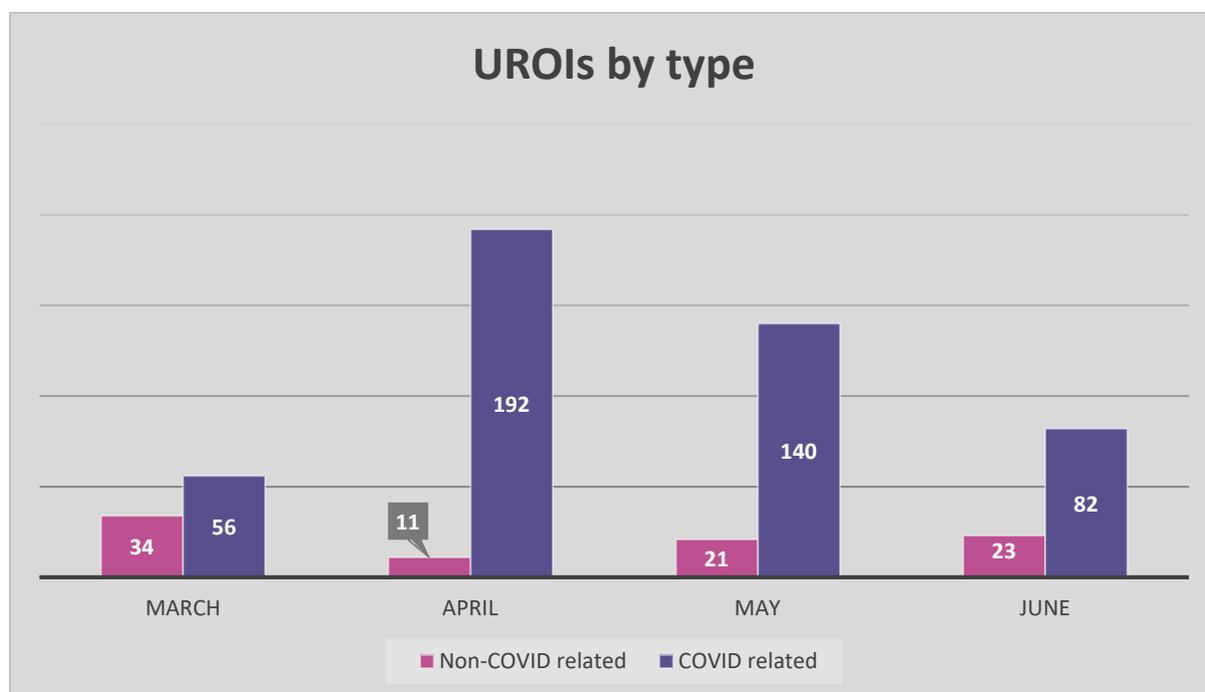


While most centres were in compliance with this regulation, inspectors found that there were some nursing homes that did not have appropriate numbers of staff on hand to manage care for residents. One centre was found to have had 29 members of staff that had tested positive for COVID-19 and were thus unavailable to work. This resulted in knock-on negative effects in terms of nursing care for residents and the proper cleaning of the centre in line with national guidance. In another example, residents at risk of a fall or of leaving the centre unaccompanied were not adequately supervised due to staff shortages. Non-compliances were also found in relation to care staff carrying out multiple tasks such as laundry and kitchen duties. Such multi-tasking by the same members of staff poses a risk of cross infection in centres. In addition, there were instances of insufficient staff being available at night-time.

## The human impact — what we heard from residents, relatives and staff

Throughout the course of the pandemic, inspectors and HIQA staff spoke with many people who were directly affected by the disease. People spoke with our inspectors during inspections and told us their stories; they also made contact with us by telephone or email in order to raise concerns or simply ask questions. These communications are referred to as UROI (unsolicited receipt of information). Figure 11 shows how the number of such pieces of information changed from March 2020 onwards.

**Figure 11. Nature of reports to HIQA from concerned persons**



The following sections summarise what we heard from residents, relatives and staff in order to highlight the human impact of the pandemic on people living and working in nursing homes and their relatives.

### Residents

In many ways, the experiences of nursing home residents throughout this pandemic mirrors that of wider society. People were often fearful, confused, angry, frustrated and lonely. The additional isolation of being in a nursing home with limited visits from loved ones and the constant fear of an outbreak only served to amplify these emotions among residents. Many residents spoke to our inspectors about missing the human touch of a family member or staff.

While some limited visits were permitted in some nursing homes, such as for families of those residents who were facing the end of their lives, there were strict controls around physical distancing, the use of screens and the number of people that were permitted to visit. This was hugely challenging for residents who may have been accustomed to seeing people every day and very much looked forward to these social occasions. One inspector reported:

Residents confirmed that they were supported and encouraged to keep in contact with their families by phone and some looked forward to window visits but wondered if they would ever be able to hug their families again.

Another inspector stated:

Residents told the inspector that they had missed seeing their family and were looking forward to having visits again but said the staff had been great during this time.

There was also a great deal of fear among residents. They were afraid of what would happen should a resident or staff member test positive for COVID-19. They were sometimes confused by the pace of change in the public health advice. One resident remarked that they were “not going to leave [their] room again until a vaccine was found”. In one centre, some residents were fearful but said that staff were a constant reassurance to them.

Heightened measures around infection prevention and control meant that nursing homes became more clinical in nature, with significant changes to the overall environment. For example, bright yellow signage warned people of infection risks, staff had to wear PPE, and clinical waste bins were much more prevalent throughout centres. After years of moving towards a more homely, social model of care, the pandemic meant the rapid re-introduction of the medical model of care.

Some residents expressed a sense of anger and frustration. For many, infection prevention and control measures meant that they were largely confined to their own bedrooms, which meant that in addition to being externally cut off from family and loved ones, they were also internally restricted and cut off from their friends in the centre. For example, they could not engage with other residents and their only form of human contact was with staff, many of whom were wearing PPE. Restrictions also meant that residents could not leave the nursing home for any reason. This created a sense of abandonment and isolation that many found difficult to cope with. One inspector reported:

The external facilitators that provided activities two hours per week were cancelled as part of COVID-19 restrictions... facilities for occupation and

recreation activities in accordance with peoples' interests and capacities remained very limited.

Residents with dementia also faced additional challenges in terms of restrictions on movement and changes to their environment.

A consistent message from residents was their appreciation for the efforts of staff and management in nursing homes. Despite the fact that staff were working long hours in extremely stressful circumstances, all residents who spoke with inspectors were enthusiastic in their praise for those that cared for them.

## **Family and friends**

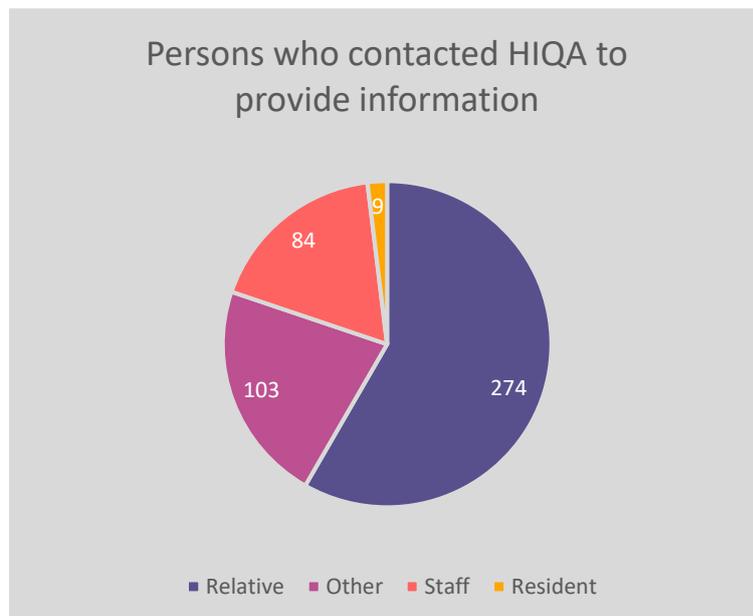
Nursing homes are often busy places with visitors coming and going throughout the day to visit family and friends. Visits such as these are extremely important for residents, and nursing homes are encouraged to be connected to the community as much as possible. The limitation on visits caused by COVID-19 — while necessary from a public health perspective — caused anxiety and worry for residents and their loved ones. Many families and friends of nursing home residents made contact with HIQA (see Figure 12 below) to ask questions and raise concerns about how nursing homes were managing the limitation on visitors, with one family saying:

My Dad is a broken man, he misses his family more than anything.

Inspectors observed inconsistencies across nursing homes regarding the facilitation of visits. Some demonstrated an innovative approach by arranging for visitors to meet residents in outdoor areas or via 'window visits'. A good indicator of the quality of a nursing home is the extent to which it is part of the local community. Inspectors heard how one centre was supported by its local community, with the inspector noting:

The centre is embedded in the local community and local shops and businesses donated PPE, chocolates, cakes and treats for the residents and staff throughout the pandemic.

**Figure 12. Persons who contacted HIQA to provide information**



However, some nursing homes were extremely reluctant to allow any visitors and were completely closed to the surrounding community. While this level of caution is somewhat understandable given the anxiety and confusion around COVID-19, this approach only served to heighten the worry for family and friends of residents. Children were also prevented from visiting

nursing homes which meant many residents could not see their grandchildren. This was challenging for children with special needs who enjoyed visiting relatives and for whom visits had become part of their routine. It was especially difficult for the younger residents of nursing homes who had small children of their own that could not visit.

One lady said the most difficult part of cocooning was not being able to hold her first grandchild who had been born just before COVID.

As nursing homes begin to admit new residents, families have spoken to us telling us how difficult this is. One family member said:

I was around there this evening before he goes into a nursing home. With the restrictions on visiting due to COVID, it will be easier to get to visit somebody in prison than to visit him in the home. Which is right and proper, don't get me wrong, it's just hard.

A common thread in many of the concerns received by HIQA related to a lack of communication from nursing homes. It appears that in the early stages of the pandemic, in March and April 2020, nursing home staff were so stretched that there was little or no time to respond to queries regarding residents. In some cases, nursing homes reported that calls to their homes increased from approximately 300 a week to in excess of 3,000 per week.

Information given to HIQA indicated that some phone calls to nursing homes went unanswered and queries as to the health and wellbeing of residents did not receive a timely response. This caused immense anxiety and worry for concerned relatives and friends, particularly in the case of nursing homes that were known to have an

outbreak of COVID-19. HIQA inspectors highlighted this shortcoming to nursing home providers and strongly advised that they have dedicated staff available to field queries from relatives and friends.

One inspector reported:

The person in charge confirmed that changes in the clinical management team and problems with communication and sharing timely information with relatives had led to some complaints.

Some people that made contact with HIQA expressed concerns regarding the implementation and adherence to public health guidance by some nursing homes. These concerns were complicated by the fast-changing nature of the public health advice. For example, some people who contacted HIQA expressed the view that all staff should be wearing full PPE in all areas of the nursing home — even though this had not been advised by the HPSC guidance at that time.

A small number of people made contact with HIQA to express concern around the media coverage of nursing homes that were known to have had outbreaks. One person contacted HIQA to say that the media presence outside the nursing home was terribly upsetting and caused them to stay away.

Another person was concerned at the use of zoom lenses which could potentially compromise the privacy and dignity of residents inside the home: “I am really afraid that they can see my Mum with their big cameras”. Some relatives that made contact with us expressed frustration at the negative media coverage and found it difficult to convey messages of support for their local nursing home: “I rang the local radio station, but they were not interested in hearing how well my relatives are cared for, they only want bad news”.

## **Staff and management**

As referenced earlier in this report, inspectors were in regular contact with nursing home management and staff throughout the course of the COVID-19 pandemic. This was facilitated through regular phone calls to nursing homes, through the HIQA Infection Prevention and Control Hub, and through on-site inspections to assess contingency planning and response to risk. It became clear quite early in these engagements that COVID-19 was having a serious impact on the wellbeing of staff.

One inspector was told:

We have some staff that are still out and it is likely they will never return, such is their upset.

Not only were staff concerned about contracting the virus themselves, they were extremely worried for the residents in their centres and for their own families. The

increased workload, coupled with shortages of staff in some nursing homes, meant that many staff who spoke with inspectors experienced feelings of guilt at not being able to spend time with residents and provide them with important human contact and reassurance.

Many nursing homes were hampered in their response to the virus due to the impact of senior staff and management falling ill with COVID-19. There were many instances of persons in charge and other managers contracting the virus and having to take time off work in order to self-isolate or self-quarantine.

Replacement staff who took over managing and overseeing the centre were often not as experienced in running and managing a service and this compromised their ability to effectively manage and respond to outbreaks. In some cases, agency staff who did not know the centre or the residents replaced experienced nurses and carers. This created anxiety amongst residents and fed into the sense of crisis in many nursing homes. Moreover, some nursing homes did not have sufficient numbers of staff to manage the needs of residents, as one inspector found:

Due to the number of staff impacted by the virus, the resultant increase in care needs of residents due to the virus, and staff shortages, there were insufficient numbers and skill-mix of staff to care for residents.

Low staff numbers also created difficulties in terms of cleaning and ensuring effective infection prevention and control. Some nursing homes were found to be short-staffed in terms of house-keeping and cleaning staff. This impacted on their ability to maintain a clean environment and meet the additional demands for sanitisation which were necessary in the context of COVID-19. "One staff member on duty was working in both the cleaning role and the laundry role". As a result the centre was not clean in all areas and the cleaning schedules required in the current infection prevention and control guidance were not in place.

Most inspectors recounted stories of management and staff becoming overwhelmed with emotion when speaking about how they managed during the pandemic. Some exhibited signs of extreme stress, fatigue, exhaustion and anxiety in trying to come to terms with what was happening around them. Despite working long hours in extremely challenging circumstances, many staff questioned whether there was more they could or should have done to keep residents safe.

One stated:

I am constantly worried, I am thinking and worrying in case I missed something.

There were cases where there were multiple residents requiring palliative care or end-of-life care which was out of proportion to the regular delivery of care and this

created significant challenges for staff. Many staff that inspectors spoke with felt it was extremely important that they made sure that no resident died alone. They also tried to ensure that they followed traditional and cultural norms as best as they could, one remarking:

We would always attend the funeral, we know the families, we also miss the person that died — we could not pay our respects and mourn — it is so sad.

Staff also expressed grief at the loss of residents while trying to cope in a very challenging situation. There were also examples of nursing homes where staff took the decision to live in the nursing home, away from their own families, in order to minimise the potential of introducing the virus to residents. One person in charge told us how they slept in the nursing home for six continuous nights due to staff shortages. Some staff came from direct provision centres and found it difficult to manage their day-to-day lives in terms of social distancing, cooking and laundry. One staff member commented: “My colleagues were great, we all pulled together and did our best.”

Some staff made contact with HIQA to express concern over the availability of resources and the implementation of public health advice. The shortage of PPE was a recurring theme of concern, particularly in the early stages of the crisis. Some staff were worried that the lack of PPE would place themselves, residents and their own families at risk of infection.

There was also some concern expressed about the level of resources and support available to private nursing homes across different CHOs. Some CHOs were reported by providers to be proactive in their engagement with nursing homes and in providing advice and support. Others were reported to have taken longer to establish clear lines of communication in their catchment area. These concerns were raised by the Chief Inspector to the HSE.

## **Systemic issues**

The COVID-19 pandemic has exposed pre-existing weaknesses in the nursing home infrastructure in Ireland which are worth highlighting. The Chief Inspector has consistently drawn attention to problems with the use of outdated facilities and multi-occupancy rooms. There remains a significant number of nursing homes that care for people in old buildings that are ill-equipped to facilitate modern-day care practices. Multi-occupancy rooms also compromise the privacy and dignity of residents and limit the space available to them to have visitors and suitable storage for their possessions.

These issues have come to the fore in the context of COVID-19 and have created difficulties around maintaining social distance and the ability to effectively cohort (separate well and unwell residents) and isolate residents where appropriate and necessary. As referenced earlier in this report, some nursing homes would not have been in a position to isolate residents if a suspected or confirmed case of COVID-19 emerged there. This makes them inherently more vulnerable to the transmission of infection, and less suited for the management of outbreaks in terms of control measures such as resident placement and environmental cleaning.

COVID-19 has also served as a reminder that there are other models of care for older people that are less developed in Ireland. Nursing homes remain the dominant form of residential care for older people with increasing care needs. While there will always be a need for this model to meet the needs of highly-dependent persons, HIQA has previously recommended<sup>3</sup> reform of the social care system for older people and people with disabilities in Ireland with a view to providing a wider range of options to those requiring increased levels of care or care for the first time. COVID-19 has also served as a reminder that there are other models of care for older people that are less developed in Ireland. Nursing homes remain the dominant form of residential care for older people with increasing care needs. While there will always be a need for this model to meet the needs of highly-dependent persons, HIQA believes models that include homecare, assisted-living and day care must be further developed. These choices have the potential to allow people remain in their homes for longer and also have obvious benefits in the context of the outbreak of infectious diseases.

The pandemic has also drawn attention to the manner in which nursing homes are integrated into community health systems. It is now evident that there was very limited clinical oversight of most nursing homes, particularly those in the private sector. In most cases, individual residents retain their own GP or move to a GP in the area where the nursing home is located. This may work well for the individual, but it means there is no overarching clinical governance of the health and welfare of the centre's resident population as a whole — as is needed in protecting residents from collective threats, such as infectious disease outbreaks.

Many nursing home providers told us how they struggled in the early stages of the pandemic to access key services such as testing or gerontology. It should be noted that this has improved significantly and there is now much closer liaison between nursing homes and local health professionals. HIQA is of the view that the systems which have evolved as a result of COVID-19 should be retained and formalised to ensure effective clinical governance in all nursing homes, especially in the context of

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<sup>3</sup> <https://www.hiqa.ie/sites/default/files/2017-05/exploring-the-regulation-of-health-and-social-care-services-op.pdf>

infection prevention and control and management of outbreaks of disease. The HSE's Community Health Organisations can play a key role in this regard.

The pandemic identified opportunities to enhance the Health Act 2007, as amended, and the regulations made under this legislation. Many regulations are not sufficient to help prevent and manage this type of public health emergency. While there is a requirement for more radical reform of the regulatory framework which governs the registration and inspection of residential services, HIQA has formally requested the Minister for Health, through his department, review and strengthen components of the Health Act and associated regulations governing the operation of designated centres such as nursing homes.

The interim changes proposed by HIQA aim to ensure that registered providers can detect, manage and respond in a sustainable way to the risk of further outbreaks of COVID-19 or indeed another such public health emergency. In addition, the changes which HIQA has proposed would allow the Chief Inspector to hold registered providers to account for failings in the management of public health emergencies and enhance protections for residents living in nursing homes and other designated centres.

## Summary and discussion

This report has sought to describe the experiences of nursing homes during the course of the COVID-19 pandemic to date through the lens of residents, their relatives and staff. This has been done by using information gathered by inspectors from HIQA and from concerned members of the public. Clearly, the impact of COVID-19 has deeply affected many people and the fallout will be with us for a considerable period of time. Our sympathies go to all those who have lost a loved one or friend as a result of the virus. There were some nursing homes that were heavily impacted in terms of the deaths of residents, and the residents and staff in these centres will need a lot of support in the coming months.

The manner in which COVID-19 spread throughout the country caused a great deal of alarm and anxiety. The pace at which the public health advice was changing led to a certain amount of confusion and some nursing homes struggled to keep up to date. Nevertheless, a tremendous effort was made to 'flatten the curve' and protect the most vulnerable. It is not yet clear whether the focus on hospitals during the early stage of the pandemic in Ireland distracted attention from other important settings such as residential care facilities, including nursing homes. Further analysis and reflection on the country's response to the pandemic will help to shed light on this and provide valuable learning for the future.

In response to the pandemic, HIQA took a number of decisions. All routine monitoring inspections were temporarily suspended in order to prevent the inadvertent spread of the virus in centres by inspectors. In parallel, inspectors contacted all centres every two weeks to monitor the situation in those centres. The Chief Inspector also established a process for those centres that were as yet free of COVID-19 to assess their level of preparedness for a COVID-19 outbreak and put in place contingency measures. This led to 44 inspections being carried in high-risk centres in May and June 2020.

HIQA also set up an Infection Prevention and Control Hub support service to advise providers and their staff. In addition to escalating concerns raised by nursing homes through the appropriate HSE channels, HIQA and the Chief Inspector maintained regular contact with the Department of Health and the HSE at senior level and also provided information to NPHET. HIQA's Information Handling Centre processed an increased volume of phone calls and emails from concerned residents, relatives and staff in nursing homes, and inspectors met and spoke with residents, families of residents and those who were bereaved, and staff in centres.

## The human impact

Residents in nursing homes who spoke with inspectors expressed a range of emotions. Some feared contracting the virus and worried about their family and friends that were not able to visit. Others felt a deep sense of isolation and loneliness as a result of the restrictions that were placed on visiting. While many were able to use phones and computers to keep in touch, the loss of human contact was keenly felt. In light of this, every effort should be made to allow visitors and improve the ability of residents to socialise. There may be merit in providing more detailed, local epidemiological data to nursing home providers. This would allow nursing home providers, in conjunction with local public health specialists, to assess the prevalence of the virus in the local area and perhaps allow them more discretion in how they manage visits and access to their centres.

Without exception, residents were deeply grateful to staff in nursing homes for the care provided in what were extremely challenging circumstances. More recent inspections have found that residents now wish to move forward and put the experience of COVID-19 behind them.

Relatives and friends of residents spoke to us about the worry and anxiety they felt for their loved ones living in nursing homes. Some relatives and friends reported that they experienced poor communication with nursing homes and that the lack of information only served to heighten their anxiety. Some relatives raised concerns regarding the adherence to public health guidance in some nursing homes and the appropriate use of PPE. There was also praise for nursing home staff in making every effort to comfort residents and ensure that they could receive visitors when it was safe to do so.

Some of our inspectors were struck by the damaging effect that the pandemic has had on staff and management in many nursing homes. Many staff members and managers were working extremely long hours in very challenging conditions. They often questioned if they were doing enough to care for their residents and keep them safe. This concern and worry was clearly overwhelming for some staff. Many became emotional when speaking with inspectors and will require time and support to get over the ordeal. This is especially true for nursing homes where residents and staff have died as a result of the virus.

While a significant number of nursing homes reported outbreaks, it should be borne in mind that many centres have to date remained COVID-free. Our programme of assessments in COVID-free centres sought to evaluate their preparedness and contingency planning if an outbreak were to occur. As has been shown in this overview report, the vast majority of homes were found to be compliant with the

regulations assessed and had comprehensive contingency plans in place in the event of a suspected or confirmed case of COVID-19.

While this is to be welcomed, it must be stated that these contingency plans are no guarantee that a nursing home would perform well in the event of an outbreak. The assessments carried out by our inspectors helped focus providers to consider all aspects of their service in the context of the pandemic.

Nursing homes that demonstrated good levels of compliance in this programme of assessments were proactive and resourceful in order to keep their residents safe. They implemented a range of infection prevention and control measures in a very short period of time. Staff were vigilant in terms of monitoring residents for symptoms and adhered to the public health guidance in order to minimise the risk of introducing or spreading COVID-19 in their places of work.

### **What COVID-19 has taught us about nursing homes**

The COVID-19 outbreak brings into sharp focus the current models of care for older people and, indeed, all forms of residential care in Ireland. The continued use of multi-occupancy rooms and outmoded premises in some nursing homes (due to end at the end of 2021) undoubtedly created a situation where the spread of infection was difficult to contain. In the short to medium-term it may be necessary to review the occupancy levels in these nursing homes to ensure they are in a position to respond to any future outbreaks of disease.

While we will take the learning from this programme of assessments and continue to monitor nursing homes throughout the course of this pandemic to protect the safety and welfare of residents, wider reform is now necessary. HIQA has previously called for reform of the regulatory framework to allow other forms of care to flourish. The current system predominately directs people into a single model of residential care when other options may be more suitable. Alternative services such as assisted-living and homecare would enhance the experience of many older people in the latter stages of their lives.

The Chief Inspector has also identified gaps in the clinical governance arrangements for private and statutory nursing homes. For many, the only form of clinical oversight is provided by general practitioners, and this is simply insufficient for many centres given their size and the complex needs of residents. Nursing homes should be more closely integrated into community health programmes, with a particular need for gerontology services.

Such improved clinical oversight would be consistent with the objectives of the Sláintecare strategy, which advocates for more integrated care systems and the alignment of governance throughout the patient care pathway. To complement the

patient pathway model, consideration should be also given to an integrated care records system. This would ensure that health professionals would have access to up-to-date information related to residents care needs to ensure the best possible care

It may also be necessary to review and enhance staff skills and skills-mix to ensure that nursing homes have access to enhanced nursing staff as well as advanced nurse practitioners, such as those skilled in infection prevention and control or care of the elderly.

The regulations governing nursing homes also need to be strengthened. It is generally good practice to regularly review regulations to ensure that they are effective, clear and are achieving their goals. The current regulations for nursing homes have been in place since 2013 and HIQA has previously called for their review and improvement. There is great potential to strengthen the regulations around important issues such as staffing levels, risk management, premises, governance and infection prevention and control. Furthermore, the regulations should be reformed to bring about a greater emphasis on a human rights-based approach to care.

### **Concluding remarks**

While we have learned much during the course of the COVID-19 pandemic, the crisis is clearly not yet over. Work is ongoing in the medical and scientific community to identify effective treatments and vaccines that can help us overcome the disease. It is important that we remain vigilant in the meantime and do everything we can to shield the most vulnerable from this virus. That will likely mean that nursing homes will continue to look different in terms of their physical environment, visiting arrangements, social activities and care practices.

While these measures are necessary from infection prevention and control and public health perspectives, there must also be a recognition of the negative impact they have on residents' wellbeing and capacity to socialise and engage with the community. We are committed to working with all nursing home providers to ensure that the impact of these measures strikes the correct balance between keeping people safe and promoting a good quality of life.

HIQA will also continue to liaise with our colleagues in the Department of Health, the HSE, the Expert Nursing Home Group and other relevant agencies in order to ensure the lessons from this pandemic are learned and used to bring about further improvements in all social care services into the future.

Some nursing homes were unable to comply with the relevant regulations through a combination of poor governance, a lack of planning and outdated facilities and

premises. As a result of COVID-19, it is absolutely vital that premises are modernised as a matter of urgency in order to facilitate physical distancing requirements, promote modern infection prevention and control practices, and provide residents with the dignity and privacy they deserve.

Reform of the regulatory framework and current models of care for older people is essential. As a country we must explore alternative, more suitable models of care, such as homecare and assisted living, and integrate clinical oversight in nursing homes. The 2013 nursing home regulations need to be strengthened to protect older people into the future, particularly with regard to staffing numbers, skill-mix, and expertise in infection prevention and control. It is clear that greater interagency collaboration will be necessary to prepare for and prevent a second-wave of COVID-19, or indeed, any future pandemics.

COVID-19 has disproportionately affected older people and has caused much anxiety, grief, fear and isolation for residents, their families, friends and carers. As we move forward and seek to improve the way we provide care to older people in Ireland, meaningful and comprehensive engagement with residents and their advocates is imperative to ensure that we learn the lessons of this public health emergency. HIQA will continue to listen to the experiences of residents and those involved in providing residential care for older people to strive for safer, better care that focuses on the human-rights and individual needs of the person.



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