Understanding the determinants of the crisis in nursing homes in the COVID-19 pandemic

Prof Desmond O'Neill MA MD FRCPI AGSF FRCP(Glasg) FGSA FRCP FRCPEdin [1]

The deep crisis in Irish nursing homes during the COVID-19 pandemic has been a long time in the making: and makes for stark reading with almost two-thirds of COVID-19 deaths in Ireland occurring in nursing homes. While not critical of the staff striving under very difficult circumstances, the plight of residents and staff arises from a deeply defective policy framework for the sector.

Health policy in Ireland is determined not by the HSE but by the Department of Health. For over a decade under Ministers from Mary Harney to Micheal Martin, Leo Veradkar, James Reilly and Simon Harris, the Department has pursued a policy of privatization of the nursing home sector disconnected from the public health system without due debate and consultation.

The care needs of this group are complex, requiring sophisticated inputs including expert leadership, expertise in nursing older people, training in nursing home medicine, infection control, gerontology, dementia care and palliative care to mention but a few (1). Even an intervention sounding as straightforward as COVID-19 testing requires a plan for backfilling staff testing positive, and support from microbiology, occupational health and public health (2).

No clear direction or strategy has been given by the Department of Health as to how these complex needs would be adequately addressed, despite concerns expressed over many years from many quarters, including the Irish Society of Physicians in Geriatric Medicine (3), SAGE Advocacy, and the recently dissolved Policy Group on Ageing of Royal College of Physicians in Ireland (4).

Contracting with nursing homes for the Nursing Home Support Scheme (the so-called Fair Deal) was left to the National Treatment Purchase Fund. While fine for contracting hip replacements and cataract operations from the relatively standardized private hospital system, there is no evidence to outsiders of any gerontological expertise or matching of funding to the needs of nursing home residents in their processes in what was effectively a range of SME businesses of varying profiles, sizes and capabilities.

An unhelpful discourse has arisen about the difference between Fair Deal funding for the majority private nursing homes and public or voluntary nursing homes. In fact, funding is low for both sectors, and it is notable that even therein that significant profit-taking has been extracted from the private sector. A report in the Sunday Times Ireland as recently as

[1] Consultant Physician in Geriatric Medicine, Tallaght University Hospital; Professor in Medical Gerontology, Trinity College Dublin.; Senior Academic in Medical Gerontology, Tallaght University Hospital; Co-PI, Irish National Audits of Stroke and Dementia Care; Co-Chair, Special Interest Group on Long-Term Care, European Geriatric Medicine Society; **Previously**: Chair, Government Working Group on Elder Abuse; President, Irish Gerontological Society and European Union Geriatric Medicine Society; Chair, Policy Group on Ageing, RCPI; Investigator, Leas Cross Report

December 2019 talked about an Old Rush, describing the enthusiasm of UK investors in investing in the profitability of the Irish nursing home sector (5): it is not clear to what extent, if at all, such profits were ploughed back into staff support and pandemic preparation.

The national standards and regulatory process for nursing homes through HIQA were not set at a level sufficient to assess clinical leadership, expertise, resilience and reserve. This was compounded by a lack of evidence that the Board of HIQA had incorporated due consideration that it role as regulator was also to continually develop and update standards on the basis of national and international evidence to include clinical leadership, resilience and pandemic preparedness (6).

Contracts and parameters of care for medical input from the doctors, mostly GPs, were not clarified or standardized. There is a widespread perception that pay and conditions for staff in the private homes are set at a level which does not support recruitment and retention of care staff, with significant withdrawal of labour due to this, fear of infection, in addition to those staff affected by, or in quarantine from, COVID-19.

The end result is **a variability of care standards and resilience that is substantially out of step with other elements of the healthcare system**: even the voice from within the system is split among the industry body representing owners, Nursing Homes Ireland, the Irish Association of Directors of Nursing and Midwifery (for the Directors of Nursing), the ICGP representing the majority of doctors working in the system, with advocacy from outside also arising from professional bodies representing specialist healthcare of older people.

The HSE responded as quickly as possible to both this flawed structure and the extreme circumstances, with extra funding for agency staff provided by an arrangement between the Department of Health and Nursing Homes Ireland, and HSE structures to support the nursing homes with advice, overview and staff where available from a very pressurized system to work with the director of nursing and GP(s) who have responsibility for the healthcare of the residents. However, marrying the public system to such a diverse private system is no easy matter, as the ongoing challenges in incorporating out-patient services in the private hospitals into the public system illustrates.

A significant missed opportunity in this regard was the failure by the Department and the HSE to roll out since 2013 the national assessment tool for needs for older people, interRAI (7). This system facilitates information transfer between nursing homes, hospitals and community, generates red flags and prompts care routines, is regularly updated in the light of emerging gerontological care research, and allows for national and international comparisons of care provided (8).

There is an urgency to resolving the crisis arising from these failed policies, as there will be an ongoing need for new admissions to nursing homes where care standards, staffing, expertise and infection control are clarified and supported in a pandemic whose strictures

may last twelve to eighteen months, or even longer. In addition, occupancy rates may need to be reduced to account for infection control and social distancing,

A key element in resolving the crisis is the establishment of clear clinical leadership, similar to the medical director role established in the USA after nursing home scandals in the 1980s, with clarity on linkages to the broad range of specialist advice and services required for all nursing homes in a defined area.

Providing these solutions will require gathering the many elements of advocacy, care and policy together to urgently set out a new blueprint for nursing home care, with openness on conflicts of interest and funding, and inspired by a vision that we should all be able to trust in uniformly high standards, care and resilience for ourselves and our loved ones when we most need it.

References

1. Fallon A, Dukelow T, Kennelly SP, O'Neill D. COVID-19 in Nursing Homes. QJM : monthly journal of the Association of Physicians. 2020.
2. Gordon AL, Goodman C, Achterberg W, Barker RO, Burns E, Hanratty B, et al. Commentary: COVID in Care Homes-Challenges and Dilemmas in Healthcare Delivery. Age Ageing. 2020.
3. O'Neill D, Gibbon J, Mulpeter K. Responding to care needs in long term care. A position paper by the Irish Society of Physicians in Geriatric Medicine. Ir Med J. 2001;94(3):72.
4. Policy Group on Ageing. Submission to SAGE Forum on Long-Term Care. Dublin: RCPI; 2016.
5. Carey B. The old rush: why investors are keen to break into Ireland's care homes market. Times Ireland. 2019(22 Dec).
6. Lum HD, Mody L, Levy CR, Ginde AA. Pandemic influenza plans in residential care facilities. J Am Geriatr Soc. 2014;62(7):1310-6.
7. McDermott-Scales L, Beaton D, McMahon F, Vereker N, McCormack B, Coen RF, et al. The National Single Assessment Tool (SAT) a pilot study in older persons care-survey results. Ir Med J. 2013;106(7):214-6.
8. Foebel AD, van Hout HP, van der Roest HG, Topinkova E, Garms-Homolova V, Frijters D, et al. Quality of care in European home care programs using the second generation interRAI Home Care Quality Indicators (HCQIs). BMC geriatrics. 2015;15(1):148.