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To the Members of the Oireachtas Special Committee on Covid-19 Response.

8th June, 2020.

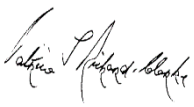
Dear Members,

Please find attached a submission on behalf of the Board of Safeguarding Ireland in relation to your consideration on the State's response to the Covid-19 pandemic. I would hope that you would consider the issues and recommendations made in this document.

I am available and would be pleased to discuss or elaborate on any of the issues outlined.

I wish all members of the Committee well in this very important work.

Yours Sincerely,



Patricia Rickard-Clarke.
Chair.

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Long Term Residential Care for Older People.

5th June, 2020.

Covid-19 has shone a light on long-term residential care for older people, probably the strongest light since the publication of the report into the Leas Cross scandal[1]. While outbreaks of Covid-19 in long-term residential care services for older people do not highlight the same issues, they do prompt discussion and debate into the current model for the provision of long-term residential care for older people.

Up to midnight on 30th May,2020, the number of clusters/outbreaks of Covid-19 in nursing homes stood at 258, while the number of clusters/outbreaks in community hospitals and long stay units was 29[2]. While the number of private/voluntary nursing homes in Ireland outnumbers the number public long stay units by a ratio of more than four to one, it is clear that residents in private nursing homes were and are much more likely to contract Covid-19 than those in public units. The National Public Health Emergency Team (NPHET) has outlined that the number of care home resident deaths, as a percentage of all Covid 19 deaths in Ireland, stands at 62%. Only Canada, at 82%, has a higher percentage. Notwithstanding the fact that it is difficult to accurately compare Covid-19 data at this time, the percentage of care home resident deaths is relatively high in Ireland. The reasons for this are likely to be explored further in time but the figures do provoke questions and an impetus to review the model of provision of long-term residential care for older people. Such a review is needed, not necessarily as a result of Covid-19, but it adds to the already compelling need for such a review which has been advocated by a number of agencies, such as Sage Advocacy and ALONE, over the last number of years. In its document - ***Overview of the Health System Response to date. Long-term residential healthcare settings*** - the NPHET stated that the "*pandemic and its impact raises questions that require focused and strategic consideration in the future, in particular for older persons, with regard to existing policies, areas of potential new policy development, the model of care for older persons, the configuration of service delivery and delivery models, congregated environments, clinical governance, a safe staffing framework and the role of the health services alongside the role of other State bodies and the private sector*"[3].

[1] *A Review of the deaths at Leas Cross Nursing Home 2002-2005. (April 2006).*

[2] *Epidemiology of COVID-19 in Ireland. Report prepared by HPSC on 01/06/2020 for National Public Health Emergency Team.*

[3] *Overview of the Health System Response to date. Long-term residential healthcare settings. (NPHET Meeting Paper, 22nd May, 2020)*

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It is a fact that, as people age, they tend to become more dependent. They tend to be at greater risk of developing chronic and enduring conditions such as Cardio-Vascular Disease, Arthritis, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, Parkinsons Disease and Dementia. This suggests that those people are in need of expert professional care, including specialized nursing and medical care.

Many people in long-term residential care have very significant dependencies. Dependency, unfortunately, creates vulnerability and ensuring basic human rights in such circumstances takes on greater significance. It is incumbent on all of us to ensure those basic human rights are safeguarded.

Notwithstanding the fact that most people living in long-term residential care have some level of dependency, there are many that could, and would prefer to, live in alternative accommodation if it was available and if there were supports provided to assist them with some of their needs. There are many older people who continue to live in their own homes, with supports, despite living with chronic conditions and being dependent on others to varying degrees.

Unfortunately, the current system of long-term care for older people accommodates, by and large, only two options, namely long-term homecare or long-term residential care. There are few other options available, despite some voluntary or community provision of sheltered housing-type arrangements. Home care and long-term residential care is provided directly by the HSE or by private or voluntary providers with funding from the HSE. Private provision of both home care and long-term residential care currently makes up a very high proportion of total care provision. The HSE website lists, by CHO, 103 approved home care provider agencies for older people that are funded to provide care by the HSE. Though some of these providers are voluntary organisations, the vast majority are for-profit agencies. The HSE's target for 2020 is to deliver 19 million hours of home care, including that provided through intensive home care packages. The majority of these hours will be delivered by private agencies.

There are approximately 30,000 long-term care beds in the state provided through 581 HIQA-registered centres for older people, i.e., long-term residential centres. Less than 130 of these are public facilities, with the vast majority of the rest privately owned. The budget for long-term care provision, i.e., the Nursing Homes Support Scheme (Fair Deal), for 2020 is just over €1bn.

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Currently, the administration of long-term care is fragmented. There is little integration between home care and long-term residential care. The process of, and tools used for, assessment for home care differs across the country. In some areas, assessment is carried out by Home Help staff, some of which have no clinical qualification, while in other areas the assessment is completed by the public health nursing service. The public health nursing service is aligned with the Primary Care Division while the budget for home care rests within the Older Persons' Division. The care needs assessment for long-term residential care is carried out by the public health nursing service and though there is a common summary assessment used, there is not one standardised tool used in the compilation of the assessment summary. The budget for long-term residential care is separate to the rest of the budget for Older Persons' Services.

There would certainly seem to be a need for all long-term care needs to be managed as one integrated service. Ideally, the provision of care for older people should embrace a continuum of care, from living at home with supports at one extreme to some form of long-term residential care at the other extreme, with a variety of options along the continuum, including, for example, -

- Home Share – Older people having someone else living with them for low rent and some support in return.
- Split Housing - Older people living (independently with or adjacent to) relatives.
- Boarding Out - People who require support moving into other people's homes on a paid basis.
- Supportive Housing - Dedicated housing for people which provides supports for independent living.
- Retirement Villages - Clustered age-friendly housing with provision for social interaction.
- Older Persons' Co-Housing Communities - Group living which groups of houses around shared space and amenities.
- Housing with Supports – Housing with 24/7 on-site support and care.
- Long Term Residential Care (LTRC) such as the Teaghlach Model or the Bruff Carebright Community.

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Long-term residential care should only be considered when all other options along the continuum have been exhausted. A pre-requisite for such a service would have to be the availability of a selection of options in each community care area.

Those older people who are most dependent, because of chronic illness, are likely to need some form of long-term residential care. However, this type of care arrangement must only be considered when all other options have been explored. In addition, the care continuum, from living at home with supports to long-term residential care, must be integrated and managed under one overall statutory system of long-term care. Every effort should be made to maintaining people in their own homes which is where the vast majority of people want to live.

In any future system for the provision of long-term care, there are a number of principles that must be embraced as integral to the system. These principles are -

- The needs, wishes and preferences of the client must be paramount. There is evidence that a number of older people are placed in long-term residential care despite their wishes to the contrary.

- A recognition that older people in need of care may have very complex care needs and, as a result, require expert nursing, specialist consultant care, old age psychiatry consultant care and other specialist care, e.g., physiotherapy, speech and language therapy, etc. This expert care must not be confined to those in long-term residential care areas but should be available and accessible on an equitable basis to all, regardless of where they live or their ability to pay. The expertise required should not be ambivalent or open to interpretation, rather there should be clear criteria on the expertise needed.

- The introduction of a standardized assessment tool to determine the health and social care needs of older people.

- Clear responsibility and accountability arrangements for clinical care in all long-term residential settings.

- Establishing mandatory minimum standards tailored to all care services along the care continuum and ensuring robust monitoring and inspection against the standards.

- Developing and implementing mandatory training and upskilling for all staff across the care continuum, appropriate to the needs of older people and to the skill set needed for each staff discipline.

- Ensuring the principles that underpin best safeguarding practice and a human rights-based approach to care are embraced across the entire system.

- Implementing safeguarding legislation, with independent advocacy a statutory entitlement.

Practical application of the principles outlined above might include the following changes that can be relatively easily and quickly implemented.

- Immediately stop the discharge of older adults from acute hospital care to long-term residential care. There are many older people who are discharged from acute hospitals to nursing homes as a quick and expeditious means of freeing up acute beds. This is actively supported through the provision of transitional care funding which provides financial support to private nursing homes to admit these clients. In order to avail of this funding, the clients and/or their families must have completed a Fair Deal application form. This practice creates a powerful incentive for acute services, families and nursing homes to promote long term residential care, sometimes against the wishes of older people and, in many cases, provides for unnecessary long-term care arrangements. It is a fact that older people tend to become increasingly dependent in acute hospital settings and, in many cases, these dependencies can be reversed if given the opportunity. The need to free up acute beds and ensure that older people are accommodated in the most appropriate setting can be achieved by converting a number of beds in public community hospitals/community nursing units into intermediate or step-down beds. These beds could be used to rehabilitate some older people following an acute illness, allowing them to gain some independence and return home, with or without supports, depending on the need.

- Implement, with immediate effect, the interRAI standardized health and social care assessment tool to determine, in a consistent and objective manner, the needs of older people.

- The HSE, Department of Health, Department of Justice and other government departments should immediately actively promote planning ahead for future healthcare needs. This should include the

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full implementation of the Assisted Decision Making Capacity Act, 2015, which includes a statutory framework for planning ahead for healthcare needs.

- All resident committees in long-term residential centres should appoint an independent advocate to attend all committee meetings.

- Immediate standardized mandatory training for all long-term residential care staff in infection prevention and control. This measure is not only in response to the Covid-19 pandemic but would also help safeguard against other common infections in long-term residential centres, e.g., influenza and norovirus.

- Each long-term residential centre should have a designated safeguarding champion to ensure the human rights of residents are respected. In that regard, all long-term residential centres should formally adopt and implement the principles outlined in the *Guidance on a Human Rights-based Approach in Health and Social Care Services.*[4]

Many of the suggestions and proposals outlined above are not new. It is a pity that we have to revisit, once again, the model of care provision for older people. We have been here before and there would appear to be general agreement on the best model of care for older people. In that context, it worth revisiting the report, 15 years later, into the Leas Cross scandal and, specifically, the recommendations contained therein. Many of the recommendations remain relevant today. Among them are –

- *The Department of Health and Children and the Health Services Executive must in its policy, as a matter of urgency, clearly and formally articulate its recognition of the complex health and social care needs of older Irish people requiring long term residential care.*

- *The provision of this care (residential care) should be clarified formally in terms of adequate numbers of adequately trained nursing and Health care assistant staff, with adequate governance structures in terms of senior nursing staff. The minimum numbers of nursing staff should be calculated using a modern instrument such as the RCN Assessment tool or the Nursing needs assessment tool, and at least half of these Nursing staff should have a diploma in Gerontological nursing. A sufficient number of middle and senior grade nursing staff relative to the size of the nursing home will be needed to be added to the calculated tool to ensure an adequate care infrastructure. Directors of Nursing in all long term facilities should have the Diploma in Gerontological nursing or*

[4] *Guidance on a Human Rights-based Approach in Health and Social Care Services. HIQA; Safeguarding Ireland. 2019.*

National Safeguarding Ireland (trading as Safeguarding Ireland) (a company limited by guarantee) CRO #612163.
RCN #20204851 Contact: paschal@safeguardingireland.org
Directors: David Byrne, Colm Nolan, Annmarie O'Connor, Louise O'Mahony, Nora Owen, Amanda Phelan, Phelim Quinn, Patricia T Rickard-Clarke (Chair), Mervyn Taylor.

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equivalent. All Health care assistants should have FETAC training or equivalent. Appropriate acculturation and Gerontological training should be provided for all non national staff.

- *An electronic version of the minimum dataset should be made mandatory for all patients in nursing home care to assist in the development of individual care plans, the monitoring of quality and the provision of national statistics and dependency, morbidity and mortality.*

- *The Irish Health Services Accreditation Board process for long term care must be radically reviewed to reflect the realities of long term care in Ireland. This would include the determination of not only training but also appropriate numbers of nursing and health care assistants proportionate to the case-mix of residents, as well as congruity with MDS data from the nursing home.*

- *Multi-disciplinary team support must be clearly specified in terms of both meeting need but also the facilitation of team work, and requires at a minimum: physiotherapy, occupational therapy, speech and language therapy, clinical nutrition and social work.*

- *Specialist medical support (geriatric medicine and Psychiatry of Old Age) needs to be developed to provide formal support to the medical officer, nursing staff and therapists not only in the care of patients but also in the development of appropriate care guidelines and therapeutic milieu. These services need protected access to dedicated specialist in patient facilities for appropriate assessment and support of those in long term care.*

The numbers of older people are increasing at a fast pace. In 2006, the year of the publication of the Review of the Deaths at Leas Cross Nursing Home, the number of people aged 65 years and older was 468,000. In the 2016 census, this number had increased to 637,567. The older population is projected to increase very significantly from its 2016 level to nearly 1.6 million by 2051. The very old population (i.e. those aged 80 years of age and over) is set to rise even more dramatically, increasing from 147,800 in 2016 to 549,000 in 2051.

It is vital that older people receive high quality health and social care that embraces their human rights, offers them choices and safeguards them from abuse in all its forms.