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Responding to Needs of Residents in Long Term Care in Ireland

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Abstract

Residents in nursing home care have borne a disproprtionate morbidity and mortality in the COVID-19 pandemic in comparison to the general population. Although the high rate of infection, morbidity and mortality in older people living in nursing homes may be attributable to increased levels of frailty and comorbidity in residents, the physical infrastructure and governance structures within nursing homes is also likely to be highly significant. The authors present, on behalf of Irish Society of Physicians in Geriatric Medicine, a position paper on changes that should be implemented to enhance the safety and quality of care for nursing home residents in Ireland.

Introduction

Residents in nursing homes represent a group with high levels of disability and co-morbidity which render them particularly vulnerable to external and internal stressors[1], as exemplified by the high death rate in Irish nursing homes during the COVID-19 pandemic. At the last census in 2016 were 22,762 people over 65 years of age (3.7%) listed as resident in nursing homes in Ireland[2]. Although this was a decrease in the proportion of the older population in residential care from 2011 it reflects an actual increase of 9.4% in people living in nursing homes in this country. As our society ages it will be increasingly important to provide high quality care for this vulnerable group. The Irish Society of Physicians in Geriatric Medicine (ISPGM) has promoted the development of improved standards of care in residential care for several decades and was the first Irish professional group to formulate improved standards of care in 2001, published in the Irish Medical Journal[3].

The pandemic has prompted the revisiting of these guidelines based on emerging research and on the evolving experiences of responding to the pandemic[4,5]. The nexus of the new recommendations arose from an expert sub-group of the Clinical Advisory Group of the National Clinical Programme for Older People primarily representing consultant geriatricians who have a specific interest in the clinical care of older people in nursing home care. The recommendations incorporate the learnings of these senior clinicians supporting nursing homes during the pandemic and is endorsed by the ISPGM. It is recognized that a broader consultation with healthcare groups involved in the care of nursing home residents should be undertaken with regards to the recommendations proposed.

It should also be acknowledged that given the current split of provision of nursing home care across public, voluntary and private sector that the recommendations reflect principles that should underpin clinical care in all three types of facilities dependent on the model applicable. Given that 80% of provision is within the private sector many of the recommendations are specific to issues identified within that sector.

The COVID pandemic has highlighted challenges in relation to nursing home governance and the roles and responsibilities of the major stakeholders, including overall policy (the Department of Health); the commissioning body (the National Treatment Purchase Fund (NTPF); the health services (Health Services Executive (HSE)); the regulatory authority (Health Information and Quality Authority (HIQA)); advocacy groups for older people; representative bodies for the range of professions involved; and the industry body representing the owners of private nursing homes (Nursing Homes Ireland) and now needs to be re-examined[6]. It is crucially important that we prioritise the needs of residents and provide equitable access to high quality healthcare for them.

Interim Recommendations

Governance

1) A review of clinical governance arrangements within private nursing homes is required to advise on the relationships between General Practitioners (GPs)/ Medical Officers, Persons in Charge (PIC), Registered Providers and care staff, in particular, as to the resilience of these structures in the context of the pandemic. These arrangements need to be able to respond to requirements for specific roles and responsibilities in outbreak management, succession in absentia in senior roles, accountability, and communication with residents and families.

2) HIQA inspection criteria will need to be revised and updated with support from the relevant National Clinical Programmes to reflect any implemented changes. In addition, HIQA should develop a specific advisory board with disciplines with expertise in nursing home care to incorporate emerging research and knowledge into quality assurance in nursing homes.

3) Rapid implementation of the assessment tool of needs for older people (Inter-RAI / Single Assessment Tool) is required and should, as previously agreed, include residents in nursing homes This will allow for essential data to be collected and will support care planning, integration with community/acute hospital specialist services, and professional development[7].

4) Improved advance care planning, with enactment of the Assisted Decision Making (Capacity) Act 2015 provisions on advance healthcare directives and with amendments to current nursing home regulations is needed. This is to ensure individualized advance care plans are made for all residents in accordance with the legislation and can be communicated across services where required.

5) There is a need for a regionalised function as part of the Sláintecare Population Health Planning that informs and determines the planning, development and scale of nursing homes based on local demography and the ability of local and regional health services. This will also be needed to support an equitable approach to the level of public and private provision within an area.

6) The relationship of the coronial system[8], HIQA and formal death notification and certification in the context of the pandemic should be examined.

7) The relationships and roles of the HSE and private sector providers where private providers are unable to continue in service, including the mechanisms by which this is overseen and escalated, should be clarified.

8) Revision of the geographical boundaries of Community Health Organisations (CHO) to align with Acute Hospital Sector grouping should be strongly considered in line with the planned Regional Integrated Care Organisations in the Sláintecare strategy.

Staffing

1) Nursing homes require an age-attuned workforce with staff who have appropriate training and certified competencies in managing their residents, many of whom have complex needs. All staff need to receive training in gerontology, dementia care and management of end of life care in line with recommendations of the National Clinical Programmes for Older People and Palliative Care, and the National Dementia Strategy[9].

2) Each nursing home should have a designated medical lead to provide clinical governance of the medical care within the home and with a reporting relationship with the proposed Regional Medical Director role, and to whom other GPs/medical officers in the nursing home have a reporting relationship. The post holder should be registered on the Irish Medical Council specialist register of GPs and have a certified competence in specialist healthcare for older people, ideally based on nursing-home medicine. They should have a requirement to maintain a record of continuous professional development (CPD)/continuous medical education (CME) relevant to their work in the nursing home. There should be specific remuneration for these roles linked to ongoing training, accreditation and an agreed model of service provision overseen by the HSE.

3) A specific Medical Director role for nursing homes should be developed and it should be linked to a system of clinical leadership that reflects the needs of older people across a population in a region (regional clinical lead for older persons) through pandemic Nursing Home Response teams[10]. This person should hold a Certificate of Completion of Specialist training, or equivalent, in a relevant field (such as Geriatric Medicine or Old Age Psychiatry). The role needs to be appropriately represented within CHO senior management structures in order to be effective. There should be specific remuneration for these roles linked to ongoing training, accreditation and an agreed model of service provision overseen by the HSE.

4) The continuation of the support structures developed through the COVID-19 Nursing Home Response teams should be sustained and enhanced as part of an overall integrated response to the pandemic and its effects in nursing homes.

5) The provision of integrated specialist supports through geriatric medicine, mental health services for older people and specialist palliative care to residents in nursing homes should form part of a network of services for older people within CHOs.

6) There should be a requirement for a trained lead in Infection Prevention and Control in each nursing home. They should have sufficient training to implement national guidelines on personal protective equipment (PPE) requirements for staff, be able to link with regional HSE Infection Prevention and Control (IPC) supports and be able to assure the local training of all staff in the appropriate use of PPE using the national training systems in place.

7) There should be an amendment to the current regulations which revoked the obligation for the Person in Charge (PIC) to have a formal gerontology qualification. The need for clinical nursing leadership and staffing with formal post-graduate gerontological training in all nursing homes should be reinstated as a matter of urgency.

8) A review of the regulatory change which removed the requirement for the presence of a Registered General Nurse on duty at all times, with additional focus on staff to resident ratio and skill mix, is required. In the context of a pandemic it is essential that all nursing staff can monitor the clinical status of patients on a regular basis, implement care plans that reflect their nursing care needs and respond appropriately as the resident's condition changes. This will also enable provision of key clinical supports including training to provide clinical care in facilities such as intravenous antibiotics, fluids and oxygen.

9) There is a need for the rapid expansion of Advance Nurse Practice roles that support specialist delivery through nurse prescribing, comprehensive assessment and liaison functions across acute, mental health and palliative services to ensure safe care can be delivered in the resident's home.

10) HSE primary care supports from all disciplines and therapies should be available to all residents in long-term care based on identified need. The availability of these supports should be prioritized in the context of pandemics where significant deconditioning results from periods of prolonged illness and isolation in residents. These services should be coordinated through scheduled multi-disciplinary review meetings and provide equity of access, based on need, to residents of private and public facilities.

11) Staffing structures in private nursing homes need to be reviewed to ensure appropriate resilience. Salary structures, terms and contracts should be linked to those of equivalent HSE grades in line with the Department of Health (DOH) Safer Staffing model. This will enable the retention of staff within facilities on an ongoing basis and is a key lever in ensuring sustainable staffing levels in facilities during pandemic. In doing so, nursing homes should aim to create an internal nursing bank to minimise their dependency on agency staff support.

12) The DoH Taskforce on Staffing and Skill mix should be reviewed to ensure that the needs of residents in long-term care settings are reflected in this work and incorporate the lessons learned from the pandemic through consultation with public and private sector providers.

13) The movement or sharing of staff across facilities needs to be done in accordance with Public Health and Infection Prevention and Control guidance and appropriate mechanisms and regulations put in place to minimise risk of transfer of infections between facilities.

14) A range of enhanced supports including occupational health, bereavement and counselling services should be put in place to support care home staff. A specific bereavement programme for families and residents should form part of these support structures.

Education/ Research

1) A career pathway for nursing home staff should be developed and linked with formal university-based training and accreditation and supported through a clinical rotation system with acute hospitals. For example, the National Frailty Education Programme provides specific frailty education across staff grades and is linked with the National Clinical Programme for Older People.

2) It is important to develop a research agenda within the nursing home environment to improve outcomes, care delivery and learning[11]. There is also a need to ensure adequate levels of representation (including residents) and expertise are available to support research delivery.

Environment

1) Nursing home environmental standards will need to reflect their ability to deliver effective Infection Prevention and Control practice. In particular, residents who live in multioccupancy rooms or who share bathrooms will require the availability of single rooms for isolation.

2) The development of a design model for nursing homes reflective of smaller units embedded in communities, e.g. Eden/Green House models as opposed to large institutions, may better meet the needs of this population especially in this time of pandemic[12]. Learning from implementation of decongregated models in intellectual disability care and elsewhere should be considered. Consideration should also be given to stepped models of care allowing people to transition from independent through supported living and into nursing home facilities allowing them to "age-in-place".

3) More broadly, a wider range of residential options for older people needs to be considered apart from living at home and moving to residential care as was highlighted in the Citizens' Assembly report on older people from December 2017[13].

4) In line with the European Network of National Human Rights Institutions (ENNHRI) recommendations, policy makers and service providers should ensure that older people are involved in the design and delivery of nursing homes[14].

5) The inclusion of post-acute care admissions under various terms such as rehabilitation, transitional care and 'step-down' in nursing homes should be reconsidered in terms of both an intrusion of transient populations of patients, visitors and staff into what is the home of a group of older people, as well as posing a hazard in terms of infection control[15]. Post-pandemic infection prevention and control arrangements will require a full physical and operational separation from the residential clients. Rehabilitation of older people requires additional specialist skills, staffing and governance arrangements and cannot be readily combined with residential services.

Discussion

The recommendations presented here by the ISPGM are intended to address the concerns of our professional body about the resilience of the nursing home sector as highlighted by the impact of the pandemic. We aim to inform public policy around the provision of supports for the nursing home sector as well as securing the provision of high-quality care for the growing population of older people in Ireland into the future.

Declaration of Conflicts of Interest:
The Authors declare that there are no conflicts of interest.

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