Covid-19: The support UK care homes need to survive

Help for the social care sector has come late in the day, but it's not just PPE and testing that it needs. Access to clinical expertise, palliative care, and bereavement support is also vital, reports Rachel Carter

Rachel Carter journalist
Worcestershire

On 16 March Donna Pierpoint locked down the nursing home she runs in Sheffield, in the hope of protecting her 38 residents from the covid-19 outbreak. Pierpoint has grabbed every piece of guidance she can get her hands on. She has pursued every avenue to get personal protective equipment (PPE) for her team at the Broomgrove Trust home. But she is scared. She knows the virus could still get in. “I feel very sad that care homes were not thought about,” she says. “Everyone was left to make their own decisions, so huge risk was put there at the beginning.”

“It’s almost as if the attitude is still that we are behind closed doors and people in care homes are old and die anyway—but that’s not right and it’s not acceptable.”

Covid-19 is moving through the UK’s care homes at an alarming rate. As at 7 May, 5117 (33%) of 15 514 care homes in England had reported an outbreak, show data from Public Health England (box 1). From 10 April to 8 May the Care Quality Commission (CQC) was notified of 8314 deaths, but it said this could still be an underestimate.

Donna Pierpoint, registered manager at Broomgrove Trust Nursing Home in Sheffield, believes that using PPE as a preventive measure, not just when a resident has symptoms to eight or 10 within 24 hours. Suddenly what had been enough PPE wasn’t any more, he says, and staff simply could not make it stretch.

Among the government’s solutions are a parallel supply chain to which care providers should be able to make direct orders and PPE drops to local resilience forums. The forums were set up under the 2004 Civil Contingencies Act to respond to emergencies and include representatives from the NHS and local councils.

However, the Local Government Association, which represents English councils, issued a statement on 24 April warning that the drops to forums had been sporadic. It said supplies held are “dwindling” and will run out “within days.”

Support for the sector has come late, and more is needed. An action plan was not published by the Department of Health and Social Care (DHSC) until 15 April, four and a half weeks after Pierpoint closed her doors, and three and half after Boris Johnson announced the wider UK lockdown.

Care home staff are still waiting for tests (box 2); a supply chain designed to tackle the PPE shortage is still weeks’ away (box 3)—these are the well known issues, but there are other difficulties England’s 685 000 care home staff are grappling with.

Box 1: Sector snapshot: the numbers
A total of 15 487 residential homes (11 333) and nursing homes (4413) are registered with the CQC. Around 410 000 people live in care homes in the UK. Public Health England says 5117 care homes have reported a covid-19 outbreak.

£3.2bn is the amount of crisis funding given to English councils, some of which will be used to alleviate the pressures on adult social care services.

Council leaders estimate that care homes will face a 10% hike in costs in April resulting from covid-19, although providers say this prediction is “woefully inadequate.”

Box 2: PPE supply consistency
A ‘lack of responsiveness’ in getting personal protective equipment to care homes has been a recurrent issue, says Adam Gordon, professor of the care of older people at the University of Nottingham. Gordon says that homes with an outbreak have gone from having one resident with symptoms to eight or 10 within 24 hours. Suddenly what had been enough PPE wasn’t any more, he says, and staff simply could not make it stretch.

Among the government’s solutions are a parallel supply chain to which care providers should be able to make direct orders and PPE drops to local resilience forums. The forums were set up under the 2004 Civil Contingencies Act to respond to emergencies and include representatives from the NHS and local councils.

However, the Local Government Association, which represents English councils, issued a statement on 24 April warning that the drops to forums had been sporadic. It said supplies held are “dwindling” and will run out “within days.”

Donna Pierpoint, registered manager at Broomgrove Trust Nursing Home in Sheffield, believes that using PPE as a preventive measure, not just when a resident has symptoms, has been crucial to her holding off an outbreak. Her staff are wearing face masks all the time. After her normal supplier capped the monthly supply at 1800 (which she says isn’t enough when you’re using it proactively) she was able to get extra stock from a local engineering company. But she knows she’s one of the lucky ones. “We’re hearing them say that all care homes will get PPE stock, but the truth of the matter isn’t that clear,” she says.
Aswini Weereratne, a barrister at Doughty Street Chambers in London, tells The BMJ that any decision to isolate residents in these circumstances “must always be taken in the person’s best interests by their carers,” following the process outlined in the Mental Capacity Act. The DHSC has confirmed there is no change to this requirement.  

“If isolation will lead to a new deprivation of liberty or add restrictions to their care which they did not have before, then the law requires there to be an assessment for a deprivation of liberty safeguard under the Mental Capacity Act,” she says.

The key, Weereratne says, is if there is a real risk to life that engages article 2 of the European Convention on Human Rights, “which there must be in congregated settings like care homes,” she says. In this instance, a person may need to be moved out of the home temporarily or cared for on a one-to-one basis, for example with the help of family.

Care staff will often be the best placed to come up with practical solutions for residents who walk with purpose, says Adam Gordon, professor of the care of older people at the University of Nottingham, as they will know them well. He says one example he has seen is staff using mobile partitions to section off a corridor, so the person could still move freely around a part of the home.

“There are also a number of areas that have set up arrangements where care home staff can access dementia specialist nurses, who are able to give advice on pharmacological management to support the staff,” he says.

### Rapid access to drugs

One issue that had not been updated by NHS England and the DHSC until recently was access to palliative care drugs. Existing law prevents care homes from keeping a stock of the drugs, and they must be supplied on a resident by resident basis.

Keeble says GPs had been asking for direction from NHS leaders “for weeks” but were told to “get on and create local policies,” which she says is “unforgivable.”

On 28 April the DHSC and NHS England published a standard operating procedure for a medicines reuse scheme in care homes. This will allow health professionals to reuse a medicine that is no longer needed by the person it was originally prescribed for, providing the criteria set out in the guidance are fully met.

Keeble and Gordon welcome this as a significant move forward. But Gordon adds that, while it is a step in the right direction, it’s not a complete fix because it still does not allow care homes to keep a stock of palliative care drugs. He says this is needed so medical staff can provide “much more responsive” care.

“A number of care home residents often have quite complex palliative care requirements, but the end of life experience with covid-19 is quite a lot more distressing than say a standard community acquired pneumonia,” he says.

“This means care home staff have to be able to access palliative care expertise, and most importantly it means they need rapid access to palliative care drugs.”

As the country moves into its 20th week of the pandemic, Keeble says GPs and community health teams need to know who their care homes are, make contact with them, and make sure they’ve got access to technology in one way or another.

“The irony is there was lots of modelling in the early days and a massive focus on hospitals; but as ever, everyone just took their eye off care homes,” she says.

### Clinical and bereavement support

Care homes need input from clinicians to help them through this crisis. NHS England’s Enhanced Health in Care Homes framework gives some indication as to what this should look like.

The model was piloted in 2016 and is now a requirement of the 2020-21 primary care contract. It emphasises the importance of care homes having access to a named GP, who is linked to a wider community health team.

Maggie Keeble, a GP for five care homes with 160 residents in Worcestershire, is driving forward this approach as part of her area’s response to the pandemic.

“I’ve been working really hard this week on a combined integrated response, so that we’ve got a medic and a district nurse in each area who is a go-to person for care homes and that these people are talking to each other as well,” she says.

Keeble, who is also clinical lead for care homes at the Herefordshire and Worcestershire Clinical Commissioning Group (CCG), has one nursing and four residential homes in her care, one of which currently has residents who have tested positive for covid-19.

She says the CCG acted quickly to get iPads into every care home, ready to enable video consultation with GPs. She’s also set up a Zoom call for all care homes in the county, which has already risen from four participants to 27.

“We’re also looking at how we can provide bereavement support for care home staff, because I’m very conscious that’s going to be a big area too,” she says.

“The chaplains network in Worcester has offered to do an online combined memorial service for staff, or one for each individual home, if they would like that.”

### Isolation arrangements

Where a home does have a suspected or confirmed case, they must isolate the resident. The International Long term Care Policy Network has published a strategy for how a building could be divided into risk zones.

Residents are put into a green, amber, or red zone, depending on whether they have no symptoms, have no symptoms but recently returned from hospital, or are displaying symptoms.

An extra challenge for staff will be isolating people with dementia, whose condition may mean they walk with purpose around the home, and those who may lack the capacity to understand why they need to be isolated and to consent to it.

### Box 3: Faster testing for patients and staff

England’s Care Quality Commission was asked to lead on organising testing for care home workers on Good Friday (10 April), by setting up appointments at satellite sites around the country. Some care homes have raised concerns that their workers are facing an average 100 km round trip to get to their nearest test site.

Kate Terroni, the CQC’s chief inspector for adult social care, tells The BMJ it booked 25 344 testing appointments for care staff as part of their emergency start-up work, before the work was passed back to the Department of Health and Social Care on 26 April.

Getting staff tested and back to work is crucial, Terroni says, not least because of the major recruitment and retention issues that already plague the sector.

“They need to know when someone has tested positive and they can make plans for staff to step in. This is a really important part of planning for the future.”

The chaplains network in Worcester has offered to do an online memorial service for those care home workers who have died.

“We also need to have bereavement support for care home staff, because this is a very difficult time for them,” Terroni says.

Rapid access to drugs

One issue that had not been updated by NHS England and the DHSC until recently was access to palliative care drugs. Existing law prevents care homes from keeping a stock of the drugs, and they must be supplied on a resident by resident basis.

Keeble says GPs had been asking for direction from NHS leaders “for weeks” but were told to “get on and create local policies,” which she says is “unforgivable.”

On 28 April the DHSC and NHS England published a standard operating procedure for a medicines reuse scheme in care homes. This will allow health professionals to reuse a medicine that is no longer needed by the person it was originally prescribed for, providing the criteria set out in the guidance are fully met.

Keeble and Gordon welcome this as a significant move forward. But Gordon adds that, while it is a step in the right direction, it’s not a complete fix because it still does not allow care homes to keep a stock of palliative care drugs. He says this is needed so medical staff can provide “much more responsive” care.

“A number of care home residents often have quite complex palliative care requirements, but the end of life experience with covid-19 is quite a lot more distressing than say a standard community acquired pneumonia,” he says.

“This means care home staff have to be able to access palliative care expertise, and most importantly it means they need rapid access to palliative care drugs.”

As the country moves into its 20th week of the pandemic, Keeble says GPs and community health teams need to know who their care homes are, make contact with them, and make sure they’ve got access to technology in one way or another.

“The irony is there was lots of modelling in the early days and a massive focus on hospitals; but as ever, everyone just took their eye off care homes,” she says.
“The lesson must be learnt that we have a lot of people in care homes, and we have as many staff caring as we do in the NHS—they are as vulnerable, they are as much on the front line, and they have been neglected for years.”

Back at Broomgrove Trust in Sheffield, Pierpoint is feeling the burden of this neglect: “There’s a long way to go, there isn’t light at the end of the tunnel yet. We’ve still got to keep going, we can’t take our finger off the pulse.

“I’m still scared that we may well get it. I just hope that we continue now to get the support, that the PPE does ramp up, and that we can get on top of this as a nation.”

Competing interests: I have read and understood the BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

12 Iacobucci G. Covid-19: GPs have a fortnight to start organising weekly care home reviews, says NHS. BMJ 2020;369:m1827. 10.1136/bmj.m1827 32371384

Published by the BMJ Publishing Group Limited. For permission to use (where not already granted under a licence) please go to http://group.bmj.com/group/rights-licensing/permissions