Information Requested by HIQA

Background

As a result of an email received by HIQA on Monday 15th June a report has been compiled to address questions arising from unsolicited information received.
The HIQA email states:
The following unsolicited information was received in respect of 135 by the Office of the Chief Inspector (The Chief Inspector).
The complainant is concerned that:

1. **Regulation 5: Individual Assessment and Care Plan, Regulation 6: Health Care**
   The delivery of good quality care has been reduced since the commencement of the Covid pandemic (March 2020 which coincided with visiting restrictions).

2. **Regulation 15: Staffing**
   A number of experienced and well-trained staff left their positions in the designated centre which resulted in a deficit of experience, skill and knowledge.

3. **Regulation 34: Complaints Procedure**
   Concerns were not sufficiently listen to/investigated and measures required for improvements not put in place in response to complaints/concerns.

4. **Regulation 27: Infection Control, Regulation 26: Risk Management**
   Concerns have been raised in relation to the high number of residents who died during the Covid 19 outbreak period.

In order to provide sufficient assurances your report will need to be accompanied with the submission of the following information/documents: –

- Emergency contingency plan for Covid 19 pandemic to include planning in place prior to the outbreak in the centre and the designated centre's preparedness in the event of a second outbreak.
- A report of the management of Covid outbreak in the designated centre including access to medical care for residents when GP was not visiting.
- Minutes of meetings with your HSE liaison officer.
- Communication strategy with families during the pandemic.
- Investigation into Covid related deaths and reasons why Covid related deaths were **NOT** notified to HIQA as required in communication from Chief Inspector on 12/03/2020
- Staff changes from 01/01/2020 by grade and WTE including dates induction started and completed.
- Have there been any completed or ongoing staff disciplinary actions since 1st January 2020. (mindful of not breaching data protection guidance)
- Staff training matrix for 2020 for all staff training in the designated centre to include training dates scheduled and training completed.
- Number of complaints received including outcome of complaint investigation since 01/01/ 2020
- The number and risk rating of incidents and accidents since 01/03/2020.

Provider Response to HIQA

The provider has responded as per the order set out in the email received from HIQA. Where the questions noted in bullet point form relate to Regulations 5, 6, 15, 26, 27 and 34, the reponses have been provided under those headings.

1. Regulation 5: Individual Assessment and Care Plan and Regulation 6: Health Care

Below is an overview of key data, including resident reviews which provides an overview of care delivered. Data for June 20 will be compiled at the end of the month. A review of key inputs before and during the pandemic shows consistency of data in terms of reviews.

Area	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Occupancy	63	62	61	61	63	63	65	67	67	68	68	58	50
Falls/ Incidents	10	7	7	4	3	9	6	8	8	1 (fall)	4 (of which 3 were falls)	5 (all were falls)	2 (of which 1 was a fall)
Complaints	0	0	1	0	0	0	0	0	0	0	2	1	0
Transfers to acute										4	5	14	3
Pressure sores and / or wounds	0	0	0	0	0	0	0	0	0	0	0	0	0
NEDOC	0	4	2	4	1	4	4	3	11	3	3	2	2
GP Reviews & correspondence	51	65	36	68	49	71	64	63	67	65	51	72 (contacts for 56 residents)	75 (contacts for 39 residents)
BMI & MUST reviews	63	62	60	61	63	63	64	67	67	68	68	65	53

In addition to the data above there is additional data available which relates to specific reviews since February 2020.

Specific Reviews (Feb 20 to May 20)	Feb 20	Mar 20	Apr 20	May 20
Transfers to acute setting	4	5	14	3
Acute Hospital Respiratory Team visits	0	0	1 (onsite visit)	1 (onsite visit)
Physio	4	4	6 (onsite visit & virtual)	4 (onsite visit)
Palliative reviews (GP, consultant or palliative care team)	4	4	4	4
EOLC	0	1	3	3
Nutritional & dietian review	2	2	2	2
BMI & MUST reviews	68	68	65	53
Fortified Diets and/or ONS	25	27	25	22
Vitamin D	7	7	32	41
Acute Hospital Consultant Virtual Reviews	n/a	n/a	1	2
Psychiatry referrals	0	1	1	2
OT referrals	0	0	0	1

All hospital transfers noted were by agreement with residents and / or families and were linked to the residents' documented care plans and /or advance care plan.

In respect of incidents and accidents the details are included in the previous table. A further more detailed breakdown is provided below. Note that there is a fall review initiated for all falls in the nursing home.

Month	Incident	Location	Witnessed	Post Review Action
Feb 20	Fall	KK Bedroom	No	Enhance supervision
Mar 20	Behaviour	DAR Sitting room - Day	Yes	Medication review & physical review pre-psych referral & discussion with family
	Fall	DAR Bedroom - Day	No	Review placement in NH to reduce need for movement around home for resident, increase proximity to preferred location
	Fall	KK Bedroom - Night	No	Resident encouraged to use call bell to call for asssitance
	Fall	DAR Sittingroom - Day	No	General review as GC deteriorating
April	Found on floor	DAR Bedroom - Day	No	Initiated 15 minute obs
	Fall	DAR Bathroom - Day	Yes	Inititated review
	Fall	DAR Bedroom - Day	No	Medication review and review of condition
	Fall	DAR Sitting room - Day	yes	Wandering & confused. GP review initiated
	Went to the floor	DAR Sitting room - Day	yes	Wandering & confused. GP review initiated
May	Open door	DAR - Day	N/A - alarm	Initiated 15 minute obs, revised staff checklist
	Fall	DAR bedroom - Day	No	Wandering & confused. GP review initiated

1.1 Care of residents with suspected cases or confirmed cases of COVID-19

The nursing home direct care and clinical teams employed a high index of suspicion including loss of appetite /smell, GI disturbances and any changes in residents' baseline or identified residents who were /are just "not themselves".

1.1.1 Suspect cases

In the context of suspect cases the following approach was followed regarding care of residents with suspected cases of COVID-19.

- Clinical examinations including referrals for swabs
- C&D precautions started immediately in addition to Standard Precautions
- Review with GP / NEDOC
- Therapeutic treatment as advised by GP / NEDOC
- Medication and physiotherapy if needed
- Food and fluid intake charts and monitoring
- All nursing assessments ongoing including:
    - Pain relief
    - Daily review to determine referral to palliative care, acute setting or EOLC / comfort care

1.1.2 Confirmed cases

In the context of confirmed cases the following approach was followed regarding care of residents with who were confirmed positive COVID-19.

- Continue C&D precautions in addition to standard precautions
- Inform GP of positive test
- Continue therapeutic treatment based on signs and symptoms
- Continue physio
- Review plan of care as condition changes including
- Refer to
    - MDT / Clinical / Medical teams for review or
    - palliative care or
    - transfer to hospital as per family wishes

1.2 Access to GPs / Medical Support

While the nursing home was in direct contact with GPs via Healthmail and telephone, ongoing support was limited because GPs were not visiting the nursing home in person. As a result the nursing home escalated issues around access to medical care for residents as follows:

- First escalation to CHO Crisis Response Team - 20th April 2020
- Second Escalation to CHO Crisis Response Team - 7th May 2020
- Engagement with local acute hospital for medical support (resulting in):
    - Bi-weekly teleconferences for status updates and supports required with the Deputy General Manager of the hospital
    - Onsite visits by Respiratory Support Team
    - Teleconferences with consultants and the nursing home clinical team
- Engagement with HSE GP contract manager from 13th – 20th May (resulting in):
    - Onsite visit from GP A
    - Protocol in place for identifying residents requiring GP review onsite from GP B
    - Weekly virtual consultations by phone with GP C
    - Case by case reviews by telephone by GP D

    It should be noted that the majority of residents in the nursing home are under the care of GP “C” and GP “D”

GP engagement has been more consistent as a result of these escalations. The nursing home has requested that a community geriatrician and dedicated IPC resource are recruited as a link between the GPs and the acute setting to ensure that nursing home residents in the area get better access to the medical care they require.

2. Regulation 15: Staffing

Resident dependency is measured using the modified Barthel on a monthly basis or if there are changes in residents conditions prior to the monthly review. Staffing levels are then adjusted based on these dependencies to meet the care needs of the residents. The provider has set out the resident dependency on a number of dates and provided the associated staffing levels excluding any induction hours which are supernumary.

2.1 Staffing levels

Month	Resident Dependency Weekly	Resident Dependency Daily	Direct Care Staffing Level Daily
1st March	1544 (70 residents)	228	240
3rd April	1425 (66 residents)	203	240
14th April	1406 (64 residents)	201	240
1st May	1255 (58 residents)	179	182
15th May	1157 (54 residents)	165	188
1st June	821 (50 residents)	117	182

14th June	821 (50 residents)	117	186

As per the table above the staffing levels throughout the outbreak have been in excess of the assessed needs based on residents' dependency. The staff changes are detailed in the following tables which demonstrate that the number of whole time equivalent staff has actually increased from a total of 5.35 WTE that have left to 8.7 WTE staff that have been recruited. The skill mix has also increased with the addition of two full time nurses.

2.2 New recruits

The table outlines the staff recruited since the 1st January 2020.

New recruits from 01/01/2020

Surname	WTE	Department	Type of Contract	Start date	Induction hours
n/a	1	Nursing	Full-time permanent	20/01/2020	128 hrs
n/a	1	Nursing	Full-time permanent	25/02/2020	102 hrs (24 pending)
n/a	1	Care	Part-time permanent (available up to full-time hours)	22/02/2020	58 hrs
n/a	1	Care	Part-time permanent (available up to full time hrs)	07/03/2020	77 hrs
n/a	1	Care	Part-time relief (student available up to full time hours)	30/03/2020	43 hrs
n/a	1	Care / Activities / Maintenance	Part-time relief (student available up to full time hours)	30/03/2020	61 hrs as previously employed with the nursing home
n/a	1	Care	Part-time relief (student available up to full time hours)	01/04/2020	38 hrs (moving to new shift additional 36 hours scheduled)
n/a	1	House-keeping	Part-time relief (student available up to full time hours)	11/04/2020	Not required as previously employed with the nursing home
n/a	0.7	Care	Part-time relief (student available up to full time hours)	27/04/2020	66 hrs

The nursing home has a recruitment plan which includes facilitating student placement for social care, nursing and allied health professional students. The nursing home has strong links with local colleges and uses these links to facilitate placement of students in the nursing home. By working with the colleges the nursing home is provided with a steady stream of potential new recruits, who are trained and vetted. This allows the home to fill a pipeline of resources for workforce planning purposes. The home then offers employment to past students, who as a result of previous work placement in the home already have a knowledge of the environment, the residents and the way care is delivered. All the students recruited have completed manual handling and safeguarding of vulnerable adult training. They have extensive experience of 12 hour shifts in the nursing home and understand the standards required by the nursing home. The nursing home participates in a Homecare Traineeship programme where students on placement work each Monday and Tuesday for an academic year. Of the participant in this programme two were recruited once their placement was suspended due to COVID. There are also two 3rd level students who previously worked in the nursing home who were recruited back to work in the nursing home during the outbreak period. In addition the nursing home has completed a recruitment campaign via social media and is awaiting the declaration that the outbreak is over to

begin additional recruitment in order to have additional resources trained and available to replace students when they return to college.

2.3 Staff who have left the nursing home since 01/01/20

Staff who left since 01/01/2020						
Surname	**WTE**	**Department**	**Type of Contract**	**Leave Date**	**Length of service**	**Reason for leaving**
n/a	0.38	Caring	Part-time permanent	31/01/'20	9 + years	Full-time Night duty position (Not available in EL)
n/a	0.86	Caring	Full-time permanent	31/01/'20	4 months	Went back to College View as wife offered job
n/a	0.57	Caring	Part-time permanent	11/02/'20	21 months	Re-located to Navan
n/a	0.86	Caring	Part-time permanent	27/02/'20	12 months	Was on HSE waiting list - CGH
n/a	0.42	Caring	Part-time permanent	27/02/'20	2 weeks	Failed probation
n/a	n/a	Caring	Full-time then Relief	04/04/'20	2 + years	Student Nurse in England - recruited as HCA due to COVID
n/a	0.28	Caring	Part-time permanent	01/05/'20	8 + years	Retired
n/a	1	Caring	Relief	05/05/'20	4 weeks	Failed probation
n/a	0.28	Housekeeping	Part-time permanent	26/05/'20	16 months	Resigned due to health issues
n/a	0.7	Activities	Part-time permanent	04/06/'20	12 + years	Taking time out to raise child
n/a	n/a	Nursing	Relief	07/06/'20	6 months	Relief staff nurse - went back to South of country to live

Since the outbreak there have been staff changes as a result of staff having to self-isolate from April 2020 either as a close contact or confirmed as a positive case. These changes are documented on our daily staff monitor which forms part of the daily reporting to the HSE and the Department of Public Health. This is available for review and a sample staff monitor has been included as an attachment.

2.4 Disciplinary Procedures

There have been no completed or ongoing staff disciplinary actions since 1st January 2020, so there is no additional information provided in relation to this heading.

3. Regulation 34: Complaints procedure

The nursing home has a very proactive approach to the management of complaints.
All concerns, feedback and complaints are dealt with quickly and documented.
From 1st January 2020 until now there have been three complaints. All complaints were reviewed by the PIC and or the provider and were closed out. An overview of the number of complaints and the outcome regarding same is set out in the table below.

Date & Name	Outcome
12th March - Family	Satisfactory
22nd March – Resident	Satisfactory
14th April - Family	No further input from family following last correspondence

4. Regulation 27: Infection Control and Regulation 36: Risk Management

The email from the Authority sets out additional bulletpoints under section 4. These bulletpoints are addressed in the outbreak report below or under the relevant regulation.

4.1 Outbreak report

4.1.1 Introduction

From the 1st Feburary to the 30th March there were 17 movements in total from either the community, the acute setting or another residential care facility. The last admission from an acute setting was on the 23rd March. The last admission from a long term care facility was on the 30th March which had been booked for a number of weeks. Prior to that admission's arrival a decision was taken by the management team to cease all further admissions to the nursing home.

All admissions after the 6th of March were placed on contact and droplet precautions and isoloated in single rooms with dedicated ensuites for 14 days. From the 23rd March a decision was taken to maintain two single ensuite bedrooms as dedicated isolation areas.

After the 27th March as per NPHET guidance in relation to cocooning, residents were cocooned in their rooms. Group activities ceased and 1 to 1 activities were prioritized for all residents with an enhanced activities programme using additional activities co-ordinators. Residents were facilitated in very small groups of 2 -3 people for small activities and were facilitated to socially distance during these activities.

In early April 4 residents became unwell. The nursing home liaised the local Department of Public Health. The residents who were unwell met the criteria for signs and symptoms of COVID-19 at the time. The case definition of COVID-19 at that time was any 2 symptoms of either:

- Fever/Chills
- Cough
- Respiratory tract infection

Tests were requested via the residents GP. Contingency plans were immediately implemented as a precautionary measure. These plans related to cohorting a group of staff to care for those residents who became suspects, the area was cordoned off, signage in relation to contact and droplet precautions was put in place, advice and guidance was provided to all employees in relation to isolation of affected residents, use of PPE and restricted access to the affected area.

For all non-affected residents from 1st – 22nd April standard precautions were in place where a resident was neither a suspect or confirmed case.

All confirmed and suspected COVID cases and all admissions and /or readmissions from hospital were placed on Contact and Droplet precautions for minimum 14 days as per guidelines and were cared for in single rooms with dedicated en-suite bathrooms.

Since March there has been ongoing communication with all staff in relation to COVID-19 and the importance of good IPC practices. Refresher training via HSE Land was completed by staff and an additional presentation in relation to COVID-19 was made available to staff and discussed at handovers. A programme of daily and weekly communication started via socially distanced meetings, departmental WhatsApp Groups, group texts and emails.

4.1.2 Investigation

On the 1st April the symptoms of the first four resident cases were temperature and cough. Based on Department of Public Health advice, swabs were requested for these four residents. The first resident was swabbed by NAS on 1st April and the result was received on 8th April, confirming that the resident was positive for COVID-19. This resident had been in an acute setting on the 27th March with chest pain and remained in the acute setting for approximately 12 hours before returning to the nursing home.

At that time the guidance made no reference to transfers from hospital within 12 hours or after 12 hours and whether these residents required isolation. This requirement to isolate residents with contact and droplet precautions after 12 hours or more in hospital did not come into guidance until the 2nd of June. And the isolation requirement did not come into effect until 7th April. However the nursing home did place this resident on contact/ droplet precautions on his return.

The second resident was transferred to hospital for IV fluids on 1st April on the request of family with agreement from NEDOC. This resident was tested in hospital and was confirmed not detected for COVID-19.
There third and fourth residents who were awaiting swabs were tested by NAS on the 2nd April. Their results were received by the 8th and 10th April respectively. The results confirmed that both residents were positive for COVID-19.

The nursing home began engaging on a daily basis with the Department of Public Health and completed a daily report of any suspect cases of either residents or staff.
The nursing home outbreak was declared on 8th April when the first positive result was confirmed. The Department of Public Health was informed of the outbreak immediately. HIQA was also informed of the positive result using the NF02.
The nursing home engaged with the HSE liaison a CHO Crisis Response Team daily monitor format was provided to send daily reports to the HSE. Daily reports to the Department of Public Health and daily updates to HIQA continued as per guidance.
By the 8th April there were a further 8 residents who were suspects within the same unit awaiting testing. Four of those residents did not meet the criteria for suspicion at that time i.e. were asymptomatic. It took between 9 and 16 days before test results were received for these residents. Out of those 8 residents, 7 residents were confirmed positive and one resident was confirmed as not detected. Some residents who required admission to the acute setting for further therapeutic intervention were transferred to hospital. These transfers were agreed with the resident's GP and the resident's family. The acute setting was informed of the resident's status as was NAS. Where residents were transferred to hospital with a COVID-19 test result pending, the resident was re-tested in the hospital with results provided within the same day.

However in the nursing home setting test results in April continued to take up to 16 days. All residents who were suspects continued to be cared for with contact and droplet precautions in place and were isolated in single rooms with dedicated en-suite toilets and bathrooms wherever possible. Mass testing of residents in the nursing home took place on the 17th April. The table below sets out the results of mass testing on the 17th April.

Results of Mass testing which took place on 17th April.

Residents positive	Residents asymptomatic and positive	Residents not detected	Residents not detected on 17/4/20 who tested positive on 6/5/20
1 resident	7 residents	11	15 – of these 15 residents, 11 were later positive and asymptomatic as per mass testing requested by the nursing home further to discussions with the Department of Public Health

Mass testing took place on the 17th April with results received on the 27th April. One resident was confirmed positive who had symptoms while seven residents were confirmed positive and asymptomatic.

There were another 15 residents who were not detected on the 17th April from the dementia specific unit. However on the 2nd May one resident in that unit became unwell, although they did not meet the case definition for COVID-19.

As a result of this resident becoming unwell the provider liaised with the Department of Public Health on the 3rd May to request further testing for all previously unaffected nursing home residents with same day results. The Department of Public Health requested that an email be submitted regarding testing. On advice from the Department of Public Health liaison, the provider sent an email to the Department of Public Health, the local hospital and the HSE CHO liaison team.

On the 5th May the hospital reverted back to confirm they could complete same day testing if the nursing home could swab the residents and if the Department of Public Health would email agreement of the testing plan directly to the hospital. However on the 6th May the Department of Public Health telephoned the provider and stated the Department would not agree to the plan for testing with same day results.

Due to a high degree of suspicion in relation to the residents in the dementia unit, testing proceeded with the support of NAS on the 6th May with results back on the 8th May. When results were received on the 8th May, the nursing home was able to use the information to cohort residents, particularly those who engage in purposeful walking. In addition contact and droplet precautions were applied to the rooms of the affected residents who were asymptomatic and positive. All remaining unaffected residents remained in their rooms with one to one activities and access to fresh air and walking supported.

4.1.3 Environmental investigation

As already stated there were 17 admissions / re-admissions in total from the acute setting, other long term care facility or the community to the nursing home from the 1st February to 30th March 2020. Out of those 17 admissions / readmissions 13 of those admissions of new residents or re-admission of existing residents were from the acute setting to the nursing home. It is possible that contributed to transmission of the virus into the nursing home.
It should be noted that at the time suspect cases were emerging in the nursing home the national guidance did not state staff should wear masks with residents unless the residents were either suspects or confirmed cases. It is possible that contributed to transmission of the virus between asymptomatic residents and asymptomatic staff.
Further investigation during the outbreak as a result of audits identified additional actions required in respect of decluttering and additional review of cleaning schedules. These findings were immediately actioned.

4.1.4 Contributing factors identified

The outbreak in this nursing home was multifactorial. A number of contributing factors are highlighted below.

- no clear guidelines available in the early stages of the pandemic,
- testing criteria did not address the issues of different presentations in the older population,
- re-admissions from acute settings during March with refusal to test before discharge,
- in late March there was little knowledge of asymptomatic transmission and early April evidence was just beginning to emerge
- a significant number of both asymptomatic and positive residents and staff at the same time ,
- insufficient supply of PPE during suspect phase despite having additional supplies in place pre-outbreak, due to global shortage, supply chains committed all stocks to

HSE only and HSE was unable to supply PPE until a nursing home had confirmed cases (nursing home used builders providers to source goggles boiler suits etc.),
- slow testing and extremely slow results which limited the effectiveness of cohorting. Affected residents who were suspected of having COVID-19 had to remain in situ until they were confirmed positive. And in particular the asymptomatic element of the virus made cohorting of residents and staff as per guidance extremely difficult
- high levels of community transmission in the local area, specifically in the local acute hospital
- challenges maintaining cocooning for people living with dementia or cognitive impairments who frequently engage in purposeful walking,
- the historic focus pre-pandemic on a homely cluttered environment using the Butterfly model was not aligned with the stringent IPC requirements and conversion of the nursing home to a much more clinical setting,
- limited engagement of state agencies in a supportive role,
- deterioration in residents psycho-social well-being during isolation making ongoing isolation more difficult, and necessitating small group activities to continue on occasion to relieve resident distress
- no integrated care pathways linking the nursing home to GPs, community geriatrician, dedicated community IPC resource and acute services
- general fatigue of all employees from senior management to the front line team working tirelessly to maintain high standards of care for the residents and during periods where large numbers of staff were required to self-isolate

All of these factors have contributed to the scale and duration of the outbreak.

5. Risk Management

Much work was completed in late February / early March as part of preparation and contingency planning which related to the management of the risks associated with the COVID-19 pandemic. Additional work continues on a daily basis in relation to the ongoing management of the nursing home in the context of COVID-19 and the related guidelines.

Work completed in relation to COVID-19 includes:

- Review of policies
- Completion of a preparedness plan
- Completion of a contingency plan
- COVID-19 policy and related training
- Specific Risk Register for COVID-19
- Review of supply chains
- Review of care plans, medications in light of emerging guidance etc.
- Attendance at webinars
- Engagement with MDTs, GPs and pharmacies as part of preparedness plans

In addition to the above the nursing home completed and continues to conduct:

- Active daily monitoring of both residents and staff
- reviews of guidance in relation to use of PPE
- reviews of appropriate signage based on the resident status
- reviews and updates of practices within the nursing home based on any changes in COVID-19 guidance from the HSE, HPSC, The Department of Public Health, HIQA, NPHET and Department of Health.
- ongoing physical distancing, isolation and cocooning of residents
- self-isolation of staff as close contacts or confirmed cases, when symptomatic or as a result of mass testing results

6. Investigation into COVID-19 related deaths

The provider and the entire team are devastated that there were twelve confirmed deaths related to COVID-19 and one suspected death related to COVID-19. As per the request from HIQA an overview into the underlying conditions of these residents is provided below. The residents are referred with the unique identifier number assigned to them as part of ongoing notifications to HIQA.

Note that as soon as there was a change in condition these residents were isolated, contact and droplet precautions were started, family members and staff were informed of the residents' status.







The provider would like to take this opportunity to acknowledge the deep sadness of all the residents and staff of the nursing home at the loss of these 13 people who were dearly loved by their families and friends and by all the staff who work in the nursing home.

7. Communication

A communication plan was put in place which outlined how communications would be managed for residents, families and staff. It was agreed that different methods of communication would be used including letters, emails, telephone calls, Whatsapp, group text, video messaging, social media depending on the group, the number of people to communicate with and the frequency required. A copy of the communications plan is attached with this document. In addition to

communications with residents, families, staff, suppliers there was also daily communication with state agencies. These communications included
Daily EMT meetings / teleconferences
Bi-weekly calls with the local hospital and with CHO HSE liaison team (or more if required)
Daily updates to HIQA, the HSE and the Department Public Health.

8. NFO1 Notifications to HIQA

As part of our preparedness and contingency planning the nursing home had completed anticipatory prescribing of all palliative medicines as per the HSE guidance and associated algorithms. In our view this effectively placed residents on 'comfort care' measures meaning that death would be anticipated for some residents and therefore this did not fit the definition provided in the Handbook of an unexpected death.

The HIQA Monitoring Notifications Handbook states:

> *The regulations do not define an 'unexpected death'. However, the Chief Inspector has offered this definition to assist in making this notification. As per HIQA "An unexpected death is one that was not anticipated or occurred earlier than expected."*

The nursing home was already completing daily updates to HIQA in relation to the outbreak, via the HIQA daily update form from the 21st April as per Communique 8. The amended NF02A Notification Form was introduced after that date and the nursing home had already submitted an NFO2 on the 9th April, so we were advised to continue with the daily update form on the HIQA portal. Both the HIQA daily update and the NFO2A were put in place to enable daily reporting of new cases and to reduce the administrative burden on providers. This form does not include a section for reporting of COVID related deaths which may have provided HIQA with this information in a streamlined and timely manner. It is acknowledged that an outbreak notification is different to an unexpected death notification, however given the anticipated high numbers of deaths in the vulnerable categories (as per international data) it is disappointing that the COVID related deaths were not included in the NF02A, the daily update form or a similar amended NF01 was not created for this purpose to alert Providers. Finally, at no point before or during the pandemic did the nursing home receive any specific directive or communique from HIQA stating that all COVID related deaths were to be reported as unexpected deaths.
The nursing home had 13 deaths (including 1 suspect case) associated with COVID. Three of these deaths occurred in the Nursing Home and the 4 of residents had End of Life Care plans in place as the deaths were anticipated. The other 9 deaths which includes the 1 suspect COVID case occurred in General Hospital and as per ongoing communication with the Hospital and with the families of the residents, these deaths were all anticipated therefore not unexpected.
The nursing home had 47 positive cases of COVID (this figure includes the 1 suspect case). Of the 47 cases 34 residents recovered from COVID mainly due to the high level of nursing care provided by the staff with limited onsite medical review. The care provided was supported and monitored before and during the outbreak by the management team who worked tirelessly day and night from March 2020 with little support from public bodies, multi-disciplinary teams and pastoral care. Resident's social needs, psychological wellbeing and spiritual needs were met by the activity team supported by the care, nursing teams and management teams.

The person in charge had a telephone conversation with a representative from HIQA on the 13th March. Areas discussed included bed numbers, residents in hospital, visiting restrictions, staff, confirmation that the nursing home had received updated notifications information. There was also a discussion about how the Authority was there to support nursing homes during this difficult time.

The registered provider representative had a telephone conversation with a representative from HIQA on the 9th April. During the conversation the provider representative completed a full overview of the daily reporting and contingency plans. The nursing home informed the representative that it was completing daily updates to the Department of Public Health and the HSE CHO 1 CRT. [redacted]

9. Additional Information / Attachments

Attachments provided as supplementary evidence to this report include:

- The nursing home contingency plan
- The nursing home communications plan
- A sample of EMT minutes is attached however the daily monitor for resident and staff for CHO, internal daily monitor for residents and staff and daily report to the Department of Public Health not shared due to GDPR issues but available for review.
- Communications between the nursing home and the HSE liaison contact can be provided if required (as there is a significant number of emails it may be difficult to forward them as one file)
- Staff training matrix with names removed

Report Ends