



**The  
Strategy  
Unit.**

## **COVID-19 and Coronavirus evidence alerting**

**Rapid scan 1: Effects on people in care/nursing homes  
(and other residential facilities) including approaches  
to protecting workers and residents**

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**Midlands and Lancashire**  
Commissioning Support Unit

**The Strategy Unit** is working in collaboration with the Health Foundation, King's Fund, Nuffield Trust, and Imperial College Healthcare Partners to provide additional analytical support to the NHS nationally in its overall response to COVID-19. The organisations will use their expertise to focus on questions that the NHS may lack the immediate resources to look at, which may be more medium-term, cut across sectors, or benefit from independent analysis. They will be sharing their knowledge, information, multi-disciplinary analytical skills, and extensive links to support different parts of the health and care system, arms-length bodies and government departments working on the COVID-19 response. For more information please email [mlcsu.covid.analytics@nhs.net](mailto:mlcsu.covid.analytics@nhs.net).

This rapid summary is part of an evidence alert service which has developed from requests for evidence to support recovery planning. Our first priority is to highlight key papers to inform decisions, policy and planning and our approach is pragmatic rather than exhaustive. More information on our methodology is provided in the Appendix.

# A short note about evidence analysis and COVID-19

The emerging evidence base on COVID-19 and Coronavirus is growing quickly. The research community has responded to the pandemic quickly and publishers are fast-tracking papers and providing open access. This inevitably leads to some trade-offs:

- Findings are shared quickly but there are implications for quality as the usual peer review is curtailed - so we need to be mindful of bias in research methods and quality of reporting.
- The pace of learning is such that, at the moment, it is not feasible to conduct a traditional review which summarises and synthesises what we know. The evidence base is growing so quickly that our understanding is continually shifting.

Our approach is to trawl the rapidly growing knowledge base, to filter findings which are relevant to planning and policy and to highlight new and emerging learning:

- This rapid scan provides a snapshot of emerging evidence.
- A weekly alert will highlight new papers.
- We will also maintain an evidence tracker, providing a single point of access to the papers highlighted in this scan and in weekly alerts.

There are, of course, initiatives around the UK and internationally to scan and track evidence and we'll endeavour to avoid duplication as far as possible.

# Introduction

The latest data suggests that care homes and other residential facilities are disproportionately impacted by the COVID-19 outbreak.

This rapid scan has been created to collate new and emerging evidence on implications for care homes and residential facilities and transferable lessons from previous pandemics and major incidents.

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# Summary

People in residential settings are often amongst the most vulnerable in society. Whilst there is a growing evidence base in relation to care homes and nursing homes, there seems to be little relating to other settings, such as supported housing, homeless shelters, prisons and refuges. However, some of the learning may be transferable. There are a number of recurring themes specific to residential settings:

**PPE:** highlighting issues with supply chains as well as a need for more training for staff in how to use PPE effectively.

**Reducing the spread:** as well as the need for increased hygiene and decontamination, there are gaps in testing. Tests are focused on individuals with respiratory symptoms yet individuals may present with no/atypical symptoms. One study notes that some symptoms (e.g. cough) are often present in homeless people so not a good indicator of infection.

**Surge planning:** includes planning for future peaks and protecting high-risk patients (such as those with dementia who “walk with intent”) and suggests a need for multi-agency planning.




**Staffing:** the attempt to cover staffing gaps through temporary staff may exacerbate spread, particularly where staff are deployed across multiple sites. Retention is identified as a key issue to address during recovery planning.

**Communication:** there is some evidence to suggest that awareness of the implications COVID-19 is low amongst some residents, suggesting a need for more communication. There are also recommendations to improve systematic communication both with other services and with relatives of residents.

**Isolation and distancing:** qualitative studies suggest a concern with the unintended consequences of distancing in a population where anxiety and depression are prevalent. Recovery planning should include procedures for reintroducing visitors safely.

**Technology:** Some studies are exploring the use of telemedicine as a means of delivering care remotely. However, access to technology remains an issue in residential settings. There are also suggestions that “no-touch technology”, which may limit spread, are not in widespread use.

# Expert commentary

|         |  |                                    |  |
|---------|--|------------------------------------|--|
| 1/5/20  |  <p>nuffieldtrust<br/>evidence for better health care</p> | Nigel Edwards and<br>Natasha Curry | <a href="#">Deaths in care homes: what do the numbers tell us?<sup>1</sup></a>               |
| 30/4/20 |  <p>The King's Fund</p>                                   | Adam Gordon and<br>Claire Goodman  | <a href="#">Tackling the COVID-19 outbreak in care homes<sup>2</sup></a>                     |
| 28/4/20 |  <p>The<br/>Health<br/>Foundation</p>                    | Sarah Deeny                        | <a href="#">Dire warnings from care home sector borne out in the latest data<sup>3</sup></a> |

# Guidance

|   |   |
|---|---|
| British Geriatrics Society  | <a href="#">COVID-19: Managing the COVID-19 pandemic in care homes for older people</a> <sup>4</sup>  |
| Department of Health and Social Care, Care Quality Commission, Public Health England, and NHS England | <a href="#">Coronavirus (COVID-19): admission and care of people in care homes</a> <sup>5</sup>   |
| Public Health England   | <a href="#">COVID-19: how to work safely in care homes</a> <sup>6</sup>   |
| Public Health England   | <a href="#">COVID-19: guidance for supported living provision</a> <sup>7</sup>  |
| WHO   | <a href="#">Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19</a> . Interim guidance 21 March 2020. <sup>8</sup> |

# Rapid reviews

## [How can pandemic spreads be contained in care homes? Taking into account: 1. Human resources 2. Nursing activities/medications 3. The role of external visitors.](#)

**Koshkouei M; Abel L; and Pilbeam C (2020) Oxford COVID-19 Evidence Service Team, Centre for Evidence-Based Medicine.<sup>9</sup>**

This rapid review, based on 30 studies, explores the effectiveness of different infection control interventions and strategies, highlighting the following as most significant:

- Hand hygiene: While education interventions to improve hand hygiene in care homes achieve limited results, adequate provision of hand sanitiser and gloves, along with line management support, have been shown to reduce infection rates.
- Environmental decontamination: Daily cleaning of most touched surfaces and weekly deep clean reduce infection spread.
- Staff rotation: The evidence supports limiting movement of staff between care homes. Care homes relying on temporary staff should be aware that these staff are a key potential source of infection.
- Visitors: No evidence on restricting visitors was identified, but if visitors have similar impact as staff re-entry, then restriction is supported.
- Testing: Rapid identification of cases among both staff and residents through testing may facilitate a coordinated response that minimises within-care home spread, although further evidence is needed.
- Quality of life: Education of residents can aid compliance with mitigation strategies, and address considerations of quality of life and anxiety. Further research on maintaining quality of life in care homes during outbreaks is urgently needed.

## [Guidelines for preventing respiratory illness in older adults aged 60 years and above living in long-term care. A rapid review of clinical practice guidelines.](#)

**Rios P; Radhakrishnan A; Thomas SM et al (2020) St Michael's Unity Health Toronto.<sup>10</sup>**

This review of 17 clinical practice guidelines found that the most commonly recommended prevention strategies across the clinical practice guidelines were:

hand hygiene, wearing personal protective equipment, social distancing/isolation, disinfecting surfaces, droplet precautions, surveillance and evaluation, conducting diagnostic testing to confirm suspected respiratory illness, policies and procedures for visitors, policies and procedures for staff, and respiratory hygiene/cough etiquette.

For managing respiratory illness in long-term care facilities, the majority of the clinical practice guidelines recommended antivirals for prophylaxis of staff and/or residents. However, most of the clinical practice guidelines failed to address multiple AGREE-II items, suggesting that they are most likely based on expert opinion.



# Emerging COVID-19 evidence *(not peer-reviewed)*

## [Mortality associated with COVID-19 outbreaks in care homes: early international evidence.](#)

**Adelina Comas-Herrera (CPEC, LSE) and Joseba Zalakain (2020) Article in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE** <sup>11</sup>

This paper looks at emerging epidemiological studies, data reports and news reports on deaths in care homes. The brief summary highlights some of the risk factors contributing to spread in care homes, including:

- Staff who worked while symptomatic
- Staff who worked in more than one facility
- Inadequate familiarity with and adherence to Personal Protection Equipment (PPE) guidance
- Challenges to implementing proper infection control practices, including inadequate supplies of PPE and alcohol-based hand sanitizer
- Delayed recognition of access due to low index of suspicion
- Limited availability of testing
- Difficulty identifying persons with COVID-19 on the basis of signs and symptoms alone

## [Social inequality and the risk of being in a nursing home during the COVID-19 pandemic.](#)

**Fabrizio Bernardi; Marco Cozzani and Francesca Zanasi (2020) DOI 10.31235/osf.io/ksefy.** <sup>12</sup>

This study explores the socioeconomic dimensions of nursing homes and the implications for health inequalities in relation to COVID-19: *"Our analyses show that low-educated individuals are more likely to live in nursing homes. This result is found across the 13 countries included in our study. In the majority of countries, we find odds ratio close or greater than two, suggesting that differences in the probability of living in a care home by education are sizeable.*

*Given the extremely high death toll in care homes, evidence on differences in the probability of being in care home provides indirect but clear evidence of the existence of social inequality in the risk of mortality linked to COVID-19. The finding of our article therefore contradicts the idea that COVID-19 affects all equally and add socioeconomic status to the gender and age as important dimensions to consider, when studying COVID mortality. The finding that low socio-economic groups are disproportionately present in nursing homes and thus more exposed to the pandemic also raises issues of social justice. Guaranteeing adequate protection against infection in the nursing homes is paramount issue not only of public health in reducing the scope of the pandemic, but also of social policy toward inequality reduction."*

# Emerging COVID-19 evidence (*not peer-reviewed*)

## [The problem of asymptomatic COVID-19 infections among care home staff and residents: emerging evidence and implications.](#)

**Comas-Herrera A (2020) Briefing note in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 18th April, 2020.**<sup>13</sup>

This briefing note explores:

- Testing – learning from the most recent guidance from the Robert Koch Institute (Germany) covering hospital discharge to nursing homes
- Improving awareness of atypical symptoms – learning from British Geriatrics Society guidance about symptoms other than cough or fever as an indication of COVID-19
- Isolation – learning from countries which have had low rates of outbreaks in care homes (e.g. Singapore and South Korea) which have very strict processes to isolate and test all care home residents and staff who not only have symptoms or who may have had contact with people who have COVID-19.
- Physical distancing – recommendations include: “zoning”; the use of hotels and hospital admission.

## [Impact of COVID-19 on residents of Canada’s long-term care homes – ongoing challenges and policy response.](#)

**Amy T. Hsu and Natasha Lane (2020) Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 23 April 2020.**<sup>14</sup>

This paper explores the case mortality rate in care homes across Canada and resulting policy changes to manage infection spread:

*"While emphasis has been placed on ensuring redeployed and temporary staff as well as contractors receive appropriate training and education to perform their new assignments, the rapid redeployment and broad introduction of temporary staff in the long-term care sector may have unintended consequences, specifically the rapid transmission across several homes within a short period of time. [...] Early data from the U.S. show the ability of long-term care workers to spread COVID-19 between facilities where they are employed, which may have led to one of the newest containment measures being considered across multiple Canadian provinces — the restriction of healthcare workers to employment at a single home. As low wages and part-time hours for many long-term care employees necessitate that they work at multiple homes to earn a living wage, infection control policies to restrict employees to work at one home must account for the staff shortages and inadequate employee wages such measures will exacerbate. [...]"*

*The rapid spread of COVID-19 in Canada’s long-term care homes highlights pre-existing and systemic issues — such as shared accommodations and understaffing — as well as the slow implementation of effective infection control measures at the start of the COVID-19 outbreak. [...] British Columbia’s policy to ensure equitable compensation to support their employee single-site order is an important step to slowing fatalities from COVID-19 in Canadian long-term care homes. The repercussions of other provinces’ attempts at increasing staffing and minimizing spread between homes are yet to be seen. Subsequent versions of this report will explore other policy changes and<sup>10</sup> their impact on COVID-19 in Canada’s long-term care homes. "*

# Emerging COVID-19 evidence (not peer-reviewed)

## [Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility — King County, Washington, March 2020.](#)

**Anne Kimball; Kelly M. Hatfield; Melissa Arons et al (2020) MMWR Morb Mortal Wkly Rep 2020;69:377–381.<sup>15</sup>**

This report shares learning from one of the most significant outbreaks in US care homes:

*"Sixteen days after introduction of SARS-CoV-2 into facility A, facility-wide testing identified a 30.3% prevalence of infection among residents, indicating very rapid spread, despite early adoption of infection prevention and control measures. Approximately half of all residents with positive test results did not have any symptoms at the time of testing, suggesting that transmission from asymptomatic and presymptomatic residents, who were not recognized as having SARS-CoV-2 infection and therefore not isolated, might have contributed to further spread. [...] Current interventions for preventing SARS-CoV-2 transmission primarily rely on presence of signs and symptoms to identify and isolate residents or patients who might have COVID-19. [...]"*

*Skilled nursing facilities (SNFs) have additional infection prevention and control challenges compared with those of assisted living or independent living long-term care facilities. For example, SNF residents might be in shared rooms rather than individual apartments, and there is often prolonged and close contact between residents and health care providers related to the residents' medical conditions and cognitive function. The index patient in this outbreak was a health care provider, which might have contributed to rapid spread in the facility. In addition, health care personnel in all types of long-term care facilities might have limited experience with proper use of PPE. Symptom ascertainment and room isolation can be exceptionally challenging in elderly residents with neurologic conditions, including dementia. In addition, symptoms of COVID-19 are common and might have multiple etiologies in this population; 24.5% of facility A residents with negative test results for SARS-CoV-2 reported typical or atypical symptoms."*

## [Detection of SARS-CoV-2 Among Residents and Staff Members of an Independent and Assisted Living Community for Older Adults — Seattle, Washington, 2020.](#)

**Alison C. Roxby; Alexander L. Greninger; Kelly M. Hatfield et al (2020) MMWR Morb Mortal Wkly Rep 2020;69:416–418.<sup>16</sup>**

This shares learning from another facility within the same state:

*"In this senior independent and assisted living facility, symptom screening of residents did not identify persons who had positive test results for SARS-CoV-2; three of the four residents who had positive test results were asymptomatic at the time of testing, and one reported a cough that had resolved. Moreover, >40% of residents who had test results (whether positive or negative) reported one or more symptoms potentially compatible with COVID-19 during the preceding 2 weeks.*

*That only four residents had positive test results differed markedly from reports from two Seattle SNFs that experienced high COVID-19 transmission, morbidity, and mortality (2,3). Possible explanations for differences in findings in this residential community from those in SNFs include more social distancing among residents and less contact with health care providers in independent and assisted living communities than that in skilled nursing facilities. In addition, early implementation of stringent isolation and protective measures after identification of two COVID-19 cases might have been effective in minimizing spread of the virus."*

# Emerging COVID-19 evidence (not peer-reviewed)

## [COVID-19 in older adults: clinical, psychosocial and public health considerations.](#)

**John P. Mills; Keith S. Kaye and Lona Mody (2020)** *JCI Insight*. 2020. <https://doi.org/10.1172/jci.insight.139292>.<sup>17</sup>

This paper explores lessons learned to date, suggesting that the risk of unintended consequences of restricted access to routine healthcare and social distancing should be monitored and mitigated: *"With older adults bearing a disproportionate brunt of adverse outcomes, consolidation of outpatient operations and social distancing measures, health community-dwelling older adults are devoid of necessary support, knowledge, and adaptive strategies to manage their day-to-day routines and are at risk of worsening their underlying comorbidities. Communicating with 'well and worried' older adults using virtual lectures via senior community-based centers and learning communities, and ramping up virtual and video health visits have helped mitigate some of these concerns – albeit only to those who have access to these resources."*

The paper also explores the issues around supply chain of PPE and the use of "no-touch technology" to reduce infection spread: *"The situation is often worse in nursing homes, where typically, less PPE is available on site, and adaption of novel infection prevention technology often occurs much later than in acute care settings."*

There are also implications for workforce planning and management: *"Developing a robust pandemic response plan in nursing homes requires not only physical but human capital. Sustaining a healthy and well-trained workforce is essential and requires investment through standardized education on hand hygiene and PPE use, as well as generous sick leave policies and overall prioritization of staff retention."*

## [COVID-19, Post-acute Care Preparedness and Nursing Homes: Flawed Policy in the Fog of War.](#)

**Jerry H. Gurwitz (2020)** *Journal of the American Geriatrics Society* <https://doi.org/10.1111/jgs.16499>.<sup>18</sup>

This editorial shares lessons learned from Massachusetts where plans to create dedicated post-acute care facilities, involving relocating hundreds of nursing home residents, were halted:

*"The Massachusetts experience holds valuable lessons for states presently coping with the need for more post-acute care beds or in planning for a possible resurgence later in the year. Past experiences from natural disasters reveal that older residents of long-term care and skilled nursing facilities do not fare well with emergency evacuations. It follows that the rapid emptying of nursing homes to create post-acute sites for the COVID-19 surge is likely to have similar adverse consequences. Abruptly relocating large numbers of long-term care residents to other facilities in the midst of a pandemic layers on additional risk, amplifying the negative effects on this highly susceptible population due to asymptomatic viral transmission. [...]*

*Several lessons are apparent. First, the emptying of nursing homes displacing large numbers of long-term care residents is the worst possible option for creating post-acute care capacity to decompress hospitals. Second, nursing homes have become an epicenter for the shifting pandemic and thus must be prepared to care for large numbers of residents with COVID-19 infection. At a minimum, this requires appropriate safety equipment and training to minimize risk to staff and uninfected residents. Third, testing in nursing homes is of paramount importance, especially with the high prevalence of asymptomatic infection."*

# Emerging COVID-19 evidence (not peer-reviewed)

## [Failing our Most Vulnerable: COVID-19 and Long-Term Care Facilities in Ontario.](#)

**David N. Fisman; Isaac Bogoch and Lauren Lapointe-Shaw (2020) medRxiv <https://doi.org/10.1101/2020.04.14.20065557>.<sup>19</sup>**

This paper explores risks in long term care facilities and makes recommendations for policymakers:

*"Transmission of infection is not the only mechanism whereby infection in staff could result in increased mortality in a vulnerable older population. Fear of COVID-19 may result in absenteeism by staff, which could itself lead to death through dehydration and other mechanisms in a high-needs population, which would be consistent with the lagged effects we demonstrate here.*

*[...]*  
*The prevention of such deaths requires strategic guidance from health regions and the provision of sufficient testing and personal protective equipment. Provision of personal protective equipment has benefits both in bidirectional prevention of SARS-CoV-2 transmission, and in providing workers peace of mind, in order to stay on the job. Expanded testing, including testing of minimally symptomatic infection, will facilitate early identification of infection, and implementation of effective infection control strategies. Also needed are integrated regional approaches to LTC human resource management, such as limiting workers to a single facility and ensuring that these workers earn a living wage to prevent the need for multiple jobs while at the same time maintaining adequate staffing levels."*

## [A Health System Response to COVID-19 in Long Term Care and Post-Acute Care: A Three-Phase Approach.](#)

**Gina Kim; Mengru Wang and Hanh Pan (2020) Journal of the American Geriatrics Society, doi 10.1111/jgs.16513<sup>20</sup>**

This paper describes the approach (Initial, Delayed and Surge) developed by the University of Washington's Post-Acute Care Network, and shares lessons learned:

*"The Initial Phase focuses on optimizing communication, reviewing current infection control practices, and creating a centralized process to track and test the target population. The Delayed Phase provides education and reinforces infection prevention and control practices to all staff. The Surge Phase aims to adequately prepare facilities to respond to an outbreak, by deploying a "Drop Team" within 24 hours when needed. [...] Having an established relationship with partnering SNFs undoubtedly provided a level of trust that allowed for effective coordination and delivery of services. [...]*

*An important early lesson was identifying the need for a command center to aid distressed SNFs and other congregate living environments in the deployment of information and resources. As COVID-19 cases emerged in SNFs throughout King County and surrounding areas, it became clear that a command center was needed to monitor surging cases, supply chain challenges, staffing shortages, and diagnostic and clinical support. [...]*

*An early lesson learned would be to incorporate a telemedicine readiness assessment survey for SNF leadership to better understand existing technological and staffing capabilities. Within our network, there was variable technological access in place leading to delays in implementation."*

# Emerging COVID-19 evidence (not peer-reviewed)

## Data Note: How might Coronavirus Affect Residents in Nursing Facilities?

**Priya Chidambaram (2020) Medicaid.** <sup>21</sup>

This paper is an analysis of some of the risks facing nursing facilities in the US based on available data on comorbidities, risk factors and capacity. Of particular interest are the risks to mental wellbeing and the risks associated with capacity and density:

*“Anxiety and depression are also common among nursing facility residents, and these health problems may be exacerbated by fear, worry, or social isolation due to COVID-19. Residents in nursing facilities are at risk of being diagnosed with psychiatric disorders, with nearly 40% having experienced symptoms of depression (Table 1). [...] Research on family involvement in long-term care has shown that family visitation can have potentially positive effects on cognitive and behavioral health diagnoses.<sup>1</sup> Thus, visitor restrictions in nursing facilities, which are currently being implemented to lower the risk of exposure among residents who would be vulnerable to illness if infected, may also have negative impacts on residents’ mental health and increase the incidence of depressive symptoms.*”

*Resident density could have an impact on how fast an outbreak of COVID-19 might spread in a particular facility. Nationally, four of every five nursing facility beds were filled in 2017, with some states such as New York and DC reporting even higher occupancy density (over 90%) (Table 1). Higher occupant density puts residents at risk of quicker spread.”*

## Re-imagining Long-term Residential Care in the COVID-19 Crisis.

**Pat Armstrong, Hugh Armstrong, Jacqueline Choiniere et al (2020) Ottawa, Canadian Centre for Policy Alternatives.** <sup>22</sup>

This report draws on lessons to date from the current pandemic and considers how delivery of long term residential care may need to change. Recommendations relate to ownership, workforce planning, physical environments, surge planning, procurement of services and supply of PPE:

*“Our project was based from the start on several explicit assumptions that grew out of our previous work, assumptions that have been reinforced by our research and by the current crisis. Five of those assumptions are particularly relevant to the research on this labour force and relate to an additional overall assumption: care is a relationship that needs fostering and support. First, the conditions of work are the conditions of care. Although there has been a great deal of recent discussion about resident-focused care, staff cannot easily focus on residents if the conditions do not now allow them the resources, the structures, the support, the time, and the capacity to do so. Second, as the determinants of health teach us and as is becoming increasingly obvious once again with the pandemic, housekeeping, dietary, laundry, clerical and recreation services are critical components in care. Third, the labour in nursing homes includes a host of paid and unpaid work carried out not only by staff, families and volunteers but also by paid staff who take on unpaid work. Fourth, care work is skilled work, and those doing the work require ongoing education and training for the nursing home environment. Fifth, the bulk of the labour is carried out by women, many of whom are racialized and/or new to this country. As well, women account for the majority of residents, although the number of men is increasing. Moreover, the resident population has become increasingly diverse. In keeping with our search for promising practices, these are principles that establish the basis for research, policies and practices which themselves may vary with context.”*

# Emerging COVID-19 evidence (not peer-reviewed)

## Germany and the COVID-19 long-term care situation.

**Klara Lorenz-Dant (2020) Country report in LTCcovid.org, International Long Term Care Policy Network, CPEC-LSE, 23 April 2020. <sup>23</sup>**

This paper describes the current impact on care homes and associated policy/guidance:

*"On 22 April 2020 [...] there have been 15,266 COVID-19 infections recorded in care settings. Out of these, 8,258 were residents and 6,008 staff. 1,599 or residents and 20 members of staff have been reported to have died. This amounts to about 1/3 of all registered deaths due to COVID-19 in Germany."*

Ongoing lessons learned relate to the frequency of testing to manage the risk of staff bringing in infection; the supply of PPE; and the risk of ageism and discrimination:

*"The society [German Society for Gerontology and Geriatrics] concludes that it would unethical, discriminatory and irresponsible to enforce quarantine on one million people based on their chronological age, while younger people do not have to endure such measures. The statement further declares the responsibility to reflect carefully on the consequences of measures and to offer possibilities for interventions that can support groups such as people living with dementia and their relatives during this difficult time. Should triage decisions become necessary in Germany, they should not purely be based on age. "*

## Impact of the COVID-19 Outbreak on Long-Term Care in the United States.

**Courtney Harold Van Houtven, Nathan A. Boucher, Walter D. Dawson (2020) Country report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 24th April 2020. <sup>24</sup>**

This paper describes the current impact on care homes and associated policy/guidance in the US. Lessons relate to pre-shift screening and testing, PPE, increased communication with families and financial sustainability of homes. There are also references to ageism:

*"Living in the shadows is isolating for members of this community, staff, and patients/residents alike. Staff, because their role in healthcare delivery is seen as being not as important as those of working in hospitals where things "get fixed." Patients/residents, because they need more care than we are willing or able to give them in community. Now social distancing during our pandemic has amplified the isolation that already existed, for patients and residents especially, but also for staff as they struggle to be seen as "essential" workers. The pandemic's impact on LTC facilities can be harnessed to bring to light this overlooked area and the discrimination against aging and disabled communities. The heightened infection rates and deaths observed among Black, Latino, and Native American communities nationally will likely be seen in LTC facilities, and will require another call to action for these particularly disadvantaged groups (older/disabled and minority status). "*

There are also references to the impact on other residential facilities which have arguably received less attention:

*"There are beginning to be reports of group homes having infection spreading. A general feeling exists that this population, estimated to total approximately 6 million people, has been overlooked during this crisis. Another important point that has not been considered is that intellectually disabled individuals commonly work in jobs with a great level of exposure risk, including grocery store bagging, etc. Thus, congregant living in group homes and exposure of work both need to be addressed."*

# Lessons from previous pandemics and major incidents

## Impact of SARS Visiting Restrictions on Relatives of Long-Term Care Residents.

Lynn McCleary; Mona Munro; Linda Jackson et al (2005) *Journal of Social Work in Long-Term Care*, Vol. 3(3/4), 3-20. <sup>25</sup>

*"Visiting restrictions had a significant impact on spouses and adult children of the residents at this geriatric facility. Participants described a disruption in their caregiving and the care provided by privately paid staff. They worried about the effect the restrictions were having on their vulnerable relatives' physical and emotional well-being. Participants described negative and positive effects for their relatives during this time. According to the participants, what was most helpful was being reassured about their relatives' well-being.*

*Communication was very important to the participants. Easy access to up-to-date information about how the facility was implementing Ministry of Health directives made a difference. Based on learning from families during the SARS outbreak, recognizing the importance of communication during an outbreak, Baycrest has developed a new group messaging telephone system, which is intended to facilitate speedy information exchange with families whenever needed.*

*Even more important than clear, timely communication about SARS related policy and practice was communication about their relatives. Previous research has found that relatives are often frustrated by not receiving information about the resident's daily life (Hertzberg et al., 2001). What helped relieve participants' anxiety about their relatives was timely, accurate information about their relatives' condition and care. Our findings about what reassured relatives are consistent with previous research showing that one reason relatives visit during mealtimes is because they want to be certain that the resident eats (Hertzberg et al., 2001). During the visiting restrictions, social workers organized a system whereby families received regular phone calls and updates from social workers or other staff. For example, the staff who assisted with feeding would call the relatives after the meal or assist the resident to call the family."*

## Experiencing SARS: Perspectives of the elderly residents and health care professionals in a Hong Kong nursing home.

Mimi M.Y. Tse; Sandra P.Y. Pun and Iris F.F. Benzie (2003) *Geriatric Nursing*, 24(5): 266–269. <sup>26</sup>

This paper explored the level of knowledge amongst residents, which was relatively low given that information had been shared via multiple channels. The paper also considers staff attitudes to the outbreak:

*"Increasing awareness of SARS in the elderly and their caregivers and enhancing preventive measures are crucial to avoid new outbreaks. The worry and fear of an outbreak of SARS among staff working in the nursing home are still high. More in-service training, support, and counseling are strongly indicated to promote prevention and improve quality of care. Tailored education for the residents of elderly care homes is also important because their active participation is needed in SARS prevention, and their fears and concerns of SARS, while often justified and possibly useful, must not be allowed to compromise their quality of life."*



# Lessons from previous pandemics and major incidents

## [Homelessness and the Response to Emerging Infectious Disease Outbreaks: Lessons from SARS.](#)

**Cheryl S. Leung; Minnie M. Ho; Alex Kiss et al (2008) Journal of Urban Health 85(3):402-10. <sup>27</sup>**

This paper shares lessons learned from Toronto following a SARS outbreak:

*“As the outbreak unfolded, the value of designating a single official contact person as the main source of timely and accurate information for homeless service providers was recognized. [...] Following the outbreak, an email alert system was created to permit rapid dissemination of urgent health advisories to homeless agencies. Many larger homeless service agencies developed crisis management teams during the SARS outbreak that became an ongoing part of their organizational structure to address future emergencies. [...]*

*Many shelters and drop-ins enhanced their basic infection control procedures during the SARS outbreak, encouraging frequent hand-washing or hand sanitizer use, appropriate use of masks and gloves by staff, and increased surface cleaning and disinfection. However, policies varied widely across agencies due to a lack of specific guidelines and the cost and limited availability of supplies. Health officials did not arrange for personal protective equipment to be supplied to homeless agencies because they were not classified as health-care facilities. [...]*

*Shelters used the public health-screening protocol designed to identify individuals with possible symptoms of SARS (fever, cough, shortness of breath, chills, rigors, malaise, or headache) but found that a large proportion of homeless individuals had one or more of these symptoms, especially cough. [...]*

*A working group with representatives from public health, shelter services, and community agencies was established to prepare an outbreak response planning guide for homeless service providers, which was incorporated into the city’s pandemic influenza plan.<sup>15</sup> To improve knowledge regarding communicable disease and infection control principals, this working group oversaw the development of a communicable disease training manual and educational program for homeless agency staff. Shelter providers were also introduced to the use of illness-surveillance records to track symptom clusters among shelter residents.[...]*

*In the event of a future outbreak, homeless services may have to be consolidated at a reduced number of sites due to staff shortages and the need to halt new admissions at shelters with high attack rates. A process for making such decisions and issuing clear directives to service providers needs to be developed.”*

# Ongoing studies

| Study title   | Study type     | Country                | Link  |
|---|----------------|------------------------|---|
| <b>Gerontological Telemonitoring of Older Adults Living in Nursing Homes With COVID-19 Disease (COVIDeHPAD)</b>   | Clinical Trial | France                 | <a href="https://clinicaltrials.gov/ct2/show/NCT04337788">https://clinicaltrials.gov/ct2/show/NCT04337788</a>   |
| <b>COPE Study: COVID-19 in Older PEople - the influence of frailty and multimorbidity on survival. A multicentre, international observational study</b> | Observational  | International (UK-led) | <a href="https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/281951/">https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/281951/</a> |

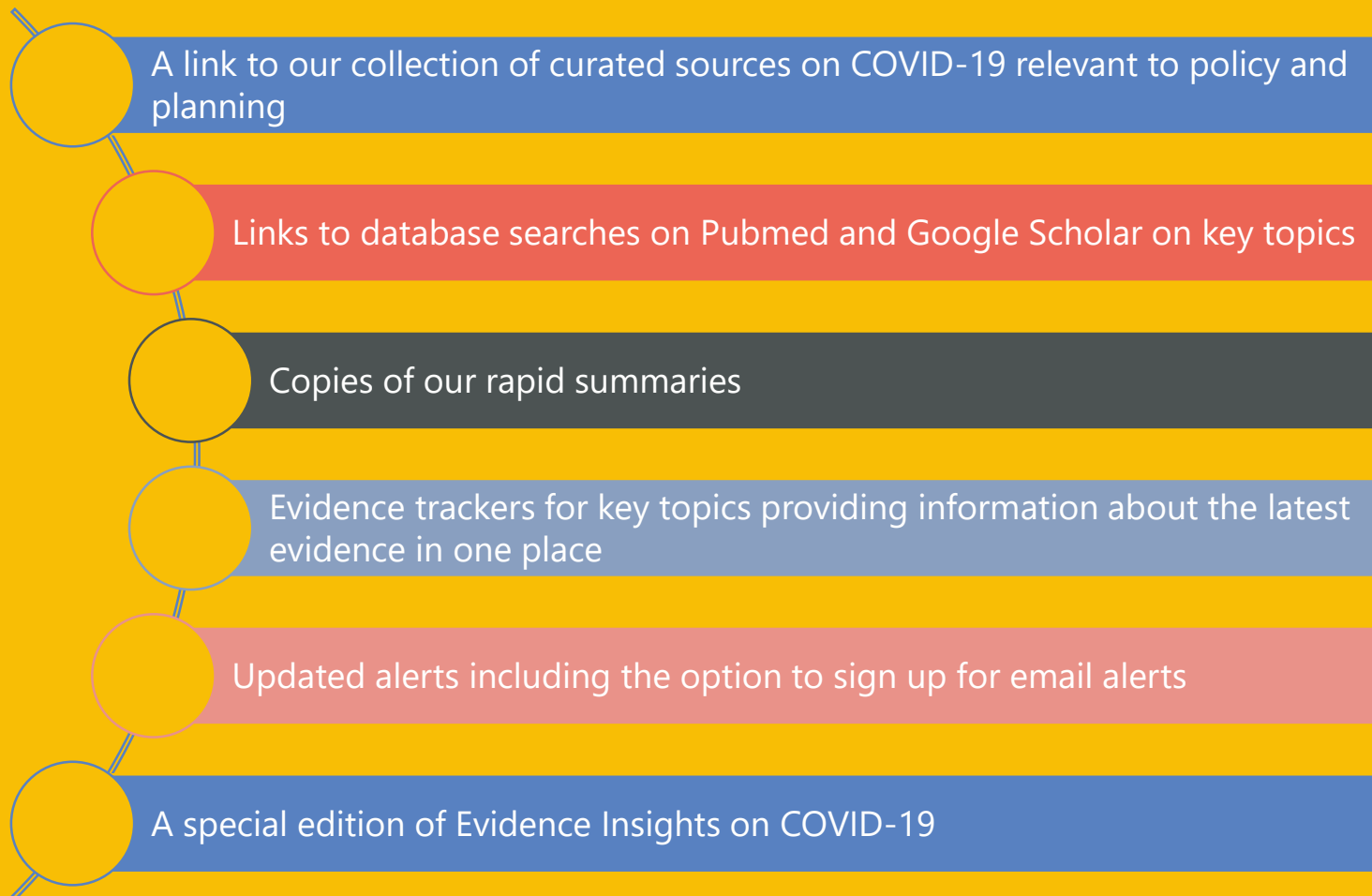
# Other useful resources

| Title  | Country       | Link  |
|--|---------------|---|
| LTC responses to COVID-19  | International | <a href="https://ltccovid.org/">https://ltccovid.org/</a>   |
| Preparedness Checklist for Nursing Homes and Other Long-Term Care Settings | US            | <a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html">https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html</a> |

# Keep up to date

Keep up with new and emerging evidence via our web page, where you will find:

<https://www.strategyunitwm.nhs.uk/COVID-19-and-coronavirus>



# Links

1. <https://www.nuffieldtrust.org.uk/news-item/deaths-in-care-homes-what-do-the-numbers-tell-us>
2. <https://www.kingsfund.org.uk/blog/2020/04/tackling-covid-19-outbreak-care-homes>
3. <https://www.health.org.uk/news-and-comment/news/dire-warnings-from-care-home-sector-borne-out-in-the-latest>
4. <https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes>
5. <https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes>
6. <https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-care-homes>
7. <https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-for-supported-living-provision>
8. [https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC\\_long\\_term\\_care-2020.1-eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf)
9. <https://www.cebm.net/covid-19/how-can-pandemic-spreads-be-contained-in-care-homes/>
10. <https://jbi.global/sites/default/files/2020-04/Guidelines%20for%20preventing%20respiratory%20illness%20in%20older%20adults%20aged%2060%20years%20and%20above%20living%20in%20long-term%20care.pdf>
11. <https://alzheimeriberoamerica.org/wp-content/uploads/2020/04/Mortality-associated-with-COVID-12-April-3.pdf>
12. <https://osf.io/preprints/socarxiv/ksefy/>
13. <https://ltccovid.org/wp-content/uploads/2020/04/note-on-asymptomatic-transmission-in-care-homes.pdf>
14. <https://ltccovid.org/wp-content/uploads/2020/04/LTC-COVID19-situation-in-Canada-22-April-2020-1.pdf>
15. [https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm?s\\_cid=mm6913e1\\_w](https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm?s_cid=mm6913e1_w)
16. [https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e2.htm?s\\_cid=mm6914e2\\_w](https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e2.htm?s_cid=mm6914e2_w)
17. <https://insight.jci.org/articles/view/139292/pdf>
18. <https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.16499>
19. <https://www.medrxiv.org/content/10.1101/2020.04.14.20065557v1.full.pdf>
20. <https://onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16513>

21. <https://www.kff.org/medicaid/issue-brief/data-note-how-might-coronavirus-affect-residents-in-nursing-facilities/>
22. [https://www.policyalternatives.ca/sites/default/files/uploads/publications/National Office/2020/04/Reimagining residential care COVID crisis.pdf](https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2020/04/Reimagining%20residential%20care%20COVID%20crisis.pdf)
23. <https://ltccovid.org/wp-content/uploads/2020/04/Germany LTC COVID-19-23-April-2020 updated.pdf>
24. <https://ltccovid.org/wp-content/uploads/2020/04/USA-LTC-COVID-situation-report-24-April-2020.pdf>
25. <https://www.researchgate.net/publication/232821695> Impact of SARS Visiting Restrictions on Relatives of Long-Term Care Residents
26. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7124276/>
27. <https://www.researchgate.net/publication/5504450> Homelessness and the Response to Emerging Infectious Disease Outbreaks Lessons from SARS
28. <https://wakelet.com/@COVID-19Collaboration>

# Appendix - Methodology



## Scoping the review

### Geography Settings

International  
All care settings – secondary, primary, community, independent – unless specified

### Language/s

No language restrictions but please note there is no budget for translation. Therefore, we will prioritise translated materials where available and will source translations within existing resource.

### Dates

We may limit evidence relating to earlier pandemics/major incidents to the last 10 years, should the volume of results be high, to focus on contemporary literature.

## Search sources and locations

### Bibliographic databases:

- Pubmed
- Google Scholar
- Cochrane Library
- CINAHL
- Global Health
- Disaster Lit

### Aggregators and search engines:

- NHS Evidence
- TRIP (using Covid filters)

### Grey literature:

via our [curated collection](#) of resources on COVID-19 and Coronavirus <sup>28</sup>