Department of Health
An Roinn Sláinte
Männystrie O Poustie
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# COVID-19: The Safe at Home Model
# May 2020

## Context and need

1. There is growing international evidence that people living in care homes are particularly vulnerable to severe COVID-19 infections and that they are experiencing high rates of mortality as a result. Evidence is emerging to suggest that, internationally, COVID-related deaths among care home residents can range between 19% and 62%.[1] Given that the death rate amongst the older population is significantly higher than the younger population, there is a particular need to protect care homes. Guidance is already in place asking homes to strictly limit visitors and to put in place infection prevention and control measures. Updated advice on testing confirms that all residents and staff of care homes where there is an outbreak should be tested (whether they have symptoms or not) and all new or returning residents should be tested prior to admission to a care home. When an outbreak occurs, expert advice is available from the PHA.

2. However, with COVID-19 circulating widely in the community the risks of infection being introduced into care homes are significant and there is therefore a need to consider what further measures can be taken. A significant number of homes have suffered infections of COVID-19 and we must seek ways to stop or limit these infections in order to maintain the quality of life for residents, protect those most vulnerable and save lives.

3. The Department of Health (DoH) has therefore developed the Safe at Home model. In this model, staff would be asked to live-in, either in the home itself or at a self-contained location close by, for a period of time. This approach should be complemented by periods of self-isolation when staff are not living in, and by increased testing and symptom checking of residents, staff and their household members.

4. We are keen to test this approach in a small number of care homes that would be in a position to safely implement it. Our focus in testing the approach is primarily to learn quickly about the benefits associated with it, any challenges and difficulties that may arise, and to quickly disseminate that learning across other care homes. We recognise that full scale rollout across Northern Ireland is unlikely to be feasible, however we are keen to explore whether elements of the approach may be suitable for adoption by other homes.

5. The rest of this paper sets out the rationale for the approach, the key elements associated with its implementation, and the criteria which—in our view—must be satisfied for a home to safely implement the Safe at Home

[1] https://ltccovid.org/2020/04/12/mortality-associated-with-covid-19-outbreaks-in-care-homes-early-international-evidence/

model. Any care home provider that considers it can satisfy these criteria and would be interested in piloting the model may wish to contact the Department to consider what additional support may be available to pilot the model, and how we can work together to disseminate any learning as it emerges. Further information including contact details and the application process are set out at paragraphs 23-26.

6. This model has been developed in consultation with the Public Health Agency and has been agreed by the Chief Medical Officer.

Rationale

7. All residents in care homes are now shielding, and therefore should not be leaving the home. COVID-19 can therefore only be introduced by someone entering the home or by being carried into the home on an object. The carrier could be a new resident, a visitor or a staff member. Therefore, measures which restrict movement into and out of homes are essential in trying to minimise the risk of COVID-19 transmission.

8. A number of such measures are already in place. Visitors have been restricted to the absolute bare minimum (including visits from HSC professional staff). In line with revised guidance for nursing and residential homes published by DoH in April 2020, patients being discharged from hospitals to care homes, or people being admitted to care homes, must be tested prior to being admitted to the home and subject to isolation for 14 days. Where homes, because of their physical layout, are unable to support isolation of new or returning residents, HSC Trusts will seek alternative arrangements, including the use of step-down beds where this is considered appropriate. All staff and residents of care homes where there is an outbreak are also being tested, regardless of whether they have symptoms.

9. There are however further steps that can be taken to seek to move closer to “cocooning” or “hermetically sealing” the home from infection. We know that some care homes locally have already taken steps to support staff to live in or close to the homes in which they work, in an effort to both protect care home residents and also staff and their families from the risks of COVID-19 transmission.

10. In addition, international examples of best practice are also highlighting approaches which seek to minimise the movement of staff into and out of homes. For example, the Singapore Ministry of Health recently announced that—in addition to prioritising testing for all care home residents and staff—it would work with homes to facilitate lodging (either in homes or in nearby hotels) for staff to minimise their risk of exposure to the virus in the community and potential for the virus to enter the home this way, and would provide an additional allowance to staff in recognition of

the personal sacrifices associated with the approach.[2] In one region in South Korea, 564 social welfare homes were quarantined with staff working for two weeks without leaving the facility. Staff were provided with financial incentives and were required to self-isolate when not working. As a result, 560 of the homes remained free of the virus (the other 4 had experienced an outbreak by the time the approach was employed).[3]

11. The Safe at Home model seeks to add to the evidence emerging from other countries and to rapidly learn from the approach, to identify any benefits and challenges, so that learning can be quickly shared across all care homes and other settings in Northern Ireland. Alongside other measures which have been put in place, including expanded testing and protocols on discharge from hospitals to care homes, the Safe at Home approach has the potential to significantly contribute to a reduction in the route through which the infection could be introduced to care homes.

12. Enhanced monitoring of staff and residents will also help to ensure that any positive cases of the virus are identified at the earliest possible stage, even where residents or staff are asymptomatic, and swift action can be taken to minimise the risk of spread, through further isolation of the resident or the managed absence of a staff member.

Objectives

13. In the context of the above, the objectives of the Safe at Home model are:

**Objective 1**: test the impact of staff living in care homes, or in a self-contained location close by, on infection prevention and control;

**Objective 2**: understand the practical challenges, costs and requirements associated with such an approach.

**Objective 3**: learn more about the benefits of extensive testing for staff, their families and all care home residents, including gathering further evidence on asymptomatic carriers;

**Objective 4**: test the acceptability of this approach for staff, care home residents and their families, including additional support needed to safeguard their emotional wellbeing; and

[2] https://www.moh.gov.sg/news-highlights/details/additional-covid-19-support-measures-for-all-homes-serving-the-elderly
[3] https://ltccovid.org/2020/03/26/report-the-south-korean-approach-to-managing-covid-19-outbreaks-in-residential-care-settings-and-to-maintaining-community-based-care-services/

**Objective 5**: consider the scope for expanding this approach more widely, recognising that it will not be feasible to implement the model in full across all care homes.

Principles

14. Before describing the model in detail, there are some essential principles which must underpin its implementation in any care home. These are as follows:

    a. The physical and emotional wellbeing of residents and staff is paramount.

    b. It must be recognised that implementation of the model in any care home is a significant ask of staff, and will impact on their personal lives at what is already a very difficult and challenging time for staff working in this environment.

    c. Staff should be suitably recompensed for the additional commitment associated with implementation of the model.

    d. No member of staff in any home should be disadvantaged as a result of a decision to test the model.

    e. No member of staff should feel compelled to participate in the model. Where, for whatever reason, a member of staff does not wish to participate in the model, the onus must be on the care home provider/ registered manager to identify—in agreement with the staff member—suitable alternative arrangements for the duration of the approach.

    f. The physical premises of the care home must be suitable for the safe implementation of the Safe at Home model. Appropriate accommodation, including single-sex sleeping, changing and showering facilities, must be available.

    g. Staff participating in the model must have meaningful rest and relaxation time while living in.

    h. Adequate supports must be available to help staff keep in touch with their loved ones.

    i. Any home wishing to test the Safe at Home model must conduct a thorough risk assessment in advance.

    j. The Safe at Home model should only be tested in homes where there is no current outbreak.

k. Testing of the Safe at Home model must be accompanied by the full range of infection prevention and control measures detailed in DoH guidance for nursing and residential homes (April 2020). These include use of PPE in line with guidance, isolation and physical distancing measures, and cleaning and laundry arrangements.

Safe at Home Model - Specifications

15. In summary, the Safe at Home model envisages staff living in, or in self-contained accommodation close to, the care homes in which they work. It is envisaged that staff would live in for a period of at least seven days. Staff would be rostered to work a set number of hours each day, but would remain in the home—or in designated self-contained accommodation—during the hours they are not rostered to work.

16. Precise details of working patterns will be subject to agreement between the employer and staff, and will need to be signed off by DoH to ensure that arrangements are in line with the model as described.

17. The key elements of the approach are set out below. These have been separated into pre-living in and in-home arrangements, and based on a live-in period of seven days. Any expressions of interest from providers will need to demonstrate that they are in a position to deliver on these.

Pre-living in

a. The participating homes will be closed to all new admissions.

b. Participating homes will undergo an enhanced clean prior to the start of living in arrangements.

c. Participating homes must have sufficient supplies (enough for at least 8 days) of all necessary PPE.

d. All residents of participating care homes will be tested prior to the pilot commencing.

e. Prior to beginning each seven day rota, staff will self-isolate for at least 48 hours.

f. Staff will be tested 48 hours prior to beginning each seven day rota. Other members of their household will also be tested.

g. In addition to testing, during the self-isolation period, staff will also be asked to self-screen during this time and have their temperature checked twice a day.

h. On-call staff will also need to be available, in the event that rostered staff are identified as having COVID-19. These staff must be tested prior to entering the home.

In-home arrangements

a. Strict visiting restrictions must be applied. Only essential visits will be permitted, in line with regional guidance.

b. Appropriate sleeping and living arrangements must be available for staff living in. Ideally these should be within the home, or if this is not feasible consideration can be given to staff being accommodated at a suitable contained location close to the care home, for example in a hotel or similar self-contained accommodation. If this is the case, arrangements for transporting staff to the care home will need to be in place. Accommodation should include private showering/ changing facilities, and also arrangements for meal provision.

c. Beds and living areas must be configured in such a way as to ensure necessary physical distancing, and communal areas should be largely out of bounds.

d. Participating staff will be provided with their meals, free of charge.

e. The care home provider will need to provide appropriate facilities for staff down-time and additional support for staff wellbeing, including maintaining contact with their families.

f. Twice daily symptom checking, including temperature checks, of both staff and residents will be undertaken, recorded and tracked.

g. Staff will be re-tested five days after the initial swab to provide a midweek result.

h. Should an outbreak occur in the home during the pilot, all staff and residents will be tested.

i. Residents will be supported to maintain social distancing and access communal areas where this is part of the agreed COVID-19 risk assessment and care plan.

j. There must be clear measures to safeguard residents against abuse or exploitation.

k. Anything moved between rooms must be disinfected.

l. Cleaning and laundry arrangements must be in line with PHA guidelines.

18. The pilot will be time limited, for a period of at least six weeks initially before a rapid evaluation to facilitate the decision whether to continue, expand or stop.

Remuneration

19. Details of additional remuneration for staff participating in the model will be for agreement between employers and staff. As above, any remuneration should recognise the significant additional commitment and personal sacrifice associated with staff agreeing to participate in the model.

Monitoring and Evaluation

20. DoH will establish a learning group, co-chaired by the Chief Social Work Officer and the Chief Nursing Officer, to provide oversight of arrangements to pilot the Safe at Home model and ensure that emerging learning is identified and disseminated quickly. Participating care homes would be required to participate in this learning group to provide regular feedback and identify learning as it emerges.

21. This group will meet frequently (at least twice a week for the duration of the pilot) to rapidly identify and act on any learning. A mechanism will be put in place to support the rapid identification and sharing of learning across the system as appropriate.

22. Evaluation will be undertaken against the stated objectives for the pilot as follows:

**Objective 1**: test the impact of staff living in care homes, or in a self-contained location close by, on infection prevention and control

The numbers of suspected or confirmed cases of flu like illnesses (FLI) of COVID-19 will be closely monitored. In addition to the usual reporting arrangements, numbers of suspected or confirmed cases of FLI and COVID-19 in each participating home will be reported at each meeting of the learning group.

**Objective 2**: understand the practical challenges, costs and requirements associated with such an approach.

Participating homes will report any challenges encountered to the learning group, and costs and additional requirements that emerge during the pilot will be tracked.

**Objective 3**: learn about any benefits of extensive testing for staff, their families and all care home residents, including gathering evidence on asymptomatic carriers;

Participating care homes will need to identify whether positive test results were from symptomatic or asymptomatic staff and report back to the learning group

**Objective 4**: test the acceptability of this approach for staff, care home residents and their families, including additional support needed to safeguard their emotional wellbeing; and

Feedback from staff, residents and their families will be sought during the pilot. Arrangements will need to be in place to ensure that this feedback is collected and reviewed objectively, and that individuals are supported to provide feedback freely and openly.

**Objective 5**: consider the scope for expanding this approach more widely, recognising that it will not be feasible to implement the model in full across all care homes.

The learning group will compile a report at the end of the pilot study, which will include an evaluation of the benefits and costs associated with the approach, including proposals to support wider rollout if this is indicated.

Further information

23. Any care home providers who consider that they would be in a position to pilot the Safe at Home model for a period of at least six weeks are invited to contact the Department of Health to discuss their plans and consider what additional support the Department may be able to provide.

24. Providers should contact Sean Scullion, Elderly and Community Care Unit in the first instance, by email at sean.scullion@health-ni.gov.uk on 028 9052 3159 or 07890 546544.

25. Care home providers interested in testing the model will need to be able to demonstrate that they can safely implement the approach as detailed in this paper, that they have conducted a risk assessment and have put in place measures to mitigate any identified risks.

26. DoH will assess a home's suitability to test the Safe at Home model against a range of factors, including:

- suitability of the physical premises;
- necessary infection prevention and control measures in place;
- no cases of COVID-19 or flu-like illness in the home;
- stability of management and staffing arrangements;
- levels of regulatory compliance;
- willingness of staff to participate in the pilot;
- safeguarding arrangements in place; and
- arrangements in place to promote the physical and emotional wellbeing of staff and residents during the course of the pilot.

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