Confidential Report

HSE

A Community Nursing Home

EXECUTIVE SUMMARY

Report of Investigation of Complaints Made by Protected Disclosure

Executive Summary of Report Dated 28th May 2022

Commissioned by
National Director of Community Operations
Health Service Executive

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Report of Investigation of Complaints Raised by Protected Disclosure

Section 1 Introduction

1.1. Background

1.1.1. By letter dated 6th May 2020 a Protected Disclosure was raised by a discloser to Mr Paul Reid, Chief Executive of the HSE through the Discloser's Solicitors. The disclosure contained a document entitled *My Points of Testimony,* which sets out the concerns raised by the Discloser. The concerns refer to the alleged care of residents at a Community Nursing Home (CNH) from 6th March 2020 up to 1st May 2020, and with reference to specific concerns between 25th March 2020 to 6th April 2020 regarding in particular Ward 1 at the CNH. The areas of concern relate to a COVID-19 outbreak at the Unit during this period.

1.1.2. The Protected Disclosure was accepted by the Authorised Person of the HSE and notified to the HSE Chief Operations Officer on 11th May 2020. The Authorised Person initiated the actions required under the HSE Framework for the Protected Disclosures Act 2014. The HSE Chief Operating Officer assigned the National Director Community Operations to act as Commissioning Manager for the investigation.

1.1.3. Having reviewed the disclosure, the Commissioner appointed an Investigation Team comprising of an Independent Chairperson, a Consultant Geriatrician, and a RGN, Community Operations Quality & Patient Safety, to investigate the concerns under Terms of Reference and Methodology for the Investigation.

1.1.4. The Discloser has requested anonymity throughout the Investigation. In this regard, the Investigation maintained its responsibilities in accordance with Section 16 of the Protected Disclosures Act, 2014. To protect the identity of the Discloser, in this report the Investigation has anonymised the names of all persons it met in the course of the Investigation, along with the identity of the Nursing Home and the Investigation Team.

1.1.5. In accordance with the terms of reference, the final report is issued to the Commissioning Manager. Prior to the final report being presented to the Commissioner, a preliminary report with conclusions based on the evidence gathered in the course of the investigation was provided to persons who may be deemed to be adversely affected by the conclusions. These persons were

invited to provide clarifications or challenge any aspect of the evidence to the Investigation in writing. The clarifications that were submitted have been considered in preparing this final report.

1.1.6. A summary of the concerns raised by the Discloser are set out in Section 2 below.

1.2. The Community Nursing Home

The Community Nursing Home (CNH) is a statutory body owned and managed by the Health Service Executive (HSE) under the governance of a Community Health Organisation (CHO).

1.2.1. CNH is a continuous care residential care setting supporting older adults over the age of 65 years, with many levels of dependency. The facility provides residential care for up to 150 male and female adult residents of all levels of dependency. The facility consists of two purpose-built buildings, House 1, 100 beds and House 2, 50 beds. The buildings have two storeys and are divided into six units. Each ward is made up of single and shared multi-occupancy rooms. The residential service is made up of six wards and there is 25 beds in each ward.

1.2.2. The units in CNH are governed by the Health Act 2007 (Care and Welfare in Designated Centres for Older People) Regulations 2013 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

1.2.3. In January 2020, there were 150 beds which were made up of 6 units, with 25 residents living in each unit. The accommodation of each unit is made up of 17 single rooms, 2 x 2 bedded rooms (4 residents) and 1 x 4 bedded room (4 residents), giving 25 residents in each ward as provided in the ward layout records by the CHN).

1.2.4. Separate to the CNH facility and on the same campus area is a hospital. The hospital has 48 beds and provides care for older persons in the community, a stroke rehabilitation unit of 10 beds for adults of all ages, a Day Hospital, and a Healthy Ageing Clinic. The disclosure does only relates to the CNH.

1.2.5. The registered provider for the CNH is the HSE. At the time of the COVID-19 outbreak addressed in this report (March 2020), an Assistant Director of Nursing was identified as the Person in Charge. The most recent HIQA Inspection Report prior to the outbreak[1] identified that *there was suitable and sufficient staffing and skill-mix in place to deliver a good standard of care in the units, that arrangements were in place to ensure that there was adequate clinical*

[1] HIQA Inspection 28th August 2019 published on 28 November 2019

supervision and direction for staff by the nurse managers. The two persons in charge were experienced in care of the older person and were supported in their roles by senior managers, nurse managers and the multidisciplinary team. The HIQA Inspection report also identified there *were management systems in place but this did not support constant and effective monitoring to ensure that the service provided was safe, appropriate and effectively monitored. This was as a result of a combined approach with another organisation that shared the campus.*

1.2.6. The CNH facility is overseen by a Hospital Manager. A Consultant Geriatrician is appointed to the Hospital and the CNH as the lead geriatrician with responsibility for the CNH. In this capacity they provide clinical governance over all the services in the CNH, the Rehab Unit, and the day hospital. In total there are eleven doctors on the team including Registrar and SHOs. There is no Clinical Director on site. The Investigation was advised that the CNH is a Nurse Led Unit. A General Manager with the CHO who is the registered provider for HIQA registration.

1.2.7. Nurse management at the CNH consists of a Director of Nursing (DON), and two Assistant Directors of Nursing (ADON). The DON is line manager of the ADONs. Each ward is assigned a Clinical Nurse Manager 2 (CNM2) who is supervisory to the nursing compliment. Each ward is assigned a Clinical Nurse Manager 1 (Nurse Manager). The Nurse Manager supports the role and function of the CNM2. The Nurse Manager is included in the staffing levels and has a case load but is also there to provide a supervisory status in the absence of the CNM2. There are 5 nursing administration staff (site managers) assigned to night duty across both sites. 3 staff are at CMN2 level and 2 are senior staff nurses. Only one staff member is assigned to work over the 150 bedded unit at night. During the COVID-19 Outbreak, a senior nurse was assigned to work in each house (one in House 1 and one in House 2) to cut down on crossover of staff and for increased supervision and support to staff on the wards.

1.2.8. Staff Nurses are allocated to work in care pairs with a Health Care Assistant. During the daytime there is one care pair assigned to 8 or 9 residents. At night-time there is one nurse and one HCA assigned to each ward of 25 residents.

1.2.9. There is a nursing supervisor who works at night-time to support and oversee the nursing care of the CNH and an ADON assigned to 75 beds each. Each is the PIC for their respective units.

1.2.10. House 1, the 100 bedded unit, consists of four wards Ward 1, Ward 3, Ward 4, and Ward 2. House 2, the 50 bedded unit, consists of two wards (Ward 5 and Ward 6).

1.2.11. The optimal staffing levels on a unit for a day shift is 3 RGNs/3 HCAs and a supernumerary CNM2/1 if available. The staffing levels for a night shift is 1 RGN/1 HCA for 25 beds. Clinical decisions on staffing levels are made following assessment of the level of acuity, dependency levels and other contributing factors such as End of Life care required.

1.2.12. The multidisciplinary nursing medical and professional personnel are supported by a team of health care support staff including Health Care Workers (HCW) Health Care Assistants (HCA), Portering staff, Catering staff and a contract with cleaning staff from Derrycourt.

1.2.13. During the pandemic and where staff members needed to take sick leave, the CNH engaged with agencies to provide agency staff.

1.2.14. On 28th March 2020 the first positive case of COVID-19 was identified in CNH. A COVID-19 Outbreak was declared in the CNH on 30th March 2020. The Outbreak was officially closed on 7th July 2020, confirmed by Public Health.

1.2.15. There were 146 residents on-site when the outbreak began. It is recorded that 83 of these residents became COVID-19 Positive and sadly 22 residents died due to COVID-19 during this time. 60% of the total residential population became ill from the virus, with a fatality rate of 26.5% of infected residents

1.2.16. At the time of the Investigation total bed capacity was reduced to 134 beds in the CNH.

1.3. Overview of the Concerns Raised in the Protected Disclosure

1.3.1. The Discloser alleged serious, ongoing, life-threatening health and safety issues affecting patients and staff, particularly for a period commencing early March 2020 up to and including 14th April 2020, and the concerns raised include the period up to 1st May 2020. In their submission the Discloser sets out the concerns regarding the care of residents and CNH under twelve themes as follows:

1.1.1.1. Loose 'Visitor Restrictions.

1.1.1.2. Failure to Lock Down Wards and Buildings.

1.1.1.3. Stringent Management of Personal Protective Equipment (PPE).

1.1.1.4. End of Life Protocol.

1.1.1.5. Failure to Risk Assess 'Vulnerable' staff.

1.1.1.6. Failures related to Staff Testing.

1.1.1.7. Conflicting Role of Medical, Infection Prevention and Control (IPC) and Nursing Management Staff in Identifying, Isolating and Testing.

1.1.1.8. Failure to Isolate Symptomatic Patients.

1.1.1.9. Shared Equipment.

1.1.1.10. Contact with Relatives.

1.1.1.11. Recycled Air System and Coronavirus Risk.

1.1.1.12. Enforced Annual Leave while Wards Chronically Short Staffed.

1.3.2. The Investigation has no reason to doubt the genuineness of the above concerns raised by the Discloser.

1.3.3. For its part the CNH has maintained that it provided the appropriate care to the residents at CNH. It acknowledges the outbreak of COVID-19 was a particularly challenging time for the residents, their families, and the staff of CNH. It maintains that the care of the residents and actions to deal with the pandemic needs to be set within the context of the COVID-19 presenting an unprecedented challenge, both nationally and globally. The CNH maintain that it deployed its staff and resources as appropriate throughout the period.

1.3.4. The CNH maintained it followed guidance and advice on preparedness, planning and guidance from Nursing Homes Ireland, the Department of Health, the HSE, and HIQA (the Health Information and Quality Authority). It further submitted that specific challenges arose as a result of the changing dynamic of the virus, the changing advice on how to address the virus, shortage of Personal Protective Equipment (PPE), high levels of staff reporting sick due to the virus and/or staff who were vulnerable to the virus, the lack of availability of prompt testing of residents, and delays in confirmation of test results.

1.3.5. In addition, in the covering letter to the Discloser's submission from the Discloser's Solicitors, it was submitted that a memo was issued by the HSE to the CNH on 14th April 2020. It is alleged that this menu contained egregiously offensive and dehumanising language categorising patients as clean, dirty, and dirtiest. It was maintained as these comments amount to a contumacious breach of basic human rights and the fundamental rights of patients to respect, dignity, and bodily integrity while in the care of the state. For his part the HSE has denied all responsibility for the issuing or publishing of this memo.

1.3.6. A Deputy of Dáil Eireann contacted the Investigation on 7th December 2020 in relation to the minutes of a CHO Residential Care Teleconference that took

place on 14th May 2020. It is alleged that these minutes referred to a minute of a meeting issued by the CHO. The emails referred to an alleged instruction from CHO to take emails off the system that were issued to reinsure staff about the initial onset of COVID-19 and PPE. The Deputy asked for the *Investigation to seek a full explanation of what actually transpired in [CNH] following this meeting on the 14th May 2020 and to interview all appropriate staff*. The Investigation considered this matter and brought it to the attention of the Commissioner and sought instruction as the issues raised by the Deputy referred to a period not covered under the terms of Reference.

1.3.7. In accordance with the Terms of Reference *The investigation will address all concerns raised by the Discloser … the purpose of the investigation is to investigate the subject matter of the Protected Disclosure" …* and that the Investigation team will *seek and review all relevant documentation that is pertinent to the investigation, including appropriate policies and procedures.* The scope of the Investigation is to consider and address all aspects of the Protected Disclosure– *but not matters outside the Protected Disclosure*. On that basis the matters relating to the email of 18th May 2020 were deemed to be outside the scope of the Investigation and the Commissioning Office did not extend the remit of the investigation.

1.4. The Investigation Process

1.4.1. In accordance with the Terms of Reference, the Investigation focused on the complaints made by the Discloser and records of meetings with the Disclosure, the witnesses, associated evidence, and submissions, and the relevant CNH records provided to the Investigation.

1.4.2. The investigation at all times adhered to the principles of natural justice and complied with the HSE Protected Disclosures Procedures, issued in August 2018 (the HSE Procedures).

1.4.3. The Investigation is not focussed on establishing wrongdoing by any individual party or persons. In accordance with its terms of reference the Investigation set out to review the concerns raised and to determine whether the disclosed wrongdoings have/or are occurring, and to assist the HSE to ensure any improvement, learning or other actions can be taken in response to each aspect of the Protected Disclosure found to have occurred, be occurring, or be likely to occur in the future.

1.4.4. The steps that were by the Investigation are detailed in the main report, and include:

1.4.4.1. Meeting with the Discloser on 8th July 2020.

1.4.4.2. During August 2020 to November 2020 meeting with 32 parties whom the Investigation believed were in a position to provide evidence in relation to the concerns raised.

1.4.4.3. Responding to procedural concerns that were raised by the Discloser's representative on 10th December 2020.

1.4.4.4. Considering the representation made by the Dáil Deputy.

1.4.4.5. Meetings with family members that sought to provide evidence to the Investigation.

1.4.4.6. On 3rd February 2021 the Investigation sought access to Resident Records from the CNH. The files were provided in March 2021.

1.4.4.7. On 8th September 2021, the Investigation sought further documentary evidence/records from the CNH.

1.4.4.8. The Investigation met with further witness on 3rd October 2021, and from December 2021 to March 2022 met with six parties that were recalled to clarify issues.

1.4.4.9. Between November 2021 and January 2022, the Discloser's representative made further submissions to the Investigation that were responded to.

1.4.4.10. A Preliminary Report was issued to individuals who the Investigation deemed could be adversely affected by the conclusions on 24th March 2022.

1.4.4.11. The Investigation also met with the Discloser on 29th March 2022 to provide an update of the Investigation.

1.4.4.12. Each of the parties that received the Preliminary Report made a submission to the Investigation after receiving the Preliminary Report. The final responses and clarifications to the Preliminary Report were received by 11th May 2022. All of the submissions were considered before making final conclusions and reference to these submissions as relevant are made in the summary of evidence provided in the Main Report.

1.4.5. Overall, the Investigation held 47 meetings with various parties (41 with witnesses, 2 with Discloser, 4 with family members), met as an Investigation Team to review and consider the evidence on 52 occasions, and reviewed an extensive amount of documents and records.

1.5. Acknowledgements

1.5.1. It is evident that the impact of the pandemic amongst the management and staff of the CNH, and the sad loss of residents has had a significant and lasting effect on all those involved.

1.5.2. Under these circumstances the Investigation team are grateful for the cooperation afforded to it by the Discloser, by the management and staff of CNH, and others called as witnesses, including the relatives of four residents who sought to meet with the Investigation.

1.5.3. The Investigation acknowledges it has been asked to review and make findings on the specific allegations made by the Discloser. The bulk of these allegation occur during a short time frame between 25th March 2020 to 6th April 2020, and at a time leading up to, and just after, the first outbreak that occurred in the CNH.

1.5.4. Whilst the Investigation reviewed these matters impartially, as it must do, it is acutely aware that during this period the world was coming to grips with an unprecedented pandemic with devastating effects, particularly for elderly and vulnerable persons. The members of the Investigation Team themselves experienced the pandemic unfold and found their own personal and working lives being significantly impacted. The Investigation further acknowledges that for many of the staff at the CNH they too found the situation challenging, risked their own health, and some were hospitalised and severely ill as a consequence of becoming infected while they cared for others. In addition, the Investigation understands the significant circumstances that were presented in a residential care facility where the CNH campus is the Residents' home, and where each Resident expects to be cared for and kept safe. As elderly and vulnerable residents, who bring with them a wealth of their own life experiences, a significant respect has to be given to the Residents to ensure disruption is at a minimum for them and their families. Yet for these Residents their home life had to compete with best infection control practice to manage the clinical challenge presented by Covid-19. Sadly, during the initial outbreak, some 22 Residents lost their lives, and the Investigation Team is acutely aware of the grief this has brought to their families and the community who live and work in the CNH.

1.5.5. The Investigators remember only too well as the guidelines and responses to keep the country safe changed on a daily basis; where fear of the virus and its infection swept through every home in Ireland; and where simple matters such the scarcity of antibacterial hand lotions and face masks caused heightened concerns on a daily basis. Schools and workplaces were closed, social distancing and confinement to our local areas was imposed to keep us safe,

and in parallel information of how the virus was spreading globally featured across all news networks and set a sobering mindset for every citizen. Meanwhile the staff at CNH attended work and cared for the Residents of the CNH.

1.5.6. By end of March 2020 Italy had 12,000+ cumulative deaths, and daily deaths of 800+. The whole of Italy was in lockdown led by Lombardy and Veneto in the north. Our TV screens were full of the chaos in their hospitals. Fears of people in general, and staff in particular, for their own safety, their families' safety and the safety of the residents would have been driven by these scenes in particular. These fears would have been exacerbated as large numbers of staff became infected.

1.5.7. In the period under review in this report the Department of Health stats published on 29th March 2020 informed us that by 27th March 2020 there were 2,216 cases nationally (506, 23%, healthcare workers) and 43 deaths. Making decisions of the magnitude required in a situation with no precedent and with the fears mentioned above would have been extremely difficult.

1.5.8. The rate at which guidelines changed is evidenced in the investigation documentation. "*Between 30th March 2020 and 3rd July 2020, there were 11 revisions to HPSC guidance" (HIQA, July 2020)*. The level of review to keep up to date, and then to succinctly advise staff of the changes and implement them must have been immense. It took time for guidelines published by the WHO to be reviewed and given the imprimatur of the European Medicines Agency, and then the HSE/NEHPT before implementation. This meant staff would be aware of "planned" guidance passed by the WHO, but these would not be in place in Ireland for days or even a week.

1.5.9. The shortage of equipment, PPE shortages, and quality issues relating to PPE at the early stages of the pandemic did not feel to be as significant as one might have expected. As the wider society grappled with coping, so too did health professionals, but at a more concentrated and critical level. It was also a moving target, and during April 2020 it was recognised *"…the presentation of the virus in older people was different to that of the general population, with many residents showing no symptoms or indeed displaying symptoms that were inconsistent with the case definition for the virus…"*[2]

1.5.10. The lack of testing and the delays in getting results made decision-making hugely problematic as well as allowing time for the virus to circulate unchecked. This was primarily outside the aegis of CNH, and it is clear CNH

[2] The impact of COVID-19 on nursing homes in Ireland. HIQA July 2020

staff were aware of this challenge and worked hard in seeking resolutions and appropriate responses.

1.5.11. 148 out of 150 beds were occupied. The success of the CNH as a fully occupied campus became one of its unintended weaknesses. How to isolate or cohort residents in the early days with only two empty rooms/beds became an ever-present challenge. It became easier as beds unfortunately became available.

1.5.12. The ethos of CNH is as a nursing home rather than a medical facility. The average age of residents was 89 and the oldest was 105. It would be unlikely to find a group of people in Ireland who were more susceptible to COVID-19 once it was in the facility. Residents undoubtedly were impacted by social isolation and lack of contact with their loved ones with the intent of keeping them safe. It is acknowledged there is a significant tension between geriatric medical and nursing care versus infection control.

1.5.13. The time period under this review is very short with the bulk of the concern referring to the period from first confirmed case/death on 29th March 2020 to 6th April 2020. Generally appropriate decisions and actions were being put in place at that stage of the pandemic, and at a time where society outside the walls of the CNH was struggling to cope with the wider changes that were being imposed.

1.5.14. Set within this context the Investigation understands that the managers within the CNH must have been besieged by communications during those days. Senior managers and clinicians in CNH made every effort to respond to concerns, worries, and questions from staff which is commendable. The Investigation also acknowledges the significant effort and attendance at work over this time by the staff at the CNH.

1.5.15. These circumstances are not forgotten by the Investigation Team in considering the matters under review and in making its findings of the specific concerns raised in the disclosure.

Background to the Concerns Raised and Summary of Findings

2.1. The purpose of the investigation is to address all concerns raised by the Discloser and to investigate the subject matter of the Protected Disclosure.

2.2. The Discloser submitted their concerns in a written testimony under a series of categories. For the ease of reference and to conduct its investigation thoroughly the Investigation categorised the concerns under 12 Themes as listed in Section 1.3 above.

2.3. The issues raised by the Discloser referred to a range of concerns under each of the themes relating to the care of residents and associated alleged practices by staff at CNH in March and April 2020. It is recorded that 22 residents died from the first outbreak on 28th March 2020 up to end April 2022 due to covid related infection.

2.4. At the time of the outbreak, and during the period under review in this report, the Covid-19 virus was a new and devastating global infection that was first reported in the Republic of Ireland on 29th February 2020. The first outbreak recorded in CNH was on 28th March 2020 and by the first week of the outbreak in the CNH 24 members of staff were reported to be absent due to COVID-19 related issues. Over the period relating to the concerns being investigated the levels of regular staff who were absent remained high.

2.5. It is recognised that COVID-19 is highly infectious, with people commonly carrying it and spreading it without displaying any symptoms themselves. This holds true in the context of residential care facilities and therefore renders it difficult to manager from an infection prevention and control perspective[3]. The extent of both of these properties was not known at the start of the outbreak. These factors make it especially hard to keep COVID-19 out of nursing homes when it is circulating in the community, despite visitor restrictions[4].

2.6. In August 2021, an expert panel impact assessment report of COVID-19 in nursing homes described the impact of COVID-19 for nursing homes as "*both shocking and frightening*".[5] At the time of the outbreak in the CNH, the entire country was in initial lockdown, and globally the world was impacted by the virus. In Ireland, by late March 2020, all community, work, and social life was curtailed. Only essential workers were permitted to attend their place of work, and all media was consumed with the impact of Covid-19. Images of high

[3] HIQA (July 2020). The impact of COVID-19 on nursing homes in Ireland.

[4] Ibid.

[5] Nursing Homes Ireland/Accenture (August 2021) Covid-19 Nursing Home Expert Panel Impact Assessment

casualty rates in places such as Northern Italy, and China for example, created fearful impressions of the virus, as did reports of nursing homes outbreaks in the USA. For the first time in living memory a pandemic rocked human confidence globally.

2.7. In response to the recognition that the COVID-19 virus was a pandemic, a National Public Health Emergency Team (NPHET) for COVID-19 was established on 27th January 2020 in the Department of Health, chaired by the Chief Medical Officer. The role of NPHET was to oversee and provide national direction, guidance, support and expert advice on the development and implementation of a strategy to contain COVID-19 in Ireland. As is identified in this report the planning at national level through NPHET in preparing for the virus was comprehensive.

2.8. Frequent updates to national guidance for infection, prevention and control in residential care settings were provided by the Health Protection Surveillance Centre (HPSC) of the HSE. The HPSC also developed Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities. Between 17th March 2020 and 3rd July 2020, there were multiple revisions to HPSC guidance. Our report refers to these updates as relevant. It is recognised by HIQA that this process assisted management in nursing homes to quickly take in and understand these updates, and to ensure that all staff were aware of the changes[6].

2.9. The CNH, as a HSE owned and operated facility, was obliged to apply and adhere to HSE guidelines regarding the response to the virus. These guidelines were cascaded within the HSE to relevant areas. In the case of the CNH, HSE Community Health Area CH09 has responsibility for the facility. CNH began preparing for an outbreak from late January 2020, and during February and early March 2020 regular meetings were held in preparation for an outbreak. It appears that a focus of these preparations was to make ready the hospital facility at CNH to receive patients from the acute hospitals if needed whilst the CNH facility made its own preparations for the care of its 146 elderly residents.

2.10. In the weeks prior to the outbreak at the facility the CNH followed the national guidelines and restricted visitors to the unit. When the outbreak did occur at the CNH it immediately established its Covid Outbreak Team and began to implement its responses to protect the residents and the staff. These efforts were hampered by a number of factors including the national shortage of PPE, the high levels of regular and experienced staff who were absent, the then

[6] Nursing Homes Ireland/Accenture (August 2021) Covid-19 Nursing Home Expert Panel Impact Assessment

unknown condition of asymptomatic and atypical presentation, and the manner in which the virus actually impacted the elderly and vulnerable. In addition, the ability of staff at CNH to get residents tested in a timely manner was a challenge that impeded effective management of the residents.

2.11. Our review of the infection trends at the CNH indicates that the most critical period for the unit was from late March 2020 and during the early weeks of April 2020. During this period, 22 Residents had sadly passed away due to Covid-19. Whilst in no way attempting to lessen the significance for the loss of any single resident, the Investigation must highlight that the profile of residents in CNH represents a significantly vulnerable and elderly cohort. It is further noted that overall, the case fatality rate in CNH is not significantly different to the national average.

2.12. The staff resources available at CNH includes Consultant Geriatricians and a team of junior doctors as it shares the campus with CNH's Day Care and Long Stay Hospital. As such this would not be representative of many other nursing homes in Ireland. The Consultant Geriatrician is the lead clinician but is not a Clinical Director. The Director of Nursing is the senior Nurse Manager, and the Persons in Charge of the CNH are two Assistant Directors of Nursing. The Hospital Manager is a non-clinician and senior administrator. The person responsible for the Unit is the HSE Nominated Provider who is a HSE General Manager in area CH09 who reports to the Head of Service for Older Persons in CH09. The CNH is therefore a well-resourced unit with full access to the supports that can be provided by the HSE.

2.13. Under normal circumstances an infection outbreak is managed locally and the CNH had an outbreak control plan in place to deal with such outbreaks. As the COVID-19 pandemic was significantly different from flu the HSPC issued specific COVID-19 outbreak guidelines.

2.14. The Medical Officer of Health in Public Health has the responsibility and authority to investigate and control notifiable infectious diseases and outbreaks, under the Health Acts 1947 and 1953; Infectious Disease Regulations 1981, and subsequent amendments to these regulations[7]. Public Health therefore has a key role in relation to the management of a COVID-19 outbreak, and particularly in advising on infection control practices. The HSPC Guidelines for COVID-19 identified that a COVID-19 outbreak control team should be chaired by a public health doctor.

2.15. At the time of the outbreak in CNH, the Public Health Department HSE East was dealing with 57 outbreaks. Notwithstanding Public Health did provide

[7] https://www.hse.ie/eng/services/list/5/publichealth/publichealthdepts/moh/

immediate advice on the IPC measures required and played an active role in guiding that situation during the early stages of the outbreak. Public health escalated the need for testing, and in early April 2020 provided the services of the Clinical Lead, HSE Antimicrobial Resistance and Infection Control to advise the CNH.

2.16. The Department of Health in its review of May 2020 noted a range of guidance had been issued internationally to protect residents and staff of Long-Term Residential Care facilities (LTRCs) in the context of COVID-19. The guidance for the most part, includes recommendations on testing, screening, monitoring, isolation, cohorting, social distancing, visitation, environmental cleaning, immunisation, providing care for non-cases, caring for the recently deceased, and governance and leadership. Many similarities exist between guidance documents, including recommendations to screen people entering facilities, to monitor staff and residents for new symptoms, to restrict visitation except on compassionate grounds, to isolate suspected and confirmed cases, to cohort symptomatic residents, to regularly clean frequently touched surfaces and to develop outbreak management plans[8].

2.17. The Investigation is satisfied that based on our extensive review of the issues raised in the Protected Disclosure, the CNH struggled in the early days of the outbreak to come to grips with what was occurring. It is evident that the Covid Action Team met immediately when the first outbreak was reported and where management convened on Sunday 29th March 2020 to commence the responses. Particular efforts were made to source PPE and other supports that were required. The immediate efforts made, and time invested by senior managers and clinicians at this time included managers from CH09 who appeared to tirelessly focus on sourcing PPE to address the concerns that were emerging within the CNH amongst staff. However, it is clear that during this early period of the outbreak more could and should have been done, and the focus of this report reviews the acts and omissions of the CNH relating to the concerns raised.

2.18. The brief summary of each of the themes as set out in the following Sections below are provided to give an overview of the outcome of the investigation. The Investigation did not set out to apportion blame on any individual or group and has focussed on identifying the factual matters in relation to the concerns raised. The Investigation is based on the evidence provided and interviews with both the Discloser and key persons involved.

[8] Department of Health (May 2020) Overview of the Health System Response to date *Long-term residential healthcare settings.* NPHET Meeting Paper

2.19. In accordance with our Terms of Reference the Investigation only considered the subject matter of the Protected Disclosure. Accordingly, the period under review is primarily a period around the time of the outbreak, with related matters concerning actions to prior or the outbreak on 28th March 2020 and matters that were brought to the Discloser's attention from 6th April 2020. Only these issues were considered. On that basis the Investigation acknowledges that management and staff maintain it is unfair to draw definitive conclusions of any shortcomings over such a short period and infer that a more holistic approach is warranted to get a fuller understanding of the actual performance of the CNH in its handling of the outbreak. Whilst that may be the case, the Investigation is required to adhere to its Terms of Reference and the parameters therein, which requires that *all aspects of the Protected Disclosure must be addressed – but not matters outside the Protected Discloser*.

2.20. We understand learnings have occurred since the outbreak and we expect that issues addressed in this report provides sufficient detail to ensure any improvement, learning or other actions can be taken in response to each aspect of the Protected Disclosure found to have occurred, be occurring or be likely to occur in the future. The Investigation therefore does not make recommendation and is not required to do so under its Terms of Reference.

2.21. The Investigation acknowledges it was a difficult period for all the staff and does not doubt the genuine effort made by each and every member of staff to care for the residents. For the CNH to have experienced the outbreak at such an early stage of the pandemic clearly disadvantaged the response. During March and April 2020, the guidelines for the management of the virus was changing regularly as the Country and global experts learnt more about its transmission and devastating effect on the vulnerable and elderly. All of the staff met by the Investigation are resolute that they did their best at the time, and many staff remain impacted by their experiences and the 22 deaths that occurred in the early phases of the outbreak. We believe this effort, and the sense of loss expressed by staff should not be forgotten and deserves specific recognition. For those who are dedicated to a profession of care what occurred has to have been traumatic for many, and particularly so in a long-term care facility such as the CNH where there is a strong community ethos and familial nature of the relationships between residents and staff.

2.22. The Investigation also met a number of families of relatives that lost their lives during the period under review. The families' stories are contained in our report as relevant and brings home the sense of loss held by family members who have lost their loved ones. We express our sympathy to all of the families affected. What is evident from these stories is the frustration held from the relatives regarding communication between them and the CNH at a critical

time. The concerns from family members highlight a need for greater communication between care staff and families when any sense of a deterioration of a resident's condition occurs.

2.23. The Investigation did not conduct a clinical analysis of any residents' files or care. We did however review specific aspects of some residents' files that related to the Protected Disclosure.

2.24. In the course of our work, we did not identify any immediate safety concerns.

2.25. Taking the above into account we set out below a summary of the significant outcomes identified during the Investigation in relation to each of the themes raised in the disclosure.

2.3 Loose 'Visitor Restrictions.

2.3.1. The concerns under this disclosure refer to a failure of the CNH to restrict visitor access in a timely manner. It was noted that the CNH closed to visitors on 6th March 2020 in accordance with a Nursing Home Ireland recommendation but reopened to visitors on 9th March 2020 until 18th March 2020 when restrictions were again put in place. During this time a concern was raised to management by a member of staff about restricting visitors to the CNH.

2.3.2. Having reviewed this concern, it is clear that management responded in a timely manner to the concerns raised as is evidenced in the emails provided to the Investigation. However, it appears that in the response management failed to allay the concerns relating to visitor access that were raised.

2.3.3. The Investigation does not uphold that the CNH was in breach of its obligations under the instructions and guidelines to manage visitor restrictions that pertained at the time.

2.4 Failure to Lock Down Wards and Buildings.

2.4.1. This concern refers to a number of issues regarding locking down of wards and buildings to curtail the movement within the CNH. The concerns also refer to staff on occasion not properly adhering to the social distancing requirements.

2.4.2. Having considered this allegation the Investigation team is satisfied that the Discloser's concerns as they relate to a failure to enforce the social distancing guidelines are well founded. Whilst the investigation recognises that staff have a personal responsibility to adhere to guidelines it is the role and responsibility of supervisors to maintain safe practices amongst staff.

2.4.3. In light of the severity of the virus and complexity, age, and frailty of the residents in the CNH, the Investigation views that any breach in the requirement for social distancing should not have been tolerated. We therefore uphold this complaint.

2.5 Stringent Management of Personal Protective Equipment (PPE).

2.5.1. The concerns under this theme refer to an alleged overly stringent management of PPE, varying instructions regarding the correct use of PPE, and a lack of PPE on site which caused concern for staff.

2.5.2. The evidence supports there were issues and concerns regarding the use and availability of PPE, particularly in the beginning of the pandemic and during early weeks of the outbreak of COVID-19 in the CNH. These concerns were held by both management and staff, and in circumstances where sourcing a supply of PPE nationally was a challenge. In that context, guidance issued nationally from March 2020 suggested prudent use of PPE, and the Investigation notes a memo was issued on 12th March 2020 advising staff in the CNH about the prudent use of PPE.

2.5.3. Evidence provided to the investigation supports that managers in the CNH took a proactive role in the management of PPE which was in scarce supply nationally. This included guidelines of what needed to be in place, and a system to provide PPE to each of the wards on a daily basis. It is evident that supplies were tight where the Hospital Manager and the CH09 Head of Social Services had personally sought and collected PPE from available sources. It was therefore not due to the want of effort by management that the supplies were low.

2.5.4. A review of the inventory of PPE available to staff on a daily basis in the CNH demonstrates the challenges that existed. It is evident that management had developed an algorithm for the distribution of PPE based on residents' individual needs, and in general adhered to this to ensure the specific requirements were met. The Investigation is therefore satisfied that in the context of the challenges that existed, and in circumstances where the availability of PPE was outside of the direct control of CNH, management responded reasonably during this period.

2.5.5. Staff on the ground were very concerned about the supply of PPE and had expectations for quantities and types of PPE that could not be provided. For example, one staff member was photographed using a paper tissue to cover their face. The Investigation acknowledges that the use of face masks became mandatory as the pandemic evolved, however at the time of the Discloser's concerns this was not a requirement, and the guidelines did change. Indeed,

the guidelines at the time referred to the use of a tissue to cover the nose and mouth in circumstances of sneezing or coughing as being appropriate.

2.5.6. The Investigation finds that the Discloser had valid concerns about the provision of PPE. Whilst acknowledging the lack of supply of PPE was out of the control of the CNH, it is probable that had more effective communications occurred with staff at the time, and in particular with frontline care staff, a better understanding of the situation and plans to effectively manage PPE may have alleviated much of the concerns and stress amongst staff.

2.5.7. It is obvious that following the initial outbreak in the CNH on 28th March 2020 it took approximately seven days for a more coherent management of issues on the ground, and in particular representations had to be made by SIPTU about PPE on behalf of staff.

2.5.8. The Investigation also acknowledges the pandemic was a complete unknown and staff were naturally frightened for residents, for themselves and for their families. The Investigation acknowledges that the Discloser and other staff were reading conflicting and changing guidelines from WHO, the HSE, and from their own contacts in acute hospitals at a time when PPE stock were in short supply.

2.5.9. The Investigation therefore finds that whilst the short supply of PPE was out of the hands of local management, there was a gap in effective communication with staff. In these circumstances, a more responsive leadership would have gone a significant way to reassuring staff on the ground.

2.5.10. In summary the Investigation does not find that managers were over stringent in the management of PPE, however the Investigation concludes that effective communication with front line staff regarding the availability and use of PPE was suboptimal.

2.6 End of Life Protocol.

2.6.1. This concern refers to decisions made regarding preparations for end of life, and an alleged comment by a member of management that staff were responsible for the spreading of the virus within the CNH.

2.6.2. The Investigation is satisfied that the preparation for end-of-life care including anticipatory prescribing was within good clinical practice guidelines. We are also satisfied that end-of-life care plans were in place for residents and that staff strived to meet the wishes of residents and communicated with families and residents at end-of-life.

2.6.3. The Investigation understands the matters raised by the Discloser were based on their genuine concern about the care of the residents. Having carefully considered the evidence adduced, the Investigation is satisfied that the end-of-life care provided in the CNH was appropriate and does not uphold any wrongdoing occurred.

2.7 Failure to Risk Assess 'Vulnerable' staff.

2.7.1. This concern refers to the practices by the CNH regarding requiring some vulnerable staff to attend work, and issues relating to conflicting advice and practices regarding the management of staff during the early phases of COVID-19.

2.7.2. The Investigation acknowledges the responsibility that exists for the CNH to provide a safe working environment for staff. It is further recognised that COVID-19 posed a particular risk to health care workers which was recognised in the COVID-19 preparatory phase. It was also acknowledged by the Trade Union official met as part of the Investigation that the CNH had protocols in place for assessing staff, and it was not expected that staff who were suspected or tested positive were required to return to work outside of those protocols.

2.7.3. The Investigation acknowledges that the concerns raised in the disclosure are legitimate. Information was confusing, and testing was not readily available for staff who felt vulnerable. However, the CNH was no different to other organisations in the HSE at this time.

2.7.4. The Investigation was not provided with evidence to corroborate individual staff issues raised by the Discloser regarding for example a staff member being required to attend work while their spouse was symptomatic, or where a staff member that tested positive was required to attend work. The Investigation found no incident where a vulnerable staff member was asked to attend work.

2.7.5. It is acknowledged the staff situations observed by the Discloser regarding occupational health concerns were challenging. Indeed, sample WhatsApp messages between staff do indicate that concerns were being shared amongst staff.

2.7.6. Having considered the matter and based on the limited identification of the persons referred to in the disclosure, we do not find that the CNH failed to risk assess vulnerable staff or advised staff to stay at work contrary to the guidelines that prevailed at the time.

2.8 Failures Related to Staff Testing.

2.8.1. Under this concern the Discloser has submitted a lack of staff testing for COVID-19 and that some staff members who tested positive and were asymptomatic were required to attend work.

2.8.2. The Investigation finds that the Discloser accurately portrayed the difficult environment around testing and getting swab results that existed nationally at that time. The Investigation notes that it was not until 17th April 2020 that NPHET considered and endorsed national testing of all residential care staff with an initial widespread approach, and thereafter ongoing testing, which included both staff and patients, conducted on a rolling basis[9]. A regime for staff testing within the CNH was implemented during the week of 20th April 2020.

2.8.3. The Investigation accepts that during the early weeks of the outbreak the staff of CNH were severely disadvantaged by the unavailability of ready access to testing and swab results. However, at this time staff testing was not readily available in March and early April 2020 at the CNH.

2.8.4. The Disclosure cites a case where a Staff Member was instructed to continue to attend work when their spouse awaited a COVID swab result. While the Investigation cannot corroborate individual cases where they are anonymised and based on hearsay, there is evidence that two staff members were put on COVID leave while they were close contacts of someone awaiting a COVID result in late March 2020. This evidence suggests that the practice referred to by the Discloser may not be accurate. Based on the lack of evidence the Investigation therefore does not uphold these allegations.

2.8.5. In addition, whilst acknowledging there were concerns regarding staff testing at the time amongst staff, the Investigation does not uphold that the CNH are at fault for the challenges related to staff testing during March and April 2020.

2.8.6. The Investigation does not uphold the allegation that individual members of staff were *ordered* to come to work, and the alleged breaches regarding staff being required to attend when they should have been isolating are not upheld.

[9] Department of Health (May 2020) Overview of the Health System Response to date *Long-term residential healthcare settings.* NPHET Meeting Paper

2.9 Conflicting Role of Medical, Infection Prevention and Control (IPC) and Nursing Management Staff in Identifying, Isolating and Testing

2.9.1. These concerns refer to conflicting advice given by medical staff, IPC staff, and nursing management, and in the failure to identify isolate and test residents properly.

2.9.2. The Investigation acknowledges that at the time of the outbreak in the CNH the guidelines that applied were outlined in the document *Preliminary Coronavirus Disease (COVID-19) Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities (RCF) and Similar Units V1.0* issued on 17th March 2020 (as amended). These guidelines were updated to Version 1.1 on 30th March 2020.

2.9.3. The general advice regarding the identification of COVID-19 infection from mid-March 2020 referred to three symptoms, namely fever/high temperature; coughing; and breathing difficulties/shortness of breath. However, knowledge was emerging that for the elderly the symptoms were broader and for example may have been disguised by the general presentation expected in an elderly person such as tiredness and lack of appetite. We now know the symptoms are much broader and it is only following testing that an accurate diagnosis can be made.

2.9.4. The HSPC guidelines that were circulated at the time of the first outbreak in the CNH were clear for the need to isolate and cohort residents. On 27th March 2020 the case definition was expanded to alert clinicians to the need for a higher index of suspicion being warranted re possible atypical COVID-19 presentations in LTRC facilities and those with immunocompromise. (As reported by the Department of Health on 22nd May 2020).

2.9.5. On reviewing the document *Residential Care Facilities Guidance V1 21 March 2020* it is acknowledged that Residents in care facilities often had atypical presentation of Covid-19 infection and the guidance suggest that clinical judgement is required as the symptoms are common in the older person. The Investigation is satisfied that clinical judgement was applied in the CNH by the doctors on the ground who sought more senior advice regularly when diagnosing residents.

2.9.6. During the early stages of the outbreak in the CNH nurses were requesting medical reviews of patients with symptoms but these were often initially attributed to other conditions including the Resident's previously identified chronic illness.

2.9.7. Based on a review of the records and evidence provided the Investigation finds it is probable that some medical staff were applying the limited criteria resulting in a delay in diagnosis.

2.9.8. The Investigation also observed that limited documentation exists on the nursing notes of residents. Whilst the residents' medical notes continued as per usual, a practice of documenting emergency nursing notes only was implemented in the CNH on 1st April 2020. Therefore, a true record of the residents' status was not available. The Investigation observed that daily temperature checks as set out in the guidelines was not recorded as taking place to the level of frequency required. The investigation team noted that this practice was implemented at nurse management level in the CNH as a reaction to low staffing levels and their prioritisation of the physical care needs of residents. Consequently, the Investigation cannot account retrospectively for residents' wellbeing.

2.9.9. The Investigation recognises that a strict interpretation of the diagnostic criteria at the time of the outbreak led to delayed recognition of atypical features of COVID-19 illness in older people. The concerns presented by the Discloser closely corelates with the evolving understanding of how COVID-19 manifests in a nursing home environment. By mid-April 2020 the atypical features such a loss of appetite, gastric upset, and malaise were being acknowledged and articulated, and later became explicit in the guidelines.

2.9.10. Specific references to residents were reviewed by the Investigation and addressed in the main report.

2.9.11. With regard to swabbing and testing, the Discloser expressed concerns about the backlog in swabbing residents, and that they were told if an outbreak occurred there would be no more swabs taken. The evidence provided supports that delays in swabbing and testing were being experienced. By 2nd April 2020 there was a backlog of swabs for about 12-14 days. It is evident however that the CNH was doing its best to organise swabbing, and the delays were outside of the control of the CNH. In particular efforts were made personally by a Consultant Geriatrician to progress this matter. There was never a strategy practiced in stopping swabbing if an outbreak occurred.

2.9.12. With regard to conflicting practices as to whether it was nursing staff or clinical staff that diagnosed and authorised the swabbing of residents, the Investigation is satisfied that tests were approved by doctors in accordance with the guidelines that prevailed at the time. It is also evident that nursing staff assisted in that process as would be acceptable practice. It is evident that the Discloser was hearing different views and opinions being expressed by

various members of nursing and clinical staff, but the evidence reviewed does not support doctors were ignoring residents' symptoms when they were brought to their attention. What is evident, however, is that symptomatic residents were not always immediately identified as suspect, and this led to a delay in those residents being isolated and the contact precautions being put in place.

2.9.13. The Investigation also considered the concern that different practices regarding the diagnosing residents caused a delay in isolating during 2nd to 4th April 2020. The Investigation does find that the Discloser's concerns are warranted in that residents were displaying symptoms that had indications of COVID-19, yet the IPC guidelines regarding cohorting were not followed from 1st to 4th April 2020, and this decision created a higher risk to the residents.

2.9.14. Associated with the concerns under this theme, the investigation considered that a member of staff had sent an email to management, including nurse management, outlining concerns, and seeking clarification on the correct wearing of PPE in light of the different opinions they observed from different members of nursing and clinical staff. No response was given by the nursing team, however, the hospital management did formally acknowledge the email and provided copies of guidelines to the queries raised. The Hospital Manager also met with the staff member. The Investigation finds it hard to understand that none of the nursing management who attended work at that time and addressed in the email appear to have acknowledged or responded to the issues raised. Clearly this was upsetting to the staff member who needed to be supported and reassured in a responsive manner.

2.9.15. The Investigation also considered the concerns regarding the use of the descriptors of *clean, dirty and dirtiest* that was issued in a memo and where staff members understood this as referring to residents. The Investigation finds that this memo referred to terminology that is used from an IPC perspective in a clinical/medical setting and was not issued with the intention of referring to any specific resident.

2.10 Failure to Isolate Symptomatic Patients.

2.10.1. This element of the concern refers to issues regarding the failure to isolate symptomatic or suspect residents from March 2020, and concerns regarding some movements of residents that were made.

2.10.2. Given the highly infectious nature of COVID-19 in residential care facilities, and in order to avoid testing delays, LTRC facilities were advised to treat all residents with symptoms as probably COVID-19 positive in facilities where a

COVID-19 diagnosis had been confirmed and to avoid further delays in cohorting these residents while awaiting testing[10].

2.10.3. The Investigation has found that the CNH did not cohort and isolate in accordance with these guidelines. When the outbreak occurred some isolation and cohorting of residents occurred in a timely manner. But this process stopped for a period of days, from 1st April 2020. When the IPC Nurse from the Public Health Department became aware of this, Public Health Department actively engaged with the CNH IPC Nurse. Isolation and cohorting commenced again from 6th April 2020.

2.10.4. The basis for the decision not to isolate or cohort between 1st and 6th April 2020 is varied including a practice that the movement of a resident could not occur until testing had confirmed the case; that the Unit was at full capacity with only two vacant single rooms that could be used for isolation which impeded the cohorting or isolation of residents; that as an outbreak had occurred it was probable the infection had spread and it was not appropriate to move residents; and that HIQA regulations would not permit the movement of a resident from their home.

2.10.5. Standard 3.3 of the HIQA National Standards for Residential Care Settings for Older People[11] requires *the Responsibility for infection prevention and control is clearly defined with clear lines of accountability throughout the residential service. Policies and procedures reflect national standards for the prevention and control of Healthcare Associated Infections and relevant national guidelines*. The National guideline at the time set out advice on isolating and cohorting COVID-19 symptomatic, asymptomatic, and suspect cases.

2.10.6. The Department of Health in its May 2020 report identified that under Regulation 27 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, older people and disability providers must ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by HIQA are implemented by staff.[12]

2.10.7. Based on the HIQA standards and Regulation 27 of the Health Act 2007, the Investigation does not find there was any regulatory reason as to why cohorting and isolation could not take place without approval from HIQA.

[10] Department of Health (May 2020) Overview of the Health System Response to date *Long-term residential healthcare settings.* NPHET Meeting Paper

[11] HIQA (2016) National Standards for Residential Care Settings for Older People in Ireland

[12] Department of Health (May 2020) Overview of the Health System Response to date *Long-term residential healthcare settings.* NPHET Meeting Paper

2.10.8. Specifically, the Investigation is satisfied that the movements of residents that occurred between 24th to 28th March 2020 was in accordance with the guidelines.

2.10.9. The Investigation finds that the non-movement of residents to cohort or isolate them between infected, symptomatic, and asymptomatic during 29th March 2020 to 3rd April 2020 was not in adherence with the guidelines and amounts to poor practice in IPC management. The Investigation finds that the failure to move residents from 29th March 2020 probably contributed to poor management of the outbreak and may have put some residents at risk. It is noted at this time there was disagreement amongst nurse management relating to the movement of residents, and the Senior Clinician was seeking either test results or a direction from Public Health to move the residents.

2.10.10. In their concern the Discloser refers to an email that was sent to senior management on 29th March 2020 raising concerns about reported movement of symptomatic residents between wards. The investigation found no evidence the email was appropriately responded to. Had this email been responded to it may have alleviated many of the concerns held by that staff member.

2.10.11. On 2nd and 3rd April 2020, a worsening situation in terms of residents with symptoms of COVID-19 was observed on Ward 1. The investigation team has identified 3rd April 2020 as date the CNH realised the significance of what was happening and when the CNH recommenced a concerted IPC response in the wards to their outbreak.

2.10.12. Concerns were also expressed about a decision on 4th April 2020 to cohort residents before testing. The Investigation finds the decision to cohort symptomatic residents was appropriate and in accordance with the guidelines.

2.10.13. The Investigation considered concerns that residents with dementia were allowed wander in the wards. The evidence shows that where possible CNH used companion care to allow a one-to-one assistance for residents who wander in order to limit social interaction and promote hand hygiene and the wearing of surgical masks. The Investigation acknowledges the complexity in the management of the residents with dementia and behaviours that challenge. However, the Investigation upholds the concern that two residents with dementia were wandering and concludes that the companion care arrangement in place was not always effective.

2.10.14. The Investigation also considered a concern that a suggestion to isolate residents in the day care centre was not followed through. Whilst it is acknowledged that consideration was given to areas outside the CNH, the Investigation is of the view that appropriate assessment of the facilities and

spaces within the CNH units could have provided realistic options to facilitate cohorting of residents.

2.11 Shared Equipment.

2.11.1. The concerns under this theme refer to allegations regarding the use of shared equipment between residents. The complaint covers the period between 2nd and 4th April 2020. The shared equipment referred to thermometers, delph, and the use of a cordless phone.

2.11.2. The Investigation is satisfied that thermometers were ordered prior to the outbreak. However, the Investigation finds that the baseline of equipment in stock for CNH in March 2020 seemed to be limited.

2.11.3. It is evident that equipment including thermometers were shared between residents e.g., stethoscopes. However, where equipment needed to be shared there was clear awareness amongst staff of the need to decontaminate equipment and guidelines were issued about cleaning. The Investigation does not find this practice to be of concern.

2.11.4. The investigation concludes the CNH adhered to the guidelines regarding the use of delph for the residents.

2.11.5. The investigation noted the shared use of a cordless phone amongst residents did occur and finds that only one cordless phone on the unit was unacceptable.

2.12 Contact with Relatives.

2.12.1. This concern refers to allegations that there was a lack of communication from CNH to family members of the residents from 5th March 2020.

2.12.2. The Investigation met and listened to the stories of the four families that expressed frustrations with communications from the CNH. The Investigation welcomed this opportunity which provided a voice for some of the families and residents to convey their experiences. The Investigation finds in two of the four families it met, that the CNH did not communicate effectively with those families. This lack of communication has compounded the families' grief. At the time of meeting with the families they remained concerned about the actual care their loved ones received in the hours before their death.

2.12.3. The Investigation concludes that the staff changes due to illness in March and early April 2020, and the presence of agency workers, negatively impacted on some of the communication between the CNH and resident families. This is supported by the staff and family opinions.

2.12.4. The Investigation considered the allegation that the CNH failed to provide information on home isolation to the families of residents. There was no national recommendation for home isolation for residents of long-term care facilities. The Investigation appreciates home care was unlikely to be appropriate in view of the medical complexity and dependency level of the residents of the CNH. We therefore do not find that families should have automatically been provided an option for home care by the CNH.

2.12.5. It was also alleged that on 4th April 2020 a senior nurse manager told a nurse at the Nursing/IPC Meeting that it was better not to tell families [that COVID-19 was on site] as it would worry them. The Investigation Team is satisfied this did not occur in the manner described and was likely a misinterpretation of an overheard conversation.

2.12.6. The Investigation is satisfied that a plan was in place to communicate with families. However, in the process of putting the plan in place, the outbreak at CNH occurred followed by the first COVID-19 related death on 2nd April 2020. At this time there was a shortage of experienced staff due to Covid related absences. This Investigation finds this initially impacted on the ability of CNH to continue to communicate effectively with families of residents. From 5th April 2020 communications began to improve, and by 13th April 2020 communications with relatives was better coordinated with the support provided by Allied Health Professionals and the introduction of IT in the wards to assist in virtual meetings. The Investigation particularly commends the enhanced communication initiatives.

2.12.7. The Investigation has found there should have been better readiness in the planning of communication with the families. The challenges were discussed before the outbreak, yet by the end of March 2020 there was only one cordless phone per ward. Wi-Fi connection was insufficient. This lack of planning contributed to difficulties with families contacting CNH, and phones remaining unanswered at times.

2.12.8. Although planning was in place there was no obvious implementation of the communications plan until after the first week of the outbreak.

2.12.9. The Investigation also considered concerns regarding the communication by the CNH to families about residents who were nearing end-of-life. It was contended that these calls were deemed to be insensitive. The Investigation concludes that, in the main, the nature of these communications was sensitive. A review of the resident files that were requested by the Investigation reflects a practice of compassionate interaction occurred concerning end of life communications with families on many occasions.

2.12.10. The Investigation does acknowledge that some families may have found the end-of-life planning call to be a difficult experience, as recounted by the Discloser. However, no evidence was provided to the Investigation to corroborate this specific concern.

2.13 Recycled Air System and Coronavirus Risk.

2.13.1. This concern is in relation to information relating to a recycled air system and COVID-19 risk. It is maintained that a staff member advised management about this risk, but their email was not responded to.

2.13.2. The evidence provided supports that when management received the email, it was escalated to the Engineering Manager. The Investigation acknowledges that none of the managers copied on the email acknowledged receipt of the email.

2.13.3. Whilst the Investigation does not find that any wrongdoing occurred by not responding to the email, it concludes that a more appropriate action would have been for the email to be acknowledged.

2.14 Enforced Annual Leave while Wards Chronically Short Staffed.

2.14.1. This complaint refers to a member of staff being forced to take annual leave from 7th April 2020 despite the CNH being chronically short staffed. The staff member did seek to cancel their leave but was sent home.

2.14.2. The Investigation accepts that where possible, annual leave was granted to staff; and that it was easy to source agency staff.

2.14.3. In the circumstances it is understood the staff member was upset when leaving work and therefore management viewed it appropriate that the staff member avail of their planned annual leave. The staff member had raised a number of concerns in the days up to 4th April 2020. In light of the circumstances the Investigation does not uphold that management behaved unreasonably by requiring the staff member to take their planned leave at that time. However, it is noted specific concerns of the staff member were not addressed at that time with the staff member. The investigation finds that nursing management should have followed up with the staff member to offer support and provide a rationale for granting the annual leave and had they done so the staff member's concerns may well have been addressed at that time.

2.15 General Findings

2.15.1. This Protected Disclosure included 12 themes pertaining to the COVID-19 outbreak in the CNH during March and April 2020. The concerns raised are

associated with testing, monitoring, isolation, cohorting, social distancing, providing care for non-cases, caring for the recently deceased, monitoring staff and residents for new symptoms, restricting visitation except on compassionate grounds, isolation of suspected and confirmed cases, cohorting of symptomatic residents, outbreak management plans, and leadership actions. These are areas in which guidance has been provided to the CNH since February 2020 by the HSPC.

2.15.2. The CNH being a well-resourced facility was impacted like many other facilities with staff absences and the challenges in sourcing tests, and supplies of PPE. The Investigation acknowledges that external factors have contributed to some of the matters under investigation, and that the CNH worked earnestly to address these external challenges. We also recognise the unprecedented nature of the pandemic, and how quickly it hit Ireland with the CNH being the 58th outbreak reported to the HSE-East Public Health Department. While the Investigation team were able to explore and put into context many of the issues raised in the disclosure it is clear that this period affected the staff, residents, and families of the CNH profoundly, and sadly 22 lives were lost during the first six weeks of the outbreak in the Unit.

2.15.3. In acknowledging that the external factors were outside the control of the CNH, it is evident to the Investigation Team that much of what was required to be addressed in responding to the pandemic was within the remit of management and staff at the CNH. The national guidelines that were introduced in mid-March 2020, as updated, provided advice on the actions required to provide a safe first line defence, and how to respond when an outbreak occurs. Reviews of these guidelines (by for example the Department of Health, HIQA, and Nursing Homes Ireland) have recognised their appropriateness. CNH management were aware of these guidelines, and meeting records demonstrate that they were discussed, and preparations were being made. CH09, as the Nominated Provider, also had responsibilities to ensure the CNH was properly prepared to protect residents and staff against COVID-19.

2.15.4. It is clear to the Investigation team that when the outbreak occurred at the CNH on 28th March 2020 the management team mobilised as they would be expected to do. Based on the immediate responses observed the state of readiness of the CNH was not optimal. We find that it lacked a comprehensive direction on what issues needed to be prioritised, with an immediate focus on sourcing PPE and swabbing/testing of residents. A public health doctor did not chair the initial Covid Action Team meetings which was a recommendation in the national guidelines, and senior clinicians were not always in attendance at the early response meetings. It appears that the measures to care for residents

and the deteriorating situation within the Unit was not clearly communicated to management and CH09 in the immediate aftermath of the first outbreak.

2.15.5. Decisions relating to IPC measures such as cohorting and isolating of residents were undecided and disagreements existed based on unfounded regulatory requirements that residents could not be moved. This invariably impacted on the allocation of COVID and non-COVID teams to care for the residents and placed unnecessary demands on the use of PPE by staff. Within a matter of days of the first outbreak, the Department of Public Health became concerned about the IPC practices that were occurring on site and the lack of focus in the CNH to demonstrate a proactive approach to adhering to the guidelines in relation to cohorting and isolating.

2.15.6. During the early days of the outbreak the guidelines were changing regarding the wearing of PPE and the diagnostic symptoms for elderly persons. These changes impacted on staff with different opinions and views being expressed. Frontline staff were confused, concerned, and vulnerable as is evident in the information shared with the Investigation. Delays also occurred in recognising the symptoms of residents as COVID, particularly during the early stage of the outbreak.

2.15.7. High levels of staff absence occurred due to either being suspected with COVID, having contracted COVID, or being close contacts. A rapid response was applied to infilling staff absences by using agency staff. However, the impact of this was a disruption of the important knowledge that regular staff had of the residents. This most likely impacted on the actual care and diagnosis of residents during the early stages of the outbreak.

2.15.8. As more residents and staff were becoming infected, families were becoming concerned. This placed an extra demand on staff as families who were precluded from visiting were anxious to get news of their relative, and the level of calls to the CNH exceeded the capacity of the staff to respond.

2.15.9. It is clear from the evidence provided to the Investigation that the Discloser tried to raise concerns contemporaneously to nursing and CNH management, and where they did not always receive adequate responses and reassurances at the time.

2.15.10. Overall, looking only at this period of time as we are required to do, we have identified significant concerns as to how the preparations and initial response to the outbreak was managed. The outcomes were certainly impacted by external factors, but in the main we have identified concerns in relation to what occurred on the ground and within the facility itself. We are minded that the

various external reports and reviews referenced in our report identifies leadership and governance as having a key role.

2.15.11. It is acknowledged that there is a tension between best practice IPC and best practice geriatric care. The role of leadership is to ensure these tensions do not get in the way of protecting the interests of residents by keeping them safe in a pandemic. Leaders are also required to balance this need by guiding and directing their staff whilst managing all of the constraints that exist.

2.15.12. Leadership within the CNH and CH09 was aware of the threat of the COVID-19 virus by the mere fact they were planning and discussing it in the weeks and days prior to the first outbreak. They were cascading the guidelines and relevant information to line management and staff. Many of the witnesses we met referred to the preparation as training on hand hygiene and basic infection control practices. This training was initially focused on staff in the main CNH Hospital. In the Main Report we have mapped the required actions as set out in the guidelines against what did occur in the PPNCU based on the records and evidence provided. This exercise demonstrates where some of the shortcomings occurred, and that effective planning could have addressed many of these shortcomings.

2.15.13. In respect of leadership and governance we conclude that a gap occurred with the engagement between leadership and those on the ground. What is compelling is that all of the managers we met maintained they did their best, that they were not left wanting in responding to what occurred in front of them, and that they made decisions based on the right reasons with the care of the residents to the fore. We do not doubt that sincerity, nor the genuine efforts made by management in seeking to manage what had emerged. We got a sense that they were swamped by what occurred at the time of the outbreak and in the immediate weeks thereafter.

2.15.14. What appeared lacking was a strong sense of direction about the need to adhere to the guidelines, and the provision of guidance and reassurance to staff. Whilst the future may have been unknown, in a crisis of this nature the immediate actions need to be co-ordinated and followed. That sense of direction was not evident. We were advised decision making could have been more streamlined. The Investigation observed in the evidence that activities were fragmented and focused on resolving the external challenges (such as PPE and testing) rather than providing leadership and direction to frontline care staff.

2.15.15. What is also evident is that the unaddressed concerns of a member of staff became a problem in itself rather than being recognised as a symptom for the

actual lack of clarity on the ground. This lack of clarity in preparing for and responding to COVID-19 is the essence of many of the concerns we have considered and upheld within our investigation.

This concludes the Executive Summary.

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