Care Quality Commission

COVID-19 INSIGHT

Issue 5

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STATE OF CARE

COVID INSIGHT

INFECTION PREVENTION AND CONTROL IN CARE HOMES

Effective infection prevention and control (IPC) is essential to protect people from acquiring COVID-19. Providers need to make sure they are taking action to minimise the risk of cross-infection.

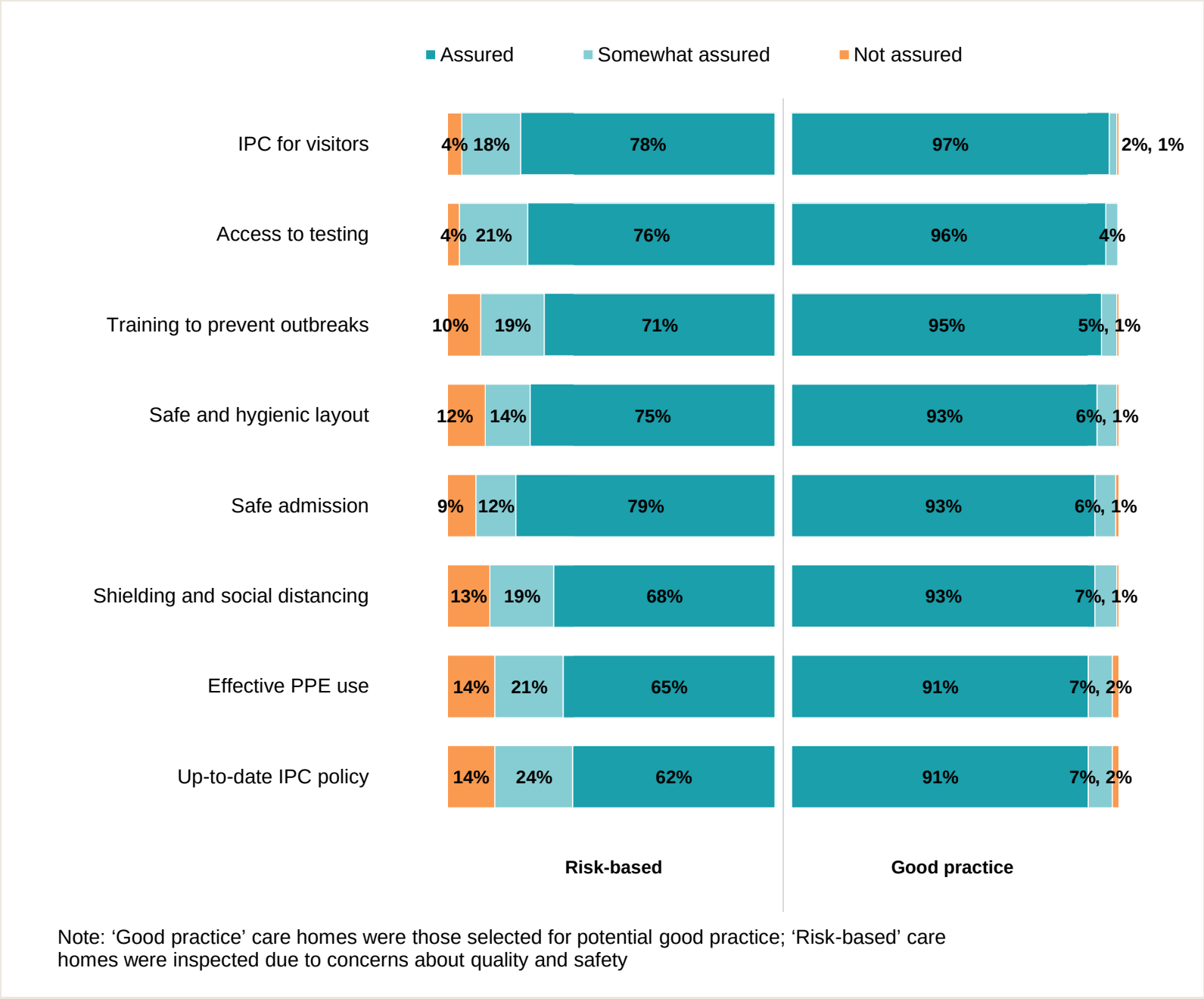
During August 2020, we carried out a special programme of IPC inspections in 301 care homes selected as potential examples of where IPC was being done well. We have also reviewed IPC in 139 ‘risked-based’ inspections between 1 August and 4 September, which were carried out in response to concerns about safety and quality. During these inspections, we reviewed how well staff and people living in care homes were protected by IPC measures, looking at assurance overall and across eight questions.

Across the 440 inspections, we found a high level of assurance in the eight questions (figure 1). At 288 of the 440 services visited (65%), inspectors were assured in all eight of the IPC questions.

Effective use of personal protective equipment (PPE) and having up-to-date policies in place were the two areas with the most gaps in assurance.

Wherever inspectors encountered poor practice, they escalated this at the time with the manager of the service and signposted to the available guidance. In a few cases an inspector returned to complete a comprehensive inspection or pursued regulatory action.

As would be expected, the care homes selected as potential good practice examples generally demonstrated higher levels of assurance across the eight questions than those where we carried out risk-based inspections.



Note: 'Good practice' care homes were those selected for potential good practice; 'Risk-based' care homes were inspected due to concerns about quality and safety

Figure 1: Assurance against IPC themes for care homes inspected between 1 August and 4 September 2020 (440 care homes in sample)

Access to visitors

IPC for visitors obtained the highest level of overall assurance (91%), with care homes working hard to comply with visitor guidance. Restrictions have come at a price, however, with many people using services feeling the impact of not seeing their families and carers in the way they are used to.

> "Relatives have been upset and have found it hard not visiting. Informing people and relatives has been very important to develop their understanding around why rules are in place. [Provider] uses two main means of communication – writing to them every week with updates about what's going on, and a question and answer document to support staff to answer questions."

Good services had effective systems in place to ensure visiting could go ahead safely. They took a person-centred approach to individual situations to ensure people's needs were met. Garden visits were well supported and homes looked for methods to keep people in touch with loved ones and the community that did not rely on people meeting face-to-face.

There were some challenges to ensuring social distancing during visits and some signage and screening procedures could have been improved.

Robust systems for screening and PPE for people entering the service were seen to be successful in preventing the spread of infection.

There are considerations for all providers going forward on balancing visiting restrictions based on current, local advice, against the rights, health and wellbeing of people who use the service and the risk of harm from isolation.

Shielding and social distancing

Most services had suitable plans in place to care for people who are symptomatic or COVID-19 positive and protect others living in the care home in the event of an outbreak. Social distancing was promoted and maintained wherever possible.

Good services took a person-centred, risk-assessed approach, and took simple practical steps to support people where social distancing was a challenge (for example, when delivering personal care or supporting people living with dementia).

To mitigate the impact of isolation good services provided meaningful activities and ensured people were included in the conversation about their isolation so they better understood it.

> "A person recently admitted to the home had to spend 14 days in isolation. Staff found out he was a keen cyclist. They have purchased a pedal exerciser and he is currently cycling from Bradford to Portsmouth. Staff have been talking to people about the challenge he set himself and this has helped him integrate into the service while in isolation."

Good practice included supporting people to access the community safely as lockdown restrictions eased.

Where inspectors found gaps in assurance this most commonly related to services that had not considered social distancing in the layout of their services and where staff did not maintain this in their interactions with each other.

Safe admissions

Good services carried out effective admission assessments despite the challenges, considered mental capacity and took action to reduce the impact of isolation.

Services routinely tested and isolated new admissions to help prevent the spread of infection.

> “The service undertook non-face-to-face assessments using video calls, talking to family and the hospital/social worker to get as much information as they could. The care home insisted the person had a negative swab as close to admission as possible with evidence of this.”

Gaps and challenges were reported where 14-day isolation on admission had not taken place.

While some services admitted new people after appropriate assessment, others made blanket decisions to refuse admissions. This had potential consequences, both in terms of financial viability and local capacity.

Effective use of PPE

Whether services used personal protective equipment (PPE) was the second lowest area of assurance.

Despite challenges at the beginning of the pandemic, the supply of PPE was seen to be working. Generally, inspectors were assured that staff understood the PPE guidelines and that safe procedures had been implemented.

Good examples of IPC using PPE began from the moment that staff arrived at work, where they would enter the separate donning/doffing area and remove the clothes that they travelled to work in to prevent contamination.

Staff wearing PPE could be difficult for people who use services. Good services engaged with people to provide reassurance, support and understanding. Risk assessments into the use of PPE were carried out as appropriate.

Good services promoted a culture of responsibility and engaged staff in the use of PPE, encouraged by ‘champions’.

> “Two or three IPC leads undertook further training to become part of the 'IPC Army'. They were given extra time to undertake additional IPC responsibilities such as PPE competency checks and assisting with more frequent audits.”

Where inspectors found gaps in assurance this related to a lack of compliance with guidance on donning and doffing of PPE, mask wearing and handwashing. Safe disposal of PPE was also an area of some concern.

Testing for staff and people who use the service

Good services had an enthusiastic, well-managed approach to testing and demonstrated going the extra mile to achieve this. Although they encouraged people who receive care to take tests, they respected their rights to refuse testing, and would risk assess them individually and consider capacity and best interest decisions.

Many providers saw routine and regular testing as vital, especially with the risk of asymptomatic spread.

> "Started regular testing as soon as it was available. Very enthusiastic about this; we have a spreadsheet tracker of everyone, weekly for staff and monthly for people using services. Took the view that if cases could be asymptomatic it was crucial to do regular testing. This approach appears to have been a key factor in reducing spread of the virus."

Where inspectors found gaps in assurance this related to a small number of services that had made no effort to implement testing or they did not properly understand the expectations.

Although inspectors were assured that care homes were taking part in testing schemes and doing everything they could to apply guidance, this does not reflect the delays reported by providers in obtaining testing kits during August. This was deemed to be outside of the homes' control by inspectors but impacted on their ability to deliver testing at the required frequency.

Layout of space and hygiene practices

Though it has always been important for care homes to be clean and hygienic, the nature of the pandemic has put these practices under the spotlight.

Services were generally clean and hygienic. Some services had removed excess furniture, decluttered and made changes to flooring and furniture covers to facilitate easier cleaning.

Some services did not have good access to spare single-occupancy rooms or en-suite facilities. In these cases, managers had to make decisions on how to balance the pre-existing needs of people while also planning for possible outbreaks.

Services recognised the considerable impact of moving people from the room that they are used to, to another room for cohorting, isolation or shielding – particularly for those with dementia.

> “Manager advised that if another resident tests positive they will try to move them to the empty bedrooms rooms downstairs. He said that not all of the residents there would agree to their room being moved and if this was attempted it could be very distressing for them.”

Staffing and staff training

Inspectors saw examples of very good staff practice across the services they visited. Staff demonstrated resilience to work under such uncertain circumstances and commitment to care for the people using services and their colleagues.

Most staff had received training and possessed good knowledge of infection prevention and control practice, and generally felt well supported.

> “All staff can complete a ‘health reflection form' to gauge how staff feel about the emotional and physical impact so far. Staff who would not speak out found a voice in the support mechanisms.”

Staff were often cohorted or assigned to areas to minimise movement and cross-infection. Reflecting the findings in a survey carried out between May and June 2020,[1] a lot of services were not using any agency staff to limit the risk of cross-infection from other services.

[1] Office for National Statistics, Impact of coronavirus in care homes in England: 26 May to 19 June 2020, July 2020

IPC policy and contingency planning

IPC policy and contingency planning was one of the most variable areas, and where we saw the least assurance.

There were services that had reviewed and updated their policies and these were communicated well with staff. In contrast, there were IPC policies that had not been updated since the start of the pandemic and contained no reference or out-of-date guidance on COVID-19, which had the potential to be dangerous.

Some services have learned from the first wave of the pandemic and could give examples and reflect on things that did not go well and what actions were taken to change that. Services also asked for feedback from the people who live at the care home and their relatives to understand how they could improve.

> “The prevention and protection plan was very detailed and shared among all the staff about what plans are in place for how to manage a possible second wave. It includes an outbreak checklist, role specific responsibilities and top tips, a symptoms checker, a standard cleaning process, housekeeping and catering teams top tips, hand hygiene guidance, PPE guidance for cohorting and zones, and cohorting guidance in the care home.”

COVID INSIGHT

THE EXPERIENCES OF HOSPITAL INPATIENTS DURING THE EARLY STAGE OF THE PANDEMIC

COVID-19 has hugely impacted on the delivery of hospital care: providers and staff have had to adapt services at speed and under huge pressure, while ensuring hospitals remain a safe environment for patients and staff.

To understand how people in hospital were affected, we commissioned a survey of inpatients who were discharged from hospital from April to May 2020, when the first wave of the pandemic was at its height.

More than 10,000 people across the country told us about the care they had received, whether they were diagnosed with COVID-19 or admitted for other reasons.

Generally, people's experiences remained positive, in line with previous inpatient surveys. Most patients overall (83%) said they felt safe from the risk of catching COVID-19 in hospital, though those who were diagnosed while in hospital were the group who felt least safe (68%), when compared with those who did not receive a COVID diagnosis (84%). People in hospital with COVID-19 reported consistently poorer experiences than those who did not have COVID.

The majority of patients said they were involved 'a great deal' or 'a fair amount' in decisions made about their care and treatment, as well as in decisions made about their discharge (77% and 73% respectively). They were similarly positive about the emotional support that they received from staff during their stay (70% said they 'always' had enough). Most said they 'always' had confidence and trust in the staff treating them (83%).

Overall, patients said they had good communication with staff during their stay – for example, 77% said they were 'always' able to get attention from staff when needed. But almost a quarter of patients said they were only 'sometimes' able to understand the information that staff gave them in response to their questions, or that they could 'never' understand the answers. Just over a quarter said that the information they were given was 'sometimes' or 'always' contradictory.

While most patients were able to keep in touch with their family and friends during the pandemic (75% said they were 'often' able to do this), 13% said they did not receive the help they needed to do so.

Patients who were in hospital during the pandemic reported high levels of cleanliness; 80% said that their room or ward was 'very clean'. Most also recalled seeing a range of infection control measures, including staff wearing PPE, handwashing, provision of waste

bins, and cleaning of surfaces. However, over a third of patients did not remember seeing social distancing measures, such as markers on the floor or signage at the entrance (this was slightly worse for those with a COVID-19 diagnosis).

Discharge and care after leaving hospital were the most problematic aspects of care. Results for people with COVID-19 were even worse. When leaving hospital, 32% of people with COVID-19 did not know what would happen next with their care, compared with 18% for people without COVID. One in three people diagnosed with COVID-19 felt help from health and social care services would have been 'useful' after leaving hospital, but did not receive this. People discharged to a care home were also less positive about the information they received prior to leaving and about their involvement in discharge arrangements.

Looking across all results from the survey, we found worrying indications that some groups of people found their hospital stays more difficult than others.

Generally, people with dementia or Alzheimer's disease, those with a mental health condition, and patients with a neurological condition reported poorer experiences of most aspects of inpatient care.

People with dementia or Alzheimer's disease:

- were least likely to say they were involved in decisions about their care or received answers to questions that they could 'always' understand
- were least likely to 'always' understand staff who were wearing PPE
- had (among groups with long-term health conditions) by far the lowest rate of feeling able to keep in touch with their families during their stay (23% said they 'never' spoke with friends or family while in hospital).

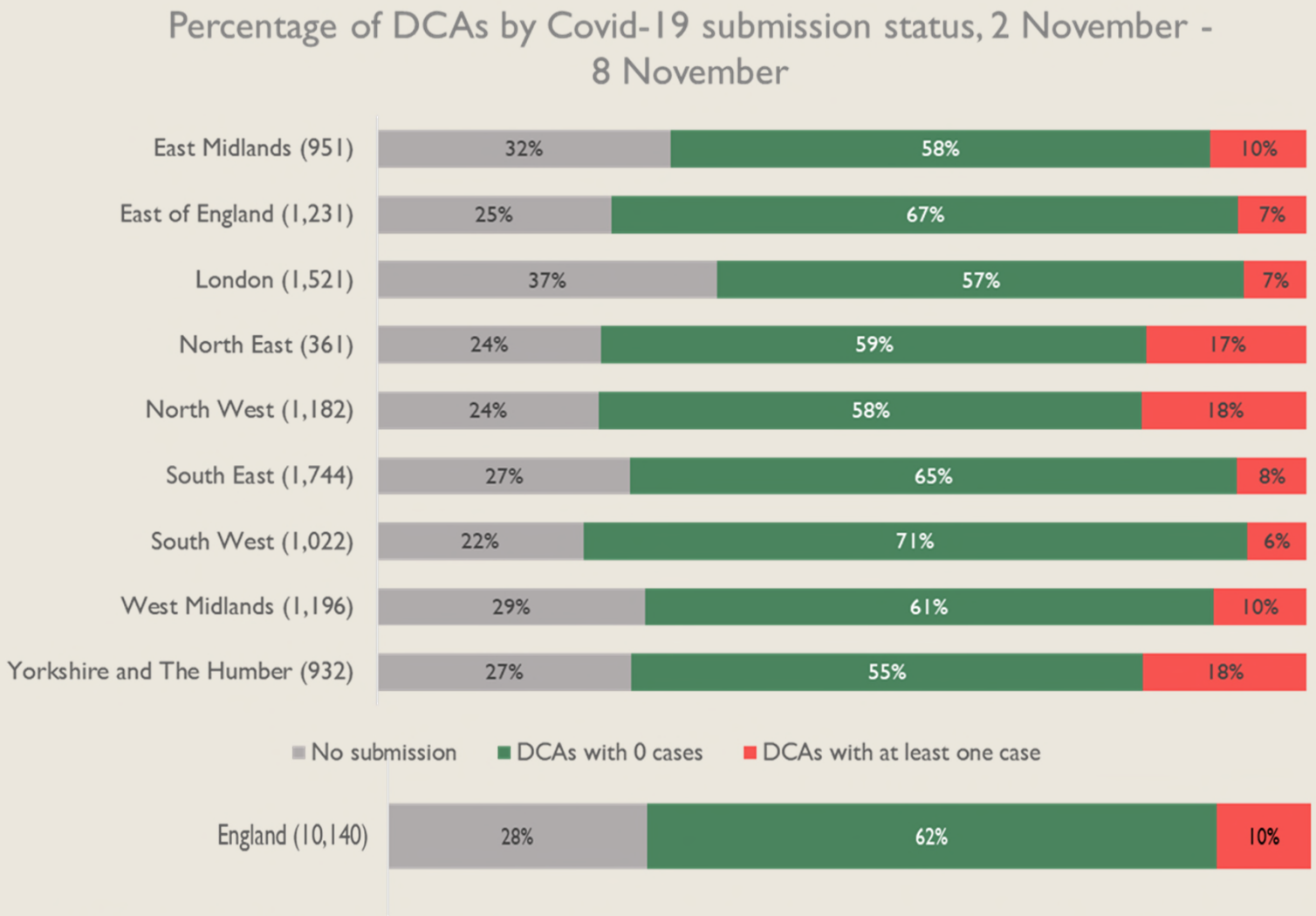
Older patients (those aged 75 and over) were also more likely to say they were unable to keep in touch with family and friends during their stay.

Deaf people, those with a learning disability, dementia or Alzheimer's, people aged over 85 and autistic people also found it particularly difficult to understand staff when they were wearing PPE.

COVID INSIGHT

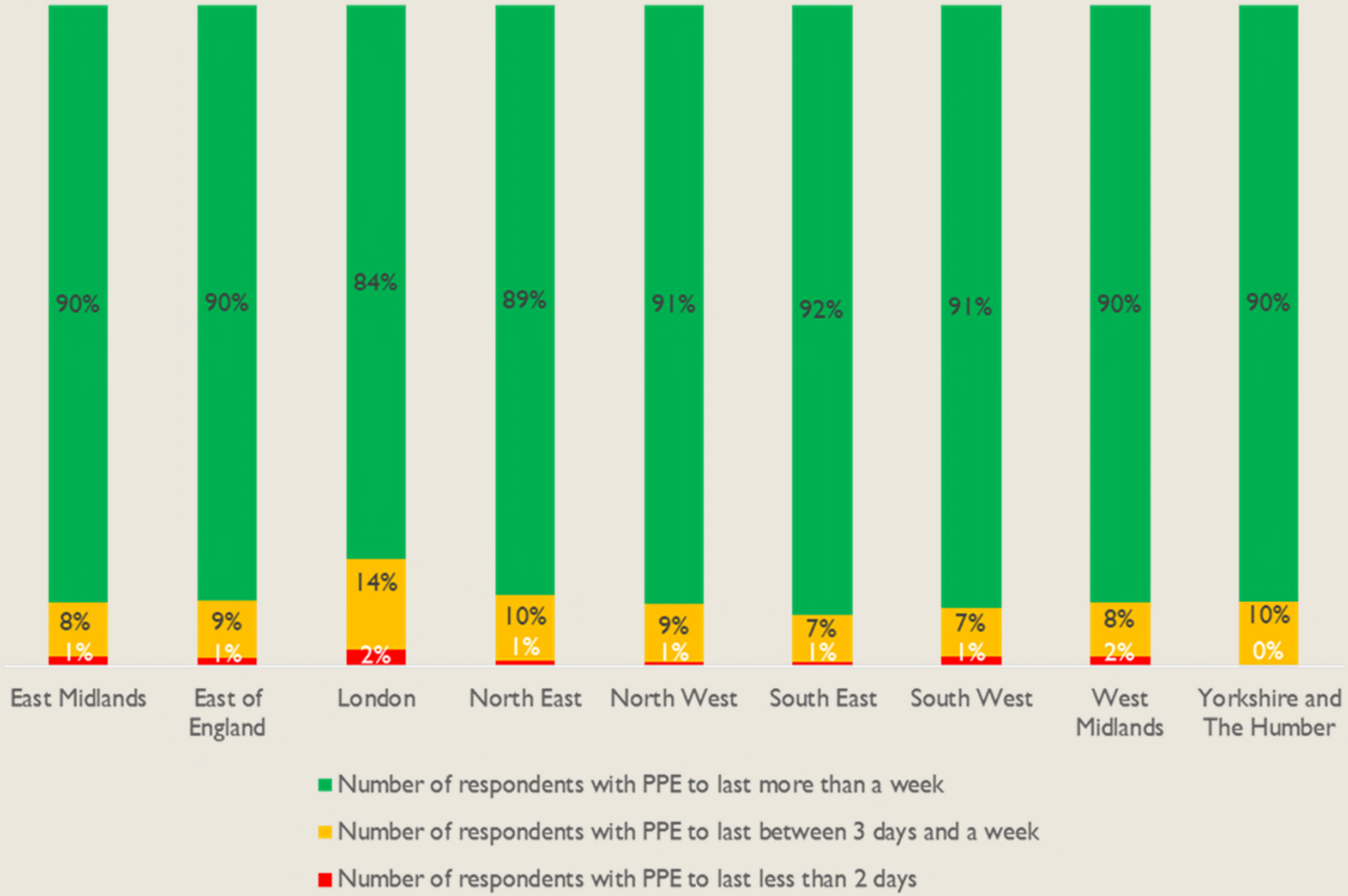
DATA APPENDIX

Homecare providers – prevalence of COVID-19



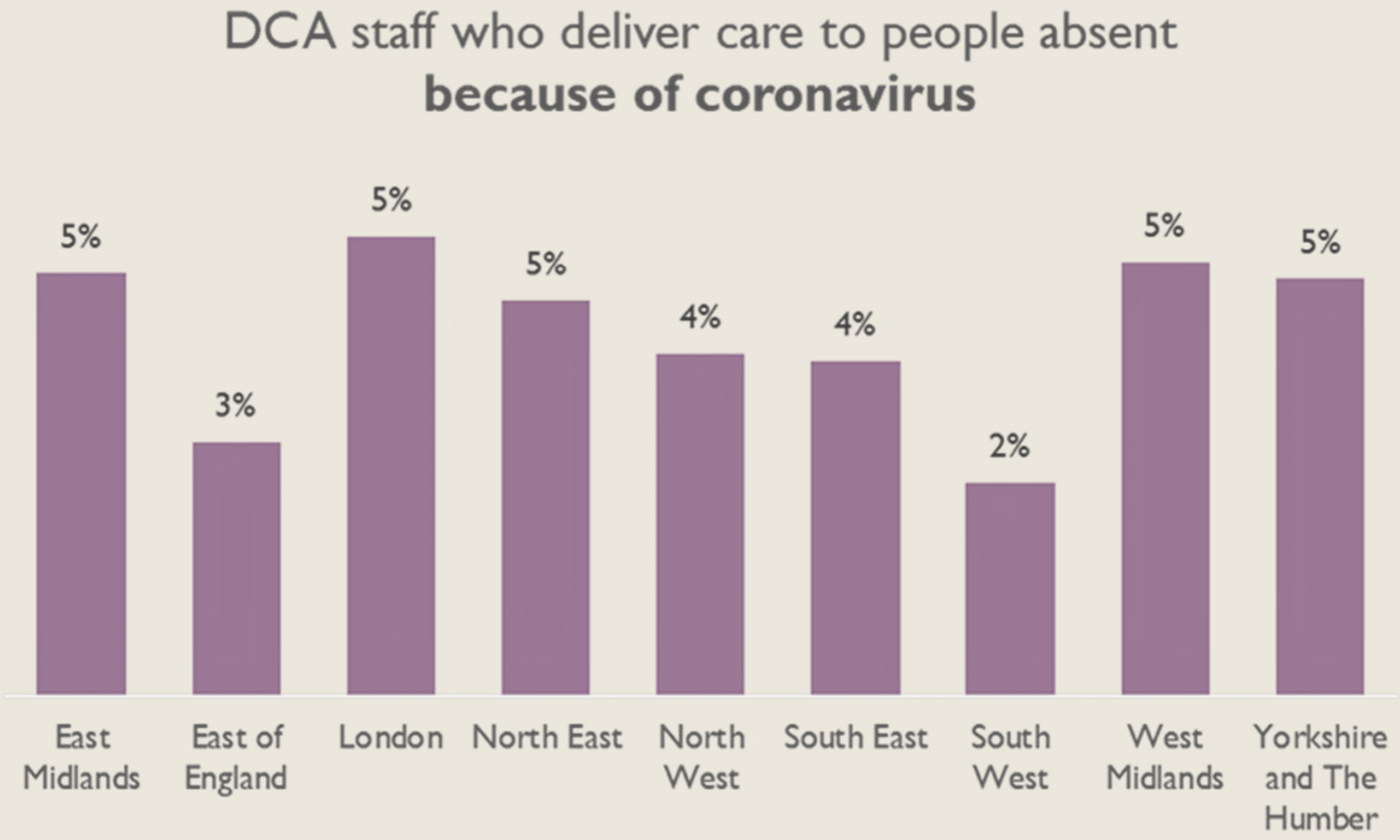
Source: CQC Domiciliary Care Agency Survey. Homecare providers with at least one case include suspected AND confirmed cases. Numbers in brackets show number of services that are primarily homecare providers in the region. Included in these figures are homecare services currently lying dormant, so completion rates are slightly higher for fully active services than this might suggest. Percentages may not add to 100% due to rounding.

Homecare providers – availability of all PPE



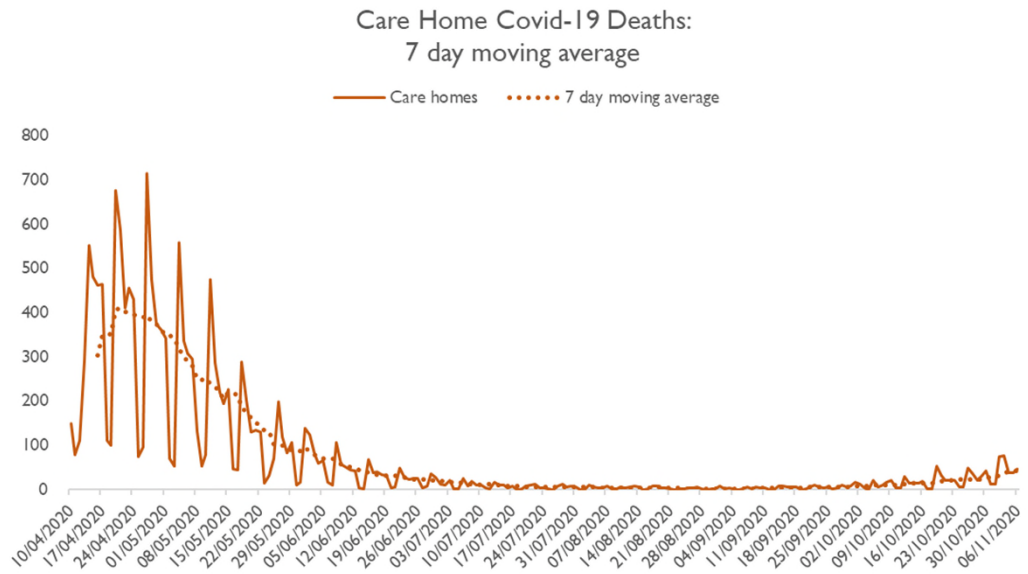
Source: CQC Domiciliary Care Agency survey – latest response in period 2-8 November 2020.

Homecare providers – staff absence



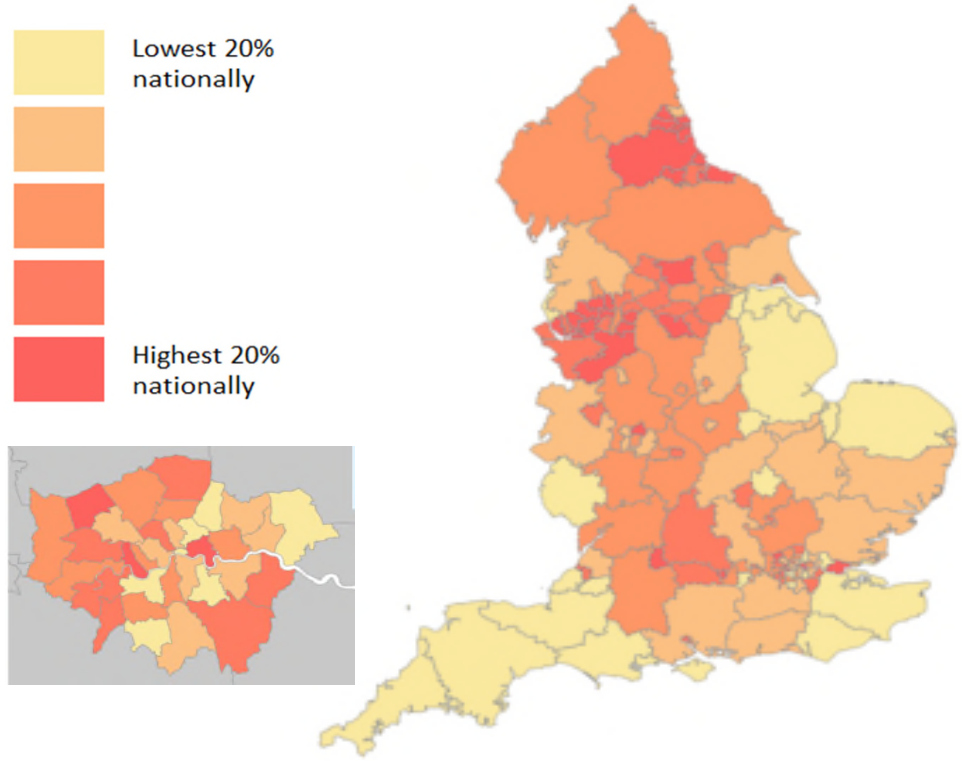
Source: CQC Domiciliary Care Agency survey – latest response in period 2-8 November 2020. Includes staff who are self-isolating or have care commitments. England average: 4%

Deaths notified by care homes



Source: CQC death notifications submitted 10/04/2020 to 06/11/2020

Number of notifications by care homes of deaths where COVID-19 is reported as suspected or confirmed per 1,000 care homes beds – 10 April to 6 November 2020

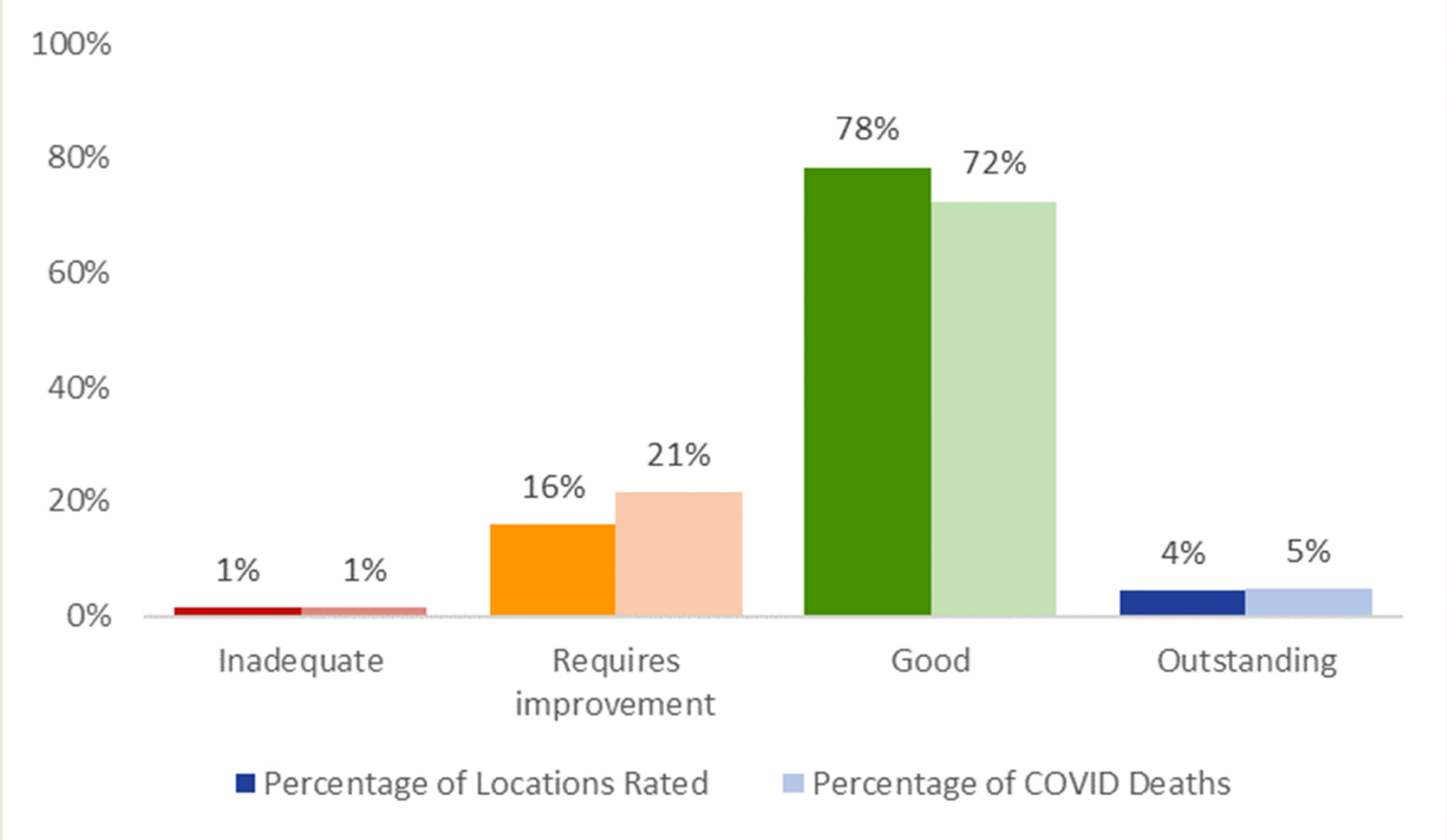


Source: CQC death notifications submitted 10/04/2020 to 06/11/2020

Deaths of people in care homes, by ratings

We have used two methods to examine deaths in care homes, where confirmed or suspected COVID-19 was flagged on the notification form, in relation to ratings.

On this page we show the percentage of all care home deaths notified to CQC within each rating band, compared with the overall distribution of ratings. For example, 21% of deaths occurred at care homes rated as requires improvement, compared with 16% of care homes that currently hold that rating.

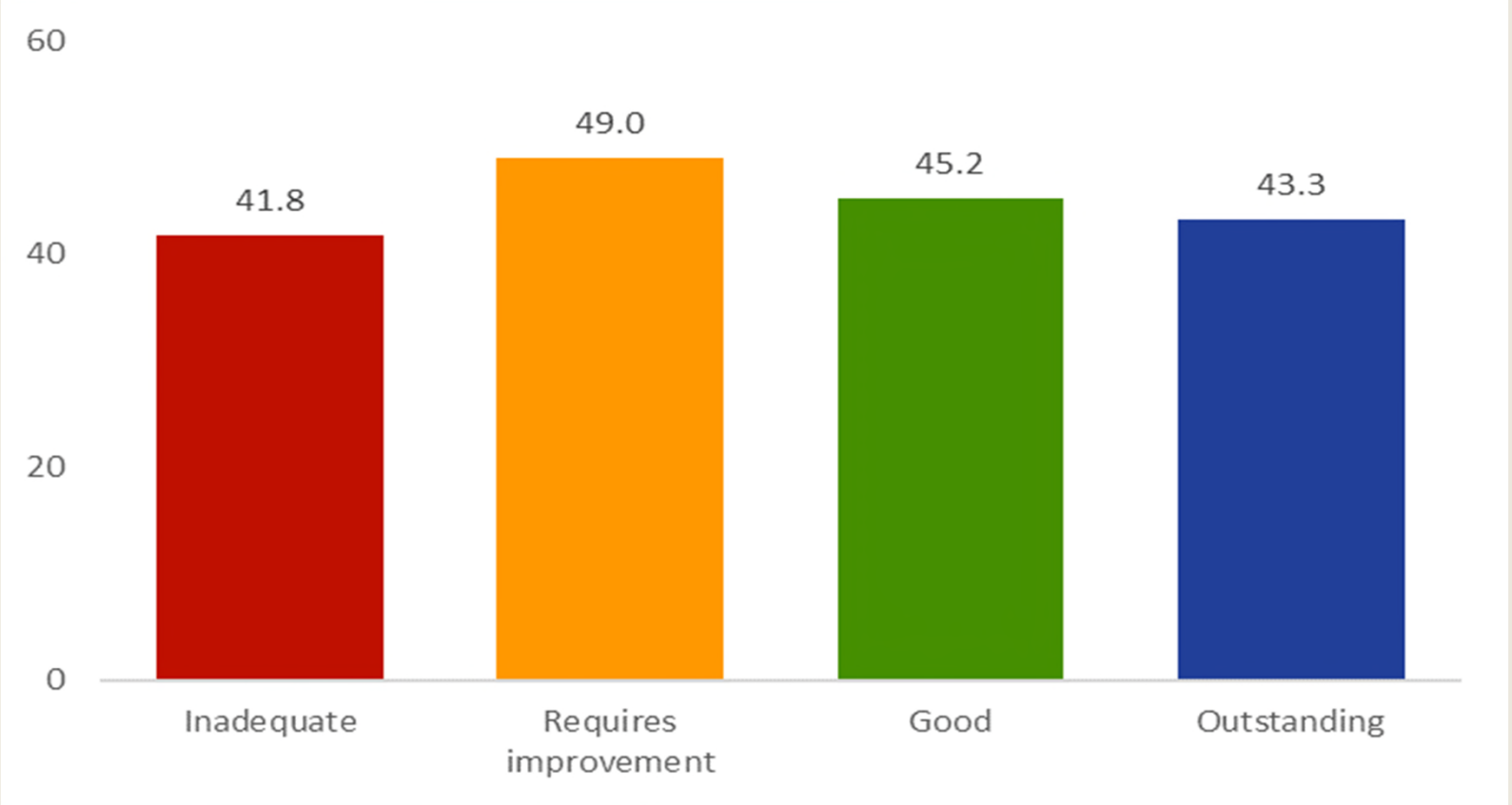


Source: CQC ratings, November 2020; notifications of deaths under Statutory Notification 16 to CQC, 10 April to 6 November 2020, where confirmed or suspected COVID-19 was flagged

Deaths of people in care homes, by ratings (contd)

The second analysis shows the rate of deaths per 1,000 beds by care home rating, which updates figures previously included in our State of Health and Adult Social Care in England, 2019/20 (page 47).

Both charts reflect a slight skew towards requires improvement, but there is no clear correlation between the number of deaths and overall rating.



Source: CQC ratings, November 2020; notifications of deaths under Statutory Notification 16 to CQC, 10 April to 6 November 2020, where confirmed or suspected COVID-19 was flagged; CQC register at 1 April 2020

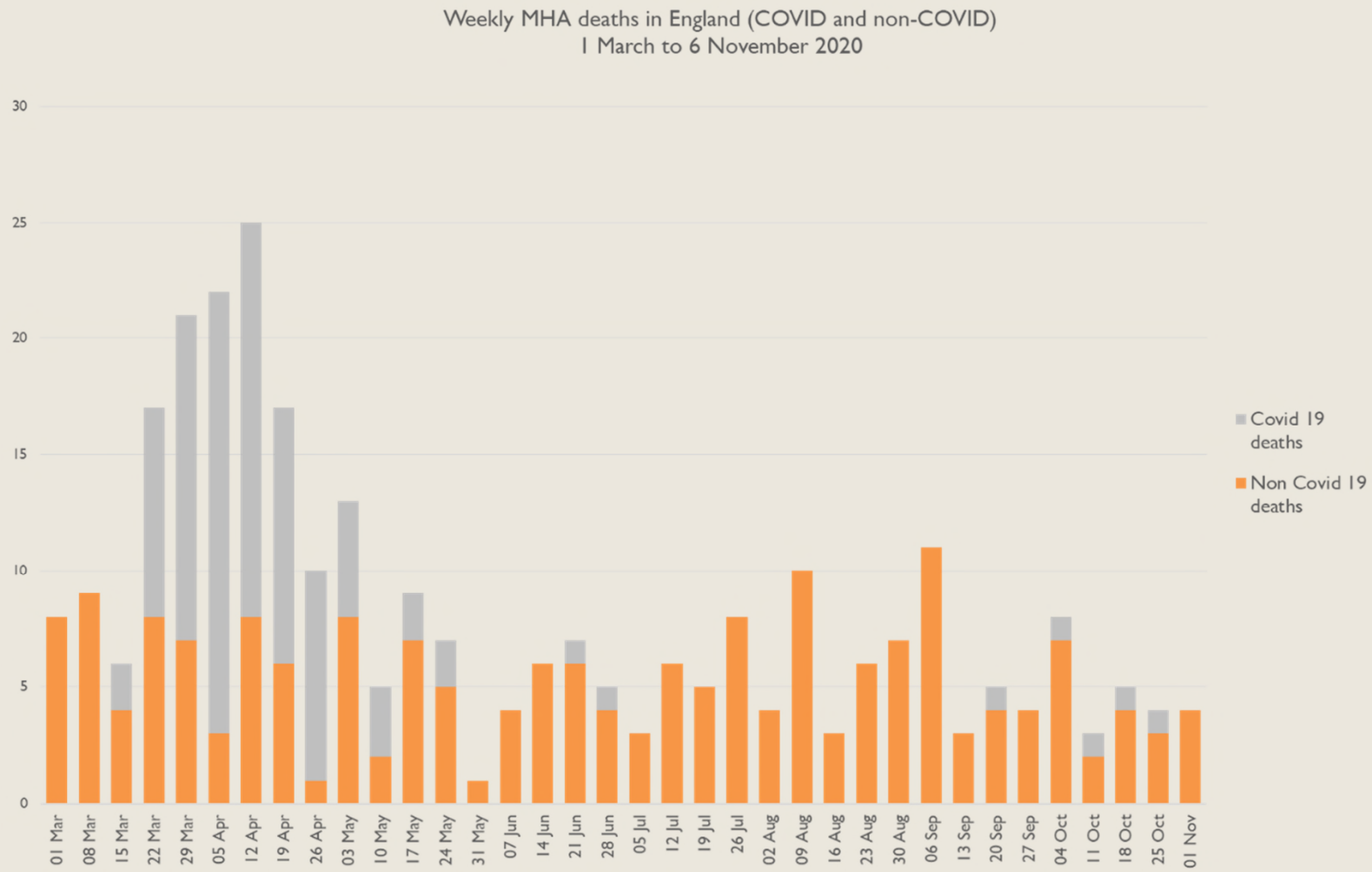
Deaths of people detained under the Mental Health Act

All providers registered with CQC must notify us about deaths of people who are detained, or liable to be detained,* under the MHA. From 1 March to 6 November 2020, we have been notified of 102 deaths that mental health providers indicated were suspected or confirmed to be related to COVID-19. A further five COVID-19 related deaths of detained patients were reported by other (non-mental health) providers.**

The chart shows the number of deaths by week of death.

* Includes detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. 'Detained patients' also includes patients subject to holding powers such as s. 4, 5, 135 or 136, and patients recalled to hospital from CTO. These counts may also include notifications about the deaths of people subject to the MHA who are in the community and not in hospital.

** Data on notifications may be updated over time and therefore successive extracts may lead to changes in overall numbers unrelated to new cases.



Deaths of people detained under the Mental Health Act (contd)

Of the 304 notifications from mental health providers in the 2020 period (covering all causes of death), 240 were from NHS organisations, of which 76 deaths were indicated as being COVID-19-related, and 64 were from independent providers, of which 26 deaths were COVID-19-related.

We have identified 16 detained patients whose deaths have been notified to us from 1 March to 6 November 2020 who had a learning disability and/or were autistic: the majority were not identified as related to confirmed or suspected COVID-19. Of these people, most also had a mental health diagnosis. Please note that these patients were identified both from a specific box being ticked on the notification form and a review of diagnoses in the free text of the form.

The table below shows all deaths of detained patients from 1 March to 6 November 2020, by age band and COVID-19 status.

Age band	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unknown	Total
Suspected or confirmed COVID-19	1	1	4	6	14	20	33	19	9	107
Not COVID-19	8	15	14	26	39	40	29	13	37	221
Total	9	16	18	32	53	60	62	32	46	328

Deaths of people detained under the Mental Health Act (contd)

The table below shows all deaths of detained patients from 1 March to 6 November 2020, by gender and COVID-19 status.

Gender	Female	Male	Unknown or unspecified	Total
Suspected or confirmed COVID-19	35	61	11	107
Not COVID-19	70	111	40	221
Total	105	172	51	328

Deaths of people detained under the Mental Health Act (contd)

The table below shows all deaths of detained patients from 1 March to 6 November 2020, by ethnicity and COVID-19 status.

Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	3	4
Black	12	20
Mixed	1	3
Other ethnic groups	0	1
White	65	110
Unknown	23	70
Not stated	3	13
Total	107	221

Deaths of people detained under the Mental Health Act (contd)

The table below shows all deaths of detained patients from 1 March to 6 November 2020 by place of death and COVID-19 status

Place of death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	62	66
Psychiatric ward	34	65
Hospital grounds	1	6
Patient's home	0	18
Public place	0	4
Other	1	26
Not stated	9	36
Total	107	221

Deaths of people with a learning disability

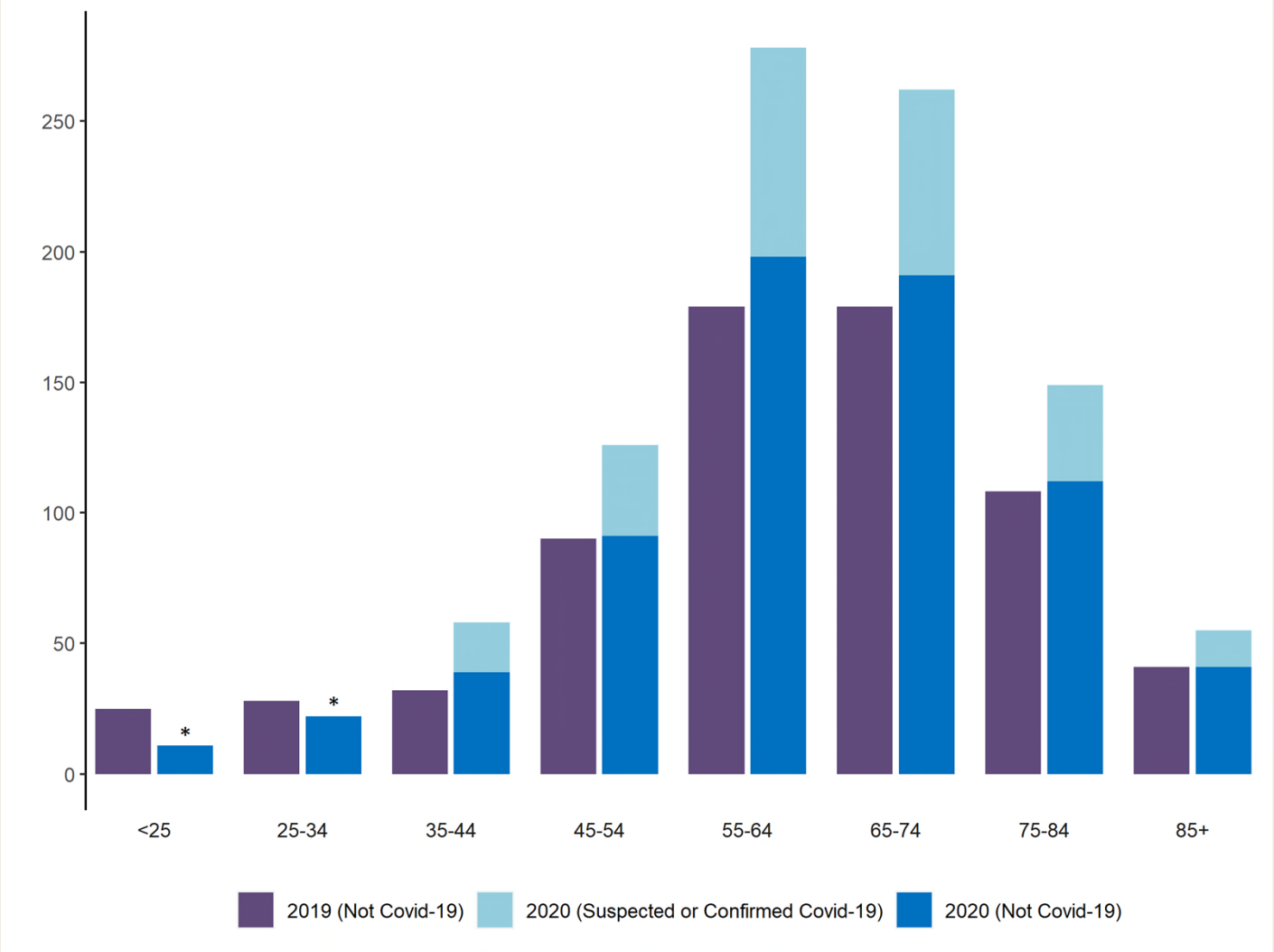
In June 2020, we published new data on the number of deaths of people who were receiving care from services that provide support for people with a learning disability and/or autism between 10 April and 15 May 2020. We have now updated this analysis for the period 10 April to 30 September.

We received notifications of the deaths of 970 people with a learning disability or autism from services identified as caring for people with learning disabilities or autism. This is 41% higher than the 687 deaths notified in the comparable period in 2019. Of the 970 people who have died during the period this year, 263 were as a result of suspected or confirmed COVID-19 as notified by the provider, and 707 were not identified as related to COVID-19.

As we noted in our previous briefing, we know that people with a learning disability are at an increased risk of respiratory illnesses and in November 2020 Public Health England published a report highlighting this issue further in relation to the impact on rates of death with COVID-19 of people with a learning disability. In March 2020, NHS England highlighted how people with a learning disability have higher rates of morbidity and mortality than the general population, and die prematurely. In 2018/19, at least 41% of people with a learning disability who died, died as a result of a respiratory condition. They have a higher prevalence of asthma and diabetes, and of being obese or underweight; all these factors make them more vulnerable to coronavirus. Our figures show that the impact on this group of people is being felt at a younger age range than in the wider population.

Deaths of people with a learning disability (contd)

Notifications from providers of services for people with learning disabilities and/or autism spectrum disorder that state the person who died had a learning disability by age and COVID-19 status: 2019 vs 2020



* Denote bars where data has been suppressed due to low numbers

Source: notifications of deaths under Statutory Notification 16 to CQC, 10 April to 30 September 2020, and comparable period in 2019

Deaths of people with a learning disability (contd)

Of the 970 people who died, 948 were received from adult social care settings. The table shows the distribution by COVID-19 status and service type.

Type of adult social care setting	Confirmed or Suspected Covid	Not Covid	Total
Community based adult social care services	124	345	469
Residential social care	135	344	479

We only show this breakdown of service types for adult social care. The remaining 22 deaths were of people notified to us by types of service in numbers less than 10; to avoid identifying individuals we have not included them here.

Deaths of people from Black and minority ethnic groups in adult social care settings

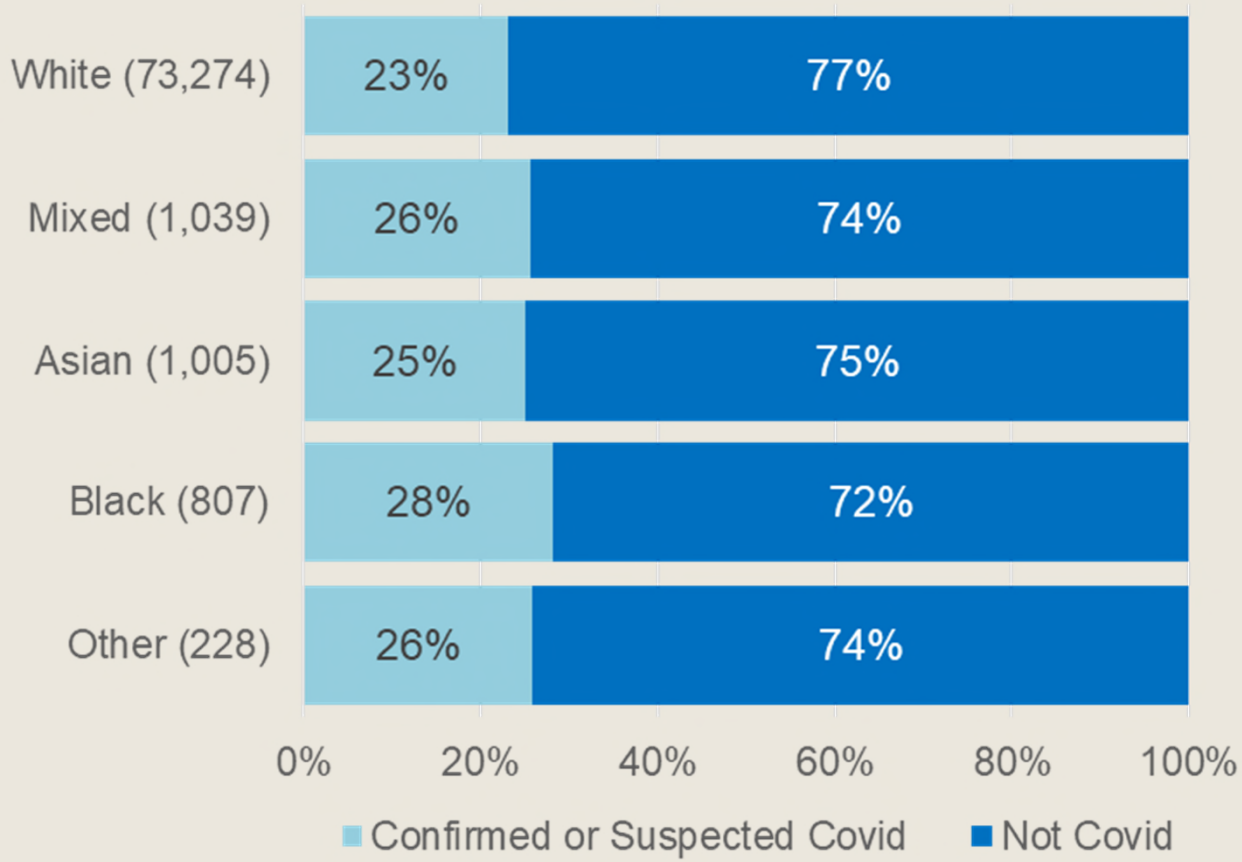
In our second COVID-19 insight briefing we published exploratory data on the ethnicity (where known) of people whose death in adult social care settings was notified to us between 10 April and 15 May 2020.

We have now updated this analysis to 30 September 2020. As we noted previously, the ethnic category fields in the notification forms are not mandatory, and for the period in question this information was missing in 12.8% of forms, which was a slight improvement on the 13.8% we observed in the period to 15 May.

Of deaths with a known ethnicity, 96% of those notified during this period were White, with Mixed, Asian and Black all just over 1% each, and 'Other' less than 0.5%. Therefore while the vast majority of deaths in these settings were of White people, once again we found that Black people in particular who died were more likely than White people to die with confirmed or suspected COVID-19 flagged on their notification form. The chart shows that 23% of White people who died were flagged as confirmed or suspected COVID-19, compared with 28% of Black people.

Notifications of deaths in all adult social care settings 10 April to 30 September 2020 by ethnic group and COVID-19 status

Source: notifications of deaths under Statutory Notification 16 to CQC, 10 April to 30 September 2020



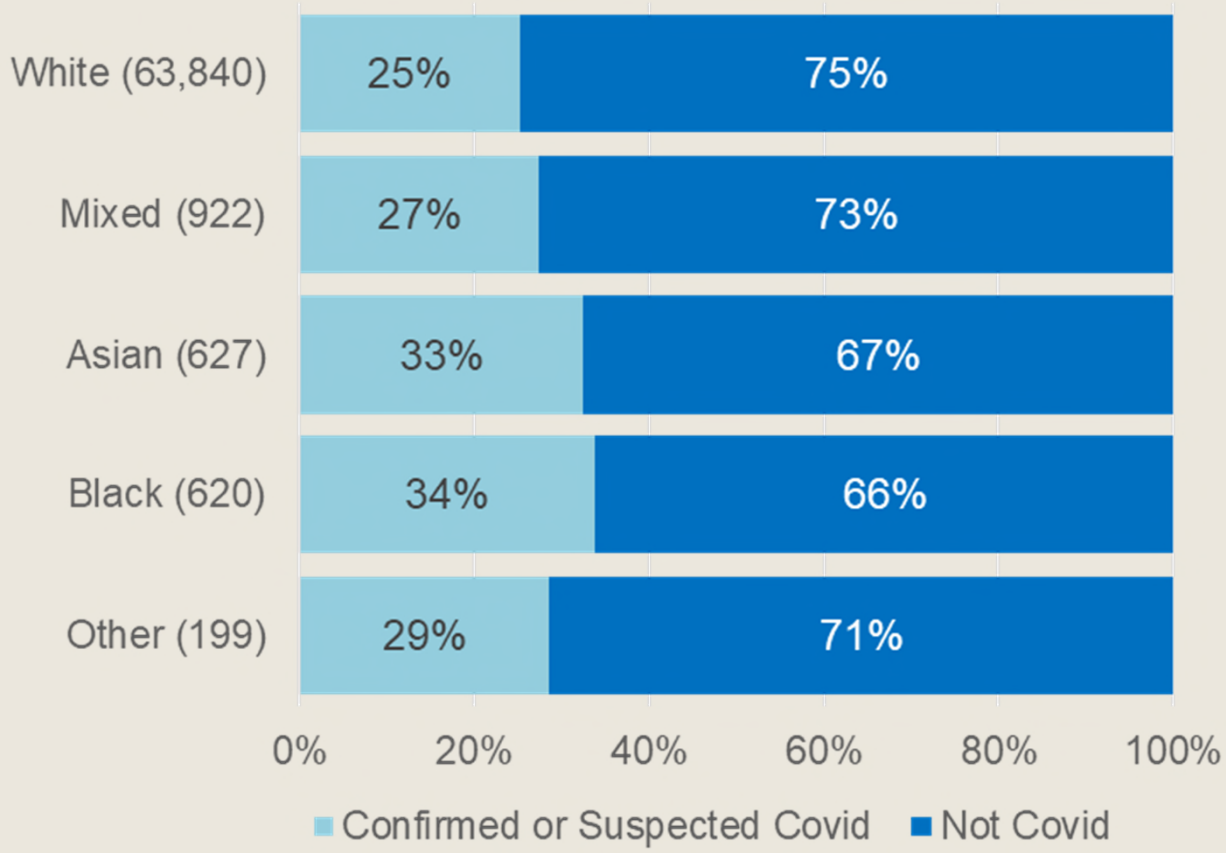
Deaths of people from Black and minority ethnic groups in adult social care settings (contd)

If we look only at care homes, this pattern is slightly more distinct. The chart shows that while 25% of White people who died were flagged as confirmed or suspected COVID-19, for Black people who died the figure was 34%.

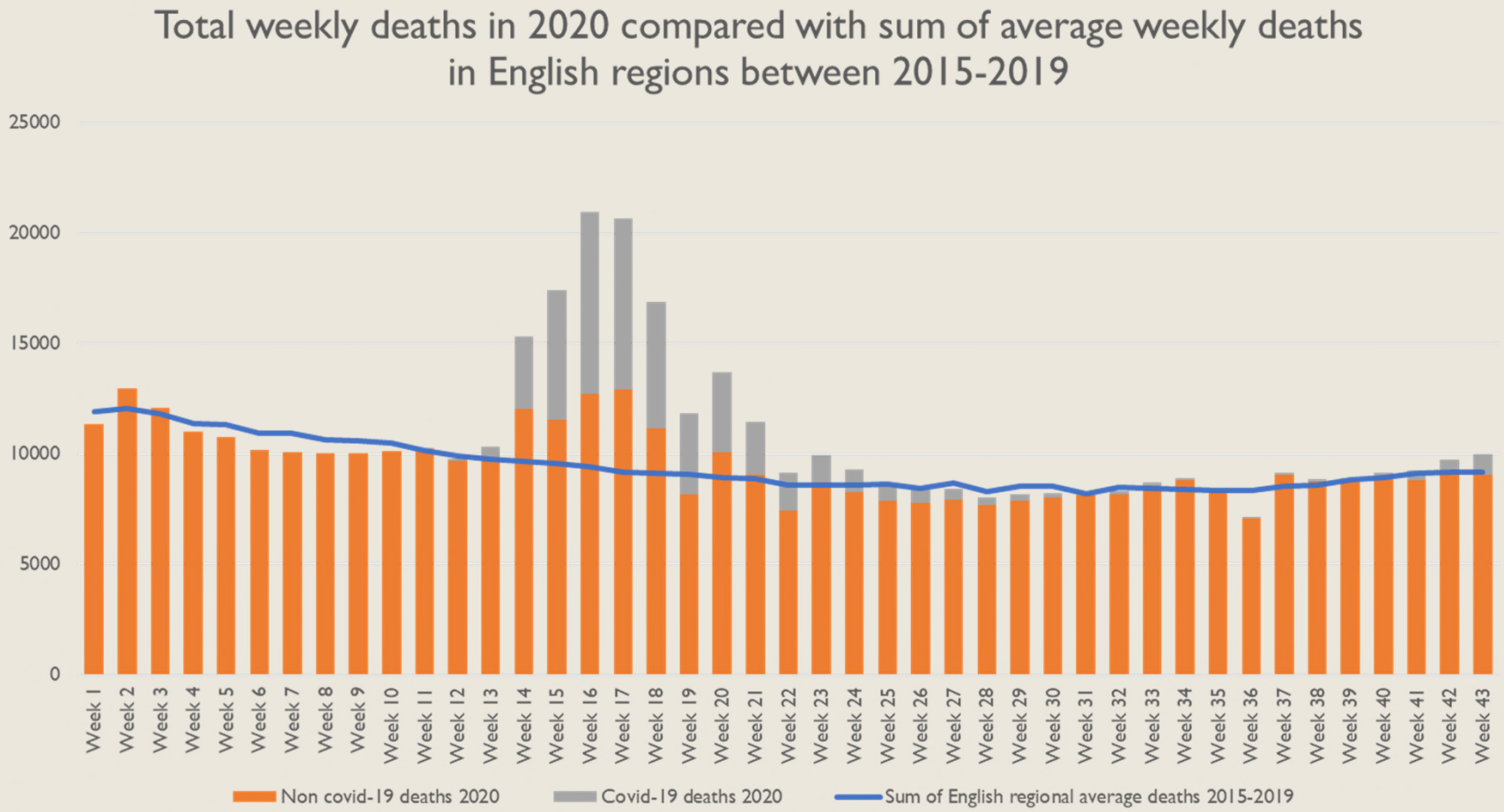
It should be noted that all these figures are somewhat lower than the percentages we reported for the period 10 April to 15 May – this is to be expected because the new time period covers a much longer period after the first wave of COVID-19 subsided.

Notifications of deaths in care homes 10 April to 30 September 2020 by ethnic group and COVID-19 status

Source: notifications of deaths under Statutory Notification 16 to CQC, 10 April to 30 September 2020



ONS data on all weekly deaths in England (COVID and non-COVID) compared with the average for 2015-2019



Source: ONS COVID/non-COVID 2020 death data:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard
and 2015-2019 death data from:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/11674fiveyearaverageweeklydeathsforenglishregionsandwalesdeathsthatoccurredbetween2015and2019 Week 43: week ending 23 October 2020