Preparedness of Residential and Nursing Homes for Pandemic Flu

Greg Fell
Yorkshire and Humber Public Health Training Scheme, Yorkshire Deanery, Academic Unit of Public Health, Institute of Health Sciences, University of Leeds, 101 Clarendon Road, Leeds LS2 9LJ, UK
Address correspondence to Greg Fell, E-mail: greg.fell@nhs.net

ABSTRACT

Background Work is being undertaken across a wide range of agencies to ensure a high level of preparedness for pandemic influenza. In England, the Department of Health has published a range of guidance to support this. The impact of pandemic flu on care homes, especially if unprepared may have a major knock on effect on the rest of the health and social care system.

Objective and Methods A rapid survey was undertaken of a small number of care homes in West Yorkshire to assess preparedness. The homes were both local authority and privately owned.

Results It was apparent that little preparation had been done at the time of the survey. A range of readily implementable ideas that may help this sector prepare was identified.

Conclusion Planning for pandemic flu in this sector will require effort and coordination across a range of sectors; it might best be coordinated through Local Resilience Forums.

Keywords emergency preparedness, pandemic flu, care homes, nursing homes, social care

Introduction

Within the health and social care sector, work is being undertaken to ensure business continuity and to enable a rapid and effective response to pandemic flu. This should minimize morbidity and mortality, economic and social impact, and impact on other public services. The ‘care home’ sector (residential, nursing homes and other institutional care) has been identified as a sector in need of support; guidance is available from the Department of Health.1,2,3

It is thought that little contingency planning has been undertaken in this sector at the front line. There is a risk that if unprepared, homes (essentially operating as small business units) fold - having negative consequences for residents, families, the rest of the health and social care sector and the economy more broadly.

Methods

In February 2007, a rapid assessment of the plans that were in place was undertaken. The sample was a small (n = 15), randomly selected sample of care and nursing homes in West Yorkshire. The homes were of mixed size and fell within both the Local Authority and Private sectors.

The purpose of this small study was to inform relevant agencies and ensure appropriate support and advice is given to the sector locally; especially in the context of the DH guidance on pandemic flu for this sector. Semi-structured interviews were conducted with the managers of the homes to elicit information on the level of planning that had been undertaken for pandemic flu.

Findings

There was a high level of consistency of responses. The findings of this study raised a number of important issues that need to be addressed as a part of contingency planning for pandemic flu. Some of the key issues are picked out below.

Greg Fell, Specialist Trainee in Public Health
Nature and scope of contingency planning in place

None of the homes surveyed had undertaken any contingency planning for pandemic flu. Most respondents focused their answers around the infection control elements of responding to (seasonal) flu. None had conducted any planning for clinical management or business continuity in a pandemic. As small business, those interviewed saw their home as responsible for planning to mitigate the impact of major events. There were significant gaps in thinking and proactive planning with respect to business continuity, case management and infection control across all the homes interviewed.

Workforce

The draft DH guidance sets out a number of planning assumptions; including anticipated staff shortages during a pandemic. All respondents stated that in the pandemic period, they would be reliant on bank or agency staff to cover workforce shortfalls.

Increased clinical need

Those interviewed were conscious of the need to provide additional clinical support in homes—particularly residential for symptomatic residents that were unable to be admitted to hospital (due to higher admission thresholds being in place). No formal planning had been undertaken for this. None of the homes had identified resources to fund any increased need for clinician input.

Occupational health

Aspects of working while symptomatic were explored. During the pandemic period, it was seen as likely that many staff would come to work while symptomatic—‘because they see themselves as dedicated’. Alternatively, they may turn in because their employer exerts pressure or because there is no sick leave for many. This has obvious infection control implications.

Amending staffing ratios

Staffing ratios are partly determined by the ‘average’ level of need. In the event of a pandemic, most saw that this ratio may need to be reviewed (due to staff shortage) but paradoxically this will be done at a time when need is highest. It was recognized that amending staffing ratios would only be done under the guidance of the regulator. None of those interviewed had planned for curtailing or cutting ‘non-essential’ activities to reduce demands on staff; or to training non-clinical staff.

Perceived impact of a 3–4 month pandemic period

All were asked to speculate how long they may be able to cope with the additional pressure of an anticipated 3–4 month pandemic. Answers ranged from 2 to 4 weeks. It was perceived likely that during the pandemic homes will be closed to new entrants (as per normal infection control practice during seasonal flu outbreaks). Following a death, beds would normally be filled promptly. It was recognized that this may not be possible during a pandemic period. Even the loss of a few residents worth of income was seen to have a large financial impact; particularly if a moratorium on new admissions were applied over a long period.

Who is and should be providing information

At the time the survey was conducted, the information provided to this sector was seen as ad hoc, inconsistent and sporadic. There was confusion around information provided about avian, seasonal and pandemic flu.

With regard to who should be providing advice, those interviewed were clear that the actual source of advice did not matter—as long as it was consistent, clear, accurate responsive and all those that need to contribute to it had done so. A number of advice sources (coordinated through one contact point) may be best to cover clinical management, infection control and business continuity aspects of planning.

A means of systematically communicating information about flu pandemic (clinical, public health and business continuity) with this whole sector was seen as critical—both pre- and during the pandemic period.

Leadership cropped up a number of times; those interviewed were unclear about ‘who is in charge’ with regard to flu pandemic, given the many aspects ranging from infection control through to business continuity. It was recommended that either the Director of Public Health or Director of Adult Social Services is responsible for ensuring that contingency planning has occurred, though many of the tasks involved may be delegated.

There was uncertainty about whose responsibility it is to support recovery, and questions as to whether this type of scenario is insurable. High-quality continuity planning could be seen as an insurance (albeit not financial) to limit loss in the event of pandemic.

Discussion

What is already known on this topic

Many organizations have undertaken substantial planning for pandemic influenza. It was thought that little planning
had been undertaken within the nursing and residential home sector. The implications of a high business failure rate in this sector, both for the residents and the knock on consequences for health and social care services might be significant.

**Main finding of this study**

This study found that (in February 2007) little planning had been undertaken and there was confusion about who was responsible, and what aspects of pandemic influenza to contingency plan for.

**What this study adds**

There was a high degree of consistency in responses to the survey. In early 2007, planning for pandemic influenza was not happening at the front line in the care home sector. However, as institutions in this sector are not category 1 responders (under the 2004 Civil Contingencies Act), there is no absolute requirement for this to happen. Little focus had been given to contingency planning in this sector prior to the DH guidance. In this context, these findings are not surprising.

However, guidance for this sector is now available. There is an opportunity to plan for a significant event that will happen. Many of the contingencies within a pandemic flu scenario (clinical, infection control and business continuity) can be planned for a priori. Preparation (for any emergency) will require planning, time and practical support to be given to the sector; possibly requiring dedicated resources. Any planning response to pandemic flu threat must be incorporated into the regulatory framework—thus be seen as a part of core business.

The Department of Health has published minimum standards for care homes, requiring owners to promote health and maintain access to health-care services, regulated by the Commission for Social Care Inspectorate. During a pandemic period, there may be considerable pressure on care homes to maintain these standards. A pandemic may require homes to deliver additional levels of care without staff or money. CSCI might need to provide advice to this sector on maintenance of standards during a pandemic period; or where standards may be relaxed; particularly around staffing ratios during (and possibly after) the pandemic period.

Those interviewed set out a number of assumptions that should be challenged. Most obviously, most cited they might be reliant on bank or agency staff to cover shortfalls during a pandemic. However, it may be that infection control arrangements in place might mitigate against staff moving between homes; and the bank or agency staff will be under high demand from other organizations and also be suffering high levels of absenteeism. Even if staff are available, it is likely that there will be a significant shortage of clinicians to cover increased need and consideration should be given to which agency could provide this and the model of care.

Care Homes are subject to commercial business pressures in a way that the NHS is not. Thus, there may be a direct tension between sensible infection control advice and economic survival. One worst-case scenario was that during (or following) a pandemic, some owners may see it as not profitable or economically viable to continue in the business and close/sell a home. This would have consequences for the residents of those homes; and knock on consequences for the stability of the sector as a whole, and more broadly health and social care services to recover from the pandemic period.

The continued flow of patients out of hospital (to free up capacity for those that are critically ill) to both home and into care homes will be critical. Without this flow, there is a risk that the health-care system will be less able to cope with pandemic.

The issue of local leadership and responsibility for coordinating planning for response and longer term recovery and (in its various aspects) was seen as crucial. A framework, for supporting care homes to plan and proving information, should be agreed through each district Pandemic Flu Planning Committee. Existing pandemic plans augmented to cover the care home sector, where this has not already happened. Local Resilience Forums should ensure that relevant contingency planning and preparedness has occurred in the care home sector. This Forum provides an opportunity to ensure that stakeholders from both Local Authority and NHS are involved in oversight of contingency planning.

Owing to nature of the business and customer group, planning needs to encompass infection control, case management and business continuity. The economic survival of the individual business (and the broader sector) may depend on sound business continuity planning.

Workshops and other educational activity may help to address some of the gaps in local planning. These might be jointly run by HPA, PCTs and Local Authorities and should include a simple ‘how to’ guide and generic contingency plans that can be adapted for local circumstances. Contingency planning should be applied to the whole supply chain; with a requirement for business continuity built into contracts.

A suggested policy solution would be for a formal requirement for local authorities to support contingency planning for small businesses assessed as high risk (i.e. in which a high failure rate could have significant knock on consequences for the economy and individual mortality/morbidity). This would fit under duty 6 of the Civil Contingencies Act.
Limitations of this study
This was a simple, small study; with only a limited number of homes interviewed. In addition, the interview schedule was internally piloted, and not externally validated. As such, caution should be exercised when generalizing these findings. There is scope for larger studies to be conducted in this area; exploring what contingency planning has been undertaken since the publication of the guidance; and where there are gaps in this planning.

References
1 An Operational and Strategic Framework. Planning for Pandemic Influenza in Adult Social Care. Department of Health, 2007.
2 Pandemic Influenza Contingency Planning. Guidance on the Provision of Healthcare in a Community Setting in England. Department of Health, 2007.
3 Guidelines for Social Care Staff. Planning for Pandemic Influenza in Adult Social Care.
4 Care Homes for Older People. National Minimum Standards Care Homes Regulations. DH, 2003.