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SUPPORTING INFORMATION
Additional supporting information may be found in the online version of the article at the publisher’s website.

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'The Unknown Unknowns' - Challenges of clinical support to domiciliary religious congregations during the COVID-19 pandemic

INTRODUCTION
The COVID-19 pandemic has exposed residential care facilities (RCFs) for older people globally and in Ireland up to 62% of outbreaks and 38% of deaths due to COVID-19 have occurred in such environments.1 In April 2020, the Irish Health Service Executive (HSE) mandated the formation of COVID-19 Clinical Support Teams (CSTs)
in the various healthcare regions in Ireland to assist community RCFs. While initial efforts focused on private regulated facilities, the first COVID-19 outbreak in an RCF in this healthcare region (Cork and Kerry) occurred in a Domiciliary Religious Congregation (DRC). DRCs are residential facilities where care is provided for retired clerics and nuns. There are in the region of 400 DRCs in Ireland. While DRCs have a long history of providing retirement facilities for members of various religious orders, they are, as a result of 30-year-old legislation, outside of the regulatory purview of the Irish Health Information and Quality Authority (HIQA). As such, no data on, including as to the extent of, the DRCs were initially available to the CST. This work begins the exercise of increasing awareness and understanding of these DRCs.

METHODS

DRCs in Cork City and County were identified using the Catholic Directory. Those facilities were asked to complete a detailed questionnaire which was administered by telephone to objectively quantify (a) resident demographics, (b) their functional requirements, and (c) the preparedness of each facility for a potential COVID-19 outbreak.

This standardized data collection tool was deployed to capture information on accommodation, staffing, and residents (demographics and functional requirements) so that the CSTs could determine if essential standards of care could be maintained should a COVID-19 outbreak occur. This was modeled on HIQA standards of COVID-19 preparedness for registered RCFs.

RESULTS

Thirty religious congregations were identified and contacted. Of these, 18 catered for multiple occupancies of ≥6 retired clerics or nuns. In total, these 18 facilities provided accommodation for 319 religious members, ranging from six to 49 residents. This represents a significant percentage of the overall population of approximately 3600 older adults residing in registered public or private facilities in this geographical area.

Resident demographics, DRC facilities, staffing, and COVID-19 preparedness are displayed in Table 1. There were 109 retired priests and 210 retired nuns living in 18 congregations. The mean age was between 70 and 79 years, with 45% being aged 80 years and older and 15% older than 90 years. Ninety-six residents required assistance with personal activities of daily living and 22 of those residents had high dependency levels

| Resident demographics | Number | Percentage |
|------------------------|--------|------------|
| Gender                 |        |            |
| Male                   | 109    | 34         |
| Female                 | 210    | 66         |
| Total no. of retired religious residing in religious congregations in Cork South: 319 |
| Age profiles (years)   |        |            |
| <70                    | 16     | 5          |
| 70–79                  | 152    | 50         |
| 80–89                  | 91     | 30         |
| 90–99                  | 41     | 14         |
| >100                   | 1      | <1         |
| One DRC of 18 inhabitants refused to disclose ages of residents, total = 301 |
| Functional and cognitive baselines | | |
| Assistance required with ADLs | 96 | 30% |
| High dependency        | 22     | 7%         |
| Known diagnosis of dementia | 45 | 14% |
| Bed-bound residents    | 17     | 5%         |

| Facilities and accommodation | Number of DRCs | Percentage |
|------------------------------|----------------|------------|
| Single building              | 12             | 66         |
| Multiple buildings           | 6              | 33         |
| Infirmary on site            | 3              | 17         |
| Single rooms                 | 18             | 100        |
| Multiple occupancy rooms     | 0              | 0          |
| Private toilet facilities    | 14             | 78         |
| Shared toilet facilities     | 4              | 22         |

| Staffing                     | Number of DRCs | Percentage |
|------------------------------|----------------|------------|
| All 18 DRCs employed private staff members. No. of staff members employed in DRCs (range 3–33, median 6) |
| Permanent staff              | 16             | 89         |
| Agency/temporary staff       | 6              | 33         |
| Nursing staff                | 8              | 44         |
| Residents caring for other residents | 3 | 17 |
| Staff trained in gerontological care | 0 | 0 |

| COVID-19 preparedness        | Number of DRCs | Percentage |
|------------------------------|----------------|------------|
| Staffing contingency plan    | 18             | 100        |
| Contingency plan is for residents to look after other residents | 4 | 22 |
| Access to PPE                | 7              | 39         |
TABLE 1 (Continued)

| COVID-19 preparedness                              | Number of DRCs | Percentage |
|---------------------------------------------------|----------------|------------|
| Staff training regarding PPE and hand washing     | 11             | 61         |
| Adherence to physical distancing                  | 16             | 89         |
| Awareness re: infection prevention and control    | 11             | 61         |
| Access to deep cleaning if required               | 4              | 22         |

Abbreviations: ADLs, activities of daily living; DRC, Domiciliary Religious Congregation; PPE, personal protective equipment.

requiring maximum assistance for baseline functioning. Forty-five residents had a documented diagnosis of dementia, 17 of whom were bed-bound.

Sixty-six percent of facilities consisted of a single building. Three facilities had a separate infirmary unit. All rooms in all facilities were single occupancy. However, four units (22%) had shared toilet facilities.

All 18 congregations had privately employed staff. Agency staff were employed in three facilities (17%). Four facilities (22%) employed a management agency to arrange all staffing remotely. Nursing staff were employed in eight facilities (44%) ranging from 2 h per week to 24 h care. Three facilities (17%) reported that residents provided full-time care for others. All 18 units reported that a contingency plan was in place for staffing should staff become unwell. However, six facilities (33%) reported the contingency plan as being that fellow retired religious residents would fill in for staff.

Each facility was asked about their awareness of COVID-19. Two facilities (11%) did not appear to fully understand the concept of social distancing. Eight facilities (44%) had staff education and training in correct use of personal protective equipment. Five facilities (28%) had no awareness regarding infection prevention control measures. Four facilities (22%) had ready access to deep cleaning of the facilities if required.

DISCUSSION

Religious orders in Ireland have a history in the provision of quality care for older persons in their residential facilities. The study demonstrates that the older adults living in those DRCs now have considerable care needs. At the time of introducing the legislation, the Government minister noted that “everybody will accept that it would not, for example, be right to insist that a monastery of Carmelite nuns who have taken a vow of poverty be obliged to comply with the standards of comfort laid down in the new regulations.” This rationale continues to carry weight from a patient autonomy perspective. However, the historic independence afforded to DRCs in Ireland needs to be reviewed given what we now know of the aging population, the considerable care needs, and the potential shortcomings in crisis preparedness. This requires a change in legislation. The pathway to this change has been provided for in an expert panel report to the Minister for Health which recommends that the “legislation underpinning nursing homes registration and operation and empowering HIQA is in place, but the current regulations need to be modernised and enhanced.” It is important that the need for integration and oversight of the DRCs in Ireland is actively pursued and broadcast so that it is affected by the drive for action created by COVID-19.

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CONFLICT OF INTEREST
The authors have no conflicts of interest to declare.

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Residents of long-term care facilities (LTCFs) are particularly vulnerable to the coronavirus disease 2019 (COVID-19).1,2 Globally, COVID-19 deaths in LTCFs account for 30%–70% of mortality in developed countries.3 In Singapore, LTCFs accounted for 0.03% of cases but 14% of COVID-19 deaths in 2020.

Having achieved a high vaccination rate of over 80% in August 2021, Singapore pivoted to an endemic COVID-19 strategy.4 This middle path approach involves cautiously opening up economically and socially while aiming to avoid high mortality rates. There were only 42 deaths in total at the start of the pivot toward an endemic COVID-19 policy in August 2021. Yet within weeks of opening up, COVID-19 infections and mortalities have risen in tandem. Vulnerable populationssuch as LTCFs and acute hospitals had an unprecedented total ban on visitors imposed on September 13, 2021. This ban, at the time of writing, has been further extended for another month.4 The rise of new variants of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), particularly the delta variant (B.1.617.2), has necessitated a review of strategies that had previously worked to contain COVID-19, even in a highly vaccinated country.

Within a month of embarking on an endemic COVID-19 strategy, nearly 25% of LTCFs across the country had detected COVID-19 cases. COVID-19 numbers in local LTCFs have increased exponentially less than 50 cases prior to the visitor ban to approximately 800 cases even with the ban in place. This begets several important considerations when COVID-19 becomes endemic:

1. Visitor bans on LTCF residents do not achieve total containment of COVID-19 and are not sustainable in the long run. The evidence shows that visitor bans do not prevent COVID-19 infections as staff movement contributes to transmission, especially with an endemic situation.5 Sharing of best practices and the development of robust protocols to facilitate safe visiting of LTCF residents are integral to maintain the welfare of residents.6,7 Telehealth should continue to be developed and is already being deployed, however these cannot fully replace in-person interactions.8

2. High vaccination rates will attenuate, but not eliminate COVID-19 mortalities. LTCF residents will continue to be disproportionately affected. Singapore practices an age-based triage strategy with home recovery as the default for fully vaccinated persons aged 12–79 years old. The majority of LTCF residents who are older and more frail are transferred to acute hospitals or community treatment facilities, as has been practiced since the start of the pandemic.4 This is not practical with healthcare facilities increasingly strained by the rapid surge of cases due to the delta variant. Instead, careful risk stratification and scaling up LTCFs to manage stable COVID-19 cases is a more sustainable long-term solution. In addition, LTCF residents should receive priority and be encouraged to take booster vaccinations against COVID-19 where indicated.9

3. Evidence has shown that the incidence of influenza has fallen dramatically due to social distancing measures. Natural immunity to influenza may have diminished among LTCF residents during this COVID-19 pandemic. In an endemic phase of COVID-19 and with the resumption of visitors, LTCFs must prepare for the resurgence of influenza and other viral epidemics that may have been suppressed with social distancing measures. Strict hygiene measures should be practiced while simultaneously encouraging vaccinations against both COVID-19 and influenza.