# Infection Prevention and Control Initiatives Briefing Paper

# Joint Department of Health / HSE Update for NPHET on COVID-19

# 21st January 2021

Date of request: 14th January 2021
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| **Action required:** |
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| ☐ For noting |
| X For discussion |
| ☐ For decision |

**Infection Prevention and Control Initiatives Briefing Paper**
**Joint Department of Health / HSE Update for NPHET on COVID-19**
**20th January 2021**

## Purpose of this paper

*For discussion:* This is a Joint DOH-HSE paper providing update on infection prevention and control (IPC) approach and initiatives in healthcare settings for COVID-19 requested by the NPHET for consideration at the meeting planned for **Thursday, 21st January 2021**.

## Summary

This paper outlines the current position on the IPC initiatives across the health and social care system in the context of the challenges presented by COVID-19 pandemic. It provides an overview of the additional targeted investment provided and outlines initiatives already undertaken and work in progress. An overview of the current situation across acute hospitals, nursing homes and mental health services is also provided.

## Introduction

Infection Prevention and Control (IPC) is a collection of practices, resources and specialist support that together help to prevent infections and minimise their impact when they do occur. IPC practices are of critical importance in protecting the function of healthcare services and mitigating the impact on vulnerable populations. IPC has been a feature of modern healthcare delivery for some time and has been successful in reducing and controlling infections such as MRSA, CPE and *C. difficile*. The foundation of IPC is the skill, care and commitment of the individual healthcare workers who provide hands on care supported by clear governance, appropriate facilities and specialist IPC support. IPC works within the context of the overall Public Health response to the control of infection. In the context of pandemic infection this interrelationship is particularly important.

The emergence of COVID-19 and associated pandemic has necessitated new ways of working in order to deliver health and social care services in different ways to protect patients, service users and staff. This has resulted in a very significant increased requirement for IPC support across the health system since the beginning of 2020. The Government's *Recovery and Resilience Plan*, and the *HSE Winter Plan*, both published in September 2020, recognise IPC as a key enabler in the delivery and maintenance of COVID-19 and the delivery of non-COVID-19 health and social care services.

IPC guidance has been fundamental in managing infections such as for influenza and has been in place pre-COVID-19 with many basic principles remain relevant in the context of COVID-19. Good IPC practice is also supported by National Standards and associated montoring programmes developed and conducted by HIQA under the Health Act 2007 Section 8 (1) (c). These are the *National standards for IPC of healthcare-associated infections in acute healthcare services (*2017) and *National Standards for IPC in Community Services* (2018). HIQA has a long-established monitoring programme to assess compliance in acute hospitals. In light of the ongoing global pandemic of COVID-19 and its impact on the quality and safety of care for patients admitted to rehabilitation and community inpatient healthcare services, which commenced in July 2020.

The National Standards provide a framework for service providers to assess and improve the service they provide, particularly during an outbreak of infection, including COVID-19. Both monitoring

programmes assess services' Capacity and Capability through the themes of Leadership, Governance, Management and Workforce and also Quality and Safety through the themes of Effective Care & Support and Safe Care & Support.

New variants of COVID-19 have been identified with one from the UK reported in Ireland in December 2020, one from South Africa earlier this month and more recently one has been identified in Brazil, although as at 15th January, there was no evidence of this last variant in Ireland. The health services are actively responding to evidence and trends in the disease progression by doing all that is practical to support best infection control practice in the healthcare setting supported intensified testing and identification and management of contacts.

While these measures have proven generally effective in controlling transmission of COVID-19 in the healthcare setting when community transmission is at low to moderate levels it is apparent that they become progressively less effective as community transmission levels increase to very high levels. The experience reported from healthcare settings is that high community transmission is associated with multiple introductions of COVID-19 into the healthcare setting. As infectious people are difficult to detect even with extensive testing, undetected introductions tend to be associated with outbreaks with containment further complicated by pressures related to staff absence. The result is that the number of hospital-acquired COVID-19 cases and outbreaks reported in recent weeks has been very high. International data from a comparable national monitoring system is not available although there are published reports from other countries of healthcare associated outbreaks of COVID-19.

COVID-19 Metrics

As at 10th January last, the COVID-19 metrics data at national level were:

- 404 cases of hospital-acquired COVID-19 (number of cases in previous 7 days).
- 83 outbreaks for COVID-19 currently open (this is not limited to new outbreaks).
- 836 new laboratory confirmed cases in hospital staff (number of cases in previous 7 days).

New cases in staff is a total, not limited to cases assessed as hospital acquired.

Further detail is provided in appendix 1.

Impact on Healthcare Workers

The current surge in Community transmission has resulted in significant levels of leave in HSE staff. At 14th January there were a total of 6,477 healthcare workers on COVID-19 related leave including 3,998 from Acute hospitals and 2,409 from Community services. Further detail on COVID-19 related absence is provided in appendix 2.

Infection rates in HCWs. In the week ending 10th January 2021, HSE acute hospitals reported 836 newly diagnosed cases of COVID-19 in hospital staff.

Vaccination Programme update

The vaccination programme for frontline healthcare workers has been rolled out since December 29th. A number of frontline healthcare workers are scheduled to receive their second dose of vaccine this week. There is reason to expect that this will begin to impact on the number of

healthcare workers developing illness due to COVID-19. It remains to be seen if this has an impact on transmission in the healthcare setting.

**Overview of New Development Funding for IPC initiatives & Progress to Date**

***Overall Approach***

Over the last few years, the Department and the HSE have worked closely to develop and adopt integrated IPC policy and funding to support co-ordinated initiatives, underpinned by the HSE governance structures. For example, in response to the Public Health Emergency on carbapenemase-producing Enterobacteriaceae (CPE).

Building on this foundation, an integrated approach to IPC in response to the COVID-19 pandemic has been taken. This allows for shared learning and multi-disciplinary synergies across the acute hospital and community sectors to be harnessed and ensures IPC sits within an overarching governance structure. Significant funding has been provided to enhance the health service's IPC responses in an integrated way across acute and community services.

Integration of IPC services improves the entire patient journey and is in line with the policy direction set out in Sláintecare. To provide clinical leadership for integration, Consultant appointments with responsibility for IPC which are hospital based but include a specified 0.5 WTE commitment to support Community services in a region aligned to their hospital appointment have been funded. These posts are open to Consultant Microbiologist or Infectious Disease Physicians with a special interest in IPC. The appointment of Surveillance Scientists will enable integrated working on IPC surveillance across both acute and community services. This approach allows for a more flexible, sustainable and resilient service supporting the needs of the whole population. It provides benefits in terms of shared surveillance data staff information, education and training resources, joint acute and community infection prevention and control governance structures, clinical placement for training purposes and implementation of quality improvement initiatives.

Given the early experiences with COVID-19, Occupational Health Service capacity was also included to support IPC across Acute and Community Services. The multidisciplinary team will include an Assistant Director of Nursing IPC who will work with the Consultant to coordinate the work of Clinical IPC Nurse Specialists and support a network of Community IPC Link Practitioners. IPC Link Practitioners will act as a link between their clinical area/service and the infection control team working to increase awareness of infection control issues and motivate staff to improve practice.

***Integrated IPC Funding Proposal 2020***

Following discussion within the Department, with the HSE, an integrated IPC proposal was submitted in late July 2020 outlining an integrated approach to IPC service funding requirements in relation to COVID-19 for 2020 and 2021. This proposal set out funding requirements across Acute Hospitals, Community Services, Occupational Health and at national level in the face of the COVID-19 pandemic and were acknowledged in the HSE Winter Plan.

Funding of approx. **€3.9m** has been provided to the HSE in 2020 with follow up funding of **€7.5m** in 2021. Under these structures, this investment supports initiatives in acute hospitals, community services, occupational health, including consultant posts providing acute and community services, capital funding to upgrade equipment and facilities, ICT systems, as well as training for IPC nurses and link practitioners.

***Update on 2020 Pay & New Development Posts***

The 2020 COVID-19 investment provides for a total of **100** posts across the service areas. These posts consist of 1 WTE at national level (to support the AMRIC National Clinical Programme), 31.5 WTEs based in community services, 46.5 WTEs based in acute services and 21 WTEs for Occupational Health services. As of Wednesday, 19th January, 24 WTEs posts are filled and remaining 76 WTEs posts are at various stages of recruitment.

A summary table of the new development IPC posts since the initial funding in 2018 is provided in appendix 3.

***Update on 2020 Non-Pay New Developments***

The 2020 COVID-19 investment also made provision for a number of non-pay requirements across the service areas, which were required for immediate minor capital support and for training and education to enable a sustainable and enhanced IPC capacity. These cover:

- Minor capital projects focused on improving water and sanitation facilities and hospital infrastructure to support IPC good practice, these include sanitary wear and pipework upgrades, decontamination equipment, ventilation and air handling improvements, equipment for hand hygiene training and support for ICT software and hardware.
- Education and training including provision for IPC link nurse education programme, training for IPC Clinical Nurse Specialists and decontamination training for dental staff.

***Budget 2021***

The provisions in Budget 2021 for antimicrobial resistance and IPC are supported by **€7m** new development funding, which allows for an additional **114** multi-disciplinary staff and other key initiatives to be rolled out in line with the agreed integrated approach, building on the previous new developments to further enhance capacity.

With regard to acute hospitals, it will enhance capacity across the multi-disciplinary IPC teams that play an important role in supporting the continued response to COVID-19, and support key initiatives to extend infection surveillance. This funding will also support community IPC teams including additional investment in staff, ICT, and specialist education and training.

**Implementation of IPC Initiatives & Progress to Date**

***Overarching AMRIC COVID-19 Response***

Governance

The HSE have an established dedicated overarching governance structure to deal with healthcare associated infection and antimicrobial resistance. This supports an integrated approach to the IPC inputs for the COVID-19 response.

The AMRIC (Antimicrobial Resistance and Infection Control) governance structure consists of:

- The National AMRIC Oversight Team, chaired by the Chief Clinical Officer.
- The National Working Group for control of transmission of COVID-19 in the acute hospital setting (referred to below is established as a Working Group of AMRIC Oversight)
- The National AMRIC Implementation Team, including dedicated Implementation Leads, one for acute hospitals services and one for community services.
- The National IPC Advisory Committee has also recently been convened.

- The AMRIC Team, a multi-disciplinary core team that runs the AMRIC National Clinical Programme.

AMRIC - Clinical Guidance and Support

Clinical guidance has been a core support for frontline staff in ensuring the latest evidence was available to inform practice as COVID-19 is a novel virus and understanding continues to evolve.

From February to December 2020 AMRIC:

- developed and where appropriate agreed with stakeholders **147 COVID IPC Guidance documents**. The AMRIC Oversight group provided overview and governance for the development of AMRIC COVID guidance. Where appropriate, some AMRIC Guidance COVID was agreed by Expert Advisory Group and considered by NPHET. All AMRIC COVID Guidance was published to www.hpsc.ie.
- delivered **32 webinars** to support front line service managers and staff to implement AMRIC COVID guidance. These are accessible to staff working in both public and private services. The webinars have had audience numbers ranging from 50 to over 3,000 – the PPE webinar was the highest attendance (3,128).
- provided IPC input and guidance to **14 HSE or national forums** in addition to the NPHET EAG and the HIQA Health Technology Assessment (HTA) Expert Advisory Group (NPHET COVID-19 Support).
- provided **IPC input and guidance to a range of front-line services** across acute and community services, statutory, non-statutory, external services and government departments.

AMRIC hosts a weekly teleconference of Consultant Microbiologists and Infectious Disease Physicians in both HSE and private hospitals. This provides a key forum for discussion and sharing of experience. This forum supports dissemination of updates and provides critical feedback from IPC practitioners, Laboratory Directors and Infectious Disease Physicians managing people with infection to inform the development of guidance.

AMRIC - Education and training

A fundamental requirement of effective IPC and is an educated workforce, building capacity within services to identify and manage IPC risk both of these are priorities for AMRIC and support services in providing a sustainable response.

In 2020, the AMRIC team completed development of a suite of 8 IPC/Antimicrobial Resistance **e-learning foundation modules** (8 modules) designed to meet the immediate IPC learning needs for all healthcare workers hosted on HSELanD. This went live in December last and accredited with NMBI and RCPI for CPD purposes.

In 2020, the AMRIC Team have collaborated with Community Operations supported by the ONMSD to develop a National IPC Link Practitioner Programme for community staff. This programme was successfully piloted in CHO 9 (16 staff trained) by ONMSD. National roll out plans are under development. This is targeted initially at nurses or health and social care professionals who are involved with direct patient care and invasive procedures. This programme is aligned to the current National Interim Guidelines for IPC and the supporting IPC framework document.

AMRIC - Communications

In a pandemic, public communications, solidarity and civic participation are a central part of any nation's response. The HSE has built trust among the population in the public health advice provided through open and transparent communication led by public health experts including the AMRIC team. Communications have been coherent, open and evidence-based and the HSE have collaborated widely across the health system and with key stakeholders. To ensure accurate and timely information, significant communications work has been undertaken to support IPC and related work.

Since March 2020, the AMRIC team have:

- Developed **17 education videos** for healthcare staff. As of 29th November last, there have been 120,458 successful completions of the HSE PPE education videos. (70,039 Community; 50,419 Acute).
- Prepared the **AMRIC PPE information page** for new HSE Staff pages. There have been 75,000 page views to this page from March to December 2020.
- Provided **15 broadcast mails** from the AMRIC team in relation to safe use of PPE, hand hygiene and infection prevention control sent to all staff.
- Developed and rolled out a refreshed HSE **RESIST hand hygiene communications campaign** to 6 HSE Hospital Groups and to a number of pilot sites in HSE Community LTRCFs.
- Produced and circulated three editions of the **RESIST newsletter** for HSE staff.
- Developed a series of **11 COVID-19 posters for staff,** covering a range of topics such as safe use of masks, donning and doffing PPE, GP clinic poster and pharmacy posters.
- Issued **19 iterations of the *'Plain English key messages for HSE spokespersons re COVID-19'*** media pack.
- Produced AMRIC pages relating to AMR, EAAD, PPE, hand hygiene and IPC which were carried in **4 editions of Health Matters** in 2020.
- Produced **7 videos, 8 posters, and 5 leaflets** for the public, including bi-lingual posters for schools and the Hand hygiene poster translated into 11 languages.
- **Ongoing twitter** calendar provided including information on hand hygiene, face coverings, etc. The highest performing AMRIC tweet on HPSC got 100,000 views.
- Delivered **68 Interviews** and responded to 95 Press queries.

AMRIC - Other

To enhance reporting and aid understanding, the HSE commenced monitoring of hospital acquired COVID-19 (HA-COV) in June 2020. This metric is included in the National Service Plan 2021 KPI suite and reporting of rates of HA-COV will commence with the January 2021 reporting cycle. Rates were low in summer months but have been increasing and reached high number week ending 10th January.

HSE Acute Operations in association with AMRIC, commenced monitoring of two additional metrics in January 2021 which were the number of open outbreaks per hospital and the number of new diagnosis of COVID-19 in Healthcare workers (as available) in each hospital. Summary data is included in Appendix 4 below.

***Acute Hospitals Response***

**Infection Prevention and Control in Acute Hospitals**

As part of the work to oversee the preparedness of acute hospitals to respond to the COVID-19 pandemic, the Department and the HSE identified the critical importance of infection, prevention and control (IPC) practices to protect both staff and patients.

On 31st March last, the NPHET mandated the implementation of a suite of 29 measures to reduce the risk of nosocomial infection in acute hospitals. The measures were designed to prevent transmission of the virus in acute hospitals; to slow the demand for specialised healthcare; safeguard risk groups; protect healthcare workers; and minimise the export of cases to other healthcare facilities and the wider community. The HSE was asked to implement these measures as a priority. In that context, the HSE affirmed that its AMRIC Oversight Group had responsibility for governance and management oversight for all issues related to COVID- 19 infection prevention and control.

In addition, HIQA undertook a desk top review of acute hospital IPC preparedness for COVID-19 and submitted a report to NPHET. While the report highlighted the progress which has been made in recent times to expand IPC capacity and capability in acute hospitals, deficits in IPC capacity were identified. Following discussion within the Department, and with the HSE, it was agreed that there was a need to consider an integrated approach to address IPC deficiencies across the acute hospital and community sectors and, as set out above, funding was provided to develop and improve IPC capacity across the system.

Since the submission of the paper to NPHET in late March, the Department has engaged continually with the HSE in relation to the implementation of the mandated measures, and to ensure an on-going focus on controlling transmission of COVID-19 in our acute hospitals. It is clear however that, given the exponential increase in the rate of community transmission of COVID-19 in recent months, acute hospitals represent a specific risk with respect to the transmission of infection.

Given the increasing numbers of hospital outbreaks and concerns in relation to the rate of transmission of infection amongst healthcare workers, the Department and the HSE have also engaged, over recent months, in relation to potential surveillance and testing strategies. The NPHET endorsed a paper on *"Serial Testing of Healthcare Workers in Acute Hospitals"*, which was presented by the HSE on 3rd December last and indicated that the HSE would implement a serial testing programme for HCWs from January 4th, 2021 at three hospital sites; in conjunction with this, testing to support an antigen validation study was to be conducted, in parallel, at one of the hospital sites.

A paper was also presented to the NPHET, by the HSE, on 3rd December on "*Enhanced measures for the control of spread of COVID-19 in Acute Hospitals*" which outlined the establishment of new national criteria for testing asymptomatic staff in response to certain signals, including the testing of all staff where a significant outbreak occurs in a hospital. The Department welcomed this commitment to mass testing in response to significant outbreaks, as well as the rollout of a trial serial testing programme in acute hospitals.

At its meeting on the 10th December, the NPHET further discussed the issue of enhanced measures and recommended that the HSE establish a National Working Group for control of transmission of

COVID-19 in the acute hospital setting. The objective to establishing this group was to ensure a consistent and appropriate national approach to managing transmission of COVID-19 in acute hospitals. This would include a particular focus on ensuring a close to real-time understanding of the settings of infection, the scope of practice of cases in healthcare workers, the mode of, and risk factors associated with, transmission, and the preventive measures in place to prevent secondary and tertiary spread of infection among healthcare staff.

On 17th and 23rd December respectively, two DoH/HSE joint papers were submitted to the NPHET and provided an overview of the steps that have been taken to help reduce the risk of nosocomial infection, including the provision of significant additional funding for IPC in 2020 and 2021. The papers set out the range of enhanced measures which have been, and will continue to be, implemented, both nationally and across the acute hospital system, to address this issue, including: the establishment, within the HSE, of the *National Working Group for control of transmission of COVID-19 in the acute hospital setting*, and the introduction of mass testing in the context of significant hospital outbreaks, as well as a trial programme of serial testing of HCWs to be rolled out in January which will help inform the development of any future serial testing programmes.

The *National Working Group for control of transmission of COVID-19 in the acute hospital setting*, which is chaired by the National Director Acute Operations, met for the first time on 21st December last. The Group meets weekly to oversee and monitor the management of the risk of transmission of COVID-19 in acute hospitals, consider hospital acquired COVID-19 rates, numbers of outbreaks and numbers of new cases of COVID-19 infection in hospital staff. The Group is central to ensure appropriate oversight and a co-ordinated and consistent approach to outbreak control across the acute hospital sector.

As part of the work of the Group, a questionnaire/checklist was developed and circulated to all acute hospitals to gather real time information in relation to the implementation of specific measures to prevent the transmission of COVID-19 within hospitals. The HSE has followed up with individual hospitals in order to ensure that any issues identified, have been addressed urgently, and as appropriate. Summary of responses included in Appendix 4 below.

A process to support the oversight by the *National Working Group for control of transmission of COVID-19 in the acute hospital setting* has been established within acute operations. The hospital groups each attend a weekly meeting with acute operations and members of the AMRIC team to review latest data on HA-COV-19, number of outbreaks and numbers of staff on sick leave. These meetings ensure that outbreak management is optimised, the impact on services and challenges presented at hospital level are considered and any additional support in terms of IPC advice, PPE issues or support with testing capacity are addressed. At recent meetings hospitals confirmed that they are actively responding to the significant pressures on acute services due to high volumes of admissions of patients with COVID-19 requiring medical support and in some cases treatment in intensive care. With over 2,000 patients in hospital with COVID-19, isolation and cohorting of patients is increasingly difficult. The situation is compounded by infrastructural deficits (particularly shortage of isolation rooms and existence of nightingale wards in several hospitals), and the high rate of staff absence due to COVID-19. In two hospital groups the Infection Control team itself is significantly reduced due to leave.

Controlling transmission is particularly challenged by the difficulties in managing asymptomatic patients who have a not-detected test on admission and have COVID-19 detected several days after admission. Therefore, patient pathways and cohorting processes are pro-actively managed on a daily and hourly basis in many hospitals. The control of outbreaks is supported by mass testing in each hospital with outbreaks. While mass testing requirements are now at a scale which is challenging in terms of swabbing and testing capacity, hospitals continue to assess risks associated with outbreaks and perform as much testing as possible with the support of Community testing services as required. Outbreak control are in place in all cases and regular meetings are held. Outbreak control teams are multidisciplinary including participation of the regional Departments of Public Health.

In order to maximise unscheduled care capacity and reduce footfall in hospitals, elective services have been curtailed. All elective services are suspended except urgent, cancer and time critical cases, with alternative pathways being explored where possible. In response to IPC team and general staff concerns a memo has issued from the CCO HSE to hospitals advising that while the existing guidance on IPC including use of PPE remains generally appropriate it is appropriate to allow greater scope for institutional and individual risk assessment with respect to PPE use and that HSE procurement will endeavour to respond to increased orders for PPE to meet requirements associated with changes requirements.

The serial testing programme for HCWs which was due to be trialled from 4th January 2021 at three acute hospital sites, namely, St Colmcille's, Loughlinstown, Naas General Hospital and St James's Hospital has been delayed because of the surge in community transmission and the necessity to divert testing resources to support community testing. However, serial testing programme commenced in St. Colmcille's Hospital on 20th January and will commence in Naas General Hospital in mid-February. An update on the serial testing programme as at 19th January 2021 is included in appendix 5.

Given the need for assurance on the implementation of specific measures to reduce the risk of nosocomial infection in the context of current challenges, and the need to ensure appropriate focus and oversight of IPC in acute hospitals, the HSE will provide to the DOH the *COVID-19 Update Acute Hospitals* report from AMRIC on a weekly basis, which covers key metrics relating to HA-COV-19, outbreak numbers and staff on COVID-19 related leave.

***Community Services Response***

Nursing Homes

*HSE Supports to Nursing Homes*

The HSE COVID-19 Response Teams (CRTs) were established to support Public Health Outbreak teams covering all residential services as well as home support settings. The purpose of these multi-disciplinary teams is to support the prevention, identification, and management of COVID-19 outbreaks across these services (public and private), including with the provision of infection prevention and control input, advice and expertise, including via site visits by an IPC specialist where appropriate and possible. The teams will operate for the duration of the pandemic. 23 COVID Response Teams are currently in operation.

The HSE has established extensive logistics at national and Community Healthcare Organisation (CHO) level providing daily requirements of PPE, free of charge, to all residential care settings and other service areas. The continued supply of PPE on both a precautionary and an outbreak basis is a key support mechanism and will continue to be provided in line with clinical and public health recommendations.

With funding from the Department of Health, Community Operations are building IPC capacity in the community. A Director of Nursing for IPC is due to take up position in February 2021. Recruitment of Community Infection Control Nurses across CHO's is underway and following recent interviews in January 2021 a national panel has been created. Recruitment of IPC nurses remains a challenge because of a lack of suitably qualified applicants. To counter this, Community Operations worked with National Human Resources to revise the eligibility criteria for these positions. In addition, Community Operations offered sponsored places to nurses across HSE community services for a post graduate certificate course in IPC. In January 2021, 50 nurses commenced this course of study.

*Implementation of the Report of the COVID-19 Nursing Homes Expert Panel*
Given the clinical trajectory of COVID-19 and the increased incidence of mortality in the older age groups and those with co-morbidities, the *COVID-19 Nursing Home Expert Panel* was established in May 2020. Experience to date, in Ireland and internationally, has also shown that residents of nursing homes are a very vulnerable population in terms of COVID-19.

The Report of the *COVID-19 Nursing Homes Expert Panel* to the Minister for Health was published in August 2020. On foot of this, implementation structures including an interagency Implementation Oversight Team (IOT) was established, with membership including representatives from the Department, the HSE, HIQA and public representation. The IOT is also supported by a stakeholder Reference Group.

The Expert Panel makes 86 recommendations and package 2 of these recommendations relate to IPC and cover a range of actions which apply to the Department, the HSE, HIQA and individual nursing home providers. In particular, recommendation 2.1 states *Develop an integrated infection prevention and control strategy in the community with particular focus on all nursing homes, public, private or voluntary.* Work is underway via the IOT to progress this recommendation. It also noted that the Government has made available **€40m** in 2021 for progressing the implementation of recommendations of the Expert Panel. The Panel also recommended (2.2) that each nursing home should adopt a clear IPC strategy, including deep clean protocols, for itself which should be incorporated into its preparedness plan. It should be reviewed regularly to ensure consistency with the HSE's community IPC strategy.

*Regulator Supports to Nursing Homes*
Under Regulation 27 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, each registered provider of a nursing home must ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority, are implemented by staff.

As the regulator of designated centres, HIQA have been closely involved in supporting the response to COVID-19 across the nursing home sector, both through their monitoring programmes, working

closely with the HSE and the establishment of an IPC Hub to provide information and guidance. HIQA developed and published a regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak and a self-assessment in April 2020. The aim of the framework is to support nursing homes to prepare for an outbreak of COVID-19 and put in place the necessary contingency plans. Providers were asked to self-assess their preparedness and inspectors then validated the provider's own self-assessment.

In September 2020, HIQA published a further assurance framework for registered providers for preparedness planning and infection prevention and control measures. Providers are required to comply with the minimum requirements of the regulations. HIQA will undertake inspections as part of this programme.

HIQA's Standards Team developed an online IPC learning module, launched on 18 August 2020, to support the implementation of the national IPC community standards. The IPC module was first hosted on the HIQA website and has moved to HSELanD to increase accessibility on 02 October. Up to mid-December 2020, approximately 15,000 people had completed the module; the majority of whom are frontline staff working in health and social care services in the community. A dissemination plan was prepared to raise awareness about the module; this included extensive coverage on social media and sending targeted emails to a wide range of stakeholder groups. As part of this engagement all registered providers of designated centres for older people and designated centres for people with a disability were contacted and asked to share details of the module with colleagues and staff. A more detailed analysis of feedback on the module will be undertaken at which point additional findings will be shared and additional tools to support implementation of national standards will be identified and developed.

Mental Health Sector Response

In April 2020, the Department asked the Mental Health Commission (MHC) to provide an ongoing risk assessment of mental health services based on disease progression, environment and staffing levels. Residential mental health services were identified as being of potentially high risk, due to the prevalence of infection and adverse results for persons over 60 years of age, with underlying medical conditions and high contact physical environments. The MHC risk-assessed each service on preparedness in all settings.

In response HSE Mental Health Services (MHS) developed a comprehensive, cross-sectoral service response to address infection risk in mental health settings and manage cases in individual residential facilities. The MHS response is guided by NPHET public health advice. It involves continuous engagement with HSE public health officials, community residential units, approved centres including acute units, specialised rehabilitation units and the national forensic hospital for COVID-19.

Residential mental health settings are covered by two sets of guidance:

1. HSPC guidance on Residential Care Facilities
2. HSPC guidance for acute settings

The Mental Health Commission continues to monitor COVID-19 progression and associated risks in mental health facilities and reports on a weekly basis to the Department and HSE.

COVID-19 mental health services risk report – 15th January 2021

- 183 services currently monitored by MHC
    - 66 approved centres, 117 community residences
- 55 services reporting suspected or confirmed cases (compared to 48 last week)
    - 44 services reporting confirmed staff cases (compared to 39 last week)
    - 22 services reporting confirmed resident cases (compared to 10 last week)
- 253 total confirmed or suspected cases (compared to 136 last week)
- 95 confirmed or suspected cases residents (compared to 40 last week)
    - 61 confirmed cases (compared to 21 last week)
    - 34 suspected cases (compared to 19 last week)
- 158 confirmed or suspected cases staff (compared to 96 last week)
    - 125 confirmed cases (compared to 76 last week)
    - 33 suspected case (compared to 20 last week)
- 3 new deaths referencing COVID-19, bringing the total to 21 to date.

**Note:** COVID-19 numbers in residential MHS continue to mirror the national outbreak with cases continuing to increase. cases have increased substantially compared to last week, from 136 to 253 this week. The majority of cases are staff related. Infection control protocols appear to be working in relation to residents in facilities.

A weekly report is provided to the Department of Health and the HSE. A tripartite oversight group, comprising of DoH Mental Health Unit, the HSE Mental Health Services and the Mental Health Commission has been established to monitor and update responses to COVID-19. The group work together to identify issues or risks arising in relation to COVID-19, find potential solutions and make follow up reports as appropriate.

**HIQA Rapid Review on IPC Guidance**

HIQA conducted a *Rapid review of current public health guidance for community settings and infection prevention and control measures in healthcare settings for COVID-19*, which was presented at the NPHET meeting on 14th January 2021.

The policy question outlined by the NPHET was:

> "In light of increased transmission of COVID-19 and the identification of new variants of concern, is the current Irish guidance in relation to public health measures in community settings and infection prevention and control measures in healthcare settings appropriate?"

The research question to inform this policy question used by HIQA in conducting the review was:

> "Have international agencies introduced any additional or more stringent public health measures in community settings or infection prevention and control measures in healthcare settings, in response to increased transmission of COVID-19 or the identification of new variants of concern?"

HIQA reviewed and compared guidance from 20 countries and three agencies with current Irish guidance for community settings and infection prevention and control measures, relevant to COVID-19. The rapid review found that, "in general, the current Irish guidance is at least as stringent, if not more stringent that that specified by the countries and agencies reviewed. However, a small number

of measures were identified that were considered to be more stringent than the current Irish guidance". It identifies some differences in the use of masks, including the use of medical grade and of N95 and or FFP2 or FFP3 respirators, temperature checks and the recommended humidity level indoors. The key points from the rapid review are provided in appendix 6.

The report concludes that "Evidence identified from scoping work does not appear to have any significant impact on the overall conclusions in the original evidence summaries, though there is some evidence to suggest that contact transmission may not be as important as droplet transmission for the spread of SARS-CoV-2. Scoping did not identify any relevant scientific literature referring to differences in the mode of transmission of the new variants of concern".

HSE AMRIC has considered the implications of the HIQA rapid review and has prepared a draft document currently under discussion to respond to each of the IPC points raised by the HIQA review.

**Conclusion**

**On-going actions agreed between HSE and DOH to control transmission of COVID-19**

- The HSE National Working Group for control of transmission of COVID-19 in the acute hospital setting will continue to actively monitor management of COVID-19 outbreaks and incidence of Hospital acquired COVID-19 in all public hospitals.
- Learning from individual sites is rapidly disseminated to all sites.
- Acute Hospital Elective services will continue to be curtailed to urgent, cancer and time dependent care.
- Alternative pathways for care including accessing services from Private hospitals under service level agreements will be advanced.
- Vigilant monitoring of staff for symptoms of COVID-19 at start of shift continues.
- All adult patients expected to stay in hospital for one night including maternity services are tested for COVID-19 (Scheduled and Unscheduled)
- Mass testing is applied based continuous risk assessment (subject to capacity constraints).
- Public Health continue to lead outbreak control response in community healthcare settings and contribute a key role to the response in acute hospitals.
- Hospitals continue to be supported by Occupational Health services as in the management of outbreaks involving HCWs.
- Alcohol hand rub and PPE supplies are maintained, and hospitals assured of adequate supplies
- Vaccination programme rolled out in accordance with sequencing plan.
- Acute Operations and AMRIC team continue to support hospitals response to current surge and escalated IPC issues will be addressed rapidly.
- Webinars arranged for clarification of issues and updates on IPC guidance.
- AMRIC hosted weekly teleconference with Consultant Microbiologists and Infectious Disease Physicians
- Continued emphasis on social distancing and basic IPC practices and standard precautions.
- Redoubled effort and immediate focus on progressing recruitment for the IPC, especially those posts to be based in acute hospitals.
- Assessment of the impact of the findings of the HIQA Rapid Review on current guidance and if applicable, the need for updates.
- Progression of a first draft of the Nursing Homes Expert Panel's recommended integrated infection prevention and control strategy for the community.

## Appendix 1 – COVID-19 Metrics

Table 1: COVID-19 Metrics data 10th January 2021

| Provider | Hospital Acquired COVID-19 (WKCOVID1) | Number of currently open outbreaks of covid 19 (this is not limited to new outbreaks) (WKCOVID2) | Number of new laboratory confirmed cases in hospital staff (WKCOVID3) |
|---|---|---|---|
| | 10/01/2021 | 10/01/2021 | 10/01/2021 |
| **National Total** | 404 | 83 | 836 |
| **Children's Health Ireland** | **0** | **0** | 44 |
| CHI at Crumlin | 0 | 0 | 34 |
| CHI at Tallaght | 0 | 0 | |
| CHI at Temple St | 0 | 0 | 10 |
| **Dublin Midlands Hospital Group** | 42 | 17 | 123 |
| Coombe Women and Infants University Hospital | 0 | 0 | 7 |
| MRH Portlaoise | 2 | 2 | 16 |
| MRH Tullamore | 11 | 3 | 18 |
| Naas General Hospital | 0 | 2 | 6 |
| St. James's Hospital | 23 | 3 | 44 |
| St. Luke's Radiation Oncology Network | 0 | 1 | 7 |
| Tallaght University Hospital | 6 | 6 | 25 |
| **Ireland East Hospital Group** | 66 | 17 | 153 |
| Mater Misericordiae University Hospital | 10 | 3 | 48 |
| MRH Mullingar | 0 | 0 | 0 |
| National Maternity Hospital | 0 | 3 | 15 |
| National Orthopaedic Hospital Cappagh | 0 | 1 | 12 |
| Our Lady's Hospital Navan | 3 | 1 | 4 |
| Royal Victoria Eye and Ear Hospital | 0 | 0 | 0 |
| St. Columcille's Hospital | 2 | 1 | 7 |
| St. Luke's General Hospital Kilkenny | 0 | 1 | 3 |
| St. Michael's Hospital | 0 | 1 | 8 |
| St. Vincent's University Hospital | 51 | 6 | 56 |
| Wexford General Hospital | 0 | | |
| **RCSI Hospitals Group** | 76 | 10 | 227 |
| Beaumont Hospital | 12 | 0 | 75 |
| Cavan General Hospital & Monaghan Hospital | 21 | 2 | 40 |
| Connolly Hospital | 21 | 1 | 44 |
| Louth County Hospital | 0 | 0 | 0 |
| Our Lady of Lourdes Hospital | 22 | 7 | 53 |
| Rotunda Hospital | 0 | 0 | 15 |
| **Saolta University Health Care Group** | 84 | 20 | 110 |
| Galway University Hospitals | 55 | 9 | 52 |
| Letterkenny University Hospital | 7 | | |
| Mayo University Hospital | 11 | 7 | 9 |
| Portiuncula University Hospital | 2 | 1 | 7 |
| Roscommon University Hospital | 0 | 0 | 4 |
| Sligo University Hospital | 9 | 3 | 38 |
| **South / South West Hospital Group** | 71 | 10 | 153 |
| Bantry General Hospital | 0 | 0 | 7 |
| Cork University Hospital | 53 | 9 | 98 |
| Cork University Maternity Hospital | 1 | 0 | 4 |
| Kilcreene Regional Orthopaedic Hospital | | | |
| Mallow General Hospital | 0 | 0 | 1 |
| Mercy University Hospital | 16 | 1 | 26 |
| South Infirmary Victoria University Hospital | 0 | 0 | 12 |
| South Tipperary General Hospital | 1 | 0 | 5 |
| UH Kerry | 0 | | |
| UH Waterford | | | |
| **UL Hospitals Group** | 65 | 9 | 26 |
| Croom Orthopaedic Hospital | 5 | 1 | 11 |
| Ennis Hospital | 0 | 0 | 2 |
| Nenagh Hospital | 1 | 0 | 0 |
| St. John's Hospital Limerick | 13 | 1 | 13 |
| UH Limerick | 46 | 7 | |
| UMH Limerick | 0 | 0 | |

## Appendix 2 – COVID-19 related Absence Data

Table 2: Absence data COVID related

**Covid-19 Related Absence (Headcount)**

**Table 1** **Reporting Cycle 6/01/21 - 12/01/21**

| Division | Medical & Dental | Nursing & Midwifery | Health & Social Care Professionals | Management & Administrative | General Support | Patient & Client Care | TOTAL COVID-19 |
|---|---|---|---|---|---|---|---|
| **Total Health Sector** | **391** | **2,513** | **646** | **596** | **793** | **1,538** | **6,477** |
| Acute Hospital Services | 357 | 1,797 | 340 | 401 | 581 | 368 | 3,844 |
| Ambulance Services | - | - | - | - | - | 154 | 154 |
| **Acute Services** | **357** | **1,797** | **340** | **401** | **581** | **522** | **3,998** |
| Community Health & Wellbeing | - | 1 | - | 1 | - | - | 2 |
| Mental Health | 13 | 182 | 16 | 16 | 22 | 41 | 290 |
| Primary Care | 14 | 119 | 42 | 65 | 34 | 70 | 344 |
| Disabilities | - | 236 | 232 | 28 | 60 | 513 | 1,069 |
| Older People | 7 | 177 | 12 | 20 | 96 | 392 | 704 |
| Social Care | 7 | 413 | 244 | 48 | 156 | 905 | 1,773 |
| **Community Services** | **34** | **715** | **302** | **130** | **212** | **1,016** | **2,409** |
| **HWB Corporate & National** | **-** | **1** | **4** | **65** | **-** | **-** | **70** |

**Appendix 3 – New Development Posts**

Table 3: New Development Posts (WTEs as at 19th January 2021)

| Summary - WTE | WTE | WTE Filled | WTE Unfilled | Total WTE | Notes |
|---|---|---|---|---|---|
| **2018** | | | | | |
| National | 4.00 | 4.00 | 0.00 | 4.00 | |
| Community | 1.00 | 1.00 | 0.00 | 1.00 | |
| Acute | 43.00 | 43.00 | 0.00 | 43.00 | |
| **2018 Totals** | **48.00** | **48.00** | **0.00** | **48.00** | |
| **2019** | | | | | |
| National | 6.00 | 2.00 | 4.00 | 6.00 | |
| Community | 20.00 | 18.00 | 2.00 | 20.00 | 2 in acting capacity |
| Acute | 12.90 | 11.40 | 1.50 | 12.90 | |
| **2019 Totals** | **38.90** | **29.40** | **9.50** | **38.90** | |
| **2020** | | | | | |
| National | 1.00 | 0.00 | 1.00 | 1.00 | |
| Community | 31.50 | 5.00 | 26.50 | 31.50 | |
| Acute | 46.50 | 10.00 | 36.50 | 46.50 | |
| Occupational Health | 21.00 | 9.00 | 12.00 | 21.00 | |
| | **100.00** | **24.00** | **76.00** | **100.00** | |
| **Totals** | **186.90** | **101.40** | **85.50** | **186.90** | |

## Appendix 4 – Update on IPC Checklist for Acute Operations

Table 4: Update on IPC Checklist for Acute Operations

| **Update 15-01-21 on Checklist Measures to control transmission COV 19 in acute hospitals Dec 20-Jan 21** | | | | |
|---|---|---|---|---|
| | ***Question*** | ***% Yes*** | | |
| | 1. Patients for elective care are checked for symptoms of viral respiratory tract infection before they attend and again when they attend. | 100% | | |
| | 2. Testing of adult patients on the scheduled care pathway SARS-COV-2 in the 3 days prior to a planned procedure for overnight stays and major procedures in line with guidance is in place | 98% | | |
| | 3. Robust processes are in place to support staff in maintaining social distancing and adhering hand to hygiene practice and mask use outside of the clinical space | 100% | | |
| | 4. Checking patients for unscheduled care for clinical features of COVID-19 at or as soon as possible after presentation is in place, with streaming to specific pathways. | 100% | | |
| | 5. Testing is in place of all adult unscheduled patients at or as soon as possible after admission to identify patients with infection not recognised by clinical assessment. | 97% | | |
| | 6. A defined process for assessment of staff for symptoms before starting a shift is implemented consistently across all hospitals and for all staff | 85% | | |
| | 7. Cohorting of all patients with infectious COVID-19 is in place unless there is a compelling clinical need for the patient to be in another location to receive appropriate care. | 100% | | |
| | 8. Defined maximum number of people at one time in any break room or meeting room, posts on the door of the room and periodic unannounced checks on adherence in place. | 95% | | |
| 9. National criteria for testing of asymptomatic staff in response to defined signals are followed | a) Single case of hospital acquired COVID-19 - in addition to identified contacts tested on day 0 and day 7 testing of all staff based on the ward in the previous 14 days and testing of all patients on the ward at the time. Additional testing of con | 93% | | |
| | b) Two or more linked cases on a ward or unit - in addition to identified contacts tested on day 0 and day 7 testing of all staff based on the ward in the previous 14 days on day 0 and day 7 and testing of all patients on the ward at the time. Addit | 95% | | |
| | c) Outbreaks on multiple wards in one hospital - in addition to identified contacts tested on day 0 and day 7 testing of all patients and all staff in the hospital (typically this would apply when 2 or more wards are affected in a model 3 hospital a | 88% | | |
| | 10. There is a process in place to minimise the use of the derogation policy for healthcare workers identified as contacts and there are processes in place to monitor this practise | 100% | | |

**Appendix 5: Update on Serial Testing Programme**

Table 5: Update on Serial Testing Programme (as at 19th January 2021)

| Area | Update |
|---|---|
| SCH | Schedule of testing completed by SCH and facility for swabbing identified on site. Referring clinician agreed. Plan for testing commencing on Wed 20th to Tue 26th. Walkthrough with stakeholders to assess readiness to commence testing completed on 14th Jan. All stakeholders are prepared for the SCH testing. |
| NGH | Gaps remain for mandatory fields (Address c. 200). Vaccine roll-out commenced Thurs 7th (580 complete, 100 due this week) and being prioritised ahead of testing. Potential delay of 2-3 weeks in prep for serial testing due to current pressures. Occ Health & Referring clinician support not yet agreed. |
| SJH | Acute Ops have been approached by St.James to undertake a testing programme to advance knowledge of COVID and vaccination. Currently under investigation by HSE. |
| Central Admin | Available to provide support for bulk upload of referral templates. |
| Community | Engaged and willing to support. NAS will provide support for label printing and test packs. |
| Swabbing | NAS resources booked to support SCH testing 20-26th. NAS reviewed the SCH site and facilities located on site and SCH to provide Admin support. |
| Labs | Informed of timeline/plans, volumes not a problem. |
| Occ Health | OHS capacity issues have been identified and potential options under review for referring clinician. |
| Contact Tracing | Availability to support to be confirmed – relatively small volumes but system currently under pressure due to current surge. |

**Appendix 6 – Key points from the HIQA Rapid Review**

**Key points**

- On 14 December 2020, a SARS-CoV-2 variant of concern was reported in the UK and on 18 December, another new variant of concern was reported by national authorities in South Africa.
- As a result of these new, highly transmittable variants, the World Health Organization (WHO) advised that prevention advice for the public should be further strengthened and infection prevention and control guidance measures reinforced.
- Guidance from 20 countries and three agencies was reviewed and compared with current Irish guidance for community settings and infection prevention and control measures, relevant to COVID-19.
- In general, the current Irish guidance is at least as stringent, if not more stringent that that specified by the countries and agencies reviewed. However, a small number of measures were identified that were considered to be more stringent than the current Irish guidance.
- In general community settings:
    - Masks should be worn in indoor work communities in Finland if more than one person is residing in that space while Irish guidance recommends face coverings are used in crowded workplaces.
    - Masks are required when anyone aged two years of age or older leaves their home, that is, indoor and outdoor settings regardless of crowding in Singapore. Whereas, in Ireland, masks are required for anyone aged 13 years or older in crowded outdoor spaces or where social distancing cannot be maintained indoors.
    - Face masks are compulsory for children aged six years and older in France.
    - There are minor differences in the recommended humidity level indoors (between 30-50% (Canada) versus 20-60% in Ireland) and the frequency and or duration of intermittent ventilation of indoor settings (rooms should be ventilated for 10 minutes three times daily (France), intermittent ventilation should be between 10 to 30 minutes depending on the season (Germany).
- In general healthcare settings:
    - N95 and or FFP2 or FFP3 respirators are recommended as standard PPE to be used by healthcare workers when caring for suspected or confirmed cases of COVID-19 in guidance from Canada, Finland, Germany, the ECDC and CDC as opposed to surgical masks in Ireland.
- With respect to transport:
    - In New Zealand, all international arrivals must wear medical grade face masks (as opposed to fabric face coverings in Ireland).
    - In Germany, FFP2 masks are to be worn on all public transport.
- In educational settings:
    - A lower minimum age at which face coverings are required in school, that is, six years (France, Spain) and 10 years (Canada, Austria) as opposed to 13 years in Ireland.
    - Use of twice daily temperature checks and symptoms screening for staff and students in Singapore.
- With respect to vulnerable groups:
    - FFP2 masks are provided to adults aged 65 years and older in Austria and to those

aged 60 years and older with certain medical conditions in Germany.
    - In Germany, medical masks and nose protection is recommended for all staff in direct contact with vulnerable groups of people, even outside the direct care of COVID-19 patients
- Some recent guidance updates, may have been prompted by concerns in relation to the new variants, for example guidance from Australia in relation to a minimum 14-day hotel-quarantine including a negative SARS-COV-2 test to exit quarantine specifically reference the UK variant of COVID-19 (SARS-CoV-2 VOC B.1.1.7). While the new variants are noted to be highly transmissible, it is unclear if their mode of transmission differs from other strains of the virus in circulation.
- Previous evidence summaries conducted by HIQA examined the relative importance of droplet versus contact transmission to the spread of SARS-CoV-2, as well as the potential for airborne transmission of SARS-CoV-2 via aerosols. These evidence summaries concluded that there was insufficient evidence to determine the relative importance of droplet versus contact transmission to the spread of SARS-CoV-2, and that there was low certainty evidence that SARS-CoV-2 may transmit via aerosols.
- Evidence identified from scoping work does not appear to have any significant impact on the overall conclusions in the original evidence summaries, though there is some evidence to suggest that contact transmission may not be as important as droplet transmission for the spread of SARS-CoV-2. Scoping did not identify any relevant scientific literature referring to differences in the mode of transmission of the new variants of concern.

ENDS