Interim Report on Impact of "Cocooning" Measures on Older People adopted March 2020 in Response to COVID-19 Pandemic

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

OLDER PEOPLE

Table of Contents

Executive Summary

This report outlines the impact of COVID-19 and the effect 'cocooning restrictions' have had on older people in Ireland, resulting in unintended consequences and health issues. It provides an overview of the government measures taken to protect the most vulnerable and the most at-risk groups with underlying conditions, along with the HSE response and health promotion activity commenced to support those cocooning. As the pandemic evolves, and longer-term restrictions and measures are put in place to protect older people, it is vital the focused response from government and society is sustained, to continue enabling and supporting those most vulnerable and self-isolating. The report concludes with several recommendations and priority areas for action to support older people, as the country moves to the next phase of the pandemic. A follow up report incorporating learning from key studies including a HRB funded study by TILDA on the impact of cocooning will inform findings and recommendations of the final report in December 2020.

People in society as they age reflect the same heterogeneity seen in the world within which they live. One of the potentially most damaging aspects of language used in reference to 'cocooning' measures was the narrative that emerged reflecting 'all' people aged over 70 as a vulnerable group. However as multiple studies have shown people who are older make a wealth of varied and substantial contributions within society (www.TILDA.ie).

In addition to the wider government response, community and societal initiatives were launched to inform and support older people and other vulnerable groups, bringing together volunteers, helplines and other platforms set up by local authorities, Non-Government Organisations (NGOs) and communities. Examples such as; Age Friendly Ireland, Alone, Alzheimer Society of Ireland, Family Carer's Ireland, Age Action, Age and Opportunity, the GAA, An post, the gardai and many others played a key role in supporting older people during the restrictions and cocooning phase.

The indirect consequences of COVID-19 and cocooning addressed in the report outline the overall health and wellbeing impacts, and health effects on older people such as functional and cognitive decline, low mood, anxiety, alcohol dependence and weight gain. Psychological wellbeing and mental health, experience of social isolation and loneliness and the impacts on physical health, risk of sarcopenia, nutrition considerations are associated risk factors arising from cocooning. The role of Vitamin D in mitigating some of the risks from the virus are also highlighted.

The overall disruption to healthcare services and resources, impact on home help provision, loss of day centres and other group activities are impacting on the growing vulnerability of some older people and carers, arising from the cessation of services and from cancellation or delays of medical appointments, treatments or surgery. This has had a significant impact on the lives of People Living with Dementia (PLWD) and family carers who are often older themselves. Both the Alzheimer Society of Ireland (ASI) and Family Carers Ireland have carried out research to explore the lived experience, challenges and needs of PLWD and Family Carers during COVID-19 that is presented in this report.

The COVID-19 pandemic has been particularly challenging and impactful on residents who live in nursing homes, their families and residential staff. One of the most immediate concerns following the announcement of visiting restrictions to nursing homes in March 2020, was the impact on residents from social isolation and separation from their families. While the residential sector has been innovative in its response developing social networks through online technologies and social media platforms, visiting restrictions still prove extremely challenging for many residents and family members. The report of the expert group (referenced in the appendix) has made 86 recommendations across 15 thematic areas which are being implemented through a national implementation and oversight team.

Finally, this interim report concludes with a series of recommendations from learnings to date to

- inform public health policy and messaging in regards to advice given to older people on social restrictions during COVID-19 pandemic
- emphasises the critical role played by community and voluntary sectors in supporting older people especially during periods of isolation
- addressing key gaps in access to health and social care provision for this group during this time.

Dr Siobhán Kennelly,
National Clinical and Advisory Group Lead, Older Persons, HSE

20th November 2020

Acknowledgments

This report reflects contributions and input from a number of the community and voluntary organisations who have supported older people since the start of the COVID-19 pandemic. Sincere thanks to the team in the National Integrated Care Programme for Older People , HSE, RCPI Clinical Advisory Group for Older People and Helen Whitty in particular for coordinating the report. Finally thanks also to Prof. Rose Anne Kenny and colleagues at TILDA and the Irish Gerontological Society for their valued input and feedback into report drafts.

Introduction

As the COVID-19 pandemic spread throughout the globe, many governments and public health services sought to implement measures and advice that would ensure that those most vulnerable to its impact would be protected from the worst of its risks. In Ireland this response took the form of specific 'cocooning' advice to those over 70 years or other high-risk vulnerable groups. This report sets out to describe the measures taken, report on the immediate impact of restrictive measures identified in available reports from several agencies and makes recommendations based on the best available evidence at this time.

The COVID-19 pandemic due to SARS-Cov-2 has rapidly spread all over the world since last December. While prevalence rates are high across all age groups (depending on rates of asymptomatic transmission), older people and those with underlying conditions are at higher risk of suffering negative outcomes. The estimated elevated rate of mortality is five times higher than the global average for those older than 80 years old. Over 95% of fatalities due to COVID-19 in Europe and around 80% in China have included people older than 60 years-old. In the US, 80% of deaths were among adults 65 and over. In Ireland > 90% of deaths have occurred in those aged over 65 with most of these deaths occurring in those over 80. In the earlier phase of pandemic, deaths in Long Term Residential Care facilities accounted for approximately 50% of these deaths.[1] Therefore, health strategies to avoid spread of coronavirus (such as quarantine and social distancing) are important and have particular implications for those in older age groups. For those living in Long Term Residential Care, the additional impact of social isolation in the context of prolonged severe visiting restrictions, has been highlighted by a number of bodies and within the Ministerial Expert Report on Nursing Homes.[2]

It has not been possible to restart many of the health and social care services previously operating prior to the pandemic in a manner that can accommodate the public health advice for social distancing. Restrictive measures therefore have had a serious and life-changing impact on older people and others in society as a result of the pandemic. Many advocacy bodies and representative groups argue that a rebalancing of restrictive measures as they apply to people in at-risk groups needs to be considered in light of the significant impact of severely restrictive measures such as those adopted under cocooning and identified under multiple studies. This paper sets out the findings of early key studies on the impact of cocooning in the Irish context, mitigated somewhat by the significant response leveraged by the community and voluntary sectors and makes several recommendations from the learnings to date to support those in the most at risk and vulnerable groups.

A follow up report incorporating learning from key studies including a HRB funded study by TILDA on the impact of cocooning will inform findings and recommendations of the final report in Dec 2020.

Contribution made by older people to Irish Society (TILDA 2020)

The narrative around older people needs to be rebalanced and older people acknowledged and valued for the huge contribution and the important role that they play in society. Findings from a recent TILDA study (2020)[3] highlight the enormous contribution that older people make to society in Ireland and to the country's economic wellbeing, either directly or in indirect ways, such as enabling others to take part in the workforce through their volunteering and caring. A sample of findings from the study show:

- **132,000 (31%)** of adults over 70s provide help and care for their spouses, relatives (not including grandchildren), neighbours or friends
- **131,700 (29%)** of over 70s provide childcare for their grandchildren, with a median number of 16 hours of care provided per month, although one in five of all grandparents over 70 provided 40 hours of childcare per month.
- **206,800 (47%)** of adults aged 70 years and over volunteered in the last year, with **75,200 (17%)** of adults over 70 years performing voluntary work every week.
- **330,400 (60%)** of adults over 70s enjoy regular social and leisure activities and 28% have four or more regular contacts.

1. Health Protection Surveillance Centre (HPSC). Epidemiology of COVID-19 in Ireland - daily reports, May 2020. Dublin: HPSC; 26 May 2020. Available from: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/
2. Department of Health (2020). COVID-19 Nursing Homes Expert Panel – Examination of Measures to 2021, Report to the Minister for Health. Available from: https://www.gov.ie/en/publication/3af5a-covid-19-nursing-homes-expert-panel-final-report/
3. Tilda Report (2020). The Contributions of the Over 70s to Irish Society: Results from Wave 5 Of the Irish Longitudinal Study On Ageing. Accessed from: https://tilda.tcd.ie/publications/reports/pdf/Report_Over70sContribution.pdf

The Importance of Language – IGS Statement April 2020

In April 2020, the Irish Gerontological Society through its President Dr Diarmuid O'Shea highlighted the 'euphemizing of age' (categorising all people within an older cohort as ill or frail) as having a considerable impact on the emerging narrative around COVID-19 and older people in particular. This statement highlighted;

- The ongoing challenge of ageism in societal and media narratives on ageing causing stigmatism and discrimination
- The importance of 'minding our language' in reframing and rephrasing how we discuss and talk about ageing
- The importance that narratives on ageing reflected the diversity of the population
- Advises media and other groups on appropriate use of language such as use of 'older people' instead of 'the elderly'

On behalf of members of the Irish Gerontological Society (IGS), Dr Diarmuid O'Shea, is campaigning for everyone, including producers, presenters and journalists to be mindful of their language and avoid the 'euphemizing of age' as we discuss and talk about this large, diverse, heterogeneous social group. As older people in our society, along with many others, play their part by shielding themselves from COVID-19 - with the support of their local communities - we all need to understand that "words matter". We must all learn to mind our language.

Ageism in Ireland today is still a challenge which, unlike racism and sexism, is not countered.

There is almost an unspoken, accepted and normalized social prejudice around it. The fastest growing demographic in Ireland is older citizens. Ageism marginalizes and excludes these people, and it should not be allowed, accepted or tolerated.

"Age is an important social issue and ageism is a serious problem. In recent years, ageist terms such as 'bed blocker', which is both stigmatising and discriminatory, have become commonplace in media reports", he said.

"Euphemising usually positions ageing as negative and burdensome, often categorizing the entire demographic as frail, ill, or dependent. I understand that this is often done thoughtlessly rather than intentionally. This is both incorrect and inappropriate. We all know many fit, active and vibrant older people, they are not a homogenous group."

(extract from IGS statement April 2020)
https://www.irishgerontology.com/news/latest-news/mind-your-language

Cocooning Measures

On the 27th March 2020, the HPSC guidance for vulnerable groups defined cocooning as

> *'a measure to protect those over 70 years or those extremely medically vulnerable by minimising interaction between them and others. This means that those who are over 70 years or those extremely medically vulnerable should not leave their homes and within their homes should minimise all non-essential contact with other members of their household. This is to protect those who are at very high risk of severe illness form COVID-19 from coming into contact with the virus'. (HPSC, 2020)*

In order to mitigate the significant risk of mortality identified at an early stage in the COVID-19 pandemic, older people and other at-risk groups were advised to 'cocoon'. Guidance was issued in March 2020 advising those over 70 years and those with underlying conditions not to leave their homes and to limit all contact with others beyond that required for essential care. In addition, a suite of measures under the government 'Community call' was put in place to support people who were cocooning with support, food, medicines and other essentials. From May 15th as the overall government restrictions lifted, advice to those previously cocooning also changed and allowed for outdoor exercise, increased social contacts and visiting in homes up to 10th August 2020.

The Department of the Taoiseach introduced several restrictions and public health measures to control the spread of coronavirus in March 2020 listed in table one below.

Table 1: COVID-19 Government Measures - Implications for Older Persons

Month	Date	Key Measures
March	25th	An Post to roll out a range of new services to help during COVID-19; Helping connect our community, helping people stay in touch, helping say hello and helping people keep up with the news.
March	27th	Guidance on Cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19 published.
April	2nd	Minister for Rural and Community Development, announced a new befriending phone-call initiative to support participants of the Seniors Alert Scheme which is being funded by the Department of Rural and Community Development. The initiative will allow older people to receive a regular phone call to check on their wellbeing and needs during the current COVID-19 emergency. The befriending scheme will be operated in conjunction with POBAL and ALONE.
April	2nd	Local authority (councils) established a COVID-19 Community Call Forum. The local forum works with State agencies and community and voluntary groups to provide supports or services to any vulnerable person who needs them.
April	02nd	Ireland launches the 'Community Call Initiative' to mobilise both state and voluntary resources to combat the effects of COVID-19
April	24th	An Taoiseach, launched a new Campaign - In This Together - which aims to help everyone in Ireland to Stay Connected, Stay Active, and look after their Mental Wellbeing throughout the COVID-19 Emergency.
May	5th	Older people advised to 'cocoon' could go outside for a short exercise or a drive up to 5 km from their home and should avoid all contact with other people
May	8th	Minister for Rural and Community Development, and the Minister of State with responsibility for Community Development, announced the launch of a €40 million package of supports for Community and Voluntary Organisations, Charities and Social Enterprises providing critical services to vulnerable individuals and groups in society arising from the COVID-19 crisis.
June	4th	National Public Health Emergency Team (NPHET) approved the guidance document entitled "Ethical Considerations Relating to Long-Term Residential Care Facilities in the Context of COVID-19".
June	8th	Phase two of reopening the economy and society commenced and individuals who were cocooning or medically vulnerable individuals are allowed a small number of visitors.
June	19th	Government approves revised Roadmap for Reopening Society and Business. Places of worship, gyms, cinemas, leisure facilities and hairdressers can open from 29 June
June	29th	Phase 3 of reopening of economy and society: all domestic travel restrictions lifted. Cafes, restaurants, hotels, hostels, galleries, museums and pubs that serve food are allowed to open but social distancing must be maintained.
July	7th	COVID-19 Tracker App for Ireland launched
July	13th	Minister for Health published the interim report of the COVID-19 Nursing Homes Expert Panel.
July	20th	Minister for Media, Tourism, Arts, Culture, Sport and the Gaeltacht announces €500,000 investment in the Creative Ireland programme's new Creativity in Older Age Programme
July	29th	HPSC updated and latest visiting guidance for nursing homes published.
August	6th	Minister for Housing, Local Government and Heritage announced the national allocations for the €73.75 million made available in 2020 for Housing Adaptation Grants for Older People and People with a Disability living in private houses.
August	10th	Phase 4 of reopening of economy and society: Crèches can reopen for the remaining workers. Weddings are permitted with limited attendance. Pubs, nightclubs will be allowed to open.
August	19th	The Minister for Health, and the Minister for Mental Health and Older People, published the COVID-19 Nursing Home Expert Panel's report.
August	27th	COVID-19 Nursing Home Expert Panel Report, an inter-agency Implementation Oversight Team was established by the Minister for Health to oversee the implementation of the recommendations of the report.
September	11th	Government issued a five-level framework to manage restrictions measures with level 5 being the most restrictive.
September	15th	Resilience and Recovery Plan for Living with COVID-19 and five levels framework published
September	24th	HSE Winter Plan Published
October	1st	Health Protection Surveillance Centre (HPSC) publish new COVID-19 Guidance on visitations to Long Term Residential Care Facilities.
October	6th	As of midnight, all counties in Ireland were placed on level 3 of the framework for a period of 3 weeks under the plan for living with COVID-19.
October	14th	Government announces, from midnight on Thursday, 15th October, the counties of Cavan, Donegal and Monaghan will be placed on Level 4 under the Plan for Living with COVID-19 until Tuesday 10th November, at which point the situation will be reviewed by the government. The rest of the country remains at Level 3 Due to the deteriorating situation with the virus across the country, the Government has decided to increase the level of restriction nationwide as provided for under Level 3 in a number of areas.
October	19th	An Taoiseach announces Ireland moving to Level 5 of the plan for living with COVID-19 as of midnight on Wednesday 21 October, all of Ireland will be placed on Level 5 and restrictions will remain in place for a period of 6 weeks. There is a provision for an extended household (or support bubble) for defined categories of individuals to support those at risk of social isolation and/or mental ill-health.

Lived Experience of Older People

A snapshot of some of the calls received by ALONE capturing the lived experiences, issues, concerns and challenges that older people faced and continue to face during this COVID-19 pandemic.[4]

4. ALONE (2020). COVID-19 Response and Weekly Activity Report.

Measures to Mitigate Cocooning Impact

The significant ask placed on older people and other vulnerable and at-risk groups who self-isolated during the cocooning phase of the COVID-19 pandemic cannot be minimised. However, it is important to celebrate the comprehensive societal and multi-agency response from citizens, governmental and non-governmental organisations and private businesses across the country who supported the population during this cocooning phase.

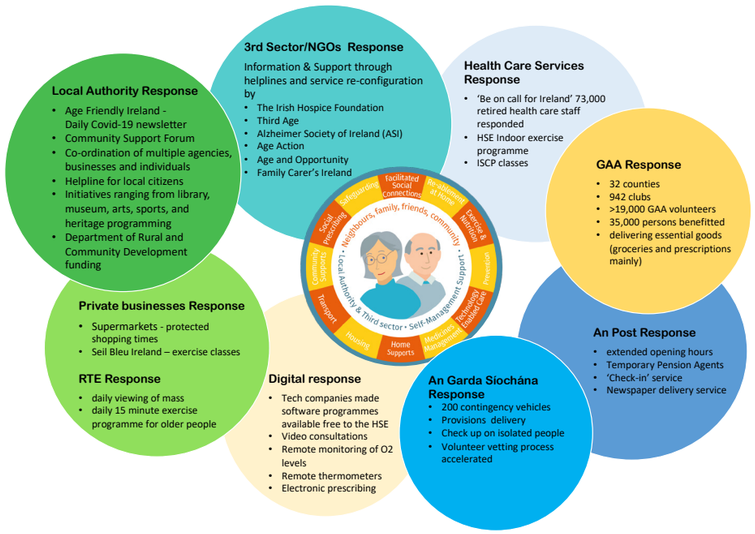
Throughout Ireland, people who were cocooning experienced a mobilisation and co-ordination of support from the whole of government, local authorities, NGO's, private business, sporting organisations, communities and citizens who stepped up to answer the call with an aim to ensure that no individual was left behind. A specific request was made for members of the general public to support these initiatives under the 'Community Call' initiative.

Whole of Society Response and 'Community Call'

In addition to the wider government response, community and societal initiatives were launched to inform and support older people and other vulnerable groups, bringing together volunteers, helplines and other platforms set up by local authorities and communities. Examples of initiatives included linking volunteers to older people through organisations such as; Age Friendly Ireland, ALONE, The Alzheimer Society of Ireland, Family Carer's Ireland, Age Action , Age and Opportunity, the GAA, An Post, the Gardai, and many others who played a vital part in supporting older people during restrictions and cocooning measures, keeping people connected and updated on HSE guidance, volunteer services and supports available.

It is not possible to reference every instance or source of this combined effort, but the examples described below and outlined in figure one provides a sample of the breath and diversity of the response that was mobilised;

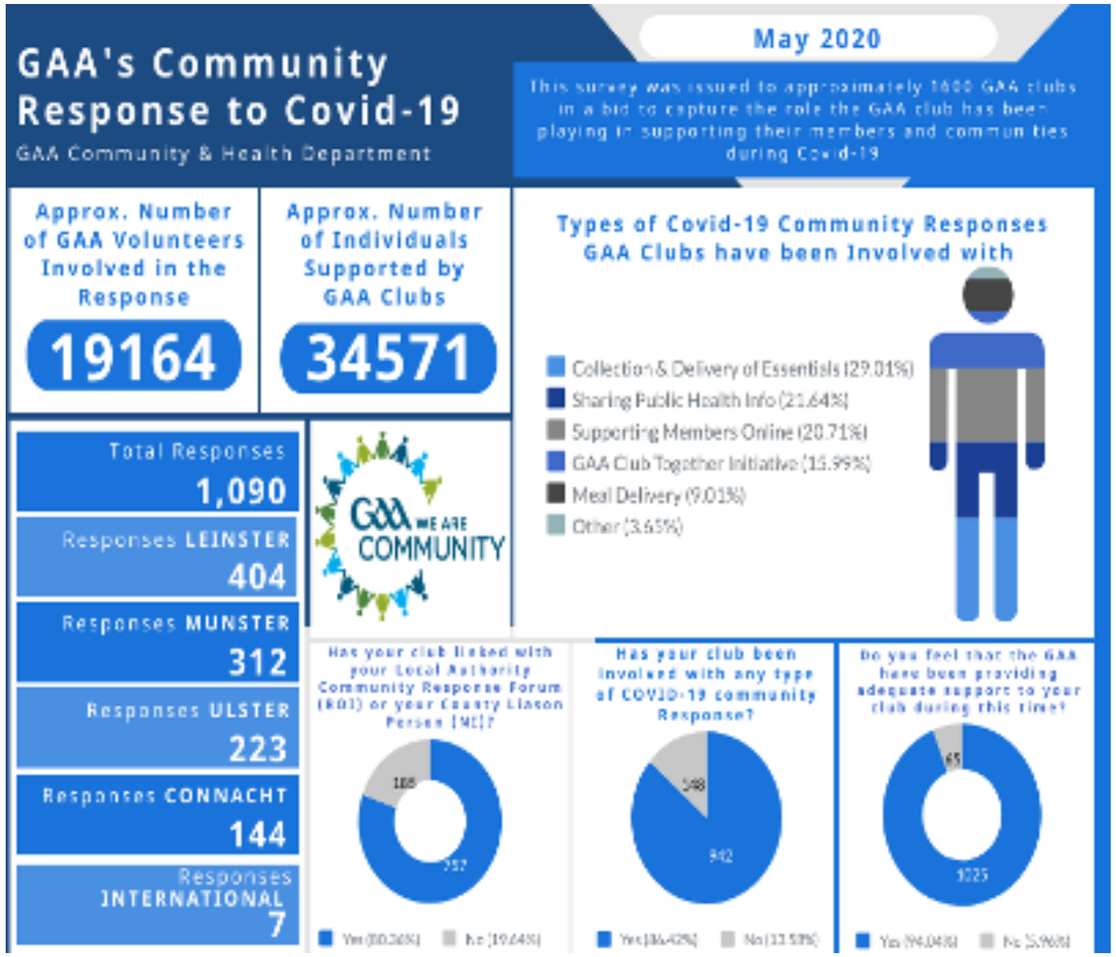
Figure 1: Examples of broad cross- sectoral response



- The government response included a comprehensive suite of communications across multiple platforms to keep the public informed. This included daily press briefings, a COVID-19 communications pack for communities, regular updates on news and current affairs programming and a number of information leaflets delivered to homes throughout the country. A €40 million package of supports was also made available for community and voluntary organisations, charities and social enterprises.

- Each local authority established a Community Support Forum to identify individuals at risk; co-ordinate the efforts of multiple agencies, businesses and individuals who stepped forward to offer assistance; and each local authority established a helpline for local citizens who needed support and information.
- Several NGO's provided information and support through their helplines, e.g. ALONE, The Irish Hospice Foundation, Third Age and re-configured services to take account of the need for a socially distanced service delivery environment e.g. Alzheimer Society of Ireland (ASI), Family Carer's Ireland.
- Age Friendly Ireland distributed a Daily COVID-19 daily essential guide to services and initiatives supporting older people in Ireland, to all local authorities, Older People's Councils, NGO groups, Age Friendly Programme Managers and other partners. The content of the newsletter included public health information, links to online resources such as exercise classes, local authority initiatives ranging from library, museum, arts, sports, and heritage programming, research updates, international events from global partners, and the direct voice of older people many of whom contributed poems, stories and videos to share with others around the country.
- An Post introduced extended opening hours and worked with Department of Social Protection to introduce emergency "Temporary Agents" who can collect pensions on behalf of those who are self-quarantining or self-isolating. They also set up a 'request a check-in' service and a newspaper delivery for people who could not get out to the shops.
- An Garda Síochána deployed 200 contingency vehicles to enable community police officers to deliver provisions to older people and check up on those who are most isolated and don't have a support structure in place. They also accelerated the vetting process to ensure volunteers can be processed to enable them to volunteer at local level especially with essentials like meals on wheels and others.
- A national call was made for retired health care staff (doctors, nurses) to return to work. The "Be on call for Ireland" initiative was launched by the then Taoiseach Leo Varadkar and had 73,000 respondants.
- A huge volume of physical activity programmes moved from gym-based classes to home based remote classes which were delivered to older people through Facebook and online platforms e.g the HSE Indoor exercise programme, Seil Bleu Ireland and the Irish Society of Chartered Physiotherapists (ISCP). RTE also broadcast a daily 15 minute exercise programme for older people who were cocooning.
- A number of technology companies made their software programmes available to the HSE free of charge. A major advance in the digital transformation of care included deployment and adoption of video conferencing for remote clinical consultations including included Blueeye and Attend Anywhere Video Consultation solutions. Other digital solutions rolled out included, TriMedika, Tritemp digital infrared thermometers enabling remote temperature taking, electronic prescriptions (requiring a piece of secondary legislation to be passed in the Dáil Éireann) and a remote monitoring solution to measure oxygen saturation level for COVID-19 patients with built in clinical alerts.
- Supermarkets introduced protected shopping times to facilitate older people and other vulnerable and at-risk groups.
- RTE scheduled a daily viewing of mass for older people who are unable to go to church.
- The GAA has played a huge role in the community response to COVID-19 highlighting the GAA as much of a community association, as it is a sporting one. The mobilisation of over 942 clubs and 19,000 GAA volunteers and response structures was activated four weeks prior to the official government launch of 'the community call initiative'. Almost 35,000 persons benefitted from the delivering essential goods (groceries and prescriptions mainly) across the 32 counties during the month of April and early May as indicated in the infographic overview of the GAA's community response on the next page.

Figure 2: GAA's Community Response to COVID-19



In this section we have made some effort to demonstrate the very broad cross-sectoral response to ensure that those who were asked to cocoon remained safe and connected to their communities around them. However, there are lessons to be learned with regard to the communication and engagement with older people and how we use their experience to improve the response in subsequent phases of COVID-19.

HSE Response and health promotion activity to support those cocooning

As part of the Covid-19 response, below are some of the key programmes and supports that were put in place to support older people and other at risk groups asked to cocoon.

Mental Health

- National Social Prescribing Programme
- Minding Your Wellbeing- tips for maintaining Mental Health being run in conjunction with ALONE/ Age Action and others
- HSE Mental Health promotion Plan
- Creative Arts Role

Health Promotion

- Smoking Cessation
- Key coordination with Heads of Service in Health & Wellbeing to drive national health promotion campaigns within communities
- Strength & balance at home campaign
- "Go for Life" campaign with Age & Opportunity
- Care Pals training with carers working in residential and day services to integrate physical activity into everyday activity. Now running online sessions 3 times weekly

Nutritional Response Programme

- Health Eating Campaign during COVID-19
- Developing appropriate information and signposting for at-risk groups vulnerable to malnutrition
- Vitamin D Supplementation as part of COVID-19 response

Office of the Nursing & Midwifery Services Director (ONMSD)

- Get Up Get Dressed Get Moving campaign- national campaign to promote activity and messaging that physical activity is key for mental health

National Integrated Care Programme for Older People

- Extensive links with community and voluntary agency sector including Age friendly Ireland and agencies working through 'Community Call' response
- Providing important feedback pathway for dedicated helplines e.g. ALONE on impact of cocooning including alcohol abuse and domestic abuse / elder abuse.

Communications

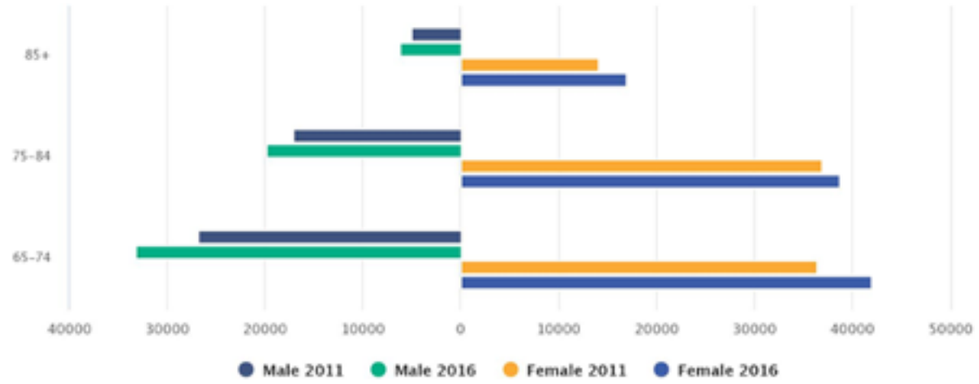
- COVID-19 campaign, Cocooning advice
- Dedicated TV Programme slot to specifically target populations who will benefit from enhanced messaging with regards to lifestyle, physical activity etc.

Evidence of Impact of Cocooning Measures

Impact on Psychological Wellbeing and Mental Health

Of the total population aged 65 years and over 156,799 are living alone representing 26.7% of the total population. Over 22,000 of these are aged >85 (CSO, 2016)

Figure 3: Older People living alone in Private households by age group, CSO, 2016



Experience of Social Isolation and Loneliness

Across the community at large reducing social contact has been one of the key public health messages to reduce the risk of contracting COVID-19. Social Isolation is defined as a "state in which an individual has a minimal number of social contacts and lacks engagement with others and the wider community" (Evans et al., 2019). A significant association between social isolation and a number of negative outcomes has been identified including loneliness, depression and anxiety (Santini et al., 2020) with further studies identifying significant association between reduced social networks and cognitive decline in later life (Evans et al., 2019).

There is a substantial body of evidence prior to the pandemic that speaks to the impact of loneliness and social isolation on physical and psychological wellbeing particularly in those living alone. However, it is recognised that the restriction and cocooning measures in particular have had a particular impact on at least some older people living alone. A range of studies are in progress to quantify some of this impact. TILDA are currently undertaking research on the impact of covid-19 on multiple facets of life on older adults, such as mental health, social engagement, physical activity, accessing services and so forth. Initial analysis should be available by mid-December, at which time this report will be updated to reflect TILDA findings.

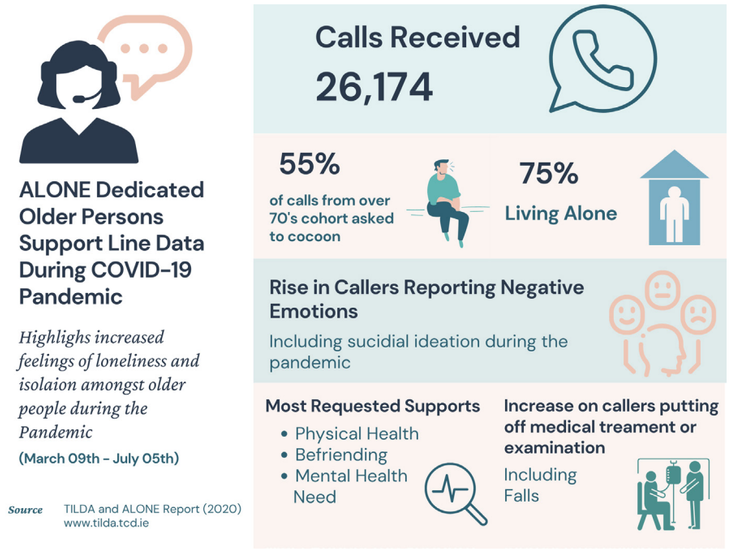
> *"older loneliness and social isolation have tangible effects on mental and physical health, particularly for adults. Individuals over the age of 60 may be uniquely at risk of experiencing the impact of loneliness. Social distancing, an intervention intended to protect at-risk individuals such as older adults, may in fact introduce further complications to the health and well-being of older adults, who find themselves more isolated secondary to the pandemic." (Tyrrell and Williams, 2020)*

Social isolation among older adults is a "serious public health concern" as it raises the risk of cardiovascular, autoimmune, neurocognitive disease (Gerst-Emerson and Jayawardhana, 2015). Social disconnection impacts on mental health and puts older adults at greater risk of depression and anxiety (Santini et al., 2020) and lowers immunity and increases inflammation. Theoretically, loneliness and social isolation will likely increase the risk of acquiring and the severity of response to COVID-19 (Wilson et al., 2020).

A literature review presenting data from eight recent cross-sectional studies highlighted increasing prevalence of anxiety, depression and sleep disturbance with significantly high prevalence levels (up to 49% for anxiety, 36% for depression in some studies) ascribed to the impact of social isolation measures advised in the context of the COVID-19 outbreak (Sepulveda-Loyola et al., 2020).

COVID-19 has caused an unprecedented disruption to the daily life of all Irish citizens and has had a significant impact on older adult's health, well-being and mental health.

A joint report from TILDA and Alone (2020) examines the issues of loneliness and social isolation with specific reference to the COVID-19 pandemic in Ireland. *"Current measures such as social distancing and cocooning in response to the COVID-19 pandemic are likely to increase levels of loneliness and social isolation."* This may have a negative effect on the wellbeing of older adults. This report indicates that public policies should be developed to ensure that these issues are addressed.



TILDA and ALONE (2020) conclude that current measures such as social distancing and cocooning in response to the COVID-19 Pandemic is likely to increase the level of loneliness and social isolation. This may have a negative effect on the wellbeing of older adults. Public policies should be developed to ensure that these issues are addressed.

There are limited qualitative data at present on the impact of COVID-19 on older people. Robinson et al., (2020) published a protocol for a longitudinal exploratory qualitative study that will explore the in-depth experiences and beliefs of older Irish adults during the COVID-19 pandemic.

In September 2020, the Irish Gerontological Society (IGS) hosted a webinar titled 'Changing Horizons 'in Gerontology: Frailty, Delirium and Interface Geriatrics'. Local examples from healthcare professionals highlighted the negative effect of cocooning on services for older people. According to Mannion (2020) patients expressed many negative effects of cocooning; experiencing loneliness, missing their daily routine of going to mass and visiting neighbours and their overall mood has been affected. The impact includes reported increases in alcohol consumption and weight gain (Mannion, 2020).

Access to digital technology to mitigate impact of isolation

TILDA (2020) report on Internet access and use among adults aged 50 and over in Ireland found Internet access decreases with age. Only 38% aged 80+ have home internet access, compared to 86% aged 50-69 years, and 66% aged 70-79 years. Access to smartphones/tablets similarly decreases with age. Only 30% aged 80+ have access to a smartphone/tablet, compared to 80% aged 50-69 years, and 60% aged 70-79 years (TILDA, 2020). Therefore while internet access and digital connectivity has played an important role in supporting older people during this time, there are significant barriers to its widespread implementation and uptake.

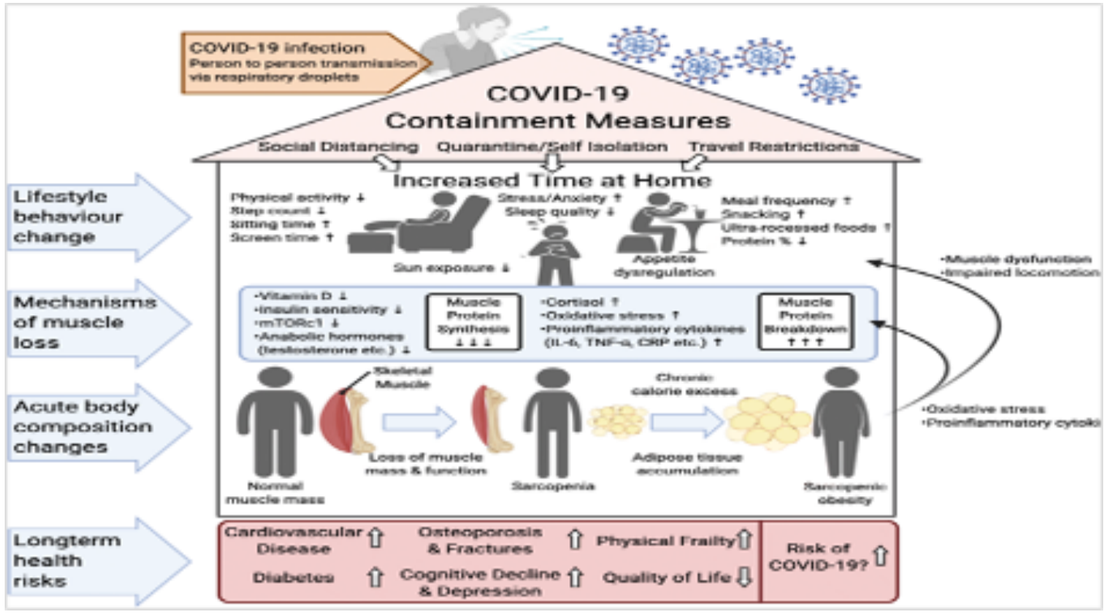
Impacts of social isolation and cocooning on Physical Health

Social participation has several positive effects on physical health in older people. Studies have reported improved dynamic balance and muscle-strength, healthy lung function and lower disabilities in comparison to those with lower rates of such participation (Sepulveda-Loyola et al., 2020). Therefore, decreasing or total restriction of social activity can be expected to result in potential negative outcomes for physical health. Global experts have emphasised the importance of increasing or maintaining physical activity levels during the pandemic with specific recommendations being made by several organisations (ISCP, 2020; WHO, 2020). Reduced physical activity also increases inflammation and impacts negatively on immune responses. Furthermore, outdoor exercise has added benefits for wellbeing, positive mental health and boosts immunity (Chowdhury et al., 2020; Ranasinghe, Ozemek and Arena, 2020; Gleeson et al., 2011). The increased burden of non-communicable diseases in older age groups has the potential to aggravate these conditions due to this challenging time and the effects of confinement (i.e. less access to medicine/medical care, outdoor activity and reduced social participation).

Risk of Sarcopenia during COVID-19

Figure 4 provides a summary of potential effects of government restrictions on lifestyle behaviors and the mechanisms by which they can lead to reduced muscle protein synthesis and increased muscle protein breakdown resulting in muscle loss. The development of sarcopenia, or in the presence of caloric excess, sarcopenic obesity, is associated with a significantly increased risk of multiple comorbidities, some of which may also increase the risk of COVID-19 infection and severity.

Figure 4 - Source: Kirwan, R., McCullough, D., Butler, T. et al. (2020) Sarcopenia during COVID-19 lockdown restrictions: long-term health effects of short-term muscle loss.



Physical Exercise

A large evidence base exists regarding the benefits of exercise and physical activity throughout the life-stages with these benefits positively enhancing outcomes in later life where maintained or enhanced with exercise training (Falck et al 2019; Theon O et al 2017). Some early studies in the European context have pointed to a reduction in exercise levels in those who were restricted to home at the peak of the pandemic. In Ireland many health promotion programmes with physical exercise at their core (e.g. ExWell®, Siel Bleu) and others reverted to delivering programmes online. However, it is not known whether this mitigated the impact of reduced physical activity at the time or what level of access the older population had to such resources.

Nutrition Considerations

Malnutrition is a serious condition that occurs when a person's diet does not contain enough nutrients to meet the demands of their body. This can affect physical health, mood, behaviour and many of the functions of the body. Many older adults who are at risk of malnutrition reside in the community.

Determinants of malnutrition in older people and during COVID-19 pandemic

In addition to having a chronic disease, the determinants of malnutrition for older people in Ireland are living alone, having a single status, having difficulties with mobility, cognitive impairment, and difficulty shopping/cooking. Financial hardship and food poverty are also a risk factor. There is substantial evidence that less time is spent eating and meals are less substantial when adults eat alone.

Recent Guidance published by HSE highlights the range of ways that nutrition may be affected by the COVID-19 pandemic.

COVID-19 has exacerbated the underlying causes of malnutrition in the following ways: (www.hse.ie/nutritionsupport)	
Disease effects that affect appetite: In mild-to moderate cases COVID-19 causes changes in eating patterns, loss of taste and smell, poor appetite. In critical illness enteral tube feeding is often required, with swallowing difficulties common in the recovery phase.	**Pre-existing conditions:** Older people with health conditions require nutritional care and COVID-19 lockdown has made it difficult for them to access this, as many community-based services are either paused or operating at a much lower capacity as staff are re-deployed.
Physical deconditioning: Hospital admission, bed, rest, and reduced activity combined with reduced nutritional intake leads to a decrease in loss of lean muscle mass and strength (sarcopenia). Malnutrition and sarcopenia can be present at any body size (Overweight or underweight) and require different nutrition care management strategies.	**Vitamin D deficiency:** Recent analysis of TILDA database has highlighted the importance of identification and treatment of Vitamin D Deficiency which is associated with both sarcopenia and increased risk of certain respiratory infections.
Loneliness and isolation: Eating alone is an independent risk factor for malnutrition. International research suggests that having a hot meal delivered every day is more beneficial than receiving a week's supply of frozen meals that can be re-heated. These types of service are 'more than a meal' because there is encouragement to get up and dressed to open the door, there is social interaction as well as the nutritional benefits of the meal. The discontinuation of day centre meal provision due to COVID-19 has potentially had a huge impact on the nutritional status of older people but is currently unknown.	

Vitamin D

In Ireland, vitamin D levels fall by about 50% from a peak in September to a trough in February (Laird et al., 2018). With much of the northern hemisphere experiencing a resurgence of the pandemic as we move into winter, it is increasingly urgent to ensure appropriate public messages to prevent vitamin D deficiency and insufficiency (Laird, Rhodes and Kenny, 2020).

Disruption to Healthcare Services and Resources

In March and April, the health-care system narrowed its focus to managing COVID-19 cases, meaning other health-care appointments and procedures were delayed. Regular check-ups, non-urgent provider visits, and elective procedures are being cancelled, putting older patients at higher risk of worsening health deterioration (Graham, 2020). Other non-essential health care services pertinent to the older people have been interrupted to reallocate health resources for the pandemic. These include psychotherapy, training for neurocognitive disorders, physiotherapy, occupational therapy, dental care, visual aids, hearing aids, elective surgeries and palliative care.

Compounding this situation are concerns that when medical care is more readily available, there will be backlogs of those needing surgeries, screenings, check-ups, and appointments, further straining the system and delaying routine care. Current National Treatment Purchase Fund (NTPF) data on waiting lists is not broken down by age category.

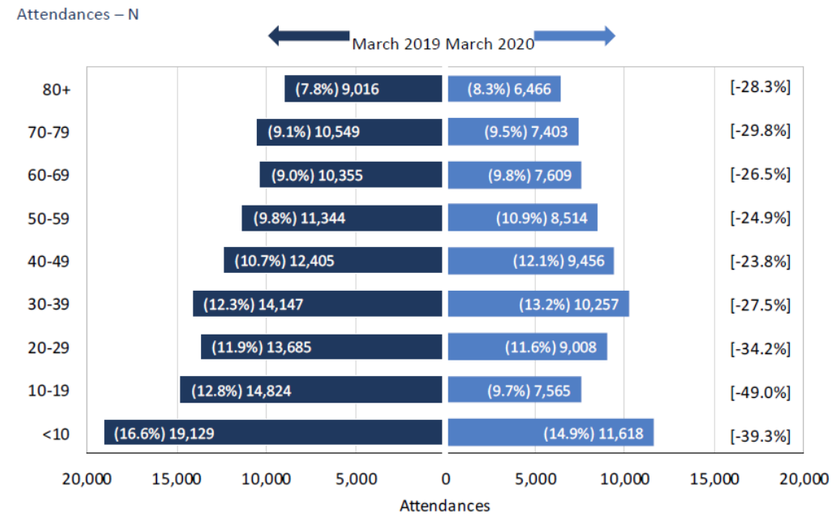
Many services have adapted to meet the needs of patients through virtual clinic supports using digital and telephone supports. However as noted earlier these have limited applicability in some older patients given barriers to accessing same.

Impact on Service Utilisation

Impact on ED attendance

From early on a dramatic reduction in ED presentations across all age groups was noted with marked reduction in presentations to ED in older age groups of >30% (ESRI,2020). Over the summer months ED attendances in older age groups have started to increase with increased presentations noted for August 2020 compared to August 2019 nationally.

FIGURE 6 ED ATTENDANCES BY AGE GROUP, N AND RATE PER 1,000 POPULATION, MARCH 2019/2020



Impact on Home Help Provision

In the immediate context of a response to a loss of home care attendants due to the impact of COVID-19 and in order to support the evolving picture of staff shortages in long term residential care facilities, the HSE assigned a priority system for access to home care. This meant that many recipients of home supports with 'lower needs' did not continue to receive their home supports during this time. The impact of this has not been evaluated at time of writing but it can be expected that such changes to care will negatively impact on both health and wellbeing outcomes.

Impact on People Living with Dementia

An estimated 55,000 people are currently living with dementia in Ireland
Alzheimers Society of Ireland (July 2020) Caring and Coping with Dementia During COVID-19

This report presents the findings of national research undertaken by the Alzheimer Society of Ireland (ASI) between 8 and 26 June 2020, which explored how people with dementia and their carer's are coping during COVID-19, and their challenges and needs. The current report consists of online and telephone surveys completed by 126 carers and 15 people with dementia. The research findings clearly demonstrate how the COVID-19 pandemic is shaping the lived experiences of carers and people with dementia.

The findings point to their growing vulnerability arising from the cessation of services and supports. According to carers, significant challenges include the cancellation or postponement of medical appointments, a marked decline in dementia symptoms coupled with an increase in responsive behaviours, the loss of routine for the person for whom they care, and boredom and anxiety. Those with dementia who took part in surveys echoed many of the concerns and challenges of carers. Additional difficulties include loneliness, social isolation, anxiety and worry, and increasing stress resulting from workload leading to burnout and crisis. The need to re-open day care and the impact of cessation of day care on the person with dementia and the carer is a strong theme throughout recent research.

Of note within this study, only 31% of respondents expressed 'confidence' in the use of internet / digital technology as a way of staying connected.

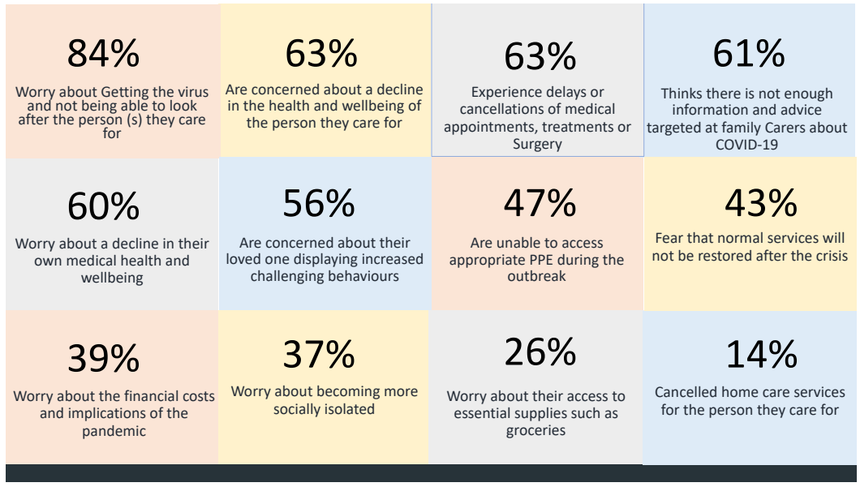
Impact on the Lives of Family Carers

Family carers who are often older themselves may be under additional strain as previous schedules and routines are disrupted and support services, such as day care centres are closed. Special considerations are required for carers who are living with People Living with Dementia (PLWD).

Preparatory plans are required should the family carer become unwell. Family Carers Ireland have developed a template for completing an 'Emergency Care Plan' which is available here. The Emergency care plan assists the family carer to record the care and support needs of the person they care for. In the event of an emergency, the emergency contact nominated can temporarily step in and have access to the necessary information.

Research carried out by Family Carers Ireland, in 2020 with 1,307 current Family Carers from a wide range of caring situations reveals that the COVID-19 crisis has had a major impact on the lives of 355,000+ family carers in Ireland.

The caring through COVID: Life in Lockdown report (2020) findings highlighted the following:



Loss of Day Centres and other Group Activities

Over 10,000 older people attend HSE day services on an ongoing basis. These services provide meals, opportunities for social interaction and an opportunity for healthcare issues to be addressed for those who are isolated (in either rural or urban areas) and lack opportunities for such contact. As in the ASI report they also provide an important opportunity for respite for many carers. Many clients attending these services routinely access them through local transport networks aligned to the individual day centre. The vulnerabilities of the client group

and the difficulties of maintaining social distancing in the facilities has meant that many have been unable to reopen. Many of the clients, carers and health & social care professionals providing services to this cohort have highlighted this as one of the most negative impacts of the COVID-19 pandemic.

Recent research conducted on the impact of the closure of Day Services on older people in Kerry looked at the impact on the quality of life of service users from a sample of day services, the impact on carers for people with dementia and the impact on the day service providers.

Table 2: Impact of the closure of Day Services on Older People in Kerry – Key findings

Existing Clients	Carers
• The company (86%) and the activities (70%) are the two things missed most by existing clients with a third (31%) missing Personal Care services. • 1 in 5 clients expressed feelings of loneliness or isolation as a result of the closure of the Day Services. • Almost half (49%) of existing clients are availing of the new or repurposed meals on wheels service. • Almost all existing clients (90%) are happy to return to the day service once restrictions are lifted	• The closure of the Day Service has had a clear impact on both the lives of the carers and people with dementia. • For carers of those with dementia the research showed the closure of services has resulted in a negative impact both on the person with dementia and the carer • Clients are missing the social interaction, personal care and routine • Carers are missing services and experiencing increased stressors

Impact on Residential Care

At the last census an estimated 5.0% of those aged 65 years and older were living in communal establishments in Ireland. There are 576 registered nursing homes in Ireland of which 440 are private or voluntary nursing homes and 3.6% of people aged over 65 reside in these settings.

On 16th March 2020, the Health Prevalence Surveillance Centre (HPSC) was notified of the first case and cluster in nursing homes. The very infectious nature of COVID-19 makes it difficult to prevent and control in residential care settings. The mortality rate seen in nursing homes was also higher, this is in the context of a more medically vulnerable and frail population. High rates of community transmission, unidentified potential for asymptomatic infection in residents and staff to increase spread, difficulty in identifying atypical presentations of a new virus in a vulnerable cohort along with a general lack of preparedness needed to meet the scale of the challenges facing the sector have been set out in the recent ministerial expert report on nursing homes (Department of Health, 2020).

Additional significant gaps in governance and oversight between private nursing homes, HSE and HIQA were also highlighted and have been comprehensively addressed within the 86 recommendations set out in the report. While a number of comprehensive responses within the health system have been put in place to mitigate the risk of pandemic for residents in the sector the pandemic continues to have many long-lasting and severe consequences for residents, families and staff.

On 19 August 2020, the DoH published the COVID-19 Nursing Homes Expert Panel Report. The report has made 86 recommendations in total across 15 thematic areas outlined in appendix one, contains a range of recommendations in line with lessons learned to date and international best practice, aimed to safeguard the residents in nursing homes over the next 12-18 months and into the longer term. While it is beyond the scope of this report to revisit the detail of these recommendations there are many broad themes that are consistently acknowledged within both reports.

A particular focus of this report has been on the impact of prolonged visiting restrictions, in place now in many Long Term Care Facilities (LTCFs) since March 2020 with further total ban on visiting since level 3 restrictions except on 'compassionate' grounds (HPSC, October 2020).

Impact of Visiting Restrictions in Long Term Care Facilities

Visiting in nursing homes was completely restricted from the 13th of March 2020. The Impact of cocooning in this setting saw:

- A reduction in or complete cessation of visiting except under certain compassionate grounds such as end of life care
- New residents or those returning from hospital admission are required to isolate for 14 days (unless they are recently recovered from COVID-19)
- Staff are now wearing masks and other elements of Personal Protective Equipment (PPE) which impacts on communication
- Communal and external activities limited or curtailed

The residential sector has been innovative in its response with the use of telehealth, IPADs and other communication to support communications with residents and between residents and families. However significant restrictions to visiting remain ongoing in many facilities and for many residents and families, this has proved to be an extremely challenging result of the pandemic restrictions, with calls being made through many advocacy bodies for urgent and immediate review of same.[5]

Updated guidance reflecting the five levels of government restrictions has been published (HPSC, October 2020). The imposition of Level 3 restrictions at time of writing has resulted in a complete ban on visiting except in critical and compassionate circumstances (the list of which has been expanded beyond exclusive visiting at end of life).

A recent review conducted by the HSE Library service sought to identify evidence linking COVID-19 outbreaks to social visiting (HSE,2020). Some key early studies within same have demonstrated that safe visiting within a controlled environment and appropriate use of PPE was not associated with reintroduction of COVID-19 in facilities. While the critical issue of the risks associated with sustained community transmission must be recognised, the rights of individuals within these facilities to receive visitors will need to be acknowledged and incorporated into guidance on an ongoing basis.

Lack of Suitable Public Transport

Driving remains the main form of personal transportation across the adult lifespan. Analysis of an early TILDA cohort showed that while driving oneself was the main mode of transport (>80%) for men in 65-69 age group this drops off gradually to 21.4% in the oldest category in a nonlinear decline throughout later life span. For women the decline in driving is more linear and more impactful dropping below 50% for women aged 75-79 and reduced to only 2.9% in the 90+ age group (Gormley and O' Neill, 2019). Therefore, access to safe, reliable public transport becomes central in maintaining health and wellbeing for this group.

As part of the public health advice those in at-risk groups have been advised to significantly limit their use of public transport. In addition, local transport services that support many groups who cannot drive e.g. Rural Link transport scheme have seen their services significantly impacted by social distancing requirements. This has resulted in significant difficulties being experienced by older people navigating and managing services to meet their medical and personal needs.

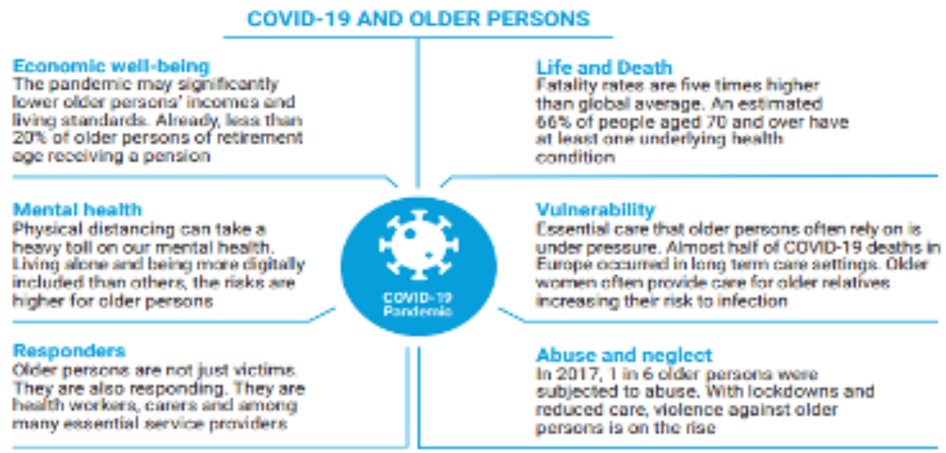
5. SAGE (September, 2020). Warning of Impact of New Visiting Restrictions on Nursing Home Residents in Dublin. Accessed from: https://www.sageadvocacy.ie/news/2020/september/but-residents-of-nursing-homes-also-have-a-right-to-see-and-enjoy-visits-with-their-loved-ones-says-sage-advocacy

Moving Forward

United Nations, Policy Brief - The Impact of COVID-19 on Older Persons

In May 2020 a policy brief by the United Nations (UN) highlighted the disproportionate and multi-faceted impact of COVID-19 on older people across a range of areas.

Figure 5: United Nations (May 2020, p.4), Policy Brief - The Impact of COVID-19 on Older Persons



The policy brief (United Nations, 2020, p.4) outlines the impact that COVID-19 has had on older people, and advises that all 'protective' measures taken to mitigate disease impact should be underpinned by principles which seek to reduce:

1. The impact on health, rights and long-term care services for older persons
2. The effects of physical distancing and stigma
3. Integrate a focus on older persons in the overall socio-economic and humanitarian responses to COVID-19
4. Harness knowledge and data, share good practices, and expand participation by older people

APPLYING LEARNING FROM 'COCOONING' MEASURES IN IRISH CONTEXT

While the data presented in this report does not constitute an exhaustive review of the literature, the significance of the issues highlighted merits an appropriate response and actions regarding the ongoing impact of severe restrictive measures placed on people, in older age groups and the potential implications arising from such restrictions.

Learning to date shows that the potential for disproportionate impact on psychological, mental, social and physical wellbeing must be cautiously considered should further revisiting of these restrictions be required in the context of the pandemic.

What is also clear is that a number of measures taken in March – May had a significantly positive impact in mitigating the risks of some of these and there is important learning that needs to be incorporated into our understanding of appropriate supports to those in the most vulnerable and at risk groups.

Given the likelihood that the COVID-19 pandemic will be with us over the medium and longer term the recommendations seek to prioritise those areas of greatest impact highlighted in the literature so far.

Recommendations

1. In acknowledging the need for simple messaging to ensure clarity, the cutoff age of >70 years does not account for the widely heterogenous variation in the older adult population. Chronological age does not equate with biological ageing which is significantly impacted on by comorbid conditions and the wider determinants of health and wellbeing. Public messaging in respect of measures needed should reflect this.

2. Significant focus in future messaging should allow for determination of perceived personal risk with more focus on what behaviour is advised e.g. outdoors exercise, maintaining contact within trusted networks e.g. social bubble (as opposed to what is advised against).

3. Specific public measures to allow for shopping or other activities in congregated settings in as safe a way as possible should be advised and optimally scheduled to take account of winter seasonal changes.

4. Use of 'support bubbles' or defined trusted social networks to support people living alone and ensure that they can access ongoing physical and social contact and support.

5. Specific consideration to be given to the reintroduction of controlled social gatherings of particular significance including attendance at church, retirement groups, day centres based on the best available evidence on mitigating risk of transmission within same.

6. Clear direction about outdoor exercise and activity to be incorporated in future guidance.

7. A specific targeted programme of health promotion activity to support physical exercise, mental health, nutrition and social wellbeing to be adopted within the HSE using a broad range of communication supports including TV, radio and social media messaging.

8. Visiting in Long Term Residential Care Facilities with appropriate supports and controls should be permitted regardless of level of Government restrictions and where there is no evidence of an active COVID-19 outbreak.

9. Develop enhanced services and pathways that enable face to face assessment and alternative access to Emergency Department in line with the work of the National Integrated Care Programme for Older People.

10. Family carers should have access to the necessary supports that allow for care to be provided in the home environment on a sustained basis. This should include respite (either in appropriate facility or through 'in-home' respite service).

11. The Government 'Community Call initiative' needs to be enhanced, sustained and formally evaluated to provide learning on what a targeted and supported approach to same might look like over a longer-term basis.

12. A specific Transport System that meets the needs of those targeted for additional restrictive measures during the Pandemic needs to be developed. This might be addressed as part of the community call. Initiatives supporting voluntary and personalized taxi services using a social bubble.

13. A reference group with older people should be established to sense check recommendations language and suitability in public health publications.

14. A scaling up of digital technology capacity specifically targeting those in hard to reach / digital-naïve groups along with a broad suite of tele-health programmes to be evaluated for ease of access and utility.

15. HSE arrangements for the provision of respite and day centres for older people to be reviewed with a view to how these services can be safely continued / restarted during pandemic.

References

Alzheimers Society of Ireland (July 2020) Caring and Coping with Dementia During COVID-19. Accessed from: https://alzheimer.ie/wp-content/uploads/2020/07/ASI-Follow-Up-COVID-Report-Final.pdf

Chowdhury M., Hossain N, Kashem M, Shahid M, Alam M. Immune response in COVID-19: a review, J. Infect. Public Health (2020), https://doi.org/10.1016/j. jiph.2020.07.001.

Central Statistics Office (2016). Census of Population 2016 – Profile 3 An Age Profile of Ireland. Available from: https://www.cso.ie/en/releasesandpublications/ep/p-cp3oy/cp3/agr/

Department of Health (2020). COVID-19 Nursing Homes Expert Panel: Final Report. Available from: https://www.gov.ie/en/publication/3af5a-covid-19-nursing-homes-expert-panel-final-report/

Economic & Social Research Institute (2020). ESRI Special Article: COVID-19 and emergency department attendances in Irish public hospitals. Available from: https://www.esri.ie/system/files/publications/QEC2020SUM_SA_lyons.pdf

Evans, I., Martyr, A., Collins, R., Brayne, C., & Clare, L. (2019). Social Isolation and Cognitive Function in Later Life: A Systematic Review and Meta-Analysis. Journal of Alzheimer's disease: JAD, 70(s1), S119–S144. https://doi.org/10.3233/JAD-180501

Flack, K. D., Ufholz, K., Johnson, L., & Roemmich, J. N. (2019). Increasing the Reinforcing Value of Exercise in Overweight Adults. Frontiers in behavioral neuroscience, 13, 265. https://doi.org/10.3389/fnbeh.2019.00265

Gerst-Emerson K, Jayawardhana J (2015). Loneliness as a public health issue: the impact of loneliness on health care utilization among older adults. Am J Public Health; 2015; 105: 1013–19.

Gleeson M, Bishop Nc, Stensel Dj, Lindley Mr, Mastana Ss, Nimmo Ma (2011). The anti-inflammatory effects of exercise: mechanisms and implications for the prevention and treatment of disease. Nat Rev Immunol. 2011 Aug 5;11(9):607-15. doi: 10.1038/nri3041.

Gormley, M., & O'Neill, D. (2019). Driving as a Travel Option for Older Adults: Findings from the Irish Longitudinal Study on Aging. Frontiers in psychology, 10, 1329. https://doi.org/10.3389/fpsyg.2019.01329

GRAHAM, J. (March 2020). Amid pandemic, programs struggle to reach vulnerable seniors living at home. Kaiser Health News. Accessed from: https://khn.org/news/as-coronavirussurges-programs-struggle-to-reach-vulnerable-seniors-living-at-home/

Health Service Executive (2020). COVID-19 HSE Clinical Guidance and Evidence: Is visiting [in the social context] associated with increased incidence of COVID-19 in long-term residential care facilities? Available from: https://hselibrary.ie/is-visiting-in-the-social-context-associated-with-increased-incidence-of-covid-19-in-long-term-residential-care-facilities/

HPSC (2020). Guidance for Vulnerable Groups. Accessed from: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/vulnerablegroupsguidance/

HPSC (October 2020). COVID-19 Guidance on visitations to Long Term Residential Care Facilities. Accessedfrom: https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Guidance%20on%20visitations%20to%20LTRCF.pdf

Irish Gerontology Society (2020). Mind your Language. Media Release Wednesday 22nd April 2020. Available from: https://www.irishgerontology.com/news/latest-news/mind-your-language

Irish Society of Chartered Physiotherapists (2020). Strength and Balance Exercises to Help Older Adults stay active during COVID-19. Available from: https://www.iscp.ie/news/Strength--Balance-Exercises-To-Help-Older-Adults-stay-active-during-COVID19-

Kirwan, R., McCullough, D., Butler, T. et al. (2020). Sarcopenia during COVID-19 lockdown restrictions: long-term health effects of short-term muscle loss. GeroScience (2020). https://doi.org/10.1007/s11357-020-00272-3

Laird E, O'Halloran AM, Carey D, Healy M, O'Connor D, Moore P, Shannon T, Molloy AM, Kenny RA. (2018) The Prevalence of Vitamin D Deficiency and the Determinants of 25(OH)D Concentration in Older Irish Adults: Data From The Irish Longitudinal Study on Ageing (TILDA). J Gerontol A Biol Sci Med Sci. 2018 Mar 14;73(4):519-525, https://doi.org/10.1093/gerona/glx168

Laird E, Rhodes J, Kenny RA. (2020). Vitamin D and Inflammation: Potential Implications for Severity of COVID-19. Ir Med J. 7;113(5):81. PMID: 32603576

Mannion, E. (2020, September). Alternative Pathways to Older Person Care: During COVID-19. [PowerPoint Presentation]. Irish Geriatric Meeting; Changing Horizons in Gerontology, Frailty, Delirium and Interface Geriatrics. Accessed from: https://www.irishgerontology.com/events/changing-horizons-gerontology-frailty-delirium-and-interface-geriatrics

Ranasinghe C, Ozemek C, Arena R. (2020) Exercise and well-being during COVID-19 - time to boost your immunity. Expert Rev Anti Infect Ther. 2020 Jul 23:1-6. doi: 10.1080/14787210.2020

Robinson, K., O'neill, A., Conneely, M., Morrissey, A., Leahy, S., Meskell, P., Pettigrew, J., & Galvin, R. (2020). Exploring the beliefs and experiences of older Irish adults and family carers during the novel coronavirus (COVID-19) pandemic: A qualitative study protocol. HRB open research, 3, 16. https://doi.org/10.12688/hrbopenres.13031.1

Santini ZI, Jose P, Cornwell PE, Cornwall, EY, et al., (2020). Social disconnectedness, perceived isolation, and symptoms of depression and anxiety among older Americans (NSHAP): a longitudinal mediation analysis. Lancet Public Health; 2020; 5: e62–70.

Theon O, Bludgett JM, Godin J et al. (2017) Association between sedentary time and mortality across levels of frailty. CMAJ (2017) 189 E 1056-64

TILDA (2020). Internet access and use among adults aged 50 and over in Ireland: Results from Wave 5 of The Irish Longitudinal Study on Ageing ISBN: 978-1-907894-3 https://www.doi.org/10.38018/TildaRe.2020-06

TILDA and ALONE (2020). Loneliness and Social Isolation in the COVID-19 Pandemic among the over 70s: Data from the Irish Longitudinal study on Ageing (TILDA) and Alone. Accessed from: https://tilda.tcd.ie/publications/reports/pdf/Report_COVID19SocialIsolation.pdf

Tyrrell, C. J., & Williams, K. N. (2020). The paradox of social distancing: Implications for older adults in the context of COVID-19. Psychological Trauma: Theory, Research, Practice, and Policy, 12(S1), S214-S216. http://dx.doi.org/10.1037/tra0000845

Wilson, S. J., Woody, A., Padin, A. C., Lin, J., Malarkey, W. B., & Kiecolt-Glaser, J. K. (2019). Loneliness and Telomere Length: Immune and Parasympathetic Function in Associations with Accelerated Aging. Annals of behavioral medicine: a publication of the Society of Behavioral Medicine, 53(6), 541–550. https://doi.org/10.1093/abm/kay064

Sepúlveda-Loyola, W., Rodríguez-Sánchez, I., Pérez-Rodríguez, P., Ganz, F., Torralba, R., Oliveira, D. V., & Rodríguez-Mañas, L. (2020). Impact of Social Isolation Due to COVID-19 on Health in Older People: Mental and Physical Effects and Recommendations. The Journal of Nutrition, Health & Aging, 1–10. Advance online publication. https://doi.org/10.1007/s12603-020-1469-2

United Nations (2020). Policy Brief: the impact of COVID-19 on older persons. Available from: https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf

World Health Organisation (2020). The impact of COVID-19 on older people. Accessed from: https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2020/05/COVID-Older-persons.pdf

Appendices

Appendix 1: COVID-19 Nursing Homes Expert Panel Recommendations (DoH, 2020)

#	Recommendation	Suggested Lead/ Agency	Suggested Timeframe
1. Public Health Measures			
1.1	Continue the enhanced public health measures for COVID-19. Disease Management in Long-term Residential Care (LTRC) adopted by NPHET at its meetings of 31st March 2020 and 3rd April 2020, including PPE supply to nursing homes; staff accommodation; contingency staffing teams; preparedness planning etc. (see appendix 2)	HSE, HIQA, Each Nursing Home Provider as relevant	Ongoing
1.2	HSE COVID-19 Response Teams have been a critical initiative. These teams must remain in place. These teams should be standardised in terms of operation and composition and must be overseen jointly by HSE CHOs and Hospital Groups, who should have joint responsibility and accountability for their operation.	HSE and Hospital Groups	Immediately and ongoing
1.3	It is critical that regional public health departments are provided with sufficient resources to have a staff complement and skill mix of team members in place to provide local support. HSE Immediately The Crowe Howarth recommended implementation process should continue on a timely basis.	HSE	Immediately Ongoing
2. Infection Prevention Control (IPC)			
2.1	Develop an integrated infection prevention and control strategy in the community with particular focus on all nursing homes, public, private or voluntary.	HSE	Within 1 month of publication of this report
2.2	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.	Each Nursing Home Provider	Within 1 month of publication of this report
2.3	In line with public health and ECDC guidance, nursing home residents should continue to be prioritised for testing with rapid reporting of results.	HSE (HPSC)	Immediate and ongoing
2.4	A plan for and monitoring of a programme of periodic testing for healthcare workers in nursing homes should be continued. Associated protocols should identify the periods.	HSE (HPSC)	Within 1 month of publication of this report – monitoring and review ongoing
2.5	Ensure there is rapid turnaround capacity in testing and contact tracing system.	HSE (HPSC)	Ongoing
2.6	It is essential that in-house staff who can undertake sample swabbing and reliable labelling are available, and that there is proximal access to a laboratory with Laboratory Information Management Systems (LIMS) follow up for contact tracing for both residents and staff.	Each Nursing Home Provider	Ongoing
2.7	(a) Infection control training should be mandatory for all grades of nursing home staff. (b) Nursing home staff should have access to 'train the trainers infection control' training programme approved by the HSE. (c) Commitment required by healthcare agencies to formally confirm evidence of IPC, including PPE training prior to allocating staff to nursing homes. Nursing home providers should not contract an agency staff without evidence of IPC/ PPE training. Each provider should have documentary assurance from the agency that the staff member has had the requisite training. HIQA should undertake compliance checks. (d) Every nursing home requires onsite access to a trained infection control lead on each shift. That lead will ensure IPC protocols are implemented and will support staff to do so.	(a) Each Nursing Home Provider (b) Each Nursing Home Provider and HSE (c) Staff Agencies and each Nursing Home Provider (d) Each Nursing Home Provider	Immediate and ongoing

2.8	A user-friendly, consistent protocol for ordering and for the ongoing supply of additional COVID-19 related PPE to nursing homes by the HSE needs to be refined. Similar protocols must be put in place for the ordering and supply of other essential COVID-19 management related equipment. These protocols should be kept under review during the pandemic. Each nursing home is responsible for and should have an emergency supply of PPE and other COVID-19 related equipment in the event of a cluster. This should be included in preparedness plans.	HSE Each Nursing Home Provider	Ongoing
2.9	Influenza vaccine should be prioritised for all residents unless medically contraindicated of all nursing homes once it becomes available and consider making it mandatory for staff	HSE and Department of Health	Planning should commence immediately
2.10	Management of entry and exit: Examine options for zoning within care homes so different entrances/exits can be used for different parts of the home. This examination should be documented with results and actions incorporated into preparedness plans	Each Nursing Home Provider	Within 3 months
3. Outbreak Management **COVID-19 is highly contagious and has atypical presentations in older adults. There needs to be a strong clinical index of suspicion. Nursing homes need an immediate action plan for when COVID-19 cases are suspected and must include the following elements, in accordance with HSE protocols**			
3.1	Access to rapid testing with fast tracked results, as above.	HSE	Ongoing
3.2	PPE to be readily available and staff training with onsite supervision on every shift to ensure PPE being used correctly. Training should be documented and records available for inspection by HIQA.	Each Nursing Home Provider HIQA (compliance oversight)	Ongoing and all staff should be trained within 2 months
3.3	Sustain protocols for self-isolation, quarantine, cohorting and referral to GP Lead.	Each Nursing Home Provider	Ongoing
3.4	Suspect cases and close contacts need to be isolated pending the results of rapid testing.	Each Nursing Home Provider	Ongoing
3.5	Facilities must have ability and space to isolate and cohort residents and a clear plan on how this will happen. This plan should be incorporated into preparedness plans.	Each Nursing Home Provider	Ongoing
3.6	Access to safe staffing levels at all times and to include required skill set on every shift.	Each Nursing Home Provider	Ongoing
3.7	Social distancing facilities for residents and staff should be in place and maintained.	Each Nursing Home Provider	Ongoing
3.8	Each provider should incorporate written plans on each of the above into their preparedness plan for review by HIQA.	Each Nursing Home Provider HIQA (compliance oversight)	Ongoing
4. Future Admissions to Nursing Homes			
4.1	Ensure all new residents coming from the community or proposed transfers from hospital are tested for COVID-19 prior to admission.	Each Nursing Home Provider and HSE	Ongoing
4.2	Admissions should only be made to nursing homes who can demonstrate their infection control measures are of sufficient standard to ensure there is no risk of onward infection. HIQA should maintain a register of those nursing homes it deems to have demonstrated sufficient infection control standard reached, to support informed decisions on admissions in this regard	Each Nursing Home Provider, HSE and HIQA	Ongoing
4.3	New Residents must be isolated according to HPSC protocol.	Each Nursing Home Provider	Ongoing
5. Nursing Home Management			
5.1	Log of all persons/staff entering nursing homes should be maintained by each nursing home and available for inspection by HIQA.	Each Nursing Home Provider HIQA (compliance oversight)	Ongoing

5.2	Nursing homes should have a clear written back-up plan when regular staff cannot work or fail to turn up for work. This should be incorporated into the nursing home's preparedness plan for review by HIQA.	Each Nursing Home Provider HIQA (compliance oversight)	Immediate
5.3	All Healthcare Assistants (HCAs) should have a relevant QQI Level 5 qualification or be working towards achieving it. A phased pathway towards achieving this should be in place. The requirement's inclusion in the regulatory framework should be considered.	Each Nursing Home Provider Department of Health (if regulation required)	An education plan for each healthcare assistant should be in place by each provider within 18 months of the publication of this Report
5.4	Framework for Safe Staffing and Skill mix (published 2018) should be prioritised and urgently developed to apply in nursing homes - public and private, nationally.	Department of Health	Within 18 months of publication of this Report
5.5	While Phase 3 of the Safe Staffing Framework is developed, in the interim, evidence and learnings from earlier phases of the Framework should be examined and used to inform interim changes to staffing in nursing homes. These learnings should also be used to develop guidance on staffing levels and skill mix in surge situations arising from COVID-19. These changes should be readjusted as Phase 3 develops and is rolled out.	Department of Health	2020
5.6	For the next 18 months or until the declaration of the end of the Global pandemic by WHO, staff employed by a nursing home should be precluded from working across multiple sites and adequate single-site employment contracts should be put in place to support this.	Each Nursing Home Provider (employment) Department of Health (if regulation required) HIQA (compliance oversight)	Planning should commence immediately
5.7	A review of employment terms and conditions of nurse and healthcare assistant staffing grades in nursing homes should be undertaken with a view to ensuring future capacity and the supply of qualified staff.	Department of Enterprise, Trade and Employment	Within 18 months
5.8	Occupational health and HR support, including psychological supports, for all staff is necessary and access should be put into place.	Each Nursing Home Provider	Immediately
5.9	Increased integration of private and voluntary nursing homes into the wider health and social care systems requires enhanced transparency of operation, funding and finances of these nursing homes. The funding and expenditure (public and private monies) utilisation by private and voluntary providers in providing and improving services should be clearly transparent and measures should be considered to ensure this.	Department of Health, NTPF, HSE	Planning should commence immediately
6. Data Analysis			
6.1	Improve linkage amongst different datasets such as CIDR with HIQA and GRO datasets. This may include updating the CIDR outbreak file data fields to include a HIQA ID.	HSE (HPSC) and HIQA	Planning should commence immediately with a view to completing linkages in 2020
6.2	Implementation of Individual Health Identifier (IHI) as a matter of priority to enable tracking of patients between community and acute hospital sectors.	HSE and Department of Health	Progress should be made without delay
6.3	Develop and introduce an integrated IT system for older persons services including residential, home support, day care, needs assessment and care planning, so as to support the provision, management, delivery and reporting of services, and especially for planning alternative service provision and planned capacity development in the event of evolving public health measures.	HSE	Introduce within 18 months or sooner

6.4	Realignment of geography used in CIDR to Regional Health Areas (RHAs), counties or other, in line with current health system structures as they evolve.	HSE (HPSC)	Planning should commence immediately
6.5	Introduction of the ability to link and track contacts into CIDR or using another data programme.	HSE (HPSC)	Planning should commence immediate
6.6	Having regard to improved data linkages (6.1), the HSE (HPSC) should produce a detailed report on the management and outcomes of the multiple clusters that occurred during the COVID-19 pandemic with learnings on causal factors and preparedness for infection prevention and control.	HSE (HPSC)	Within 9 months of the publication of this Report
6.7	HPSC, HSE and HIQA should produce a detailed epidemiological analysis comparing both risk and protection factors associated with having an outbreak or not at all in HIQA regulated facilities.	HSE (HPSC) and HIQA	Within 3 months of the publication of this Report
7. Community Support Teams			
7.1	Establish new integrated Community Support Teams with clearly defined joint leadership and responsibility across each CHO and hospital group area on a permanent basis, in line with the discussion in this chapter. In the interim, the existing COVID-19 Response Teams should remain in place.	HSE and Hospital Groups	Planning to commence immediately
7.2	In the event of a COVID-19 surge, a designated member of the future Community Support Team should always have 24/7 availability for the nursing homes in the catchment area.	HSE and Hospital Groups	Immediately
8. Clinical – General Practitioner Lead Roles on Community Support Teams and in Nursing Homes			
8.1	A GP will be a key member of each Community Support Team (and in the interim each COVID-19 Response Team).	HSE	Within 3 months of publication of this Report
8.2	One of the GPs, already caring for their patients in a nursing home, will be appointed to the additional role as a nursing home's GP Lead, and working with the Person in Charge and other senior nursing home staff will contribute to the nursing home's general oversight and governance. The Person in Charge has overall responsibility for clinical governance.	Each Nursing Home Provider and GPs	Within 18 months of publication of this Report
8.3	The sessional commitment and remuneration for the post will be specified in a contract between the nursing home and GP lead; functions would include promoting the use of instruments like the InterRAI Single Assessment Tool and the Clinical Frailty Score and optimising medication management, ensuring full compliance with e.g. influenza vaccine uptake for residents and staff in the nursing home and close liaison with community services and outreach services of acute Hospital Groups.	Each Nursing Home Provider and GPs	Within 18 months of publication of this Report
8.4	A national framework describing the role and responsibilities of the GP lead, including the elements outlined above, should be developed, so that providers can operate within a consistent and clear set of requirements.	Department of Health and HSE	Within 18 months of publication of this Report
8.5	The Department of Health with support from HIQA should explore, whether the particulars of this framework should be incorporated into the regulatory framework.	Department of Health	Within 18 months of publication of this Report
8.6	A clinical governance oversight committee should be established in all nursing homes and its inclusion in the regulatory framework should be considered – in the interim guidance on the role and composition should be developed. In time, one of the functions of this oversight committee should be to review quality indicator/resident safety reports and action appropriate follow up (see recommendation 9.4).	Each Nursing Home Provider HSE (Guidance) Department of Health (Regulation if required) HIQA (compliance oversight)	Within 9 months of publication of this Report. Within 6 months of publication of this Report. Within 18 months of publication of this Report.
9. Nursing Home Staffing/Workforce			
9.1	HIQA should carry out and publish a detailed audit of existing staffing levels (nursing and care assistant) and qualifications in all nursing homes – public, voluntary and private.	HIQA	Within 6 months of publication of this Report

9.2	It is essential to have strong informed nursing leadership on site in all nursing homes with a documented contingency plan for when leaders are absent. These plans should be incorporated into preparedness plans. They should be available for inspection by HIQA.	Each Nursing Home Provider. HIQA (compliance oversight)	Ongoing
9.3	There should be national criteria on roles and responsibilities of the Person in Charge and registered nursing staff in nursing homes. This should be incorporated into the regulatory framework.	Department of Health	Within 9 months of publication of this Report
9.4	Considering the nursing metrics and the HPSIR, a quality indicators and outcomes/resident safety model should be developed for nursing homes, requiring each nursing home to publish regular reports and to provide copies to HIQA. HIQA should establish a public register of all such reports provided by nursing homes, and oversight and validation checks should be incorporated into the regulatory framework.	Department of Health (model) Each Nursing Home Provider (Implementation) HIQA (compliance oversight)	Planning for and the development of a model and process should commence immediately with a system developed within 9 months and operational within 18 months
9.5	The development, in the medium-term, of clinical governance models in the community should be explored further by the Department of Health in conjunction with the HSE, supported by an international evidence review of models of clinical governance in nursing home settings.	Department of Health and HSE	Within 12 months
10. Education – Discipline-Specific and Inter-disciplinary			
10.1	HSE training programmes, such as e.g. HSELanD, should continue to be made available to private nursing homes and an appropriate governance structure established.	HSE	Ongoing
10.2	To promote the wider implementation of advanced healthcare directives (AHDs), education programmes, including some virtual, should be put in place and providers should facilitate greater staff participation.	The Decision Support Service and HSE Each Nursing Home Provider (facilitating staff participation)	Planning should commence immediately
10.3	Implement relevant aspects of the Assisted Decision Making (Capacity) Act 2015, once enacted, in areas such as capacity assessment, recognising each resident's will and the wider use of advanced healthcare directives.	Department of Justice and Equality in consultation with the Department of Health	Within 6 months of publication of this Report
10.4	Staff training and career development programme with a requirement that senior nursing staff will have undertaken post-graduate gerontological training and show general evidence of training competency. A phased pathway towards achieving this should be in place with clear targets set, and regulatory oversight provided to ensure that targets are met.	Each Nursing Home Provider Department of Health and HIQA (Regulation if required) HIQA (Compliance oversight)	Phased pathway and targets should be developed within 9 months (provider, with regulation developed as required (Department of Health). Each Nursing Home Provider should have a compliance plan within 3 months thereafter

10.5	Mandatory continuing education for all staff in areas such as infection control, palliative care & end of life and dementia should be introduced and a phased pathway towards achieving this should be in place with clear targets set, and regulatory oversight provided to ensure that targets are met.	Department of Health (Regulation if required) HIQA (Compliance oversight) Each Nursing Home Provider (compliance plan and pathway for all staff)	Phased pathway and targets should be developed within 9 months with regulation as required (Department of Health regulatory and HIQA compliance oversight). Each Nursing Home Provider should have a compliance plan within 3 months thereafter
11. Palliative Care			
11.1	Every nursing home should be linked with the Community Palliative Care Team in their catchment area.	HSE and Each Nursing Home Provider	Within 2 months
11.2	Visitor guidelines – individual assessments should be undertaken and documented, and compassionate visiting should be followed as recommended by the HSE and in line with HPSC visiting guidance. They should be available for inspection by HIQA.	Each Nursing Home Provider HIQA (Compliance oversight)	Immediately and ongoing
11.3	Initiate a joint HSE-IHF collaborative national programme on palliative, end-of-life and bereavement care for the nursing home sector that engages all stakeholders and improves quality of care across the sector. This initiative would be established along the same lines as the HSE-IHF Hospice Friendly Hospitals Programme (2017 to date).	HSE and Irish Hospice Foundation	Planning should commence immediately
12. Visitors to Nursing Homes			
12.1	HPSC should proactively/regularly review visiting guidelines in order to achieve a balance between individual freedoms and protective public health measures, in line with the Department of Health ethical guidance	HSE (HPSC)	Ongoing
12.2	Infrastructural adaptations may be needed including visiting rooms that can facilitate visits from friends and family.	Each Nursing Home Provider	Immediately
12.3	End of life visiting must be arranged on compassionate grounds based on clinical judgement and take account of public health measures.	Each Nursing Home Provider	Ongoing
13. Communication **Support and communication for residents and their families are a continuing priority.**			
13.1	Meaningful communications with residents and families should take place regularly in relation to visiting protocols, changes in processes and explanations relating to same.	Each Nursing Home Provider	Ongoing
13.2	Clear communication plans with residents to provide information on the ongoing situation should be developed and documented regularly. HIQA should examine these as part of the inspection process. Providers should provide regular updates about residents to the families	Each Nursing Home Provider HIQA (Compliance oversight)	Ongoing
13.3	Phone lines must be maintained and additional reception / communications staff planned for at busy periods. Purchase tablet computers if relevant and review IT solutions for use by individual residents to assist with family and friend communication and review of facilities to ensure all have access to Wi-Fi facilities. Each provider should document its review and action plan in this regard and make it available to residents, families and HIQA.	Each Nursing Home Provider	Within 3 months of publication of this report
13.4	Dedicated staff should be assigned/appointed to facilitate social activities and communication with family. Assignments / appointments should be documented with clear activity and communication plans and records in place, and available for inspection by HIQA.	Each Nursing Home Provider HIQA (Compliance oversight)	Within 3 months of publication of this report
14. Regulatory Recommendations			

14.1	Clear document outlining the roles and responsibilities of key stakeholders should be developed to include a clear overview of the roles and responsibilities of NPHET, the Department of Health, HSE, HIQA, and individual providers. This should take into account the recommendations in this Report. The ongoing approach to nursing homes should be coordinated in line with this. Official guidelines, key updates and important news relating to COVID-19 should be coordinated and distributed to providers from one statutory source to avoid duplication and confusion. Requests for information from providers should be coordinated similarly subject to existing legal requirements.	Department of Health in consultation with HSE and HIQA	Document should be developed Within 1 month of publication of this report and HIQA or the HSE should be designated as sector communications coordinator HSE and HIQA should agree a written protocol on communication within 1 month thereafter
14.2	HIQA itself identified a deficit in infection control and risk management expertise in this sector. Mandatory training records including infection control should be included. consistently in the inspection process.	HIQA	Planning should commence immediately
14.3	There are currently 22 inspectors overseeing approximately 576 facilities with a visit frequency of 18 months. While onsite inspections are labour intensive, the frequency of these should be increased.	HIQA	Immediately
14.4	The legislation underpinning nursing homes registration and operation and empowering HIQA is in place, but the current regulations need to be modernised and enhanced with additional powers and requirements. These regulations should be reviewed, including to give full effect to the recommendations of this report	Department of Health with input from HIQA	Within 6 months of publication of this report
14.5	Assessment of compliance with the regulatory assessment framework of the preparedness of designated centres for older people for a COVID-19 outbreak should be part of the inspection process.	HIQA	Immediately and ongoing
14.6	Provision should be made for regular mandatory reporting to HIQA of key operational data by each nursing home provider including data on staff numbers and grades, qualifications, occupancy levels. This data should be available to health agencies including the Department of Health to inform ongoing planning for residential care services. HIQA should ensure streamlined processes are in place for the collection, collation and reporting of such data.	Department of Health (Regulation if required) HIQA (operational processes) Each Nursing Home Provider (submission of data)	Within 6 months of publication of this Report
15. A broad range of statutory care supports for Older People			
15.1	Integration of private nursing homes into the wider framework of public health and social care should be advanced. This should be prioritised in the short-term with the implementation of the recommendations in this Report, and longer-term reform should be pursued as a key component of the intended Commission on Care.	HSE and Each Nursing Home Provider in the short term Government, HSE, Department of Health (longterm reform)	In line with timelines for relevant recommendations in this report. Planning should commence in line with the Commission on Care process

15.2	The Department of Health and HIQA should explore introducing a requirement that all nursing home providers promote, facilitate and engage meaningfully with independent advocacy services.	Department of Health and HIQA	Within 6 months of publication of this Report
15.3	The Department of Health should explore a suitable structure and process for external oversight of individual care concerns arising in nursing homes, once internal processes have been exhausted without satisfaction.	Department of Health	Within 12 to 18 months of publication of this Report
15.4	HIQA and each nursing home provider should continue to highlight and promote independent advocacy services available to residents	HIQA and Each Nursing Home Provider	Ongoing
15.5	Provide nursing home residents with full medical card eligibility equality of access to services available to community-based peers.	HSE	Immediately and ongoing
15.6	Access to home support should be expanded and prioritised.	HSE and Department of Health	Immediately
15.7	Standardised care needs assessment should be developed and rolled out. Consideration of a person's suitability for rehabilitation and/or reablement services should be mandatory prior to admission to nursing home and an opportunity for access to such services should be available. The consideration and outcome should be documented	HSE, Overseen by the Department of Health	Develop models and pathways within 9 months of publication of this Report. Ensure longer term integration within 24 months of publication of this Report
15.8	Incentives, including financial, must be explored to help provide a wider range of service and ownership models for both care in the home and in smaller congregated units/ settings. This would acknowledge and reflect most people's preferred wishes.	Government, Department of Finance, Department of Public Expenditure and Reform, in consultation with Department of Health	Within 18 months of publication of this Report
15.9	Review and as appropriate following review develop policy and underpinning legislation, as necessary, for the introduction of a single integrated system of long-term support and care, spanning all care situations with a single source of funding.	Government and Department of Health	Planning for the review should commence in line with the Commission on Care process
15.10	This choice model would be payable to the beneficiary for use either to support further care in their own home, in alternative home-based supportive care or in residential care.	Government and Department of Health	Planning for the review should commence in line with the Commission on Care process
15.11	To support this policy initiative, and in line with 15.7 national integrated care needs assessment and care planning policy and structures should be developed for older persons services. Examination of the role of resource allocation models should be undertaken including an international evidence review.	Department of Health and HSE	Policy development and commence roll out within 9 months of publication of this Report Review of Resource Allocation Modelling within 18 months of publication of this Report
15.12	The National Care Experience Programme expansion to nursing home residents should be progressed at pace.	HIQA	Within 18 months of publication of this Report

Appendix 2: Online Resources for Older People, Families and Carers

We would recommend that older adults, carers and family members follow the guidelines provided by the HSE.

Details	Guidance Links (click right on links to open)
General COVID-19	HSE Coronavirus Information World Health Organisation Q&A
NGOs/Voluntary Organisations information and Supports	Alone Alzeimhers Society of Ireland Family Carer's Ireland Age Action Age and Opportunity
Statutory Organisations	Age Friendly Ireland
Physical Activity	HSE Indoor Exercise for Older People ISCP Strength and Balance Exercises to Help Older Adutls Stay Active Seil Bleu Ireland Age and Opportunity
Psychological Resources	HSE Mental Health Support and Services during COVID-19
Nutrition	www.hse.ie/nutritionsupports.
National Helplines	· Community Call Helplines · Alzheimer Society of Ireland 1800 341 341 · Alone 0818 222 024 · HSE Live 1850 24 1850 · Third Age Senior Help Line 1850 440 444 · Aware Support Line 1800 80 48 48 · Samaritans 116 123

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

OLDER PEOPLE