# Care home visits: another area of confusion surrounding the UK's COVID-19 response


***Melanie Henwood*** *and* ***Bob Hudson*** *consider the recent guidance around visits to care home residents. They discuss the complex balance of costs and benefits and highlight the importance of adopting a nuanced and personalised approach, rather than an over-cautious standardised protocol.*

The government's attempts to combat COVID-19 are increasingly being characterised by confusion. One recent study found that just 45% of adults in England understand current government guidelines compared with 90% back in March, when stricter rules were imposed under the clear message to 'Stay home, Protect the NHS, Save Lives'. Policy on visits to care homes is on a similar trajectory of inconsistency and lack of transparency. One of the most poignant images after lockdown was of relatives gazing through windows at their friends and relatives living in care homes at a time when visiting was completely banned. This has since been replaced by some easement of visiting rules; but new DHSC guidelines threaten to reintroduce confusion and turmoil into the lives of the 400,000 plus care home residents and their families.

Since early July, many care homes have been facilitating one-to-one garden visits between residents and relatives or friends, subject to clear protocols and limitations on duration and frequency. Although far from ideal, this has been much better than the previous forced separation. Many will have struggled to maintain meaningful contact with their families through telephone or video calls, and for those people living with cognitive impairment it will have been especially difficult. The new guidance, however, could put even these modest consolations at risk.

A month before the guidance was issued, the Care Provider Alliance (the national body representing voluntary, private, and community sector care providers) produced its own protocol to support care homes reopening 'in a way which is safe and proportionate to their localised understanding of the risk'. It established a set of principles to enable providers to adopt a 'dynamic risk-based approach', and to consider the risks of allowing visitors against the risks of continuing to prevent them, with the negative consequences on residents' mental and emotional wellbeing.

The new guidance adopts much of the language and content of the Care Provider Alliance protocol but adds one potentially damaging sentence:

> *To limit risks, where visits do go ahead, this should be limited to a single constant visitor, per resident, wherever possible. This is in order to limit the overall numbers of visitors to the care home and the consequent risk of infection.*

Deciding on the policy for visits in a local authority area is apparently a matter for the Director of Public Health 'who will assess the suitability of a specified level of visiting guidance for that area taking into account relevant infection and growth rates'. However, the decision on whether or not to allow visitors and under what circumstances is an operational decision for individual care homes or their parent company.

These are enormously difficult issues and getting the balance of risks and benefits right is not straightforward. The benefits for residents of being reconnected with family and loved ones must be weighed against the increased risks of spreading infection (either into or out of the home). But to restrict visits not just to one person at a time, but to 'the same family member visiting each time' raises many ethical dilemmas. Designating one person puts significant pressure and demands on that individual that might be better shared between a small group of visitors; it also fails to allow the resident any choice or preference about who they might wish to see.

Many families and residents will probably be unaware of this situation until they collide with the new restrictions. The dilemmas are huge. Will residents (where able) be expected to nominate a favoured visitor? How, for example, can a resident with a surviving spouse and children be expected to make a single nomination? Or, in the case of a resident with cognitive impairment, how will a network of visiting support decide upon who can continue to visit a loved one and who cannot? Residents with dementia (who constitute the majority of the care home population) have already gone several months with little or no visiting support from their families; a further ongoing restriction could easily result in a permanent severing of cognitive ties with friends and families.

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In fact, the official guidance is actually packed with caveats to this visiting restriction. Directors of Public Health are urged to consider 'the wider risk environment'; the distressing effects on residents with cognitive impairments need to be taken into account; care providers are instructed to 'actively involve the resident, their relatives or friends and any advocates'; those holding power of attorney should be consulted; and regard should be had to the ethical framework on adult social care. All of this is in line with the advice in the Care Provider Alliance protocol – that responses need to be personalised via an Individual Visiting Plan. The worry is that this fine print will be overlooked.

COVID-19 has already impacted disproportionately hard on this section of the population: almost 14,000 deaths in care homes in England were attributed directly to COVID-19 between April and July 2020, and many more 'excess deaths' are also likely to be due to the virus. Those who have survived have endured loneliness and continuing separation from their loved ones, and people living with dementia and other cognitive impairment will not have understood their apparent abandonment. The pledge in early July that care home staff would be tested weekly for COVID-19 infection, and residents monthly, has also failed to be delivered because of a shortage of testing kits, and may not now be operational until the beginning of September, introducing further delays in enabling safe visiting.

Unfortunately, some care home providers appear to be focusing only on the 'single constant visitor' message and are imposing a one-size-fits-all policy across their establishments. This high degree of caution may well suit the DHSC and some care providers. At national level, the government is desperate to avoid any scandalous repetition of excess care home deaths and is anxious to tone down growing demands for an independent public inquiry into the fiasco. Meanwhile, care home providers will be concerned about the reputational loss arising from further infections and fatalities, especially in the face of legal challenges over negligence and the rising cost of obtaining insurance cover.

The claim by Matt Hancock that a 'protective ring' had been thrown around care homes from the beginning of the pandemic is widely viewed as inaccurate and disingenuous. However, this is not the time to set up new barriers around care homes or enforce inappropriate segregation of the care home resident population. We *do* need proportionality and caution in reopening care homes, but we need also to be humane and compassionate and to recognise the complex balance of costs and benefits. Developing safe procedures in an individually risk-assessed approach, backed up by regular and reliable testing, must be prioritised and the wellbeing and quality of life of residents given urgent attention.

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