Left behind in the times of COVID-19

Médecins Sans Frontières/Doctors Without Borders (MSF) sharing experiences from its intervention in care homes in Belgium

MEDECINS SANS FRONTIERES

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Summary

The COVID-19 pandemic has put a tremendous strain on some of the most advanced healthcare systems in the world. A combination of increased pressure on the equipment and care required, inadequate infection prevention and control (IPC) measures and a lack of experience in handling large-scale epidemics of infectious diseases like COVID-19 has resulted in the death of 9,731 people across Belgium.[1] More concerning, 64%[2] of these deaths have been among residents of care homes,[3] with a high proportion (close to 4,900) of these deaths occurring within these institutions themselves, sometimes in appalling conditions.

While the priority has been to maintain hospital capacity at all costs in order to cope with an influx of patients and to avoid a case scenario like in Italy or Spain, residents and staff in shared living facilities such as care homes as well as accommodation and reception centres for people living with disabilities, have been abandoned to their fate. Living spaces were transformed into makeshift hospitals which nevertheless lacked protective equipment, medical and screening equipment, enough healthcare staff to wage this unprecedented war, and knowledge on how to manage epidemics in closed environments.

Médecins Sans Frontières/Doctors Without Borders (MSF), better known for its medical and humanitarian projects in crisis settings launched an emergency intervention on 21 March 2020 in care homes in the capital, Brussels, and later in Flanders and Wallonia. In parallel, MSF set up a centre in Brussels for homeless people and migrants with COVID-19 symptoms to seek care and provided technical advice and training to several hospitals and convalescence centres.

MSF's response in care homes deployed mobile teams consisting of a nurse, health promotion officer and if needed, a psychologist. The teams provided technical expertise and training to strengthen the capacity of care home staff in infection prevention and control (IPC), and organisation of care; testing, assigning residents into cohorts according to their infection status[4] and helping with lockdown ease activity restart. As the dire needs in care homes became increasingly apparent, psychosocial support for staff quickly became a fundamental part of the teams' activities.

To ensure sustainability this intervention was conducted in close collaboration with various authorities responsible for overseeing long-term care facilities.[5] In Brussels and Wallonia, the work was also conducted in partnership with volunteer mobile teams from the Fédération des maisons médicales (FMM – Federation of Medical Houses) and with members of the Red Cross.

The intervention consisted of an initial visit, during which the team met with managers and other key individuals at care homes and conducted an assessment of the facility. MSF mobile teams then provided adapted recommendations for each care home's specific circumstances, as well continued support through follow-up calls and if needed, additional visits to train staff. Learning tools, which were created specifically for COVID-19 situations – such as posters, videos, training courses and webinars on subjects such as IPC measures, screening, mental health, and relaxation of lockdown measures – were also available and disseminated, via websites, to reach more facilities than those receiving support visits.

A total of 135 care homes received support visits from MSF (81/138 in the Brussels region, 33/602 in Wallonia and 21/821 in Flanders),[6] with a total of more than 3,000 staff members receiving our advice and support. Support required from the mobile teams was diverse and often reflected the challenges care home staff faced adapting to COVID-19, and the evolving response. The initial visit often served as a time to listen and provide an emotional debriefing session for management staff, as well as provide feedback on infection prevention measures that had already been instituted within the facilities, to provide

1 Data as available on 26 June 2020 on the overall epidemiological COVID-19 coronavirus situation in Belgium, published by Sciensano: https://covid-19.sciensano.be/fr/COVID-19-situation-epidemiologique.

2 In Flanders and Wallonia, the rate was 63%, and 68% in Brussels. Source: *Ibid.*

3 MSF intervened in care homes for elderly persons. Some of them integrate the provision of medical care to shorten or prevent hospital stays, while some don't. MSF intervention targeted both types. For convenience, both types of facilities will be referred to as "care homes" for the rest of the document.

4 For a definition of COVID-19 cases, see: https://covid-19.sciensano.be/sites/default/files/Covid19/COVID-19_Case%20definition_Testing_FR.pdf

5 Long-term care facilities, the designation under which care homes for the elderly fall, have been administered at the regional and community level since the sixth state reform. In Brussels, the agencies that manage and regulate these institutions are Cocom and Iriscare; in Flanders it is the agency Vlaams Agentschap voor Zorg and Gezondheid (VAZG); and in Wallonia, the AViQ (Agence pour une vie de qualité – Quality of Life Agency). In the German-speaking community Ministry, they are administered by the Health and Elderly Persons department.

6 It should be noted that data on care homes in the country and in each region and community respectively vary from one source to the next. We are using the data that was sent to us as part of our intervention.

some reassurance. When the issue of systematic testing of residents and staff finally became a priority for the authorities in the second week in April, their questions increasingly concerned isolation and cohorting. In the final weeks of the MSF intervention (which ended in mid-June 2020), care home staff requested advise on the relaxation of lockdown measures.

For the MSF teams, despite their experience in handling crisis situations, the COVID-19 epidemic has been unprecedented, just as it has been for care home staff. The current Belgian health and social system is extremely complex, with nine health ministers among both federal and federated bodies. It is structurally underfunded and has become increasingly privatised, and now is clearly demonstrating its limitations. To be better prepared to face a new wave of the COVID-19 epidemic, lessons must be rapidly drawn from the experience of the past few months.

The results from our visit assessments and from a nation-wide questionnaire indicate that care homes in the three regions faced the same difficulties and stumbling blocks, namely: **a lack of preparation for this type of emergency; a general lack of knowledge of basic hygiene rules and IPC; and a lack of understanding and expertise in the various protocols and recommendations (which were often not adapted to the circumstances), in particular concerning the use of personal protective equipment (PPE),[7] testing and organising care.**

When lockdown measures were implemented, care homes closed their doors to external visitors. Many care homes found themselves forced to carry out the role of hospitals, but without the resources to do so. From MSF assessments, just over half of care homes (54%) had enough protective gowns, 64% had enough FFP2 masks, and only 42% of staff in charge of laundry were protected by appropriate PPE equipment. More than one in six care homes visited by MSF had no disinfectants able to kill the coronavirus, and the disinfection of medical equipment was inadequate in 19% of cases. Only 53% of care homes considered their staff to be sufficiently informed about COVID-19 and the risk of transmission. Regarding screening, more than three in ten care homes had conducted no screening at all, only 78% had isolated suspected cases in individual rooms, and isolation or cohorting of confirmed positive cases took place in only 60% of cases. Therapeutic plans and end-of-life agreements were only systematically in place for seven out of ten facilities.

In addition, there was limited possibility to refer residents to external medical services, in particular to hospitals. Before the crisis this possibility was at 86%, which dropped to 57% during the crisis. In the care homes that our teams visited, just over 70% had received a positive response to all their calls to emergency services (112). Visits from general practitioners (GPs), were down by half from the pre-crisis period, which had a huge impact on the medical treatment of residents, not only for COVID-19 symptoms but for other health issues.

Out of their depth, care home staff, like hospital staff, have found themselves facing extreme working conditions. Concerningly, there was an increase in mental health disorders and the appearance of new symptoms, notably post-trauma symptoms, among both residents and staff, at all levels. Among staff, the most commonly observed symptoms linked to the crisis were feelings of hopelessness and despair, anxiety, panic, sadness, guilt and anger. In nine out of ten care homes, staff reported new or exacerbated symptoms amongst residents. Symptoms most reported were sadness, depression and a deterioration of cognitive capacities. Of these facilities, around 10% reported a rise in suicidal thoughts among residents, confirming the increase in "failure to thrive syndrome" – or losing the will to live which characterised the difficulty of this period for residents.

Although the analysis of our intervention shows an equivalent average preparedness and response capacity among the care homes in the country's three regions, those with a nursing director or a crisis cell coped better. Whether a care home was private, public or non-profit had no major impact on preparedness and response capacity. The feeling of being abandoned, combined with a feeling of weariness, was present in all interactions and meetings during this intervention, as care home staff felt that their sector was undervalued and increasingly stigmatised. While healthcare providers received applause, care home staff – despite their crucial front-line role – did not.

This report is intended to encourage the competent authorities to take the necessary steps to prevent tragic reoccurrences in care homes in the event of a new wave of the epidemic. Contingency planning needs to adopt a more inclusive public health approach towards the elderly and to incorporate the situation faced by care homes during the first wave. Such measures need to be adopted and implemented at the federal level, but also in the federated entities (regions and communities) on which these care homes depend, with greater consistency between these various bodies.

The measures, response protocols and approaches must be increasingly adapted and supported by governmental bodies to effectively manage and finance care homes, focusing on support and implementation rather than simply overseeing them. Priority should be placed on continual training and support in IPC equipment and techniques. The mobile team model, which ensures that care home staff benefit from advice and support, has proven its effectiveness and must be continued and copied, with the support of health authorities. More coherent and transparent epidemiological surveillance will allow care homes to have a better understanding of where they stand from an epidemiological point of view and thus be able to adapt their operational response accordingly. The mental health of both staff and patients should be addressed without delay and become an integral part of COVID-19 response plans. Care home staff have been neglected, along with the sector in which they work; their importance must be recognised.

7 Personal protective equipment (PPE) includes: a mask (surgical or FFP2); eye protection (visor or goggles); a protective gown; and gloves. For practical recommendations for PPE in care homes, refer to the following MSF tool: https://f6f63e5a-7e1f-44bd-954a-c86646b7473e.filesusr.com/ugd/072e94_8657b0a314b74839be0e2bfac202062f.pdf

Several initiatives to support care homes are emerging, with varying levels of investment from regions and communities. The degree of urgency, however, does not measure up to the urgent appeals from the care homes themselves. As ordinary life slowly resumes outside the confines of these institutions, practical measures need to be taken that target the specific needs of care home residents and staff. There is no time to lose: when the virus comes knocking once again, we cannot allow the elderly to pay the price of our indifference.

Introduction

On 31 December 2019, the World Health Organization (WHO) was notified of an outbreak of an unknown flu in China's Hubei province, which turned out to be caused by a new type of coronavirus (SARS-Cov-2).[8] The disease, soon named Coronavirus Disease-2019, or COVID-19, quickly spread to most countries around the world, including Belgium.

The first case in the country was confirmed on 4 February 2020. Faced with the outbreak of an epidemic that was rapidly gaining ground, the federal authorities activated the crisis plan and handed over management of the epidemic to the central authorities in the second week of March.

The focus, however, was quickly placed on maintaining hospitals' capacity to admit COVID-19 cases. Despite already undeniable evidence that the coronavirus spread quickly and caused a high risk of severe symptoms and mortality among the elderly, especially those living in communities in which appropriate mitigation measures[9] were lacking, care homes and their residents were left to fend for themselves. Belgium has nearly 1,600 of these facilities, with more than half located in Flanders, 602 in Wallonia, 140 in Brussels and eight in the German-speaking community. Since the sixth state reform in 2014, their oversight was decentralised, and they became the responsibility of communities and regions.

Of the 9,731 people who have died from COVID-19 in Belgium by the end of June 64% were residents of care homes.[10] Of these, 1,377 died in hospital, while 4,857 died in the institutions in which they lived. During the crisis, care homes became places to die rather than to live.

Following an increase in COVID-19 cases in Belgium, the MSF Brussels office conducted an intervention which focused on the following three pillars:

1. Ensure observation, isolation and basic care for migrants and the homeless and ensure that they have access to healthcare and are included in the COVID-19 referral system.[11]
2. Provide support to care homes to determine which infection prevention and control (IPC) measures to implement in order to prevent and better control the spread of the virus in these facilities and to improve their organisation in terms of flow and care. As well as provide, if needed, psychological assistance for staff.
3. Hospital support in Flanders (province of Antwerp) and in Mons in Wallonia, upon request by hospitals, and support in setting up certain convalescence centres.

For many years MSF has been managing multidisciplinary aid programmes for vulnerable populations in Belgium, such as asylum seekers and undocumented foreign nationals, in partnership with other organisations. The scale of this epidemic, however, was unprecedented. In the past, the main issue was the lack of access to the social safety net and healthcare for certain groups. This changed with the COVID-19 epidemic.

Given the crisis in care homes, MSF's support to hospitals was gradually replaced with activities to support the elderly in care homes. **The intervention, which was launched in the third week of March, lasted three months. It led to visits by nine MSF mobile teams to 135 care homes across the country, initially in Brussels and then in Flanders and Wallonia (in Wallonia, our approach was focused more on training and supporting partner organisations that were already operating).** This was a new sector for our organisation. It forced us to learn and develop new tools and strategies, and to adapt as much as possible to the reality of the situation and to encourage

8 For more information about COVID-19, please visit: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-coronaviruses

9 Health care considerations for older people during the COVID-19 pandemic. https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-COVID-19/technical-guidance/health-care-considerations-for-older-people-during-COVID-19-pandemic

10 Data from Sciensano, as reported on 26 June 2020. Early in the crisis, Belgium decided to report, in its data for the pandemic, both COVID-19 related deaths recorded in hospitals and those reported in care homes. The latter did not systematically undergo a confirmation test and so were reported as suspected mortality cases, meaning that they were probably linked to COVID-19 but without absolute certainty.

11 This work was conducted in collaboration with the Red Cross, Samusocial, Doctors of the World and the Plateforme citoyenne d'aide aux réfugiés.

others (both within and outside MSF) to reproduce this model or to adapt it to the specific circumstances of care homes.

In May, our interventions in care homes were already decreasing, in keeping with the decrease in the epidemiological curve and according to feedback from the care homes on the need for additional visits. On 15 June, our activities were officially handed over to competent healthcare authorities, except for the mental health component, for which the handover in Flanders was finalised at the end of June.

Although MSF's intervention lasted a short period of time and probably came too late, sharing experiences, data and analyses of our work is part of the transparency and accountability that we owe to our supporters, to our partner stakeholders and, especially, to the care homes themselves.

Having witnessed the stress that care home staff were under and, in some cases, having been their confidants, we believe that it is essential to report the difficulties experienced by care providers and technical staff in order to encourage governmental authorities to rapidly adopt emergency measures and plans in line with the real needs of care homes and to prepare for a new wave of the epidemic.

Intervention context, operational approach and activities

Intervention context

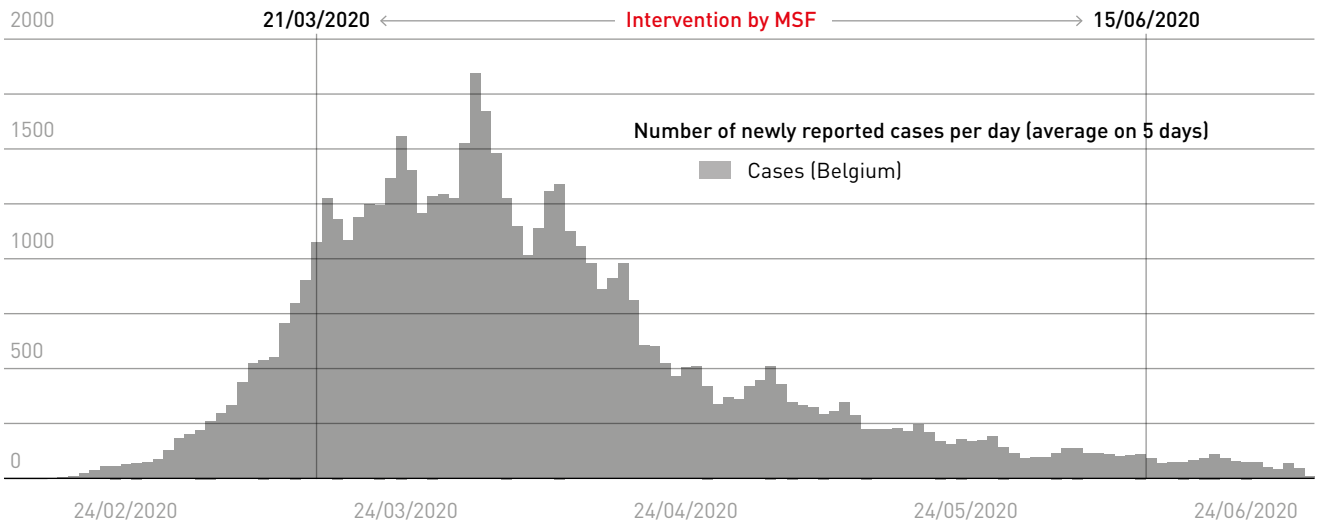
"We redirected calls from MSF reception to certain members of staff to ensure there was always someone available to answer calls. One day, I received a call from a care home director in the Brussels region. In tears, she explained that she was in an impossible situation: there were only four employees left to take care of 70 residents, and she was asking for help. The team went to visit the facility. I still get goose-bumps when I talk about it. It is unthinkable that such a scenario could be possible in our own country." (Human resources manager, MSF)

From the beginning, our intervention in care homes was driven by the fact that elderly populations are particularly vulnerable to COVID-19 due to their weaker immune systems, to the higher mortality rates linked to the new coronavirus, and to the communal environment in which they live. It was also driven by the level of distress expressed by care home staff and families of residents, who felt abandoned by the system at a time when the institutions had been asked to prohibit non-essential visits or excursions (see box 1) and when attention was focused on preventing hospital intensive care units from becoming overwhelmed.

At this time, care homes were ordered to minimise the use of protective equipment, if it was available. Ambulance operators would sometimes refuse lifesaving transfers for certain patients in emergency situations on the instruction of nearby hospitals. GPs would rarely visit a resident's bedside, where previously they would have monitored their condition. There were also instances where Coordinating and Advising Physicians in care homes who were themselves in an at-risk age group could no longer perform their duties and had to be replaced. The number of care providers and technical staff, already precariously low before the crisis due to the widespread lack of investment in the sector[12] fell even further. Combined with the poor quality of pre-existing IPC measures and the lack of screening tests, these factors reduced the ability of care homes to manage the epidemic wave within their walls.

12 KCE, Performance of the Belgian health system – REPORT 2019 (KCE Report 313C Health services research), pp 68–74. https://kce.fgov.be/sites/default/files/atoms/files/KCE_313C_Performance_Belgian_health_system_Report.pdf

Figure 1: Evolution of number of new reported cases in Belgium. (Source: Sciensano. Epidemiological data consulted on 26 June 2020).



Box 1: Key moments of the epidemic in Belgium and of MSF's response

- → **30 January 2020**: The World Health Organization (WHO) declares COVID-19 as a public health emergency of international concern (and a pandemic on 11 March).
- → **4 February**: Beginning of the epidemic in Belgium. First positive case confirmed of the new SARS-Cov-2 coronavirus, an asymptomatic man returning to the country from Hubei province, China.
- → **11 March**: The SPF Santé Publique announces the first death due to infection with the SARS-CoV-2 coronavirus.
- → **11 March (Wallonia and Brussels), 12 March (Flanders)**: Non-essential visits to care homes are forbidden as well as outside excursions by their residents (except in exceptional circumstances). This measure is justified by the need to protect the residents from coronavirus.
- → **12 March**: Faced with the epidemic outbreak, the federal health authorities trigger the crisis plan and transition to federal management of the crisis. As part of this, each region and community adapt their procedures according to decisions made by the National Security Council (CNS).
- → **13 March**: The emergency hospital plan is activated for all hospitals across the country, entailing measures such as cancelling consultations, tests and elective surgery for several weeks.
- → **18 March**: Strict lockdown measures are imposed for the entire population.
- → **21 March**: An MSF team makes its first visit to one of the largest care homes in the capital, alongside a member of the Brussels health authorities.
- → **25 March**: MSF is invited to join the Outbreak Management Group (OMG), an inter-federal platform for managing the epidemic, created following a decision by the Risk Management Group.
- → **4 April**: Walloon health authorities organise a call with all organisations involved, or with the potentially involved to combat the virus in long-term care facilities. Following a similar meeting held in northern Belgium, MSF decides to extend the geographic reach of its intervention in care homes. MSF's first visit to a care home in Flanders takes place on 8 April, alongside the VAZG. In Wallonia, the first visit takes place on 10 April.
- → **8 April**: Flemish health authorities create a task force aimed at preventing the situation from deteriorating further in long-term care facilities.
- → **9 April**: Faced with rising deaths reported in care homes, central health authorities propose a federal COVID-19 screening campaign in these facilities. A first series of tests are provided for testing staff and/or residents (decision on strategy left to the federated authorities) and to evaluate the circulation of the virus in these communities.
- → **14 April**: The Walloon Emergency Health Plan (DISUW) is created by regional authorities in the south of the country to improve health coordination in long-term care facilities in the region.
- → **15 April**: The CNS decides to reauthorize visits to care homes (initially for a designated individual only). The decision is deemed premature at multiple levels, with federated bodies (who had not been consulted), local councils, care homes themselves and MSF speaking out in the press against the decision. MSF flags the risk of undermining progress made in reducing the still-too-high number of deaths in these facilities housing highly vulnerable individuals, where screening of staff and residents has only just begun.
- → **1 June**: MSF publicly voices its continued concerns about the health situation in care homes and their ability to be able to handle a new wave of the epidemic if resources, emergency contingency plans and mental health support are not set up as soon as possible.
- → **15 June**: MSF hands over and ends its activities in care homes. By the end of June, it also hands over psychosocial support activities to partners in Flanders, where it took longer.

Figure 2: Relative proportion of COVID-19 deaths in Belgium among residents in care homes and their place of death (at the care home or in a hospital). (Source: Sciensano. Epidemiological data as reported on 26 June 2020).

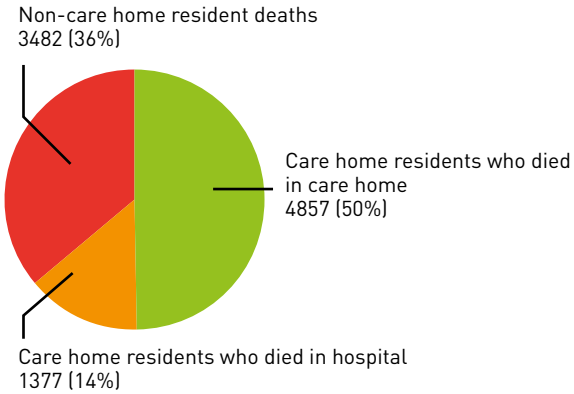
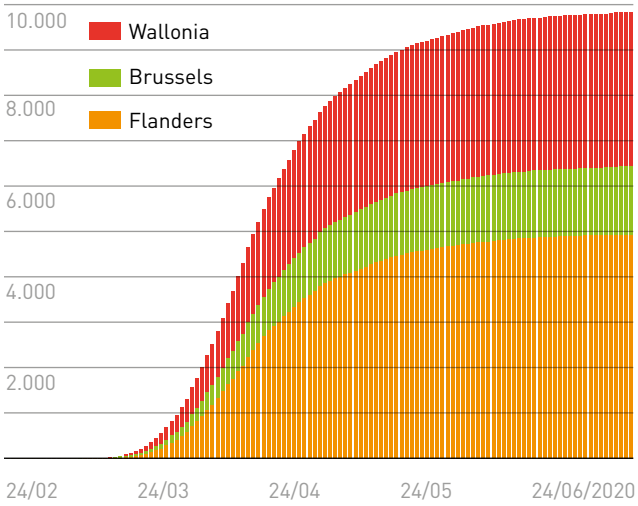


Figure 3: Cumulative number of reported Covid-19 deaths in Belgium. (Source: Sciensano. Epidemiological data as reported on 26 June 2020).



Sharing of technical expertise, adapted to the needs of staff

Due to the extent of the needs, the number of care homes in the country and MSF's capacity, it was clear from our initial discussions with health authorities in various regions that MSF's support would not include medical care for patients, the direct provision of human resources or massive supply of equipment.

It was agreed that our approach would focus on **increasing the response capacity of care home staff by sharing practical and technical expertise that would be adapted to the specific circumstances in facilities and which could be rapidly implemented.**

The intervention model entailed deploying mobile teams: a nurse, a health promotion officer and a psychologist if needed.

Objectives of MSF's intervention in care homes:

1. Assess skills and knowledge of infection prevention and control (IPC), and work to improve practices in this area to reduce coronavirus transmission.
2. Assess and improve the organisation of care in care homes in the areas of screening, cohorting patients and relaxing measures.
3. Provide psychosocial support for care home staff: reduce the intensity and frequency of symptoms; prevent signs of distress from becoming more severe; and improve psychosocial support (including referrals to partner organisations).

Activities:

1. Within care homes: mobile teams, made up of a nurse and a health promotion officer, conduct an assessment and provide advice and training. If necessary, a psychologist joins the team.
2. For care homes and other long-term care facilities that were visited:
- Organisation of webinars, including post-webinar follow up (FAQs, discussions via email and phone).
- Creation and implementation of advice and practical protocols.

3. Regular consultation with governmental agencies and commissions responsible for care homes to identify needs, establish which institutions to visit as a priority, and discuss guidelines and webinars. Regular online meetings with long-term care facilities crisis response coordination bodies at the federal and federated levels.

With respect to the inclusion of mental health activities: Given the needs encountered, it quickly proved necessary for psychologists to set up mental health activities, either individually or in group sessions, depending on the needs.

Given the number of care homes requiring support, mobile teams were also trained in basic psychological care and psycho education on topics such as stress, anxiety and self-care. This approach allowed the assessment visit to include training, information sessions and components relating to the mental health of residents and staff wellbeing. Given the extent of the needs, the teams also turned to external services and referred cases to ensure better and more sustainable support.

Staff capacity building also included the creation of tools, posters, protocols, websites, videos and the organisation of on-site or online training (webinars) adapted to the specific needs of care homes as the epidemic evolved. Subjects covered included:
- Assistance with the rational use of personal protective equipment (PPE) in care homes
- Organisation of testing for SARS-CoV-2, interpretation of the results and strategies to cohort residents according to their status
- Improvements in environmental control (cleaning and disinfection) and hygiene measures, particularly in ancillary services (kitchens and laundry rooms)
- Psychosocial support
- Arrangements for the end of lockdown and the resumption of routine activities.

Some sessions were aimed at staff at a specific care home, other online sessions involved all long-term care facilities in the region. The subjects were discussed beforehand with the partner governmental agencies. Some of their members, along with care home managers, Coordinating Doctors and other experts, including for example AFRAMECO (L'Association Francophone des Médecins Coordinateurs et Conseillers en Maisons de Repos et de Soins – The French-speaking Association of Coordinating and Advising Physicians in Care Homes) were invited to join the panel of webinar contributors in order to establish an information exchange to meet the precise needs of the facilities and thereby create a link.

To ensure the broadest possible dissemination and use of the tools, two websites were also developed, one created by MSF,[13] the other developed in partnership with the Red Cross.[14]

13 https://www.COVID-resources.msf.be/ (Password: COVID19msf).
14 https://COVID19-mr-wzc.be/maison-de-repos.html

Box 2: Sequence of activities carried out in care homes visited by MSF mobile teams:

1. **Assessment**: After making telephone contact with the facility, a mobile team travelled to the site for the initial visit. This meeting usually included a member of management, the medical coordinator and adviser, the care manager and a cleaning manager (depending on their availability). Focused on open discussion, the meeting often provided care home staff with the opportunity to emotionally debrief and vent their frustration over their sense of having been abandoned.

2. **Tour of the building**: A tour of the facility was carried out to understand the operation of the care home and to see what IPC measures were already in place. The goal was to understand the specifics of each site and the difficulties encountered so that the most appropriate recommendations could be made. An assessment tool filled in during and after the visit, which covered various domains of observation, had been prepared by a multidisciplinary team (health promoters, nurses, psychologists) and was gradually improved over time.[15] The objective was to assess the procedures in place and to analyse the need for technical support and staff training in order to best protect care home staff and residents from the virus.

3. **Report and recommendations**: After this initial visit, the team drew up a report based on their observations and recommendations, adapted to each facility and to its actual working conditions. This report was sent by email to the care home and to the government body service in charge of care homes.

4. **Information and question session**: Based on the team's observations and the availability of care home staff, the team organised a second visit to give a presentation. The presentation contained basic information on COVID-19, its transmission and basic precautionary measures, along with sessions on psychosocial aspects (stress management, prevention of burnout, resilience building, etc). The sessions were illustrated with examples observed in the care home in question. The team then answered questions from the care home staff. The presentations were carried out either in group sessions with different profiles, or as a presentation by profession/service/floor.

5. **Follow-up**: The team stayed in contact with the care home to understand how the situation was evolving and to see if there were any other questions or a need for additional visits.

Identification of the facilities and cooperation with the coordinating bodies and partners

The approach used to select which care homes to visit was similar between regions, in as much as MSF coordinated with authorities' long-term care facilities in their jurisdiction and based the selection on a set of jointly established criteria. These criteria included: number of confirmed and suspected cases; number of deaths; level of staff absenteeism; response capacity and managerial presence; and proactive requests for support. The mobile teams also responded, in certain cases, to direct requests from individual care homes.

- **In Brussels**, where activities were initially focused, MSF worked with the Joint Community Commission (Commission communautaire commune – Cocom), services responsible for prevention and hygiene, and facility control and inspection in residential homes,[16] as well as Iriscare.[17] Iriscare oversaw the selection of care homes authorised to receive MSF support.
- **In Flanders**, MSF worked with the Outbreak Support Team and the Infectious disease control and prevention service of the Agency for Care and Health (Vlaams Agentschap Zorg en Gezondheid – VAZG)[18], to draw up a list of priorities based on reported cases and pre-COVID-19 information on the capacity of the various care homes to manage such a situation.
- **In Wallonia**, MSF worked with the regional health and care agency (Agence wallonne pour une vie de qualité (AViQ))[19] and the community-level Federation of "medical houses", Fédération des maisons médicales – (FMM), which received requests for support directly from care homes and responded according to a defined strategy and organisational structure, where the response included the MSF teams.

At federal and federated level, **participation in the various meetings of the coordinating bodies was an integral part of MSF's care home-related activities.** These made it possible to increase our access to the facilities, share information on our practical experience

Federated level: On occasion, the various government bodies responsible for care homes had structured their partners into coordinated crisis management systems, such as the Walloon emergency healthcare system (Dispositif Sanitaire d'Urgence Wallon – DISUW) in Wallonia. The frequency of meetings and the level of cooperation varied greatly between regions, Brussels being the region where demand and intervention were greater and more consistent.

Federal level: MSF was invited to join the Outbreak Management Group (OMG), created on 20 March following a decision by the Risk Management Group concerning the COVID-19 situation in long-term care facilities. This group, coordinated by members of the Federal Public Health Service (SPF Santé publique), included representatives from the different federated

15 Initially, the assessment primarily focused on IPC measures and standard precautions concerning healthcare as well as cleaning and disinfection. Ancillary services (kitchen, laundry, waste management) were later included, followed by information concerning communication, health promotion, psychosocial wellbeing and medical care. This assessment tool and the 11 domains assessed is covered in the part on main needs observed and assessed.

16 For more information on Cocom, see their website: https://www.ccc-ggc.brussels/fr

17 For more information on Iriscare, see their website: https://www.iriscare.brussels/fr/

18 For more information on VAZG, see their website: https://www.zorg-en-gezondheid.be/

19 For more information on AViQ, see their website: https://www.aviq.be/

bodies, the Federal Public Health Service's Directorate-General for Healthcare (Direction générale des soins de santé – DGGS), MSF and Sciensano (National Public Health Institute). The Belgian Ministry of Defence and Fedasil (the federal agency that manages asylum seekers) joined the group when necessary. The goal of these meetings (three times per week to start with, now weekly) is to monitor the development of the COVID-19 epidemic in long-term care facilities, to identify specific support needs, to standardise procedures for managing outbreaks and for the analysis of epidemiological data, and to create a platform for sharing best practice and for potential support from the federal level.

A point on testing

Testing is essential because it helps to manage the risk of infection and limit transmission, in other words to control the epidemic and reduce the number of new cases, especially if it is used in a targeted manner (particularly the most vulnerable people and front-line workers). On 9 April, the Belgian federal government launched a testing campaign targeted at care homes, although initially with a limited number of tests and with a rather vague strategy that did not correspond with the facilities' actual situation or capacities. Under this strategy, 12 care homes were selected in the Brussels region. Iriscare asked for support from MSF in the four care homes that requested it. Teams from the FMM and Médecins du Peuple were also trained by MSF. The intervention was short and targeted for our teams, who thought that other medical resources could manage this testing. However, we thought it important to provide support via practical and safe guidance in the collection of swabs in the initial phase, and the theme of testing was included in the developed teaching support tools and made more widely available.

Box 3: Regional variations in intervention

Brussels

On 21 March 2020, an MSF team carried out its first visit in one of the biggest care homes in the capital, together with the doctor in charge of the Cocom's hygiene and prevention service.[20] In total, **out of 138 care homes in the Brussels region, 121 were contacted by a support team and 86 were visited by a mobile team (with 81 of those visits involving MSF's teams).**

The entire package of activities was provided, **even though the focus in this region was more on visits rather than webinars**, due to the geographical proximity of the facilities. In addition, in four of the 12 pilot care homes, we helped implement the federal COVID-19 testing campaign and assisted with the set-up of cohorting in the supported care homes in general.[21]

As this was the first intervention zone, the visits by MSF's mobile teams in the capital revealed the considerable mental health needs of care home staff. Few facilities had a psychologist on site, and the after-work telephone and online support offered by mental health associations was not successful due to staff fatigue. The mobile teams therefore set up preventive and proactive measures.

Following discussions with the FMM and the Red Cross, a partnership to increase the number of mobile teams available was put in place. Between mid-April and mid-May, two teams from each organisation respectively were trained by MSF via joint visits and webinars.

Following that, six people from the Cocom (three from the prevention and hygiene service and three from the control and inspection service) attended training enabling the coordination and support of teams deployed in the event of a new peak in the epidemic. Since May, this commission has centralised and overseen mental health support requests by, dispatching them to mental health services in the region.

20 The Joint Community Commission (Commission communautaire commune – Cocom) essentially manages personal matters in the bilingual territory of Brussels Capital, including personal assistance and health. The services in charge of hygiene and prevention in long term care facilities, as well as their control and certification, were the partner services introduced to the work of the mobile teams.

21 We helped the facilities prepare concrete measures to group or isolate patients according to their COVID-19 status in a safe and realistic way.

Flanders

On 4 April, the decision was made to respond in Flanders following meetings the previous day with the VAZG and following several alerts received from care home directors, Coordinating and Advising Physicians and even IPC nurses at hospitals in the region who were being submerged by calls from care homes. The idea was to support the VAZG's Outbreak Support Teams at the most affected sites in the provinces of Antwerp, Limburg and Flemish Brabant.

Three MSF teams were set up. The first visit to a care home was made jointly on 8 April. **In total, MSF's mobile teams visited 21 care homes, making a total of 46 visits (including six with the OST team). We also visited two centres for people with disabilities and a youth detention centre.** The package of activities was similar to that provided in the Brussels region.

The bi-weekly meetings with the VAZG made it possible to identify needs, prioritise the care homes to visit, and discuss protocols and the content and configuration of the webinars. Our key contacts were the VAZG 'field' teams. However, the chance to interact with higher ranks of the agency was limited, as was contact with the COVID-19 crisis group for long-term care facilities set up on 8 April by regional health authorities.[22]

MSF's mobile teams delivered mental health 'first aid' and psycho-educational training in most of care homes visited; nine of the people trained held management positions.

From the outset, it was agreed that MSF would train and support the VAZG mobile teams for response purposes during the crisis and to ensure continuity in the long term. At the end of April, we communicated the needs that we were seeing in view of the support required in care homes. The summary document included the objectives, activities and required job profiles. It was only on 12 June, however, that we obtained confirmation that the 15 mobile teams requested would be operational in long-term care facilities in Flanders (including care homes) possibly from July. Follow-up has since been handed over to the Infection Prevention Service, responsible for coordinating the mobile teams. Psychosocial support for care home staff has been provided since mid-June by the Mental Health Centres (Centra voor geestelijke gezondheidszorg – CGG).

Wallonia

MSF's decision to provide support to care homes in Wallonia was made on 4 April. The Brussels package of activities was replicated, but with a focus on broader training and support of the mobile teams of other organisations – primarily the FMM, the Red Cross, and the teams of the AViQ. This was carried out as part of the DISUW, set up by regional authorities on 14 April.

Eighty per cent of MSF's visits to care homes were carried out as part of support provided to a partner. In total, 27 partner teams were trained to carry out the initial visits to care homes. This approach not only made it possible to increase the number of facilities that could receive on-site support, but it also ensured some continuity of the model after MSF's intervention, as well as encouraging local support networks.

From 10 April to 12 June, MSF mobile teams participated in 50% of the initial visits carried out, covering 33 care homes and 10 long-term care facilities for people with disabilities. In total, 85 homes (out of a total of 109 contacted) received at least one visit from a mobile team that was part of the DISUW, including 62 care homes and 23 long-term care facilities for people with disabilities. It should be noted that two care homes required closer monitoring with several visits, including support from a multidisciplinary hospital team (comprising a psychiatrist, an infectious diseases specialist and an IPC nurse) for one of them, which proved very useful.

Most of the visits took place in the province of Liège (40 visits) where coaching for the FMM mobile teams started earlier, followed by Hainaut (29 visits), Namur (24 visits), Walloon Brabant (11 visits) and Luxembourg (1 visit). For the facilities that were not visited, a distance learning and experience sharing component was added.

To facilitate visits by the teams of the partner organisations, standard operating procedures concerning the different stages of support were developed, as well as various tools and webinars. In addition, this material (protocols, posters, videos) was shared with other organisations via online platforms. At the end of the intervention, a final webinar was organised for members of the AViQ, given their role as focal points and in case of future needs (with the support of the Red Cross). The Walloon Ministry of Health has also secured one year of funding for 48 psychologists who will strengthen psychiatric home care services to support staff and residents of care homes, amongst others.

22 Task Force created by the Belgian Department of Wellbeing, Public Health and Family.

Main needs identified in care homes

Sources

The following observations are based on a combination of various analyses and sources, including:

- **Analysis of the assessment tool (see *box 4*)** developed by MSF during its interventions in care homes, which includes data from 121 establishments visited (15 in Flanders, 78 in Brussels and 28 in Wallonia).[23] This tool was used by the teams during their first visits to facilities. It was intended to provide a 'snapshot' of the situation at the establishment, complementing the qualitative information gathered during discussions with key members of the management team. By combining this information, they were better able to guide the recommendations made to the care homes.
- **Qualitative information** gathered during these visits and during discussions with care home staff.
- **An analysis of the follow-up calls** concerning the support provided by MSF, as well as the situation in terms of implementation of suggested recommendations and outstanding needs.
- **The results of a questionnaire sent to all care homes in the country at the end of May 2020**, mainly focusing on mental health but also including information on staff attendance; internal and external referral capacities before and during the crisis; new psychological symptoms affecting staff and residents; and priority needs for future support (excluding MSF). A total of 983 establishments responded to this questionnaire, though it is important to note that 88% of these were in Flanders (with 5% in Brussels and 7% in Wallonia).

Note to readers: *It is important to note that the qualitative and quantitative data which the presented observations are based are limited in time, type of criteria assessed, and proportionality of our interventions, which were more significant in Brussels than in the rest of the country. Moreover, the responses to our nationwide questionnaire came mostly from care homes in Flanders. Nevertheless, despite these limitations, these indicators make it possible to extract certain key trends, paving the way to better policies to meet the needs of care homes as they emerge from the first wave of the crisis and to prepare for a new wave.*

Care home capacities

Total scores (the combination of scores in the 11 domains assessed by the assessment tool) were calculated and compared between regions of the country. **The results show that there is not much difference between regions in terms of average scores in these domains (see *figure 4*), indicating that care homes across the country had a similar level of preparedness and response capacity to the crisis.**

However, a significant number of care homes (one out of six) failed to reach 50% across all measured domains, **indicating a particularly critical situation for some of them**. This trend was more prevalent in the north of the country (where 27% of care homes did not reach this threshold, compared to 18% in Brussels and 7% in Wallonia).

In the care homes visited in the three regions, mental health was the worst-off category, with an average score of only 50% (worse than the categories related to IPC, which were the main targets of the assessment due to the known problems in this domain). The **lack of available visual materials** such as health and hygiene promotion posters, as well as **problems with laundry and waste management**, were also among the weakest areas in care homes, as shown in ***figure 5***.

> *'In one of the care homes, we found a man who was dying on his own, without care and without even a single personal belonging around him, because he had been moved into a different room from his usual one. There were faeces in the hallway and there was no food in the fridges. A crisis meeting with the relevant parties and authorities took place the next day.' (MSF Medical Coordinator).*

23 Not all the supported care homes were included in the analysis, as the tool was gradually developed and completed according to the situations encountered. Whenever it was possible to code data retrospectively, this was done.

Figure 4: Results of MSF assessment tools during visits to care homes. Total median scores in 11 domains by region [median and interquartile range (IQR)].

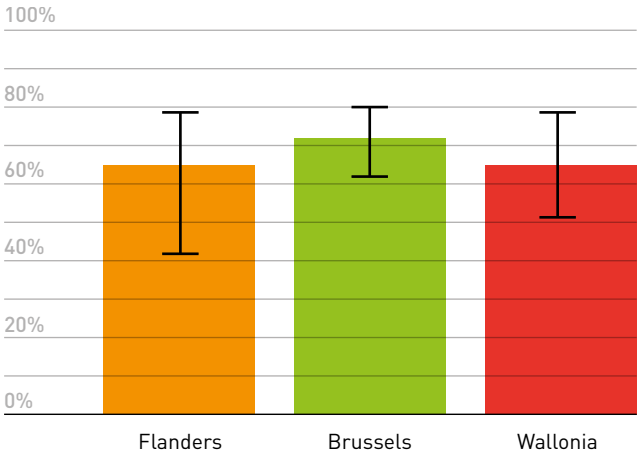
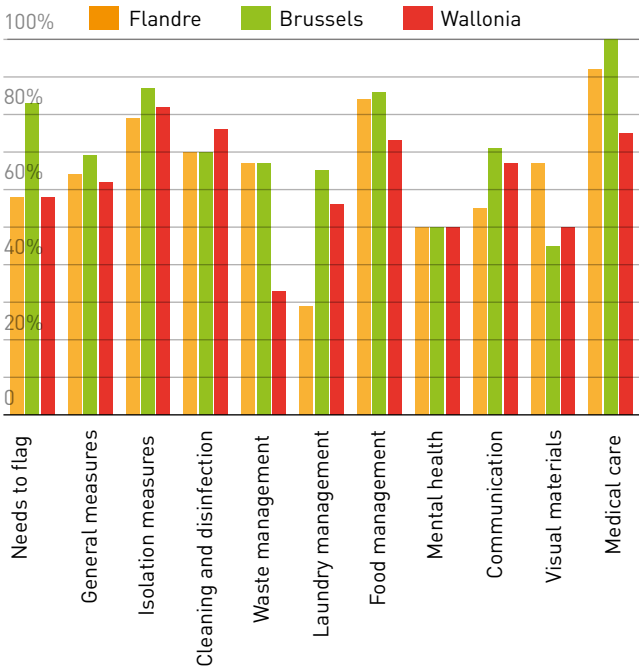


Figure 5: Results of the MSF assessment tool during visits to care homes. Median sub-scores for the 11 domains assessed by region.



Box 4: The 11 key domains covered by the mobile teams' assessment tool:

1. **Needs to be flagged to the relevant authorities** such as the existence of a crisis cell, medical and non-medical staff, test, availability of masks, cleaning products and disinfectant, body bags, etc.

2. **General measures** (implementation of precautionary measures, respect for social distancing, cohorting of existing confirmed patients, visiting procedures, etc.).

3. **Measures for the care of residents placed in isolation** (specifically-allocated medical staff, clear recommendations for PPE, identified areas for dressing and undressing, access to masks, gloves, etc.).

4. **Cleaning and disinfection** (use of disinfectant that is effective against the virus, contact points cleaned or not, clear recommendations available, etc.).

5. **Waste management** (existence of clear cycle, pedal bins, protection of responsible staff, etc.).

6. **Laundry management** (availability of guidance for families, clear cycle, protection of staff, etc.).

7. **Food management** (cycle, meals preferably served in rooms, procedures for clearing, COVID-19 rooms served last, etc.).

8. **Mental health** (detection of signs of emotional and psychological reaction among staff and residents, available support, ability to refer serious cases, etc.).

9. **Communication/information flow** (available resources, difficulties encountered, level of knowledge, need for training and tools, etc.).

10. **Availability of posters and signs in key locations** (information on COVID-19, social distancing, hand hygiene, PPE recommendations, etc.).

11. **Medical observation of residents** (availability of clear therapeutic plans, palliative care, tools for detecting signs of deterioration, calls to 112 having been answered, etc.).

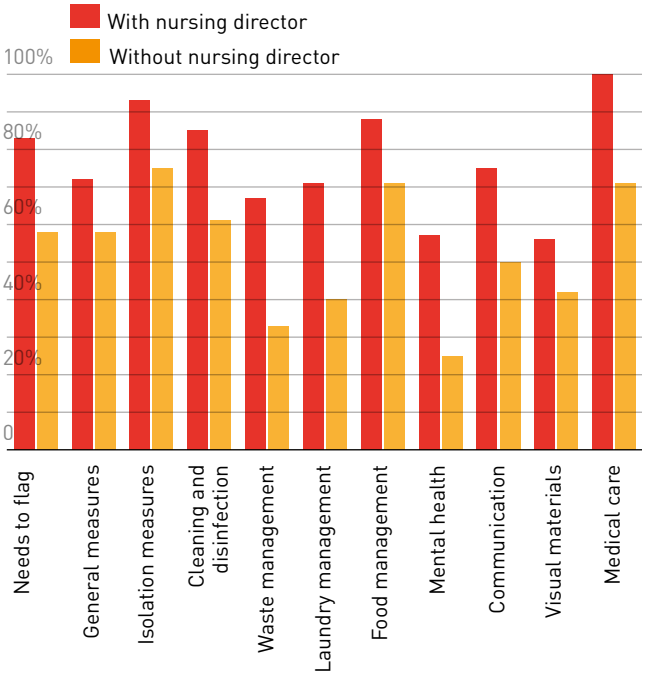
In all three regions, **the presence of a nursing director had a significant positive effect** on the ability of care homes to cope with COVID-19, across all the domains assessed. The **presence of a crisis cell** in the care home was also beneficial, although to a lesser extent, as shown in ***figures 6 and 7***. Efforts to strengthen these domains are to be encouraged as, at the time of the assessments, only 72% of care homes had a nursing director and only 59% had a crisis cell.

The status of the care homes, i.e. whether private, public or non-profit, **did not play a role** in the response capacity of the facilities visited**. In contrast, belonging to group** whether a private commercial group or a public network helped overall, albeit marginally.

It should also be noted that the analysis shows that **care homes that had no cases of COVID-19 were not necessarily better prepared or more responsive** to the epidemic (median score of 76% versus 71%). This suggests that they may simply have been fortunate enough not to have had any cases at the time of the assessment, or conversely that the affected care homes had already begun to invest more in improving their situation, positively impacting their outcomes.

Difficulties in assessing and calculating the quantities of equipment and reserve stocks needed often compounded existing weaknesses, particularly for emergency orders from health authorities (when equipment was available). Faced with the lack of support, some better resourced care homes resorted to alternative solutions, placing direct orders online, but sometimes with doubts about the quality of the equipment provided.

Figure 6: Results of the analysis of the MSF assessment tools during visits to care homes: comparison according to presence of nursing director. Median sub-scores for the 11 domains assessed.



It should be noted that the impact of the COVID-19 crisis on the financial capacity of care homes is a matter of growing concern for many managing bodies, especially in smaller establishments. Significant expenses were outlaid during the crisis, while occupancy rates fell because of deaths among residents. Most of the care homes we visited had vacant rooms, which, in terms of organisation of care and IPC, made it possible to cohort residents in some cases, but economic viability post-crisis and the potential need to keep some rooms vacant in case of a new wave is causing concern in care homes.

Box 5: Three phases of the epidemic, with different needs

'First phase': During the first phase of MSF's intervention in the country, when the number of cases was still increasing in an exponential way, we could observe that the main concerns were supply shortages, human resources, the absence of clear guidance on use of PPE, as well as fear of saturation of ICU beds in hospitals.

'Plateau phase': During the plateau phase, when testing capacity was increased and people started to have experience of COVID-19, concerns arose about how to make the best use of tests and what to do with tests results. At this point, some care homes started zoning patients based on test results. MSF's mobile teams had already been working in care homes for two weeks by then and were able to provide advice and guidance regarding the reorganisation of care. Management teams felt the need to share their experience of the first phase and to seek reassurance about the decisions they had taken and the measures they had put in place. Mental health support for staff was identified as a main priority and concerns grew about the mental health of residents.

'Deconfinement': Finally, with the ease of lockdown measures, new concerns arose, such as the restarting of non-COVID medical activities in care homes and how to increase contact with the outside world (family visits, external professionals) and within the care home itself (activities for residents), increasing the risk of cross-contamination.

Human resources

> *"People would clap for hospital staff, but care home staff, who were also on the frontline, were left behind. Worse, they were stigmatised." (MSF coordinator).*

A shortage of HR to deal with the crisis

Even though care home staff were on the frontline in the fight against the pandemic, they received little recognition. Key human resources issues included:

- **High rate of absenteeism** (see ***Figure 8***), due to fear or sick leave, exacerbating an already fragile situation in terms of pre-crisis HR levels.
- **Existing lack of resources** in the sector, with a direct impact on the working environment of staff and the degree of professional strain, both physical and mental.
- **A lack of investment** in staff expertise and capacity building (particularly in IPC), with an almost total absence of continuous training, even though a large proportion of care home staff are not nurses but nursing assistants.
- **A lack of understanding of roles** among staff and few staff meetings.
- **A marked reduction in the number of visits by GPs** and in some cases by Coordinating and Advising Physicians, making the task of staff more difficult. Sometimes a nurse had to make decisions about a patient in place of a doctor.
- **Technical staff** (cleaning, kitchen staff, etc.) **overlooked** in health recommendations and protocols, tools and information sessions, despite their essential role and the risks involved (not forgetting volunteers, when they were allowed).

Pressure and tensions among staff

- **Staff feeling guilty** for failing to meet the challenges and for possibly infecting residents, at the same time as **facing stigma** from the surrounding community and in the media. Some reported being accused of incompetence, of killing old people and of spreading the virus through their neighbourhood. Some staff also spoke of their frustration at not being able to provide the necessary psychological support to residents. Staff also faced considerable **pressure from families of residents**.
- **Unease among staff who were absent at the height of the crisis**, who feel less prepared and less informed in the event of a new wave of infections. They sometimes face disapproval from colleagues who 'stayed on the frontline' through the crisis, leading to tensions.
- **A sense of being abandoned** by the outside world and by the authorities, despite having worked tirelessly throughout the epidemic. One MSF mobile team member reported:

> *"One nurse had lost both her father and her grandfather to COVID-19 over a period of barely two weeks. She tried to visit them in hospital but was refused access to their bedsides. Despite her losses and her grief, she continued to come to work."*

- The **lack of psychosocial support**, whether preventive or palliative, has greatly affected staff. There is a very real danger of burn-out and post-traumatic syndromes in the coming weeks and months, which can already be observed. The psychological impact of the crisis on care home staff and residents is addressed in the section on mental health.

Figure 7: Results of the analysis of the MSF assessment tools during visits to care homes: comparison according to presence of crisis cell. Median sub-scores for the 11 domains assessed.

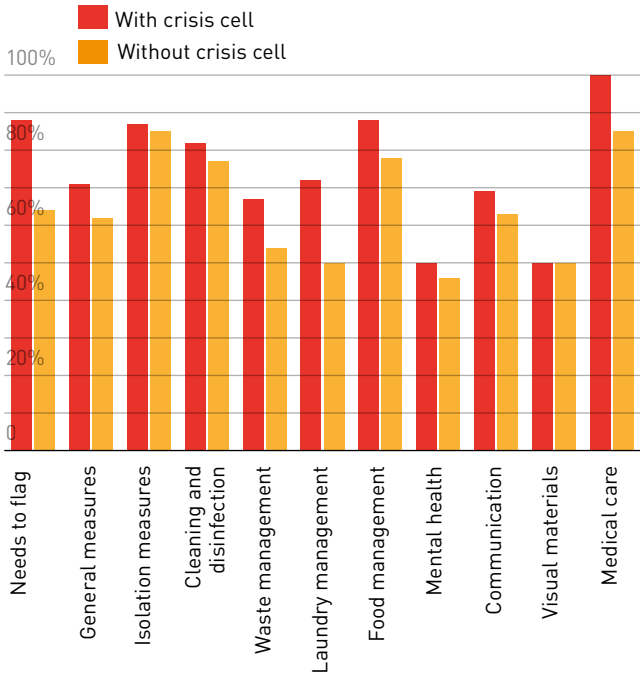
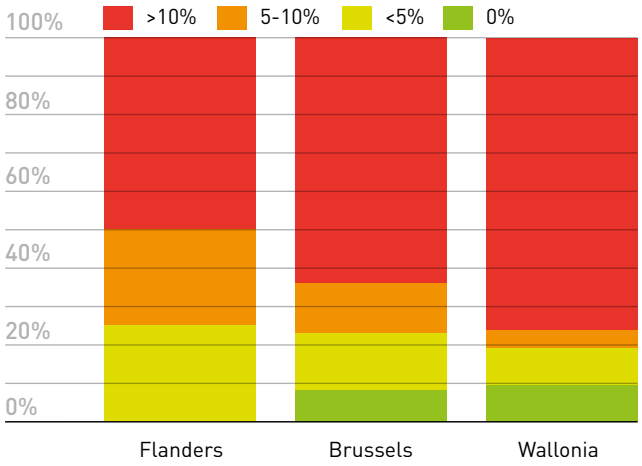


Figure 8: Rate of absenteeism among staff reported by care homes visited by MSF mobile teams and degree of severity (0%; 0-5%; 5-10%; more than 10%)



Infection prevention and control (IPC)

According to the care homes responding to the questionnaire, only 36% of them were not affected by the virus, while in 34% of them, more than 10% of residents were infected, indicating that **most care homes for the elderly were directly affected by COVID-19**. Once introduced, the virus spread like wildfire, largely due to inadequate or non-existent IPC measures.

Our teams initially wondered whether, in a country like Belgium, they would need to include basic hygiene training in their support. It soon proved to be necessary. The situation that we encountered in the care homes we visited revealed accumulated shortcomings and needs in this domain, often pre-existing, but exacerbated once the virus entered the facilities. During the crisis, attention had to be mainly focused on infection control rather than on prevention, with the results that we know today, in some cases even leading to two simultaneous viral epidemics (the novel coronavirus and norovirus in particular).

The main needs in terms of IPC can be summarised as follows:

- **Shortage of personal protective equipment (PPE)**, leaving some members of staff (especially, but not only, those who did not come into direct contact with patients) without adequate or even any protection for weeks. Data from our assessment tools show that **only 64% of the care homes visited had sufficient FFP2 masks. There were enough protective gowns in just 54% of cases, and among laundry staff, only 42% had access to suitable PPE.**

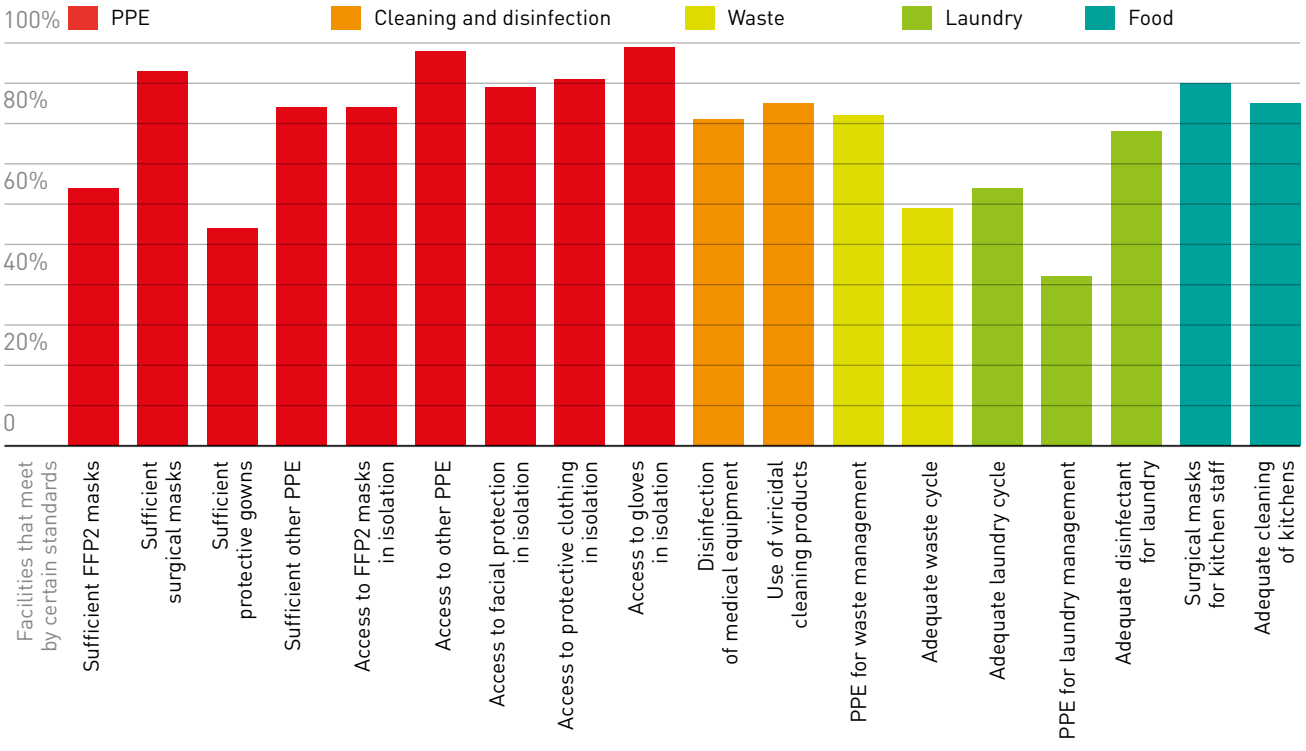
The blatant difference between the situation in care homes and the provision of protective equipment to external frontline staff was difficult for care home staff to bear. The coordinator of MSF's intervention in the Brussels region reports:

> *"One of the worst affected care homes that we visited told us that they found themselves without any protective equipment whatsoever, while a team of ambulance drivers dressed as 'astronauts' took about 30 minutes to disinfect their ambulance in front of the door. This discrepancy in available equipment only highlighted their feeling of being left behind in the emergency response."*

- **Environmental control practices (such as cleaning and disinfection) were not adapted** to a crisis situation with viral transmission, and there was insufficient knowledge about what to do, for example:
  - **Fifteen per cent** of care homes visited had no **virucidal products**.
  - **Disinfection of medical equipment was unsuitable in 19% of cases.**
  - In terms of laundry, **only 64% of care homes visited had separate circuits for dirty and clean linen. In kitchens, only 59% had an appropriate waste management system.** Basic guidance for managing these ancillary services was needed.

- **In terms of information:**
  - **Only 53% of care homes assessed felt that their staff were sufficiently informed about coronavirus**, not to mention external personnel such as temporary staff, cleaning companies or volunteers, who were not always adequately

Figure 9: Results of the analysis of the MSF assessment tools during visits to care homes. Proportion of facilities attaining minimum standards in the selected indicators.



briefed. This came on top of a low basic starting point, but also a lack of compliance with standard precautions, even by some GPs and Coordinating Physicians (while hospitals benefit from experts in the field, audits and continuous training).

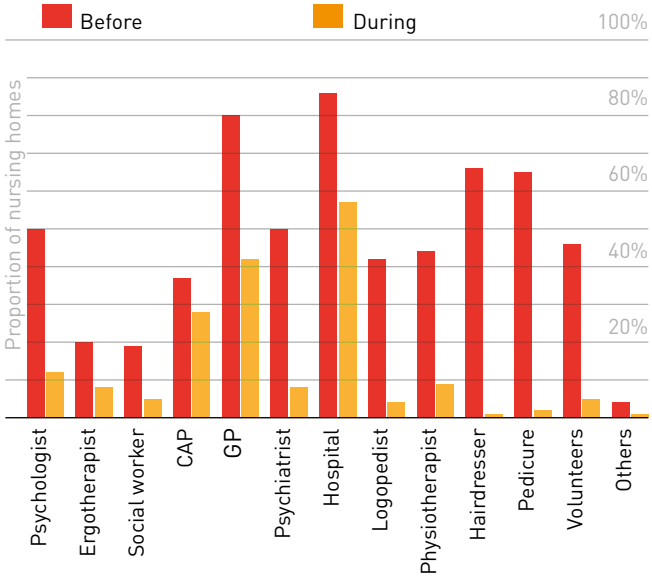
- The recommendations and guidelines lacked clarity and were often not adapted to the reality in care homes, leading to difficulties (and lack of space) in cohorting patients according to their COVID-19 status, and in ensuring more appropriate treatment cycles for infected laundry, waste and medical equipment.

A health promotion officer explains:

> *"Infection prevention and control measures were so erratic in some care homes that, during visits, health workers were seen wearing bin liners as protective aprons, or they were seen dressed in full protective gear but moving from room to room without disinfection, spreading the virus from one room to another. In some places, the floor was so chlorinated that our shoes stuck to the floor, not to mention the toxic fumes that this concentration produced. It was clear that basic hygiene measures were already very weak before the crisis. One day, our team found itself face to face with a rat in a care home kitchen."*

Combined with the lack of systematic testing of staff and residents (at least until mid-April), these failures resulted in an increase in nosocomial infection rates within care homes and had an unprecedented impact on the health – and lives – of residents, staff and their families.

Figure 10: Results of the analysis of the MSF questionnaire sent to care homes nationwide. Comparison before and during the COVID-19 crisis of the possibility for care homes to refer patients to an external service or for visits by external services to the care home.



Organisation of care and medical treatment of residents

According to the nationwide questionnaire sent to care homes, **GP visits were down by half** during the crisis compared to before the crisis (see ***figure 10***). Lack of protective equipment, fear of the virus on the part of both GPs and care home managers, and the obstacle of their own age in some cases, all contributed to this situation, which had a major impact on the medical care provided to residents.

Coordinating and Advising Physicians– when still available and present – often ended up **taking decisions on behalf of patients they did not generally care for, complicating the quality of medical care for residents, the definition and clarity of treatments to be followed, and even decisions about whether a patient should be referred to external services**.

The overall picture was **completed by the shortages of almost everything** (protective equipment, tests, clear guidelines and recommendations), by **staff who were overworked and insufficient in numbers, by sub-optimal hygiene and disinfection measures, and by a living environment inappropriate for a medical response of this magnitude**. The result: **only 68% of care homes visited by MSF teams were testing patients, only 78% of facilities placed suspected cases in single rooms, and isolation or cohorting of confirmed COVID-19 positive cases took place in only 6 care homes out of 10.**

Regarding referrals of patients to external support services coming to the care home, ***figure 10*** shows a **clear drop in these capacities compared to the pre-crisis period, with a decline in the referral of serious cases to hospital, from 86% to 57%.**

Only just over 70% of care homes visited by our teams reported that all their calls to emergency services (112) received a positive response. The criteria invoked by these services for accepting or refusing to transfer a patient were often unclear. Some residents in an emergency (who wanted to be referred) were not transferred, while others were. Some care home managers reported being told by ambulance crews arriving at the door:

> *"Do you have oxygen? If you do, we won't take the resident. And give them more morphine."*

In other cases, paramedics had been instructed by their referral hospital not to take patients over a certain age, often 75 but sometimes as low as 65.

This situation was denounced by MSF during a media briefing in mid-April, indicating that:

> *"[...] the measures taken in the first phase to protect hospital capacity may have been sensible, but that it was time to adjust the strategy." (Doctor in charge of MSF's response).*

Finally, it should be noted that the **lack of therapeutic plans (systematically present in only 71% of cases) and end-of-life agreements (present in 70% of cases) greatly complicated the management of serious cases**, creating undesirable situations in a time of crisis.

Mental health

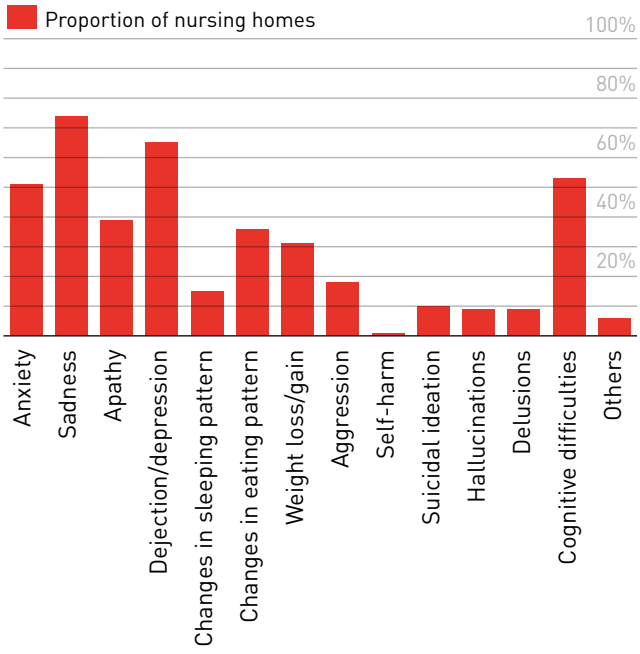
The emotional and psychological symptoms observed in care home staff and residents during the COVID-19 crisis are indicative of the toll it has exacted on people's mental health in general. This is particularly true in the case of elderly people living in a closed environment, who are isolated or suffering from cognitive decline, as they can become increasingly angry, stressed, agitated, withdrawn or overly suspicious.

Among care home staff, feelings of helplessness, despair, anxiety, panic, sadness, guilt and anger were the most common crisis-related symptoms observed by our psychologists.

> *"During a group session, the occupational therapist left the room in tears. One resident who she was very close to who was acquainted to her children, had died alone without being able to say goodbye to her. Worse still, she felt incredibly guilty that, because of the lack of resources, she might have been the source of some of the infections." (MSF psychologist)*

Among residents, nine out of ten care homes responding to the questionnaire reported exacerbated or new psychological symptoms, with sadness, depression and deterioration of cognitive abilities at the top of the list. About 10% of care homes reported an **increase in suicidal thoughts** among their residents, as well as the idea of resorting to euthanasia (included in the 'Other' category in ***figure 11***), confirming the **increase in "failure to thrive syndrome"** (or losing the will to live) seen in the care homes visited by our mobile teams.

Figure 11: Results of the analysis of the MSF to questionnaire of care homes (nationwide questionnaire). Proportion of care homes reporting an increase in psychological symptoms among residents, as observed during the COVID-19 crisis.



The greatest needs expressed by residents during the crisis were for contact with their families, visits, walks in the open air, physical contact and contact with other residents, according to the care homes that contributed to the national questionnaire.

These acute mental health issues affecting care home staff and residents were initially overshadowed by the crisis response, but are now priority areas to be strengthened, and should be recognised as such by managers of care homes and by Belgian health authorities at both federal and federated levels. Actions must follow words if these needs are to be addressed in the short and medium term.

> *"At one point, there was no space for reflection on psychosocial problems, but now we see that there is a real need." (Comment from a senior nurse in response to the nationwide questionnaire).*

Communication and Information flow:

As shown in ***figure 5***, the **lack of available visual materials (such as health and hygiene promotion posters) was one of the most common gap encountered** in care homes visited by MSF mobile teams, thereby impacting staff knowledge about COVID-19 and infection risks. **Communication and information sharing with staff, residents, families, also had shortcomings.**

Difficulties in communication were exacerbated by the **multiplicity of recommendations, protocols and guidelines** issued by health authorities as well as alternative sources such as medical associations, care home umbrella groups, the media. They also lacked **clarity and the practical implementation advices and were not matching the reality in care homes**. This resulted in weakened information flow and had a knock-on effect on the care homes ability to control the situation, thereby impacting the reputation of facilities and their staff.

A striking example of the gap between what was advocated and the reality in care homes was undoubtedly the mid-April decision by the CNS to allow the resumption of visits to care homes (for a specifically designated person). This decision was immediately condemned by federated and communal authorities, as well as by MSF, which warned of the risks of a decision that was premature in view of the continued transmission and excessive mortality rates in care homes.

The mismatch between the guidelines, expectations and capacities of care homes also resulted in confusion and increased stress for staff, as well as for residents and their families:

- The rational use of protective equipment was compulsory from the beginning of March. This required staff to use certain items of protective equipment repeatedly. However, this was not always feasible in terms of washing capacity or space in the corridors for repeatedly dressing and undressing.
- Cohorting not only requires a complete adaptation and reorganisation of the premises, it also requires space, since it involves grouping residents according to their status

(negative, suspect or confirmed COVID). This was often not feasible. It also had an impact on the mental health of some residents who found themselves forced to move from a room where they had lived for years.
- Staff members did not always know which measures to take due to the lack of clarity and constant changes in recommendations.

> *"Sometimes, even before the crisis, they didn't know when they were supposed to wear gloves. In other cases, they were wearing two pairs on top of each other. Another example: some care homes that mainly housed people with dementia were being told to keep residents confined in their rooms, which was just impossible." (MSF medical officer)*

- Some care home groups told their members not to hire any temporary staff, even though there was no such instruction from the government. This caused major problems for some care homes.
- In another example, some families of care home residents received a message from the management that all was well, soon after the death of their relative within that same care home.

The information collected and transmitted for the epidemiological surveillance of COVID-19 in Belgium was also problematic:
- Despite efforts to align data collection during the crisis, the **multiplication of data collection systems** had an impact on monitoring effectiveness and on consistency between the federated entities. The Walloon and Flemish regions had their own collection system and had to subsequently encode their results in the federal-level Sciensano system, while care homes in Brussels and the German-speaking community encoded their data directly into the central system (LimeSurvey).
- **Care homes came under pressure to provide data** for these collection systems, but the **information required was not always clear** to care home managers. Moreover, **some did not systematically fill in the data forms**, thus affecting the quality of warning systems which were intended to determine care home needs and urgency levels.
- Because of the initial confidentiality of epidemiological surveillance reports, care homes were not able to understand what was being done with their data, nor to gauge the seriousness of their situation and where they stood in the epidemic picture. Some care home managers told us that they felt that this pressure, and the **lack of transparency**, was more for the purposes of monitoring and identifying epidemic outbreaks to prepare hospitals for an influx of patients, rather than to assess the seriousness of care home needs and to decide on the support required and the operational strategy to adopt.
- The reporting of the analysis of the epidemiological data was initially unsuitable for gaining an understanding of the situation in care homes.

Main needs requiring support according to care homes

In the nationwide questionnaire, the most frequent responses from care homes regrading types of additional support needed to better accommodate their residents:

- **Psychosocial training and staff support ("care for care providers")**
- **The adequate provision of medical staff**
- **Psychosocial support for residents by an in-house psychologist and increased opportunities to refer patients to external services.**

The need for religious support and greater access to residents' families in cases of emergency were also noted in the comments, as was the need for training for care home managers.

MSF intervention: lessons learned and feedback from care homes

The question was raised within MSF as to whether there was genuinely any added value in launching an emergency intervention for an extremely short period in a context such as Belgium, solely through the provision of technical expertise and in facilities with which we were not familiar. Looking back at the crisis and our response, there is no doubt as to its value.

For care homes: external, tailored and neutral support of MSF's mobile teams was appreciated. Initially, some care homes were apprehensive of MSF teams assuming that their role would be to inspect and control facilities, without providing support or solution for problems. On many occasion, we surprised by the gratitude expressed by our interlocuters for the **concrete guidance but also the opportunities for positive discussion and a listening ear in the face of difficult choices and sense of abandonment.**

Also mentioned as positive elements of the support were the capacity of MSF's mobile teams to provide **practical recommendations and respond to 'burning issues' while considering the specific requirements and limitations of each care home; and the teams' capacity to take positions and decisions despite scientific uncertainty about certain issues** (while being transparent about this uncertainty). Overall, **the advice given during the visit was better retained and implemented to a large extent**.

The support of an expert hospital team from the local area (in hygiene, infectiology, psychiatry or geriatrics), which happened in several instances, highlighted the **importance of having a local network involving hospitals and care homes**, even outside formal agreements between them.

The analysis of the visits and of the follow-up calls from care homes also indicates that **most of the post-visit recommendations were implemented.** In the cases where they were not implemented, this was mainly due to a lack of time or resources or due to their incompatibility with the reality in the care homes. For example, while our teams had adapted the recommendations on cleaning and disinfecting to three times a week instead of daily, this was not always possible for care homes which lacked the resources during the crisis.

This underlines the **importance of translating general directives into specific support measures** within the care homes themselves, which are adapted to the expectations of the facilities and to the most urgent needs. In our experience, **an approach based on mobile teams comprised of two or three people is both effective and easy to replicate.**

Within MSF: This intervention enabled us to improve our practical knowledge about COVID-19, to establish expertise about the reality of the situation in care homes and to learn lessons in relation to operational approaches for other programmes. One of the major benefits in terms of acquired knowledge was the need for a **multidisciplinary approach to infection prevention and control, beyond strictly care provision. – with webinars, hands-on on-site training and the development of tools that will remain available online – is a model that has proven successful**, allowing the number of mobile team visits to be streamlined and benefiting a greater number of care homes in terms of advice and tools.

This intervention also provided an insight into the **scale of the mental health requirements during this crisis and in this type of environment**. The findings have also been shared by care homes, which see psychosocial support requirements as their next priority. The results of our intervention indicate that **psychological support in situ, within the care home themselves, is more effective** than online websites and tools.

In general: MSF's position as an experienced actor recognised in the practical management of epidemics and an "external" actor to the existing Belgian healthcare system enabled us to unite people, forge links, easily share information and train and support other actors, regardless of their professional background or function in the healthcare system.

The **openness towards MSF's involvement on the part of the authorities coordinating the emergency response, at both central and regional levels**, enabled us to increase the efficiency of our intervention and to ensure that leadership was maintained by the various coordination authorities, helping us achieve better uptake of our activities in the long term. It also allowed us to influence various strategies and recommendations, including federal policies and instructions, albeit to a limited extent. **While collaboration with the authorities was generally productive, this does not mean that the serious**

health emergency in care homes should not have been identified much earlier. This delay, including within MSF, is a major collective societal failure which we all need to acknowledge.

It should be noted that MSF's levels of interaction and involvement were not the same everywhere. **While inclusive participation was predominant in the central OMG platform and in Brussels** (probably due to our prior work there with immigrants and undocumented people, as well as to the scale of our intervention in care homes in the capital during the crisis), **matters were more complex in the north of the country**.

In Flanders, it was more difficult to establish interaction with the higher levels of the relevant care and healthcare agency and ministry, in contrast to our exchanges with VAZG teams on the ground. As a result, it took six weeks to get a response to our early April requests to take over our activities and adopt the mobile team model. Another example: despite our repeated requests, the doors of the various working groups of the long-term care facilities Task Force" set up by the cabinet of the regional health minister were not open to us, except in the field of psychosocial health (albeit belatedly). While around 50 care homes were identified by VAZG inspection services as being in a precarious position prior to COVID-19 (and as a result probably in greater need of support during the epidemic), this list was never shared with the agency prevention teams or with MSF.

Finally, the **involvement of various civil society players** (medical associations and federations, non-governmental organisations, the Red Cross, mental health associations etc) in the crisis response **represented genuine added value and played a key role**. It is vitally **important to capitalise** on the knowledge and experience gained by these various actors to guide further response strategies and measures. **However, the structural preparation for a new wave** of COVID-19 in care homes **should primarily be carried out at a governmental level**, as the government is responsible for individuals' social protection, health and wellbeing.

Recommendations

Residents of care homes are especially vulnerable to the new coronavirus due to their age and frequent co-morbidities. Furthermore, the physical proximity of residents of long-term care facilities can enable the rapid and silent spread of the infection (which is often asymptomatic), amongst residents and staff. In the event of a new upsurge in the epidemic, care home staff will once again be on the frontline, despite being already exhausted by the impact of the first wave.

The effectiveness of these essential and exposed front-line workers will depend significantly on the support available from the various authorities responsible for the health and wellbeing of people in long-term care facilities.

To learn from the painful lessons of the first outbreak in care homes, and reinforce preparedness and preparedness for new epidemic waves, ***we recommend some urgent changes in the response:***

- The complex structure of political responsibilities in Belgium means that extra efforts are needed to overcome some potential incoherence in tackling an outbreak such as COVID-19. ***There needs to be clarification on who is doing what, and on how to assure effective contingency, collaboration, complementarity and communication within the federated entities, but also across levels and in the different ministries.***

- ***A specific updated and adequately resourced response plan is needed for care homes***, at federal and regional level, with a clear division of roles and responsibilities and assured coherence. This should include preventive measures, but also guidance and resources to manage an outbreak in a care home from the earliest stage possible and reduce the human costs. A clear mobilisation plan and process is needed for engaging extra staff when needed to compensate for absenteeism or illness. A budget for extra PPE, IPC equipment and adaptations in infrastructure needs to be available rapidly. Feedback from frontline care home staff and residents on strengths and weaknesses of the approach during the first semester of 2020 should inform and shape the updated plan, as well as from civil society organisations that provided support.

- ***Guidance and protocols need to be adapted and complemented with practical support –preferably on-site -on how to implement the instructions***. Without considering the reality in care homes, communication from authorities to the facilities missed its goal and the potential benefit of general guidance was lost, creating yet more stress for already overwhelmed staff.

- ***As of now, refresher courses and practical training sessions should be widely disseminated*** and thus contribute to better preparedness for an outbreak. Refresher or basic courses on hygiene, disinfection and the principles of IPC should be organised for all care home staff, including kitchen and logistics support staff and volunteers. In particular, care homes that have faced no infections among their residents so far should get a specific practical training, as they may face future outbreaks without having experienced the first wave.

- ***Providing specific support to care homes pays off.*** Facilities with a nursing director and those with a crisis cell performed better in terms of indicators of preparedness and reaction. Practical and on-site support by MSF and fellow mobile teams was very appreciated by care home managers and staff. This support enabled them to deal with extremely difficult situations, to feel less abandoned and to feel greater confidence in dealing with the risks and mitigating the human costs of the epidemic. Most care homes managed to implement recommendations in a reasonable timespan after such support. We recommend the ***creation of similar mobile teams*** that can be deployed rapidly and in response to requests for help from care homes.

- ***Resources should be allocated to ensure this support staff***, preferably identified ahead of the outbreak, is given the means to support certain care homes when hit by the epidemic.

- ***Coaching and other support networks*** – preferably including on-site visits and on-call staff – should be implemented as soon as possible.

- ***The referral guidance for residents' sick with suspected or confirmed COVID-19 needs to be improved*** to avoid misplaced reluctance to provide adequate clinical care and/or to avoid putting informal pressure on residents or their families. The ***access to and continuity of care*** for care home

residents need to be guaranteed through secured hospital referrals and transfer criteria, as well as the usual GP visits or through an alternative health practitioner with access to patients' records. This also means that ***updated therapeutic and end-of-life plans need to be systematically present***. A similar back-up system for the ***Coordinating and Advising Physician is needed, whose role also needs to be redefined***.

– ***A need for increased mental healthcare*** was identified during the intervention, both for staff and residents. Psychological care and consultations should be considered essential services for care homes. Mental healthcare should be included from the start of any intervention in such facilities. Mobile teams should be identified and trained in psychological first aid to deal with requests for support with care home staff who are experiencing high levels of stress and anxiety. Referral systems and on-site support by external psychologists must be increased (in crisis and non-crisis times), without financial barriers to impede this much needed care.

– ***As epidemiological trends slow, care homes cannot let their guard down***, because of the risk of the virus spreading quickly among a group of frail people in their care. ***Regular testing of staff and residents is recommended*** to detect infectious people as early as possible. Increased and accelerated testing capacity can help care homes to monitor their situation and base decisions for increased IPC or individual isolation and group cohorting on test results.

– ***Harmonisation of surveillance data*** across the regions is highly recommended, as the differing recording systems cause confusion and do not allow correct interpretation of the situation. A lack of transparent sharing of data from epidemiological reports with the care homes hampered their insight into their specific situation and impeded them from making necessary decisions.

– ***Initiatives of civil society organisations should be encouraged and mapped around*** care homes. Links with authorities at various levels should be facilitated to allow complementarity and collaboration with public servants and policy makers. We also recommend organising and facilitating an ***exchange of experiences between care homes, managers, nursing staff and support/logistics staff to share practical lessons learned and coping mechanisms*** during these demanding COVID-19 times.

– Finally, we would like to stress ***the importance in an epidemic outbreak of going beyond individual clinical care which is mainly managed by private practitioners and hospitals***. We recommend adopting a public health approach aimed at early detection and rapid mitigation of transmission, aided by field epidemiology and infection control measures; decisions should be guided by epidemic observations and should target specific at-risk population groups.

Conclusion

The priority of the authorities to preserve hospital capacities while the epidemic curve was rising, coupled with the lack of an emergency response plan that included long-term care facilities, led to a lack of attention and proactive measures for people at risk of infection and severe complications, especially elderly populations in care homes. The potential sources of infection for a community living within a confined space were underestimated, regarding the role of staff (often asymptomatic carriers), as well as the unknown presence of the virus within care homes before the alert.

These facilities were forced to close their doors and to transform into makeshift hospitals, while lacking proper preparation, knowledge, staff or material resources. The lack of equipment and of clear strategies and capacities, for testing, led to additional delays in the implementation of measures to isolate suspected cases, to group ill residents together and test staff to reduce viral transmission.

More comprehensive analysis is required to assess the efficiency and the consequences of mitigation and response measures that were adopted by the country's various governmental bodies and the impact of delays on their implementation. The shortcomings led to numerous deaths which could have been avoided, and caused unnecessary suffering for residents, their families and staff in care homes.

Our teams' assessment of 135 care homes and a nationwide questionnaire confirm the lack of preparation for the emergency, the gap between response capacities and requirements, and the human physical and mental health toll. However, most of the care homes that our mobile teams visited had not received a previous visit. No one to hear their concerns about what might happen and to help them to wage war against coronavirus. In their day-to-day activities, our teams listened to distressed managers, nurses and technical staff who felt abandoned, as the disease gained ground and they lost residents who had become friends. The staff felt guilty and ashamed about not being able to do more and were stigmatised regardless of their frontline role and long working hours.

Although the intervention by MSF during the COVID-19 crisis in Belgium was not necessarily a straightforward solution, and it led us to question the genuine added-value that we could contribute within such a limited timeframe, no doubts remain today. Care home staff did not feel judged by our teams and their performance was not scored. Instead, we assessed the situation alongside management teams and put forward specific tailored solutions for infection prevention and control, the organisation of care and mental health. The staff felt supported in their efforts to combat the disease or to prevent its spread and felt better equipped to carry out their tasks in safer conditions.

The last few weeks of MSF's intervention were dedicated to supporting the few care homes which requested more support, and to ensuring that the authorities would take over our activities. In addition to sharing tools and knowledge, certain advocacy initiatives were also required. We publicly expressed our concern about the fact that, despite the strengthened capacities of the care homes that received support from various partners, the system is not ready to deal with a new health crisis on such a scale.

Our role does not involve participating in the political architecture which this country should adopt to ensure a better response to a new wave of COVID-19, but to encourage the immediate development and adoption of a coherent, credible and properly funded contingency and response plan to avoid further human tragedy in care homes at state and federated levels. This plan should be based on the experiences of the care homes themselves and on the diverse parties involved, but also – and above all – on the experience of the residents during the crisis.

As in many other countries, elderly populations – too frail and old to be a priority – have been overlooked in the emergency response. It is high time that these individuals, and the care home staff who have been stretched to the limit, were given the status and respect they deserve, and that action be urgently taken.

Useful links

https://www.covid-resources.msf.be/
(password: Covid19msf)
https://covid19-mr-wzc.be/maison-de-repos.html
www.info-coronavirus.be
https://www.health.belgium.be/en
https://www.sciensano.be/en
https://www.ccc-ggc.brussels/
https://www.iriscare.brussels/fr/
https://www.aviq.be
https://www.zorg-en-gezondheid.be/
http://www.ostbelgienlive.be/
https://www.maisonmedicale.org/
https://www.croix-rouge.be/
http://www.aframeco.be/
https://domusmedica.be/
https://www.dezorgsamen.be/
https://zorgenvoormorgen.be/
http://www.cresam.be/offre-de-soins
http://www.reseaupartenaires107.be
https://www.psyformed.com
https://www.psy.be/fr

Abbreviations

AFRAMECO: L'Association Francophone des Médecins Coordinateurs et Conseillers en Maisons de Repos et de Soins – The French-speaking Association of Coordinating and Advising Physicians in Care Home

AViQ: Agence pour une vie de qualité – Quality of Life Agency

CAP: Coordinating and Advising Physician

CH: care home

CNS: National Security Council

CGG: Centrum voor geestelijke gezondheidszorg (centre de santé mentale – Mental Health Centre)

Cocom: Commission communautaire commune – Joint Community Commission

DGGS: Direction générale Gezondheidszorg – Soins de Santé – Directorat-General for Healthcare

FMM: Fédération des maisons médicales – Federation of Medical Houses

GP: general practitioner

IPC: infection prevention and control

MSF: Médecins Sans Frontières/ Doctors without Borders

OMG: outbreak management group

OST: outbreak support team

PPE: personal protective equipment

Sciensano: National Public Health Institute

SPF Santé Publique: Federal Public Health Service

VAZG: Vlaams Agentschap Zorg en Gezondheid – Agency for Care and Health

WHO: World Health Organization

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