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The COVID-19 Long-Term Care situation in the Islands of Malta and Gozo

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Corrections and comments are welcome at info@ltccovid.org. This document was last updated on 6 June 2020 and may be subject to revision.

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1. Key points

- The pandemic response team had been in place well before the first COVID-19 case was registered in Malta. The first case was registered on the 7 March 2020, and during the first 2 weeks of the pandemic all cases were imported. A mandatory 2-week quarantine was put in place for all in-coming travellers during the second week of the pandemic.
- Malta's size and population were potentially favourable towards ensuring better COVID-19 control measures. Nine (9) deaths have been recorded to date.
- The Superintendent of Public Health together with the COVID-19 Response Team were key towards ensuring effective and timely mitigation efforts both with the general public as well as ensuring that the local health care system was robust enough to meet the needs brought about by the pandemic.
- The daily medical bulletins broadcast by the Superintendent of Public Health kept the public continually updated on COVID-19 matters. The bulletins provide the Public Health Authority with a publicly accessible platform to focus and strengthen health promotion efforts in respect to the COVID-19 pandemic.
- Swabbing and contact tracing within the 3 testing hubs on the Island were key towards controlling the pandemic.
- A series of measures were put in place early on with the key aim of ordering categories of persons referred to as 'vulnerable', to remain segregated in their residences, (except in the cases of attendance for medical appointments, obtain medical care or treatment, acquire food, medicine, other daily necessities, or to attend to any other essential or urgent personal matters).
- The voluntary response by management and health care professionals within the care homes on the Island was paramount towards recording no deaths within these facilities; the majority of care homes were in lockdown for 12 weeks, whilst other care homes worked on 1, 2 or 3 week shifts. Swabbing of health care professionals was mandatory prior to assuming duties within the residential care facilities.
- As of the 4 May 2020, the Superintendent of Public Health embarked on a stepwise relaxation of measures. The first measure was followed by the second and third relaxation of measures on the 22 May 2020 and 5 June 2020.

2. Introduction

Malta, had a pandemic response plan in place prior to the pandemic, which was updated in February 2020. The Superintendent of Public Health holds legislative authority, making recommendations to a Cabinet Interministerial Committee chaired by the Deputy Prime Minister and Minister for Health.

In accordance with the Public Health Act (Chapter 465 of the Laws of Malta), a public health emergency was declared on the 1 April with effect from 7 March 2020, the day when the first imported case of COVID-19 was registered in Malta (LN 115 of 2020, Health Promotion & Disease Prevention Directorate, Ministry for Health, Malta.)

Legal notices were successively published regularly and with urgency in relation to the public health measures issued by the health authorities, responsible for (a) social distancing measures, (b) closure of public places, (c) non-essential retail outlets and (d) lock down for those at highest risk within society.

The procurement of personal protective equipment (PPE), medical equipment and all the requirements related to the pandemic response took place through a single centre to ensure adequate planning for critical resources and accountability of utilisation.

3. Impact of COVID-19 so far

3.1. Number of positive cases in population and deaths

The number of registered cases until the 3 June 2020 stood at 622 cases with 9 deaths. The number of recovered patients stood at 576, whilst 37 cases remained active. This was the lowest number of active cases since the 17 March, 10 days into the pandemic. (Health Promotion & Disease Prevention Directorate, Ministry for Health, Malta).

Figure 1: Number of COVID-19 cases between 7 March 2020 and 3 June 2020.

New Cases

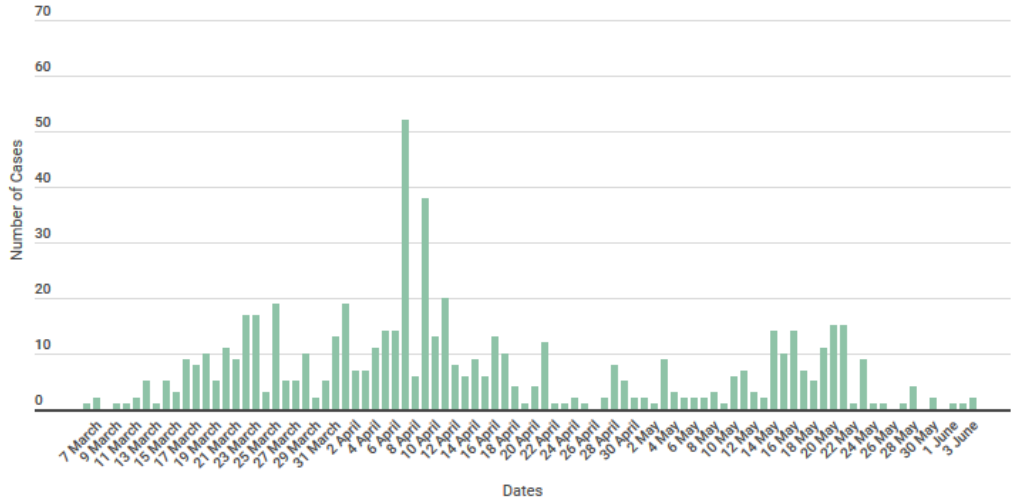


Figure 2: Distribution of Cases by Gender, 7 March 2020 - 3 June 2020. (Health Promotion & Disease Prevention Directorate, Ministry for Health, Malta)

Distribution of Cases by Gender

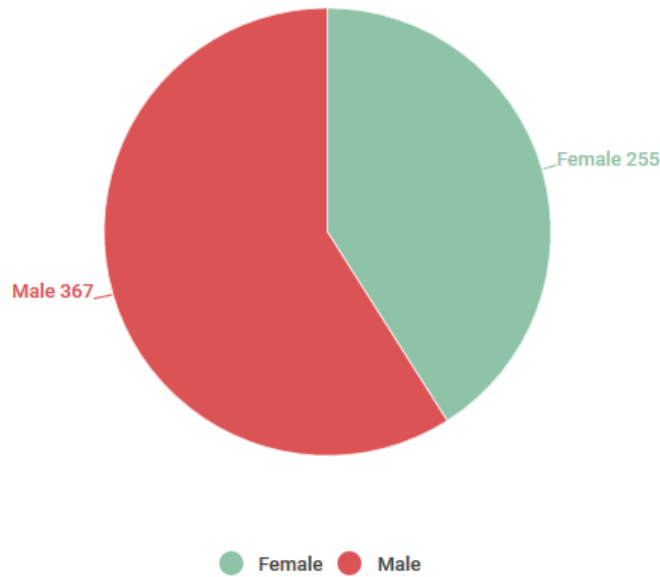


Figure 3: Distribution of Cases by Age, between the 7 March 2020 and 3 June 2020. (Health Promotion & Disease Prevention Directorate, Ministry for Health, Malta)

Distribution of Cases by Age

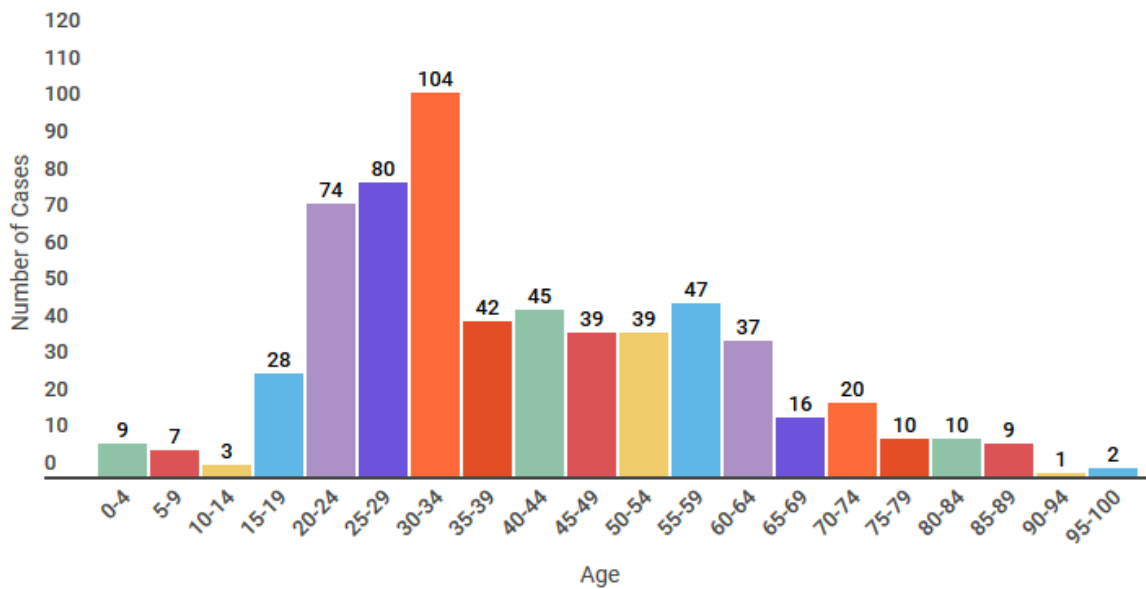


Figure 4: Deaths by gender for the time frame 7 March 2020 – 3 June 2020. Females by age: 92 and 96 years old, one passed at the sister island, Gozo General Hospital (GGH), the other at Mater Dei Hospital (MDH); Males by age: 3 aged 79 years, 81 years and 97 years passed at Karin Grech Rehabilitation Hospital (KGRH), 4 aged 84 years, 53 years, 56 years and 68 years passed at MDH. (Health Promotion & Disease Prevention Directorate, Ministry for Health, Malta).

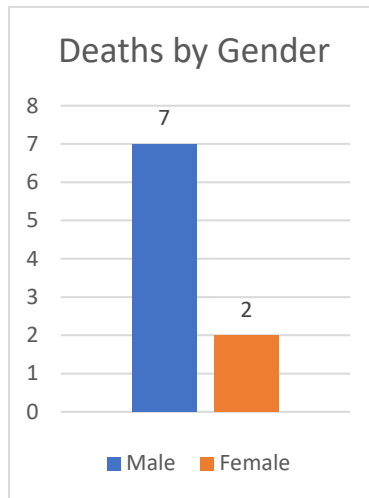
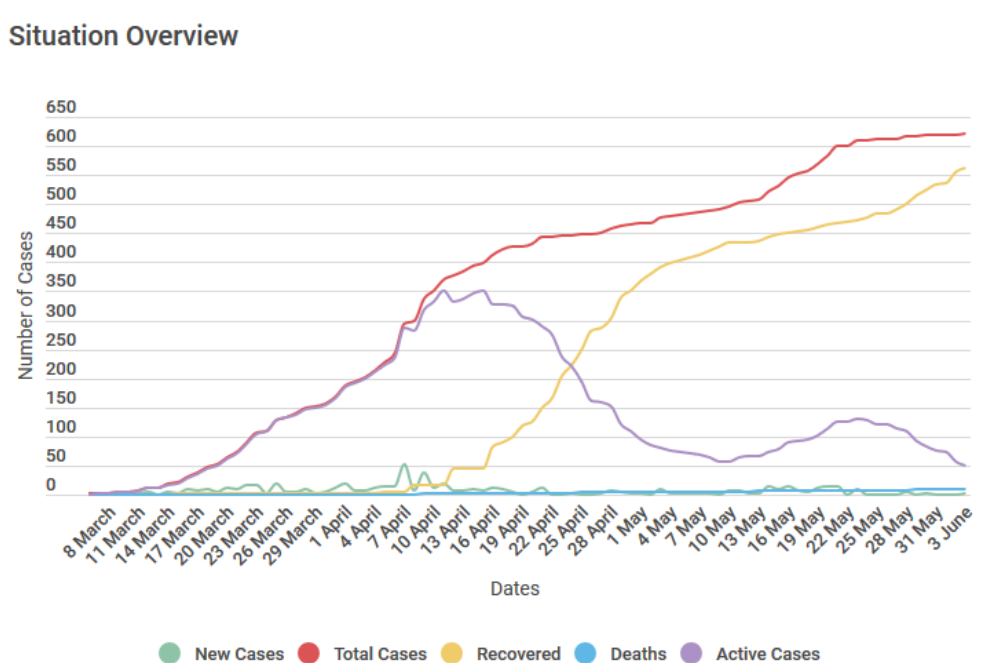


Figure 5: Situation overview by new cases, recovered, active cases, deaths and total cases for the period 7 March 2020 – 3 June 2020. (Health Promotion & Disease Prevention Directorate, Ministry for Health, Malta)



3.2. Population level measures to contain spread of COVID-19

At the time of writing, first week in June 2020, 622 cases and 9 deaths have been recorded in the islands of Malta and Gozo. The health system has, since the first reported case, on 7 March 2020, rapidly developed the capacity to care for COVID-19 positive cases. Malta never introduced a complete lockdown. Despite this, however, legal notices were put in place by the Superintendent of Public Health to mitigate and protect the Maltese population.

During the initial 2 weeks of the pandemic all registered cases were imported. The first community infection was registered around the 16 March with 2 health care workers testing positive for COVID-19 having been in contact with another health care worker who had recently travelled to Italy.

During the prior week, Malta had moved towards banning travel from Italy, Spain, Germany, Switzerland and France and later by ordering that all arrivals from all countries were to observe a mandatory 2 weeks quarantine. All passenger flights inbound to Malta were temporarily suspended as of 20 March 2020. Ports were also temporarily closed off.

Moreover, Malta also introduced other measures to prevent community spread, including (a) a ban on large gatherings, (b) closing off all educational institutions for a week (both of which were later closed off indefinitely and to date remain closed), (c) suspension of all religious activities, and (d) postponement of court cases and non-essential medical services.

Of focal importance is the legal notice issued on the 28 March 2020, by the Superintendent of Public Health ordering that categories of persons referred to as 'vulnerable' in the document, were to remain segregated in their residences, (except in the cases of attendance for medical appointments, obtain medical care or treatment, acquisition of food, medicine, other daily necessities, or attendance to any other essential or urgent personal matters). The definition of vulnerable persons included, (a) persons over 65 years of age, (b) pregnant women, (c) persons living with chronic illnesses or medical conditions (insulin dependent diabetics, immunosuppressed persons, persons undergoing immunosuppressive treatment, patients suffering from cancer or undergoing chemotherapy within the last 6 months, patients on dialysis, patients with respiratory problem exacerbations, patients suffering from cardiac disease as well as patients who had undergone cardiac intervention or surgical procedures during the last 6 months, patients attending heart failure clinics and patients on oral steroids), (Health Promotion & Disease Prevention Directorate, Ministry for Health, Malta)

Daily medical bulletins were ongoing from the 7 March 2020 running until the 3 June 2020 and broadcasted on the media.

The following are some of the more salient measures (<https://legislation.mt/>) put in place by the local Public Health Authorities (through legal notices), during the initial days of the pandemic. Some of these measures are currently being repealed:

- (1) 24 February 2020 – all passengers arriving in Malta were to be screened by thermal cameras. Passengers disembarking from vessels at Grand Harbour and catamaran terminal were also scanned. At the Mater Dei Hospital, all patients with respiratory symptoms were checked for COVID-19.
- (2) 25 February 2020 – in-bound travellers from Italy were to self-quarantine for a period of 14 days. All Maltese citizens were asked not to travel to regions of Italy affected by the outbreak. Some work places, requested their staff who had recently returned from Italy to work from home as well as deferred non-essential travels to Italy.

- (3) 11 March 2020 – a ban on all sea and air travel, except for cargo was established. A mandatory 14 –day quarantine for persons travelling from Germany, France, Spain and Switzerland was ordered against a fine of €1000.
- (4) 12 March 2020 – All educational institutions, child care facilities, and day centres for older persons were closed whilst all religious and political activities were suspended.
- (5) 13 March 2020 – Mandatory 14- day quarantine was extended to travellers returning from any country.
- (6) 17 March 2020 – A period of mandatory quarantine for persons testing positive for COVID-19 and penalties of €3000 in case of non-compliance was set up. Patients had to remain in quarantine until effectively cleared as COVID-19 negative by medical doctors.
- (7) 18 March 2020 – Closure of bars, restaurants, cafeterias, snack bars, cinemas, gymnasiums, museums and exhibitions, clubs, discotheques and night clubs, open-air markets, indoor swimming pools, national swimming pool, gaming premises and bingo halls, casinos, gaming parlours, lotto booths and betting shops. (Restaurants including restaurants in hotels, snack bars and kiosks remained open to only provide delivery and take-away services to the community).
- (8) 22 March 2020 – Fine was increased to €10,000 in case of infected persons infringing the quarantine regulations.
- (9) 28 March 2020 – As indicated earlier, persons deemed as ‘vulnerable’ were ordered to shelter in place.
- (10) 28 March 2020 – Educational institutions were ordered to remain closed until the end of scholastic/university terms. Teaching switched to online modes. The Secondary Educational Certificate examinations were not held and students were issued certification based on the mid-year mock exams. Intermediate and A Level exams to be held in September 2020.
- (11) 31 March 2020 - Groups exceeding 3 persons in public areas were to be fined €100 each. Wi-Fi services in public places, such as community gardens, were switched off. On the 4 May 2020, this measure was relaxed to groups of 4 persons. On the 22 May 2020, the number was increased to 6 persons and by the 5 June 2020, this number increased to 75 persons.
- (12) 3 April 2020 - Tighter travel restrictions for Ferry crossing between Malta and Gozo came into force and only those with a valid reason were allowed to board. On the 4 May 2020, this legal notice was revoked.
- (13) 7th April 2020 - In view of the ever-increasing spread of the COVID-19 and in view of the increasing lockdowns of airports abroad, Maltese nationals currently abroad were urged to return to Malta by not later than Sunday 12th April 2020.
- (14) 9 April 2020 – Mater Dei Hospital suspended all visiting hours.
- (15) 30 April 2020 – Government augmented the existing wage supplement for businesses affected by the impact of COVID-19 for a further 2 months, now extended to cover May and June 2020. Government was spending in excess of €100 million a month to save jobs and businesses and to ensure that the economy remained intact and hence able to quickly recover after this crisis.
- (16) 30 April 2020 - Malta’s flight ban was extended until the end of May and later until the end of June. Airport and ports will resume operations to countries termed by Public Health as ‘safe corridor territories’ on the 1 July 2020. There is no mandatory coronavirus testing for persons arriving from these countries. (These countries include, Iceland, Slovakia, Cyprus, Lithuania, Israel, Norway, Switzerland, Estonia, Denmark, Hungary, Austria, Luxembourg, Germany, Czech Republic, Finland, Sicily, Sardinia and Ireland.)
- (17) 30 April 2020 - The Commissioner for Inland Revenue extended the COVID-19 tax deferral scheme due in March 2020, to the end of June 2020.

Testing

Laboratory tests for COVID-19 took place in 2 laboratories in Malta, with Mater Dei Hospital Laboratory serving as the reference point. Testing capacity increased to enable several 100 polymerase chain-based reaction (PCR) tests for COVID-19 and performed daily.

There are 3 separate drive-through testing areas, in addition to the one dedicated solely for testing health care professionals. Persons attend by appointment. There are provisions in place for those persons who do not have their own transport. Initially, these used up a lot of resource as paired doctors in PPE were being driven around to carry out these tests in the home of the person requiring the test. Now the use of 'dirty' cabs has been implemented, where patients are brought to the testing centres and cabs are decontaminated after each use.

Within community health care centres and acute hospitals, a swab test for COVID-19 is taken for all those who present with respiratory symptoms. This was extended as a pre-operative test for partners of parturient women and prior to emergency surgeries.

To date over 75,000 tests have been performed. Generally 1000 tests were performed daily. Information campaigns and the media were directed towards emphasising the importance of turning up for one's appointment. Another factor increasing the uptake of testing was initiating a new policy to extend testing for asymptomatic persons in large companies on a voluntary basis. During this exercise, a number of symptomatic cases were also identified and successively contact tracing was extended to their close contacts¹.

Another factor that potentially increased the nasal swab testing was the COVID-19 Symptom Checker released on the 30 April 2020. The COVID Symptom Checker is a new application that can be accessed from any computing device at <https://covid19check.gov.mt>. This is a short self-assessment test which asks a number of questions related to one's symptoms and guides the user to further actions, including calling the helpline if the application algorithm determines that the inputted symptoms fulfill the COVID-19 criteria. This self-assessment tool serves as a tool for syndromic surveillance to enable authorities to correlate the number of cases to the reports of symptoms through this app. It is anonymous and requires no name or form of identification to be inputted making this very acceptable to the end user².

The Maltese Government is looking into the possibility of acquiring new technologies such as mobile apps to facilitate contact tracing. It is important that any technology used in this regard will not impinge on the civil rights or personal privacy of the person³.

To date, Public Health Authorities have embarked on a step wise transitioning process towards gradually re-opening the country, with mitigation measures in place (mainly consisting of wearing of masks/visors, social distancing, monitoring and screening of body temperature, regular disinfection of work surfaces, regular and *ad hoc* visits by Health Inspectors and thorough washing of hands). The first of these measures started on the 4 May, followed by 22 May and successively 5 June 2020.

1

https://www.maltatoday.com.mt/news/national/101828/health_authorities_worried_about_people_not_turning_up_for_covid19_tests#.XtwFJEVkg2w

² <https://timesofmalta.com/articles/view/health-minister-invites-people-to-test-covid-19-symptoms-app.788906>

³ <https://timesofmalta.com/articles/view/covid-19-restrictions-could-be-eased-in-the-coming-days-fearne.787310>

3.3. Rates of infection and mortality among long-term care users and staff

No deaths have been recorded in residential care settings for both older persons and staff.

Figure 6: Percentages of residents and staff within State-run Care Homes, Church Homes and Private Homes, swabbed for COVID-19 from 7 March 2020 until 3 June 2020, and COVID-19 positive outcomes. Total number of residents: 4244; total number of staff: 3021. (Social Care Standards Authority, Malta, sca.gov.mt)

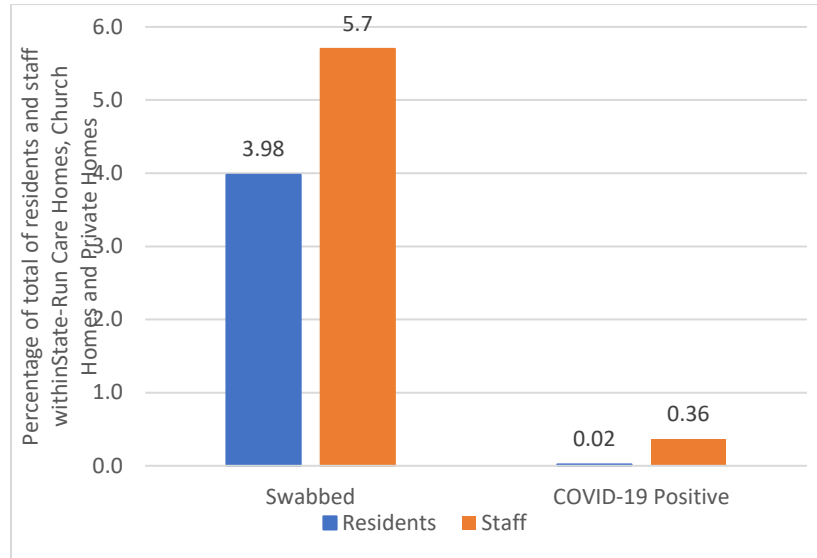
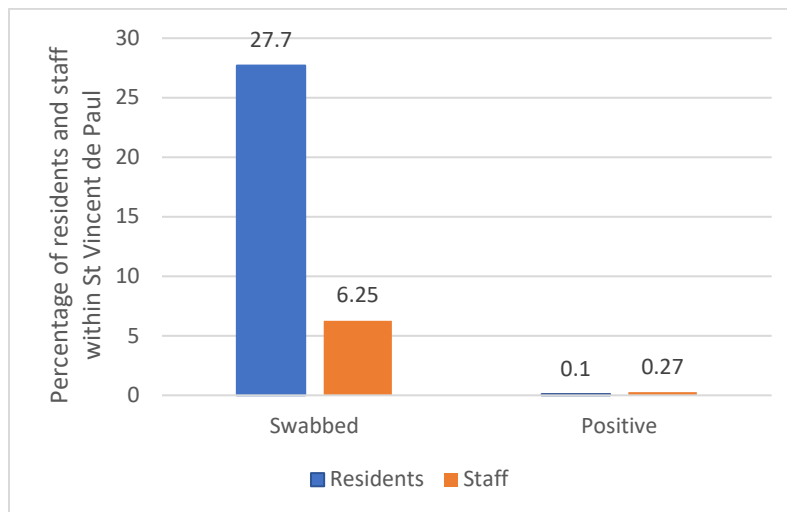


Figure 7: Percentages of residents and staff swabbed within St Vincent de Paul, and COVID-19 positive outcomes, from 7 March 2020 until 3 June 2020. Total number of residents: 985; total number of staff: 1840. (Social Care Standards Authority, Malta, sca.gov.mt)



4. Brief background to the long-term care system

In 2017, the United Nations had estimated that, by 2050, the number of persons aged 60 years and over globally would double reaching approximately 2.1 billion globally. Their projections had also indicated, that between 2017 and 2050, the number of persons aged 80 years and over was expected to increase by more than threefold.

Malta is no exception to these demographic trends. The Maltese Archipelago is an EU Member State with a number of islands, with Malta, the mainland being the largest with 442,978 inhabitants, Gozo, the second in terms of size with a population of 32,723 inhabitants and Comino with a population of a mere 3 inhabitants, (NSO, 2019).

The National Statistics Office (NSO, 2019) indicated that, by the end of 2017, 18.8% of the total Maltese and Gozitan populations would be aged 65 years and over. According to the NSO (2019), there was a 57.8% increase in older persons aged 65 years and over between 2007 and 2018. Later, the Country Health Profile (2019), also reported on Malta and Gozo's life expectancy at birth, indicating 82.4 years in 2017, the seventh highest in the EU, and 1.5 years higher than the EU average. The report also indicated a 4 year increase in the life expectancy at birth in 2000. Maltese people spend the majority of their lives in good health and in 2017, had the highest life expectancy at birth for women in the EU (73.6 years) and the second highest for men (71.9 years) after Sweden, (Country Health Profile, 2019).

Increased longevity and societal pressures, including a shift in traditional familial roles and changing family values, are the key catalysts of the decisions to seek admission into a residential care facility. The inability for the Maltese pension system to ensure that all older persons are financially stable, together with age discrimination related to economic/social contributions could potentially also dissuade the older person from remaining in her/his own home environments for as long as possible. Other determinants include the challenges faced by governments to provide holistic community services specifically targeting the challenges related to the funding of health care delivery (European Commissions, 2011; Fenech, 2018).

The residential care services for older persons in Malta consist of 40 licenced care providers, (SCSA, 2020), the largest being St Vincent de Paul Facility (SVP), a facility accommodating 985 residents with 1,840 care staff. The facility accommodates older persons with high dependency chronic care needs on a long term basis, (SCSA, 2020). The facility has 24-hour medical care on site (Azzopardi-Muscat *et al.*, 2017).

The other 39 services, accountable for 115 residential care settings spread over the islands of Malta and Gozo, are a mix of state-run, church-run and private-run residential facilities of older persons, with a total population of 4,244 residents and 3,021 health care providers. (Figure 8: State Run Homes, Figure 9: Church Homes, and Figure 10: Private Care Homes). These 39 facilities accommodate older persons with varying levels of care needs on a long term basis (SCSA, 2020).

Figure 8: Residential Services for older persons residing within State-run Homes.

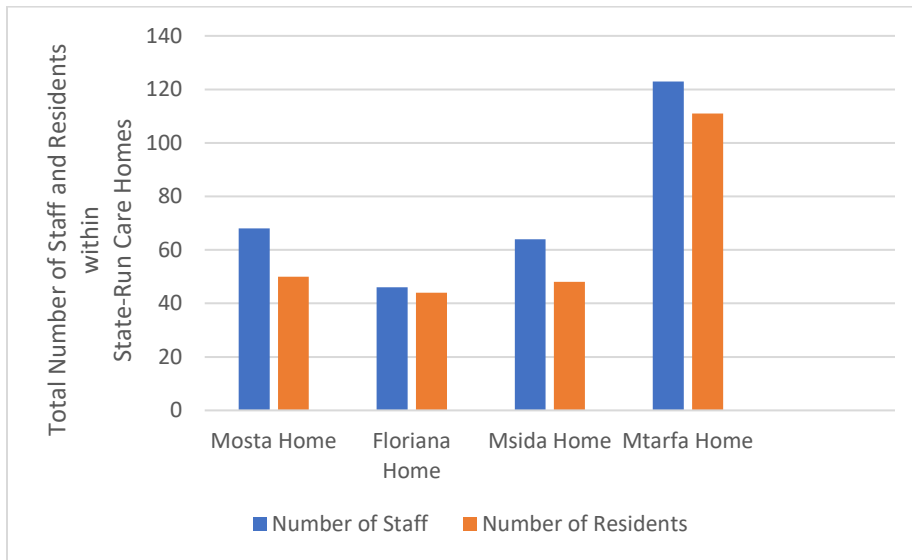
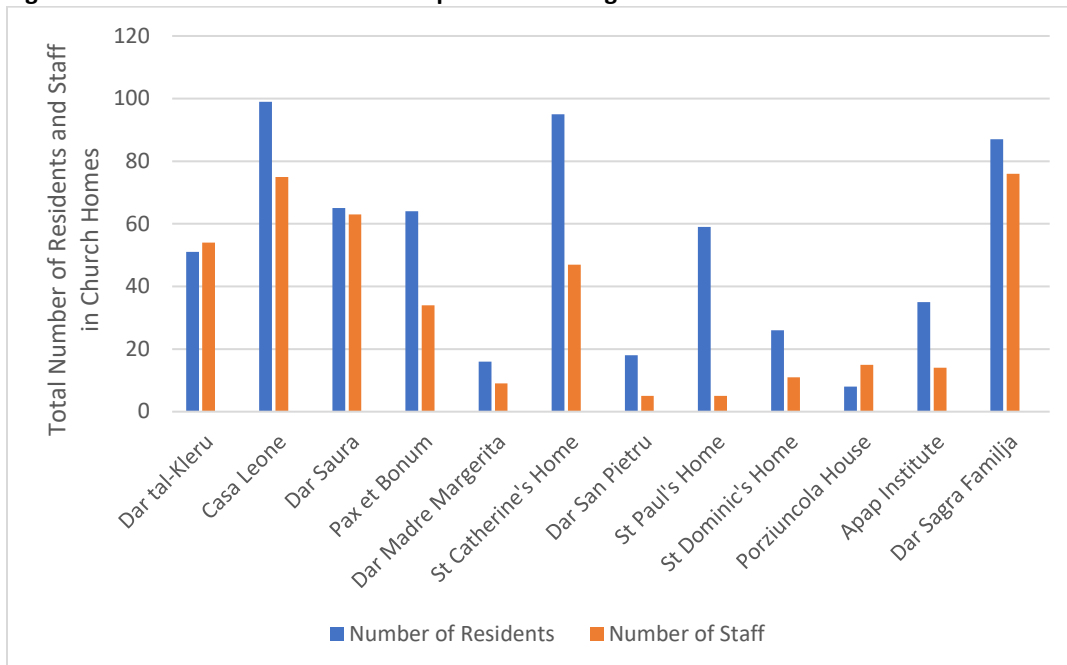
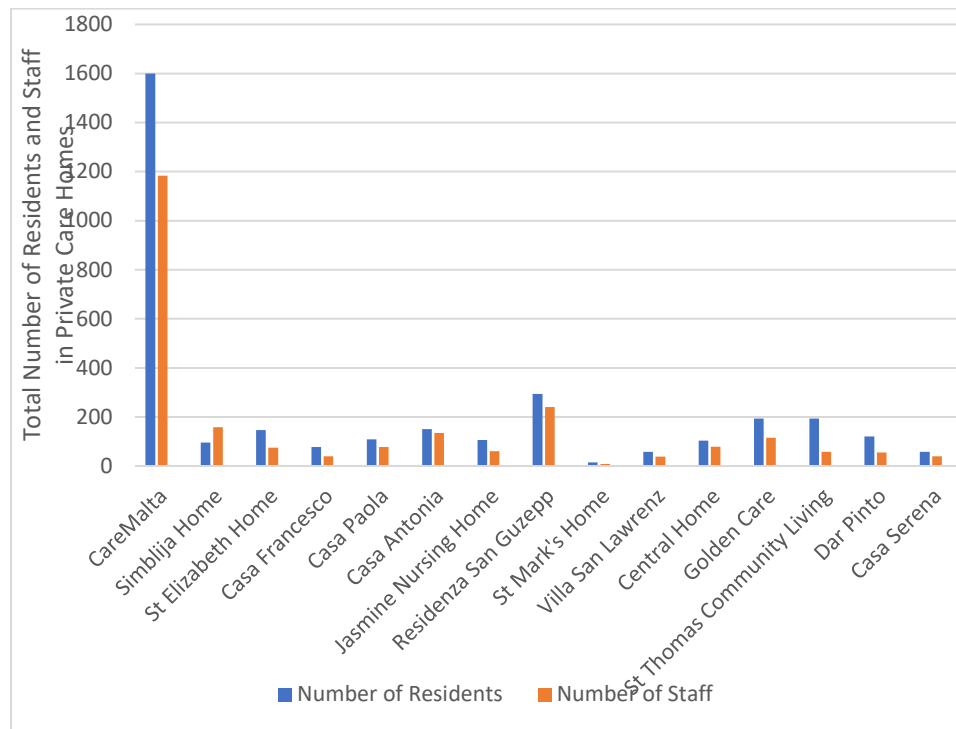


Figure 9: Residential Services for older persons residing within Church Homes. ⁴



⁴ Number of residents and staff for respective Church-run Homes is as follows, (a) Dar tal-Kleru: 51 residents to 54 staff; (b) Casa Leone: 99 residents to 75 staff; (c) Dar Saura: 65 residents to 63 staff; (d) Pax et Bonum: 64 residents to 34 staff; (e) Dar Madre Margerita: 16 residents to 9 staff; (f) St Catherine's Home: 95 residents to 47 staff; (g) Dar San Pietru: 18 residents to 5 staff; (h) St Paul's Home: 59 residents to 5 staff; (i) St Dominic's Home: 26 residents to 11 staff; (j) Porziuncola House: 8 residents to 15 staff; (k) Apap Institute: 35 residents to 14 staff; (l) Dar Sagra Familja: 87 residents to 76 staff. A total of 623 residents and 408 staff. (Social Care Standards Authority, Malta, scsa.gov.mt)

Figure 10: Residential Services for older persons residing within Private Care Homes⁵.



Both SVP and the 39 facilities have fittings and equipment specifically suited for the holistic provision of the residents' care and wellbeing (SCSA, 2020). Both categories of facilities are staffed by consultant geriatricians, doctors, nurses and allied health professionals (Azzopardi-Muscat *et al.*, 2017). Medical care within these 39 facilities is provided when the need arises.

The demand for residential care services has locally increased considerably over the past years mainly because of the reduction in the extended family which historically provided for the primary support network. Better health care systems also pushed the increase in life expectancy (Azzopardi-Muscat *et al.*, 2017; Country Health Profile, 2019; WHO, 2018). As expected, advancing age brought about inevitable physical and cognitive changes, requiring the older person to seek the services of residential care.

⁵ Number of residents and staff for respective Private Care Homes is as follows, (a) CareMalta: 1600 residents to 1183 staff; (b) Simblija Home: 96 residents to 158 staff; (c) St Elizabeth Home: 147 residents to 75 staff; (d) Casa Francesco: 77 residents to 40 staff; (e) Casa Paola: 109 residents to 77 staff; (f) Casa Antonia: 150 residents to 135 staff; (g) Jasmine Nursing Home: 106 residents to 60 staff; (h) Residenza San Guzepp: 294 residents to 240 staff; (i) St Mark's Home: 14 residents to 8 staff; (j) Villa San Lawrenz: 58 residents to 38 staff; (k) Central Home: 103 residents to 78 staff; (l) Golden Care: 194 residents to 115 staff; (m) St Thomas Community Living: 194 residents to 58 staff; (n) Dar Pinto: 120 residents to 55 staff; (o) Casa Serena: 58 residents to 40 staff. A total of 3320 residents and 2360 staff. (Social Care Standards Authority, Malta, scsa.gov.mt)

5. Long-term care policy and practice measures

5.1. Whole sector measures

The Social Care Standards Authority (SCSA), is a regulatory body set up through ACT No. XV (2018), responsible for protecting and enhancing the dignity, safety and welfare of all its service users (older persons residing within residential care settings), through licensing, establishing regulatory standards and inspecting services. To this effect, SCSA endeavours to actively involve both the older person as well as the service provider in the ongoing process of standard development and improvement.

As indicated earlier the first COVID-19 case in Malta was recorded on Saturday 7 March 2020.

In preparation and as a mitigation exercise, SCSA had defined the residential care settings as being high risk with regards to COVID-19. Immediately, SCSA issued directives mapped out in the 'SCSA COVID-19 Brief', SCSA (2020). There was immediate cooperation between the Public Health Authority and SCSA, which proved to be the primary catalyst towards safeguarding older persons within the facilities.

A. Directives and email notifications issued by SCSA

The following is a timeline of the whole sector measures issued by SCSA, prior and during the pandemic, within the residential care facilities. SCSA today remains ongoing and steadfast in its role.

- 1) Information sessions and contingency plans with respect to, (a) how/who would be taking care of the disinfection procedure of the care home should an older person test positive, (b) isolation facilities, (c) training of cleaners, (d) availability and wearing of PPE, and (e) management of cases, were carried out on the 4 March, 9 March and 12 March 2020.
- 2) Following the first COVID-19 case, a reminder was set to all the licenced residential care settings in respect of enforcing preventative measures of, (a) ensuring a clean and hygienic facility, (b) ensuring regular handwashing of older persons and staff, (c) availability of hand sanitisers for all persons entering and exiting the care home, (d) limited visitors of 2 at a time, (e) staff and relatives with flu-like symptoms advised to stay at home, and (f) restriction of visiting hours.
- 3) SCSA issued a circular on the 10 March 2020 limiting visitors and visiting hours. Initially, visitors were to book one-person at a time visiting slots. Successively, all visitors were requested to declare recent travel (if any), to particular countries, and including symptoms, and contact with potentially infected persons. Screening for fever was initiated prior to entering the residential care facility. On the 12 March 2020, all visits to the residential care facilities were suspended.
- 4) On the 12 March 2020, an emergency telephone number was circulated to all the residential care settings. Through a rota, SCSA senior management took calls, whilst noting and recording the help given to ensure consistency in replies.
- 5) A reminder addressed to service providers, health care professionals and caring staff was sent to all the residential care facilities on the 13 March 2020, in respect of hygiene practices and use and upkeep of uniforms.

- 6) A circular requesting facilitation of communication (through web conferencing and/or phone calls), between the older persons and relatives was sent on the 14 March 2020 to care home management.
- 7) All new admissions to the residential care settings were suspended on the 16 March 2020. Residents within the facilities who required hospitalisation were allowed back into the residence once fit to leave hospital and were quarantined in the facility.
- 8) Facilities were instructed (17 March 2020) to limit service delivery to the respective facility. To this effect, instructions were issued to facilitate laundry in-house (where possible) and also requested relatives to limit laundry related visits to once a week.
- 9) Following live-in requests by management and staff (23 March 2020), facility management were instructed to liaise with SCSA regarding decisions for live-in arrangements. Staff had to voluntarily opt for a live-in, and facilities had to ensure adequate sleeping arrangements and provision of food. Facilities who had opted for live-in arrangements either followed a 2 or 3 weekly rota. Other care homes opted to stay in lockdown until ease of measures from the Public Health Authority. In the latter, homes spent a total of 12 weeks in lockdown. In the 2 or 3 weekly rota, staff were advised on mandatory swabbing prior to entering the facility for the live-in period. The Public Health Authority, coordinated the COVID-19 swabbing for staff. Through a circular dated 16 April 2020, facilities were instructed on how and when to call for swabs and the documentation required upon return of swabs.

Staff live-in arrangements

Some of the private residential care facilities took further steps toward preventive measures across a number of homes. This arrangement started on the 16 March 2020 with the voluntary commitment of health care workers to live in house for a period of 3 weeks. Office staff worked remotely from home. Dormitories were set up to cater for the employees. Care workers were provided with separate laundry facilities, facilities for staff clothes and linen, staff meals and supplies, internet usage for family Skype calls, and psychological sessions in the case of need. The contingency plans highlighted how all supplies to the residential facility had to stop at the door, where items would be disinfected and later transported in-house by the staff under lockdown. Entry to the residential care facility was only limited to medical emergencies, where the necessary PPE was to be used exclusively for such situations. Plans were made for an external centralised mortuary in case of casualties. All admissions to the care homes were stopped.

As expected there was an increase in expenses with staff working for longer hours and living away from their loved ones. Nonetheless care homes took this change in their stride.

Older persons, were very much aware of the situation outside the care home, 'worked' hand-in-hand with health care workers. Activities within the facilities' gardens, cinema nights, music, and crafts were key towards ensuring high spirits for both older persons and health care workers, Figure 11 and Figure 12.

⁸Figure 11: Older persons enjoying crafts at Casa Antonia.



⁹Figure 14: Exercise activities at Casa Antonia.



^{8, 9} <https://lovinmalta.com/news/news-human-interest/wonderfully-surreal-how-a-maltese-care-home-is-coping-in-lockdown/>

- 10) SCSA facilitated bulk buying of PPE (25 March 2020), where facilities were put in contact with the supplier. This was ensued to alleviate the facilities' concerns should they not find any on the market. Active Ageing and Community Care successively prepared a video on the use and disposal of PPE which was distributed to the facilities on the 14 April 2020.
- 11) Through a circular dated 6 April 2020, facilities were requested to update SCSA's records concerning the number of occupied, vacant and contingency beds every Tuesday and Friday. This helped SCSA coordinate the requests of beds when received by the Public Health Authority or when any movement of the older persons was necessary. Successively, on the 9 April 2020, another circular requested a 10% contingency in beds and isolation facilities as well as the introduction of resident to carer allocation system.
- 12) SCSA requested through a circular dated 9 April 2020, for facilities to (a) ensure that staff worked solely in one residential facility to prevent possible cross facility infection, (b) coordinate transport of staff between their private homes and the facility, and (c) provide daily updates for both older persons and staff, of suspected positive cases, requests for swabbing and confirmation of positive results. The Public Health Authority provided training on swabbing techniques and use of PPE on the 16 April 2020.
- 13) The technical report published by the European Centre for Disease Prevention and Control in respect of face mask use was provided to the facilities on the 9 April 2020. On the 6 May 2020, 2 private companies donated 22,000 masks to the facilities. On the 9 April 2020, the National Hospital Chaplain liaised with SCSA in order for the authority to pass on information to the facilities related to requests for religious assistance to the residential care settings.
- 14) Through a circular dated 10 April 2020, the facilities' Legal Responsible Person was given responsibility for ensuring that staff exhibiting symptoms were not to report for work prior to seeking professional advice, and staff had to test negative to resume work duties. Earlier, on the 16 March 2020, facilities were instructed to communicate with SCSA in the case of a suspected COVID-19 case.
- 15) Through mutual collaboration (14 March 2020), the Public Health Authority and SCSA ensured that the 'Pharmacy of Your Choice Scheme', would be supplying the facilities with a 2-months' supply of pharmaceuticals, instead of the monthly medicinal provision.
- 16) On Mother's Day, 4 May 2020, SCSA recommended the facilities that relatives wishing to bring in personal gifts were able to do so, however, allowing care home management had to ensure that the gifts would be kept in a safe place to allow for the stabilisation period.

B. Legal Notices

The enactment of various Legal Notices, ensured that the dignity, safety and welfare of the older persons in the facilities were safeguarded during the exceptional circumstances of the COVID-19 pandemic.

An emergency licence was granted in exceptional circumstances through Legal Notice 74 of 2020. Within the local context the emergency licence, referred to a license issued by SCSA for the provision of a social welfare service, (SCSA, 2020). To-date a total of 12 emergency licenses were issued ranging from non-governmental organisations to the private sector providing social welfare services to older persons. This process remains on-going and further applications are being processed in this regard.

In addition, the continuation of the essential social welfare services during these exceptional circumstance were guaranteed for (a) the residential social welfare services for older persons and (b) for older persons living with dementia. This was assured through Legal Notice 149 of 2020. This legal notice was essential in order to legally oblige social welfare services to continue operating and functioning during these circumstances, and management and staff to keep providing their services.

All the essential social welfare services were directly accountable to the Chief Executive Office of the Social Care Standards Authority. These include, (a) any significant changes to the services, including, those relating to operational matters, (b) the provision of services, (c) contingency plans or amendments thereof, (d) live-in arrangements of staff and (e) all major incidents involving older persons and staff.

C. Monitoring and supportive measures

Information sessions through video and telephone calls had been ongoing replacing face-to-face meetings. Meetings between the facilities' service providers and SCSA were held on a weekly basis. When required, the topics were also discussed with the Public Health Authority for better guidance on the relevant subject matter. The topics brought out during these meetings varied and the following is a highlight of the more succinct matters raised, (a) information sought on passing away of residents particularly related on how to take care of the body; who would issue the death certificate considering the shortage of medical officers at the time; and what measures were required to return the older person's belongings to relatives; (b) information was also sought on ways to remunerate staff doing extra hours and whether there should be overtime capping; (c) information was pursued on the right protocol should an older person test positive to COVID-19; (d) training on the use of PPE; (e) guidance was sought in the case of hospital appointments for older persons and in the case of relatives wishing to take older persons out to lunch in their own community home; (f) a meeting with the service providers in the facilities was central to these calls where SCSA requested information about the financial expenses incurred by the residential facility and which were over and beyond the usual expenses. In such cases and where necessary SCSA discussed these issues at Ministerial and Cabinet levels; and (g) calls with facilities on lock down to ensure that circulars, and instructions were adhered to particularly related to infection control, 10% bed contingency planning, follow up on lockdown situations, older person allocations and isolation facilities.

The Quality Assurance Office within SCSA also continued receiving complaints, concerns and incident reporting from 'locked-out' relatives. All the complaints were settled immediately through dialogue and collaboration with all parties.

One residential care facility cleared an area close to the entrance of the home and invested in glass and aluminium shields for relatives to visit whilst keeping the older persons safe.

D. Liaison with Authorities

Collaboration between the Public Health Authority and SCSA, was and remains central during these exceptional circumstance. Of note:

- 1) The Public Health Authority and Active Ageing and Community Care (AACC) were continuously updated by SCSA in respect of the bed occupancy within the facilities. This facilitated movement of older persons in order for the Mater Dei Hospital (National Hospital), to have the required number of empty beds. SCSA was always present on the ground during movement of the older persons.
- 2) Public Health Authority were kept updated by SCSA on the numbers of residents and staff within the residential facilities.
- 3) Staff details were also provided to the Public Health Authority for potential COVID-19 antibody testing.
- 4) A virtual meeting with the Superintendent of Public Health, Consultant to the Superintendent, Head of Pathology and SCSA was essential to discuss the logistics of staff entering into 3-weekly lockdowns. Focal to the meeting was swabbing of staff prior to entering the lockdown. A maximum of 30 swabs per day were ensured. Policies for homes including (a) the timing of calling for swabs from the Department of Pathology, (b) how and who had to swab, (c) where to take the swabs once these were carried out and (d) receipt of results, drafting and forwarding to Public Health Authority.
- 5) To ease the burden on the Public Health Authority, a protocol for the suspected cases of individuals in lockdown was also drafted.
- 6) SCSA assisted the Public Health Authority by conducting a study on seropositivity for COVID-19 antibodies. Staff participating in the live-in arrangements, voluntarily participated in this study.
- 7) The Public Health Authority requested SCSA to provide a list of those older persons on regular nebuliser therapy.
- 8) The Public Health Authority also distributed guidelines on (a) general infection measures, (b) handling of groceries, (c) medication and supplies, and (d) donning/doffing/disposing of PPE to the facilities.

In addition, SCSA also liaised with Office of the Prime Minister on data regarding availability of generators and storage units within the residential care facilities. The Communications Office within SCSA extended its focus towards raising awareness to the general public on COVID-19. Newspaper articles and media spots were paramount towards reassuring relatives that the older persons were safe within the respective facilities, highlighting the fact that all decisions were taken in their best interests. SCSA also organised 9 sectorial infection control training sessions for staff within the facilities. Moreover, SCSA strengthened its active and regular participation in international fora through webinars organised by The European Social Network (ESN), The European Partnership for Supervisory Organisation in Health Services and Social Care (EPSO) and The International Foundation for Integrated Care (IFIC).

E. Strategic HR and Transformational Changes within SCSA

Early on and in the eventuality of a National Lockdown, staff members at SCSA were identified and provision for all necessary amenities of kitchen appliances, food provision, sanitary and sleeping facilities were ensured.

Upon the Government's announcement of the first active COVID-19 case on the 7 March 2020, all facilities were visited by SCSA, reminding them of the preventative measures that were required. All issued circulars were backed by telephone calls to the respective Care Home Management, by the SCSA assessors. At the Public Health Authority's recommendations, visits by assessors to the facilities were reduced, and when required the recommended social distancing was observed. Feedback sent to the Authority, mostly by relatives of the older persons, was followed up through both telephone calls and visits.

5.2. Care coordination issues

5.2.1. Hospital discharges to the community

Older persons discharged back into the community from the main acute, palliative, and rehabilitative settings were expected, even to date, to remain in mandatory quarantine for a period of 15 days from day of discharge.

5.2.2. Hospital discharges to residential and nursing homes

Residents within the residential care facilities and requiring hospitalisation were allowed back into the residences once fit to leave hospital and quarantined in the facilities themselves. This arrangement remains ongoing.

5.3. Care homes (including supported living, residential and nursing homes, skilled nursing facilities)

5.3.1. Prevention of COVID-19 infections

A set of guidelines to prevent COVID-19 infections, prepared by SCSA in collaboration with the Public Health Authority, was made available to the residential care facilities, in the first week of March 2020 (SCSA, 2020). The guidelines included, (a) occurrence of transmission of the virus, (b) infection control and hygienic measures, (c) physical distancing, (d) bathroom and toilet hygiene, (e) entry and exit to and from the facility, (f) handling of groceries, medication, and supplies prior to entering the facility, (g) use of PPE, (h) donning and doffing, including the sequence of donning and doffing, (i) caring for older persons (not known or suspected to be COVID-19 positive), (j) use of PPE when swabbing older persons for COVID-19, (k) disposing of PPE (particular reference was made to the nun's veil in the case of Church Homes), (l) disinfection of a room in the case of a positive case, and (m) preparing carers for the live-in period within the residential care facilities.

Further to the above, as of the 25 May 2020, the Superintendent of Public Health in collaboration with SCSA, announced the first set of relaxation measures.

A number of protocols which relatives and friends had to abide to, were imposed, including, (a) visits required to be booked 2 days in advance, (b) 4 persons were allowed to visit at a time for a total duration of 15 minutes, (c) relatives had to wear face masks during the entire duration of the visit and required monitoring of temperatures and (d) relatives visited the older persons from behind an acrylic structure. Special accommodations were put in place for bed bound older persons so that they too could interact with their loved ones, (SCSA Circular 22/2020).

Occupational Therapists, Physiotherapists, Podiatrists and Speech Language Pathologists attending to rehabilitative sessions within the care homes were required to follow these set of measures, (a) therapists had to wear a face mask or a visor or both when the session was of longer duration than 30 minutes, aprons when necessary, gloves and use of alcohol sanitisers, (b) the therapist had to attend to one care home per day, (c) in the case of a care facility with multiple floors, the therapist only attended to 2 floors and in the case of an urgent visit in another floor, this would be attended to prior to the other floors, (d) clean uniforms which were to be removed once the therapist returned home or to the office, and (e) therapists assessed older persons in care home's clinic wherever possible.

5.3.2. Controlling spread once infection is suspected or has entered a facility

All residential care facilities had contingency plans of isolation units. Any older person who would have tested COVID-19 positive was transferred to these units.

5.4. Community-based care

All community services resumed on the 1 June 2020, following mitigation measures as indicated below. A set of internal guidelines were drafted by SCSA in collaboration with the Public Health Authority and the Active Ageing and Community Care.

5.4.1. Day Services

Older persons and staff attended Day Care Services and Dementia Active Ageing Hubs on a rotational basis as of the 1 June 2020. Priority for attendance was given to those older persons living with their families and receiving no other service. Particular attention was given to cleaning and disinfection of the centre prior to receiving the older persons and at the end of the day. Older persons were informed of how operations would resume together with their days and hours of attendance. Social distancing measures were explained. All staff and older persons were to bring a change of shoes with them for outdoor and indoor activities, kept secured at the Day Care Centre. Staff were to wear visors throughout the working day. Older persons were required to wear masks or visors throughout the day. In the case of older persons who did not tolerate the mask because of sensory issues, stricter respiratory hygiene by staff was ensured. Alcohol sanitisers were provided on the premises and regular handwashing was implemented throughout the day. Temperature monitoring of staff and older persons took place.

5.4.2. Home Help

Home Help Supervisors, performed essential visits only for the (a) new cases, (b) introduction of helpers to the older person and (c) urgent problems.

Helpers wore a mask or visor at all times when providing a service within the older person's home. Older persons and helpers had to ensure a 2m distance and avoid any physical contact. Where possible the older person stayed in another room away from the helper. The helper had to sanitise hands prior to entry and exit of the older person's residence.

In order to safeguard both the health care workers and older persons, and prior to attending to the older person's house, supervisors had to ensure that, (a) no member of the household was feeling unwell or was in quarantine due to exposure to COVID-19, (b) the older person had to wear a mask or visor, (c) the older person prepared all the necessary items required for the service or for the purpose of the visit beforehand, (d) a window or a yard door were always open in order for adequate ventilation, preferably 30 minutes before the visit or provision of the service, and (e) only members of the household were present during the home visit or provision of service.

5.4.3. Community Visits to older persons from clinicians

The guidelines brought together the services offered by the Allied Health Professionals (Occupational Therapists, Physiotherapists and Podiatrists), Dementia Intervention Team, Nursing Services and the Social Work Unit.

The guidelines provided for exploring the use of technology instead of face-to-face visits based on a risk assessment. Clinicians carried out a home visit only if deemed necessary and if the use of technology was considered insufficient in the circumstances. Clinicians had to consider that the household they would be visiting was a potential COVID-19 high risk situation and took all the protective and infection-prevention precautions as necessary, (a) prior to the visit, telephone contact was made with the household before the actual visit to assess what interventions were needed and how much time would be allocated for the visit, (b) during the telephone call, the clinician had to confirm that no member of the household was unwell, or in self-isolation due to exposure to COVID-19, (c) clinicians had to (i) liaise between themselves as who would be present during the visit in order to facilitate any required paper work and items in advance to reduce time spent at the household, (ii) prepare beforehand all the necessary equipment needed during the visit, (iii) secure apron, gloves, masks and visor, sanitiser and ensure a secure way of disposing of the PPE, (iv) ensure a way of washing hands prior to and immediately after leaving each household, for example by using alcohol hand rubs.

During the home visit, the clinician/s had to (a) put on surgical mask, apron and gloves prior to entering the household, (b) confirm again that no member of the household was unwell or in self-isolation due to COVID-19 exposure, (c) ask household members to open any doors or windows, (d) avoid touching surfaces and refrain from putting on personal items down on surfaces, (e) avoid touching the face, (f) keep a minimum of 2 meters distance from other persons, (g) keep not more than 2 persons at a time in the older person's room, (h) keep the visits as brief and focused as possible, (i) dispose of the PPE in a garbage bag prior to leaving the household and leave it with the relative or older person so as to be discarded properly as mixed garbage, and (l) apply hand hygiene again.

After the home visit, the clinician had to, (a) sanitize any equipment brought out of the home after the visit, for example, using disinfectant wipes for phones, laptops, medical equipment, (b) sanitize the surfaces where prior cleaning had taken place, (c) wash hands using alcohol hand rub and (d) at the end of the day, remove and wash clothes that may have been exposed to the virus, and have a shower.

5.4.4. Measures to prevent spread of COVID-19 infection

On a national level, Malta is currently going through a step wise relaxation of measures with the intent of keeping risk to a minimum for this high risk category. Community services (Dementia Intervention Team, Allied Health Services, and Nursing) to the older persons have resumed. Home Help Services have since resumed whilst Meals-on-Wheels maintained their operations throughout.

Notwithstanding, advice for the older person cohort remained to shelter in place.

5.5. Impact on unpaid carers and measures to support them

The COVID-19 disrupted the community services. Allied Health Professionals provided e-health for a short while.

5.6. Impact on persons living with dementia and measures to support them

Early on during the pandemic, the Superintendent of Public Health had categorised persons living with dementia as a high risk group or 'vulnerable'. For the past 12 weeks older persons living with dementia and informal carers have largely sheltered at home. The services of the Dementia Intervention Team within the community was restricted during the pandemic and contact with informal carers was kept via telephone calls.

Unofficial information from relatives and guardians, Dementia Intervention Team and Community Allied Health Professionals attending to the older person living with dementia, has indicated the constraints families and the older person are going through during this taxing time. Families are frustrated about the lack of a clear exit strategy. They spoke of their limbo in the current situation reiterating that whilst measures for the country were being step wise relaxed, however, high risk categories were advised towards sheltering in place.

The Parliamentary Secretary for the Rights of Persons with Disability and Active Ageing launched the National Dementia Strategy in April 2015 (NCAA, 2015). The strategic policy included a work programme spread over 9 years, until 2023, and mainly focused towards improving the quality of life of persons living with dementia, and informal carers. The policy resulted in the inception

of the Dementia Intervention Team (DIT)⁶. The team is comprised of 2 nurses and 2 occupational therapists, providing a community-based service to persons living with dementia and informal carers. This service implemented a holistic assessment and care plan, carried out within the home environment of the older person living with dementia, with the ultimate aim being for the older person to live actively within the community.

Locally, it is estimated that 6,071 older persons, equivalent to 1.5% of the Maltese population live with dementia. This figure is expected to rise to 3.5% of the general population by 2050, (NCAA, 2015).

At the height of the COVID-19 pandemic, DIT's intervention within the community was curtailed to urgent visits only. Virtual contact was maintained solely by electronic means, with a round the clock helpline providing telephone respite and assistance to informal carers. Older persons living with dementia were requested to shelter in their homes, as per the Public Health Authority's guidelines and as such, all activities organised by informal carers could only take place within the confines of this environment. To-date DIT functions as pre COVID-19, with clinicians maintaining social distancing and wearing of masks or visors. This new norm is in its infant stages and much needs to be learned with respect to the impact of the lack of visits early on during the pandemic and this new reality on the older person living with dementia and the informal carers.

Older persons living with dementia within the residential facilities seem to have been more positively engaged vis-à-vis active ageing activities, when compared to older persons living with dementia within the community, (Figure 15, Figure 16, Figure 17).

Figure 15: Older persons and staff during activities at Bormla Care Home.



Source: <https://www.caremalta.com/working-hand-in-hand-all-for-one-and-one-for-all/>

⁶ <https://activeageing.gov.mt/en/Pages/Dementia-Intervention-Team.aspx>

Figure 16: Older persons during activities on Easter Day, at Casa Arkati residential facility, (Courtesy of Borg Noel, CareMalta, 2020).



Figure 17: Older person resident at Mellieha Home during a Skype Call with his family.



Source: <https://www.caremalta.com/here-for-one-another/>

As we slowly emerge from COVID-19 we need to evaluate the impact of the pandemic on the lives of the older persons living with dementia and the informal carers. What went well? Are the exit strategies for the persons living with dementia in the community adequate for their needs? It would be opportune to look and re-visit the National Dementia Strategy in the light of the past months. This is something which we need to succinctly think about and evaluate and push more efforts towards addressing the needs of older persons living with dementia and still living in the community. As professionals, it should be our goal to endeavour that older persons 'age in place' and age well within their own communities.

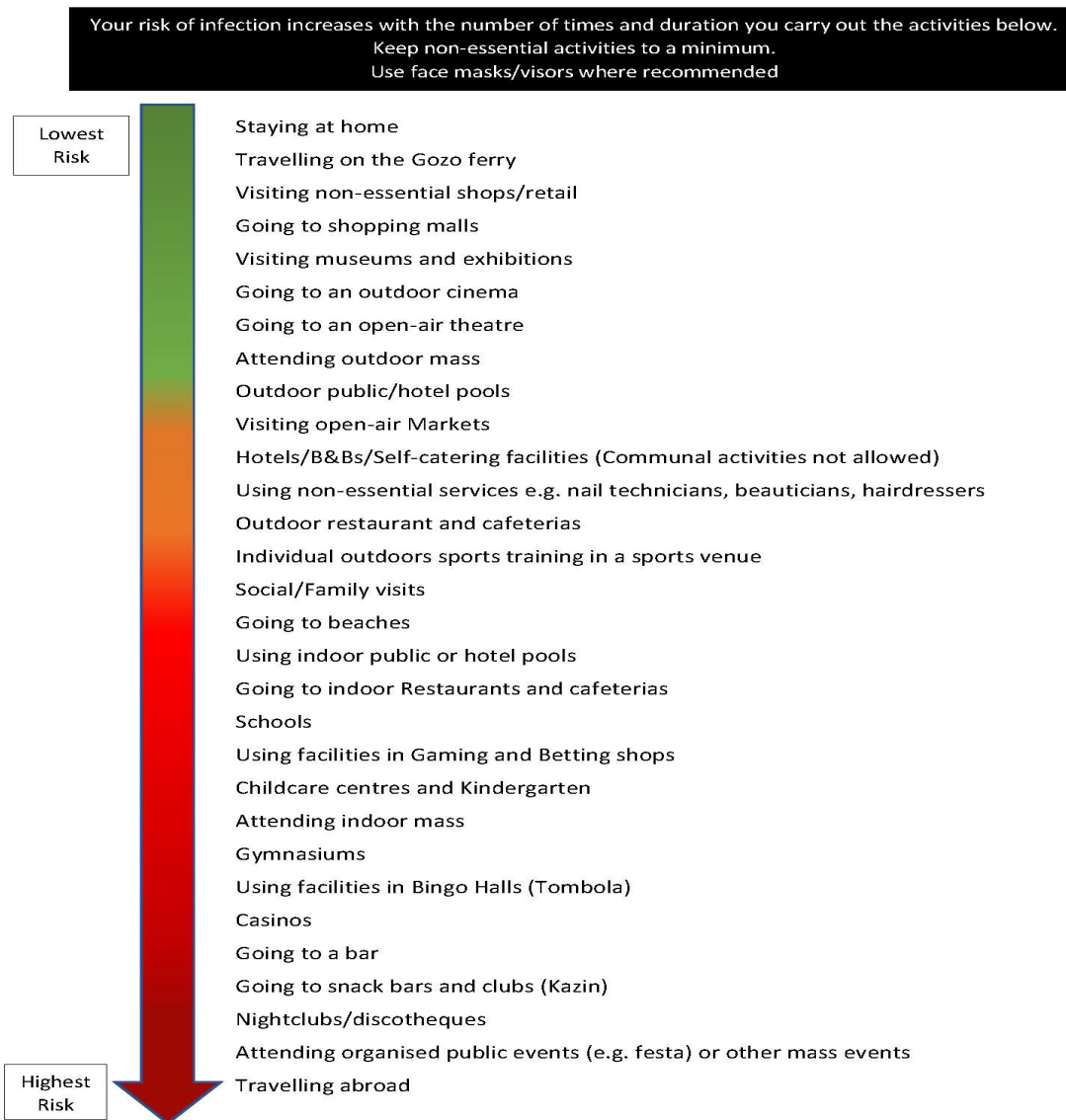
6. Lessons learnt so far

The immediate early on collaboration between the Superintendent of Public Health and the Social Standards Care Authority was paramount towards safeguarding older persons residing with residential care facilities.

There was fierceness early on from the Management of the facilities as well as the health care workers towards protecting the older persons in the facilities. This augmented the resilience within SCSA towards protecting the older persons. Mutual collaboration was paramount in the current success towards protecting the lives of the older persons residing within the care homes at this time of crisis.

Figure 18, provides a succinct overview of mitigation measures which members of the public including health care workers should be aware of in order to ensure optimal protection for themselves, their families and the older persons.

Figure 14: Guidance for Vulnerable Persons, www.covid19health.gov.mt



6.1. Short-term calls for action

Malta's transition out of the COVID-19 pandemic is being carried out in a number of phases, in line with lowering of the Reproduction Factor (R_t) among other surveillance measures. Currently the R_t factor stands at less than 0.5. Malta is following World Health Organisation (WHO) and European Centre for Disease Control (ECDC) guidance in this regard. The exit strategies of other countries are also being closely monitored. The resultant impact on their COVID-19 epidemiology, particularly through consultation with guidelines on mitigation factors required for the various social and economic activities, are also being evaluated (Health Promotion & Disease Prevention Directorate, Ministry for Health, Malta).

Gradual relaxation of public health measures in phases starting with ‘lower risk’ activities is dependent on the stability of these epidemiological surveillance measures and reliant on the discipline of the public by adopting COVID-19 mitigating measures when in retail establishments or engaged in other services which have resumed activity in the transition phase. Adequate health capacity for potential increased transmission and the effects on hospital admissions and mortality are also being considered. A suitable time period between the relaxation of measures and observation of the full effect on the relaxation of these measures in terms of stability of the epidemiological indicators was strongly recommended.

Action plans remain ongoing, as described within Section 5.

6.2. Longer term policy implications

Never before this COVID-19 time have the older persons struck a chord with the international and national communities. And care homes worldwide albeit for the wrong reasons have become the viral ‘hot-spots’ of recognition.

Now, for the right reasons, we need to keep this momentum and ensure that care homes get the platform they so rightly deserve. Primarily we need to zero in on exit strategies that allow the older persons that degree of freedom within our communities, as care homes emerge from COVID-19. We also require this departure point, to address innovative and improved approaches for relevant research within care homes.

Locally, the process instituted by the Public Health Authority and SCSA, to ramp up on the preventative care to safeguard this cohort remains ongoing. On the 4 May 2020, the Superintendent of Public Health embarked on a stepwise relaxation of measures. This measure was followed by another one on the 22 May 2020 and successively another one will follow on the 5 June 2020.

At the time of the second relaxation of measures, 22 May 2020, management from the Private Sector and Church Homes voiced their concerns on a number of matters related to the exit strategy, (a) extra costs incurred towards COVID-19 measures, (b) the increased overtime costs as more care workers were needed for cleaning or to coordinate video calls between older persons and their relatives, (c) the extra costs towards adapting spaces into living quarters, providing laundry facilities, food, and transportation of health care workers, (d) the income for private service providers dropped as admissions and respite services had stopped, (e) active older persons within the care homes inquired when they would be able to go out again.

Lives matter. Time will be our harshest critic.

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