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“Hindsight is a marvellous tool, and decisions made in good faith in real time may not work out in practice as circumstances evolve. However, we must also analyse and learn lessons so that in future we are even better equipped,” writes Professor Rowan Harwood, Editor-in-Chief of Age and Ageing.In this blog I write as a care home nurse with hindsight, reliving my shift in mid-March, when I could hear the ‘hooves of the apocalyptic horses’ approaching as coronavirus took hold. I have not worked there since, as I have instead been caring for my husband who is shielding. There’s no telling when I might return since the coronavirus peak may be still to come in the care sector. I hope though that lessons can be learned from what happened – and what didn’t happen – in care homes in the early days of the pandemic.

The fear

By mid-March, all but essential visits to care homes had been cancelled. Fear, though, remained a visitor with a strong foothold and no intention of leaving.

Faced with an ‘infodemic’ of misinformation –and some very real statistics – we care home staff knew that devastation was coming, and we didn’t know – nor were we told – how to protect ourselves. It was obvious that coronavirus would spread like wildfire in the care home setting, taking lives and further depleting an already struggling workforce.

Temperature and cough were, for many weeks, listed as the only concerning symptoms. These symptoms are however often widespread in our population, with infections, dysphagia and COPD being common. Potentially now signalling the arrival of coronavirus, these complaints became somewhat sinister. “Every time I step inside a room, the resident seems to cough,” cried one-night worker; suddenly, the ordinary had become the ominous.

Phone calls from families fanned the flames of fear: one daughter explained that she had returned from a trip overseas and was now self-isolating and another described their own likely Covid19 symptoms – yet both had already paid several visits to loved ones in the home. One agency staff member, presumably prompted by fear of losing income, refused a temperature check. Seen as ‘super-spreaders’ of the virus, agency staff [2] are essential members of a team that finds recruitment difficult. A colleague aged 72 continued to work with us, despite being at

high risk of complications should she be infected.

The fatality

According to the Nursing Times [3], "the first death involving COVID-19 recorded by the Office for National Statistics as having taken place in an English care home happened in the week ending 20th March". The same article describes how PHE had, on 13th March, removed previous advice stating that "it remains very unlikely that people receiving care in a care home will become infected."

Arriving for what was to become my last shift, I saw a bed that had been left in a hurry. The resident had been taken to hospital for the second time in ten days. Her deterioration over this time had prompted paramedics to re-admit her.

My concern, however, was the risk posed by her temporary discharge back again to the care home while still acutely unwell ("coughing up black phlegm," according to one experienced carer). Professor Rowan Harwood acknowledges in his blog that "in the name of speedy discharge to empty valuable hospital beds, care homes were denied a say on who they took back". It did not feel as if a protective ring had been thrown around us.

She was admitted back to the hospital again and later that evening, the Head of Care was informed by the resident's brother that the patient had died – and that she had tested positive for Covid19. Whether she had been contagious during her time with us between her hospital admissions was unknown. As the patient in the next room began to show symptoms, however, this seemed disturbingly likely.

The families

In 2017, I wrote an article for the Hippocratic Post entitled "Care Home Cast Away [4]". Based on the film 'Cast Away', I described similarities between Chuck Noland's (Tom Hanks') desert island experience and that of the forgotten elderly in care.

Three years later during the pandemic, care home residents are disconnected and isolated from family, friends and support networks as never before, and are at risk of both mental and physical problems, as described by Dr Fiona Lithander in her paper in A [5]ge and Ageing [5].

"Family inclusion has been an article of faith for geriatricians, especially when managing people living with delirium and dementia," writes Professor Harwood [6]. Dr Marcus Stevens also wrote about the grave consequences of loneliness seen in some care home residents, similar to a bereavement.

The total exclusion of essential family members during Covid19 has been difficult to explain. For those living with dementia, a spouse or close family member can be a vital part of the care team. It was a cruel irony that care homes were urgently seeking to recruit [7]volunte [7]e [7]rs [7] to help residents during Covid19 while family members were banned from visiting.

The futility

Vigilance is key in care home nursing. Florence Nightingale famously wrote that 'The most important practical lesson that can be given to nurses is to teach them what to observe—how to observe—what symptoms indicate improvement—what the reverse—which are of importance—which are of none—which are evidence of neglect—and of what kind of neglect'.

It is difficult to be vigilant when the threat can't be seen (as in the case of a virus) and when the symptoms are diverse and diffuse (as in COVID-19). Testing may have helped but this didn't arrive until mid-May, arguably too little, too late. We worked without masks, we managed without a full complement of cleaning staff, and we found it difficult to impose self-isolation on some residents . It felt as if we were baling out a boat with a broken bucket.

Social distancing is also futile in care home nursing. The work is intimate; there's no social distancing when you're helping to wash, dress or feed somebody. Our residents feel like family, having often spent many years in our care. We hold hands, dance with them and put an arm around them. Some scared staff tried to do this whilst holding their breath and this felt heartbreaking and hopeless in equal measure.

The future

How many more COVID-related deaths are still to come in the care home sector? Post-pandemic, will there be an epidemic of delirium, and worsened dementia, caused by social isolation? “If you could design a health care system that would generate delirium, you would design exactly the system we have with COVID-19: where patients are socially isolated, deprived of human comfort and communication…” writes geriatrician Dr Inouye [8] in the New York Times.

Furthermore, who will choose care home nursing as a career after COVID-19? Before the pandemic, care homes [9] were often seen as a ‘place of last refuge for nurses’ and they struggled to recruit staff. I delight in looking after some of society’s most vulnerable people who, in the words of Maya Angelou, might not remember what we have said or done, but may well ‘remember how we made them feel’, but it is going to take a long time to convince others to now join the profession.

For those already working in care homes, COVID-19 will leave a lasting psychological impact. They are exhausted and traumatised. Workers from overseas who have been unable to see their own families for long periods may also think again about continuing to care in a country far from home, especially if, as is suggested [10], COVID-19 outbreaks could become a longstanding feature of care home work.

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