



INTERNATIONAL
LONG TERM CARE
POLICY NETWORK

Germany and the COVID-19 long-term care situation

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Last updated: 15 April 2020

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Corrections and comments are welcome at info@ltccovid.org. This document was last updated on 15 April 2020 and may be subject to revision.

Suggested citation

Lorenz-Dant, K. (2020) *Germany and the COVID-19 long-term care situation*. Country report in LTCcovid.org, International Long Term Care Policy Network, CPEC-LSE, 15 April 2020.

Acknowledgements

The author would like to thank Adelina Comas-Herrera and John Lorenz-Dant for their feedback on preliminary versions of this report.

1. Key points

- The German government has issued financial support and loosened monitoring rules for care providers during this pandemic so that the residential and ambulatory care that people receive can be maintained.
- The federal structure of the country enhances the ability of individual states to respond to the need of their population. However, this also leads to a situation where responses differ from state to state.
- The Robert Koch Institute (RKI) provides regularly updated guidance, recommendations and advice for specific care settings.
- The RKI issues a daily update on the number of confirmed and recovered COVID-19 cases as well as of the number of COVID-19 related deaths. However, data is not disaggregated by care setting. This means that there is no information on the number of cases in institutional care settings.
- While there is detailed guidance and planning for institutional care settings, there is very little COVID-19 specific information for people with care needs living in their own homes or for their unpaid carers. There are, however, existing funding mechanisms in place to support families providing care in the community.
- There is a lack of information and advice regarding the care of people living with dementia.

2. Impact of COVID19 on Long-term care users and staff so far

2.1 Number of positive cases in population and deaths

The **Robert Koch Institute (RKI)** monitors infectious and non-communicable diseases in Germany. It also conducts research and advises relevant ministries, especially the Ministry of Health. The RKI is involved in the development of guidelines and norms. According to their daily update (as of 14 April 2020), there had been 125,098 confirmed cases of COVID-19 in Germany (an increase of 2,082 in comparison to the day before). Of the confirmed cases, 17% were in people aged 70 years or older. Out of all confirmed cases an estimated 68,100 have recovered and 2,969 people (2.4%) have died. Of those who have died, 86% of people were aged 70 or older (1).

The RKI also records COVID-19 cases among health and long-term care staff. Of the confirmed cases, 5,846 people (72% female, 28% male) worked in hospitals, doctors' surgeries, dialysis centres, ambulatory care services or in the ambulance service. The reported median age for this group is 42 years (1).

2.2 Population-level measures to contain spread of COVID-19

Since 23 March 2020 a ban on public assembly has been in place across Germany as an effort to slow the spread of the infection. Gatherings of more than two people, with few exceptions, are forbidden. This does not apply to families and persons who live in the same household. In addition, restaurants and businesses for body care (e.g. hairdressers, cosmetic studios) had to close (2,3). The Federal State of Bavaria has enforced a curfew from 20 March 2020 (starting at midnight) for two weeks initially (4). On 27 March 2020, the Federal Council (*Bundesrat*) agreed to the new legislation on the protection of the population during an epidemic situation of national significance (*Gesetz zum Schutz der Bevölkerung bei einer epidemischen Lage von nationaler Tragweite*) that had passed the German lower chamber (*Bundestag*) on 25 March 2020 (5). The law alters the usual organisation and competences of the Federal Ministry of Health (*Bundesministerium für Gesundheit*) by allowing it to declare an 'epidemic situation of national significance'. This declaration enables the Federal Ministry of Health to issue regulations and bills concerning the basic supply of medication, including narcotics, medical products, laboratory diagnostics, aids, protective equipment and products for disinfection, and to increase healthcare resources (personnel) without requiring approval from the Federal Council (*Bundesrat*). The

German lower chamber and the Federal Council can ask to cancel this law and the federal government is required to rescind these special powers as soon as they are longer required. Measures taken under the epidemic situation law to respond to the epidemic then lose their validity (6). It is understood that declaring an epidemic situation of national significance overrides the authority of the federal states that are usually in charge of managing infectious diseases.

As of 1 April 2020, the RKI changed its advice and now recommends the wearing of mouth-nose protection (community non-medical masks) in public. Medical masks should be reserved for health and care personnel. This change occurred because of evidence that many people who are asymptomatic or experience only very mild symptoms may, however, still be infectious to others. The wearing of a community mask can hold back droplets that are spread when speaking, coughing or sneezing. This reduces the risk of infecting others. There is, however, not yet sufficient evidence that wearing a community mask prevents infection. The wearing of community masks is recommended in situations where the protective distance cannot always be maintained (such as in shops). The institute further recognises the psychological effect of wearing masks to support consciousness about the importance of physical distancing. It maintains that the best way to protect oneself and others from an infection with COVID-19 is good hand hygiene, adhering to rules regarding coughing and sneezing and to keep a distance of at least 1.5 meters from others (7,8).

The districts (*Landkreise*) of Jena and Nordhausen City (*Stadt*) have made the wearing of a mouth and nose covering mandatory in shops, public transport and official buildings (e.g. town halls). The city of Jena specifies that scarfs, fabric or home-made masks that cover mouth and nose are sufficient (9).

On 6 April the RKI reported that over the preceding few days COVID-19 outbreaks in care and nursing homes had increased. In some of the outbreaks the number of people who had died are high in comparison to the national average in the same age group (10).

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

People with long-term care needs living in care and nursing homes are particularly vulnerable to COVID-19 infection. Outbreaks in these settings are therefore particularly worrying.

Over the last few weeks several outbreaks of COVID-19 have been reported in care and nursing homes across Germany. The first COVID-19 outbreak in a nursing home was reported in Würzburg, Bavaria, in a home with 149 residents. Tests among staff showed that 33 out of 58 had been infected (11). This outbreak resulted in 22 deaths (12).

In approximately mid-March, the virus entered a care and nursing home in Wolfsburg housing 165 people, most of whom live with dementia. On Sunday 29 March, 79 of the residents tested positive. By Monday 30 March, 17 residents, some of whom did not show any symptoms, had died (13). By 13 April, the number of deaths has risen to 36. It has been reported that St John's Ambulance (*Malteser*) have donated 120 protective masks (FFP2-standard) and 180 safety goggles to the nursing home(14).

On 31 March, there were reports of two further nursing homes in Lower Saxony where residents and care staff had tested positive for COVID-19. Now there is evidence of a further care home in Donau-Ries, Bavaria, where it is understood that eight residents have died (15). Furthermore, in Munich, Bavaria, it was reported that 25 residents of a nursing home as well as five carers had tested positive for COVID-19(16). In Baden-Württemberg, there are at least seven care and nursing home with positive cases. There are also reports of affected institutions in Saxony-Anhalt and North Rhine-Westphalia (17).

Since then, reports of outbreaks in care and nursing homes have continued. An article in *'die Welt'* (newspaper) from 14 April 2020 reports that of the approximately 150 care and nursing homes in Hamburg, 28 institutions have been affected by COVID-19. In these, 234 residents have been taken ill and several homes have recorded cases of death. Staff have also been infected. The Hamburg Senator for health expressed concern for people living and working in care homes. In order to better protect residents, visits from relatives have been banned and additional testing of staff should reduce the risk that the virus could be transmitted inadvertently (18).

In one care home in North-Rhine Westphalia 37 of the 70 residents and 38 carers have tested positive for COVID-19 (as of 11 April 2020). Due to staff shortages the emergency civil protection services (*Katastrophenschutz*) had to step in to look after the residents as most care staff had been infected. There was an attempt to recruit volunteers but too few people came forward. The residents with COVID-19 have been moved into hospitals in the area, while the non-infected residents are continuing to stay in the care home with the remaining carers. Following updated guidelines (see below), asymptomatic care staff are allowed to return to work after seven days in quarantine (19).

Another article from a nursing home in Schleswig-Holstein reported that 53 out of 130 residents and 19 members of staff had tested positive for COVID-19. As of 14 April, two residents and three members of staff had been taken ill. In response to the outbreak, staff only commute between their homes and the care homes. They and their cohabiting family members have otherwise been placed under quarantine (20). Contact with a second care home operated by the same provider has been cut. Staff who have tested positive but remain symptom-free continue working in the nursing home, as many of the residents live with dementia and rely on familiar carers. The residents continue to move within the institution relatively freely as it is difficult for people with dementia or psychiatric illnesses to adhere to agreements. It appears that those that so far have tested negative cannot be physically separated from those infected due to space constraints. The German Foundation for patient protection (*Stiftung Deutscher Patientenschutz*) has been reported to have criticised this procedure as extremely dangerous (21).

So far no national data or data by federal state can be found to monitor the number of people living in residential care settings affected by COVID-19, nor is information available about how many people in receipt of community-based care, or their unpaid or paid carers may be infected.

3. Brief background to the long-term care system

Germany has a population of 83.1 million. In 2018, 17.9 million people were aged 65 years and older (22% of the population) (22). According to the German Federal Statistical Office (Destatis), in 2017 there were 3.4 million people with long-term care needs, 63% women. The majority of people with long-term care needs, as in many other countries, receive support in their own homes (76%). Of those receiving support at home, 68% do so from unpaid family carers and 32% receive (additional) support through one of the 14,100 ambulatory care providers. Most of the people receiving care at home are registered as having moderate care levels (levels 2 to 3). Destatis estimates that 818,289 (24%) people with long-term care needs live in Germany's 14,500 care and nursing homes. Most people living in institutional care settings have moderate to considerable care needs (levels 3 to 4) (22).

In Germany care needs are organised into five categories, ranging from low (level 1) to severe needs (level 5). People are assigned to the different categories following an assessment of six core areas of living (mobility, cognitive and communicative abilities, behaviour and psychological issues, ability to independently take care for oneself, handling of requirements and strain related to illness, and therapy and organisation of everyday life and of social contacts) consisting of 64

criteria. The care needs must persist over at least six months. Depending on their level of need people receive different levels of support (23).

Support for long-term care needs is organised through care providers and financed largely through the long-term care insurance that every working German, irrespective of whether they are insured through a sickness fund or through a private provider, has to pay. People with long-term care needs can decide whether they prefer financial and/or in-kind support. The main goal of the insurance is to enable people with care needs to live a self-determined life. However, the long-term care insurance usually does not cover all care related costs. This is where people with long-term care needs experience out-of-pocket expenditure (24).

4. Long-Term Care policy and practice measures

4.1 Whole sector measures

4.1.1 Funding package by the federal government

On 27 March the German **Ministry of Health** (*Bundesgesundheitsministerium*) announced a funding and support package to help care institutions during the COVID-19 pandemic. The measures outlined include:

- Ambulatory and residential care will be relieved by suspending quality assessment as well as changes to assessment and the waiving of obligatory advisory visits to people with care needs.
- Long-term care insurance will reimburse institutions providing care that incur additional costs or loss of revenue due to the COVID-19 outbreak.
- In order to maintain the provision of care, institutional care settings will be allowed to deviate from certain rules and operational frameworks around staffing level.

The care insurance providers will additionally support providers to avoid gaps in supply of paid home care (25).

On 3 March, the **National Association of Statutory Health Insurance Funds** (*GKV Spitzenverband*) issued a statement on the rescue package to support care providers during the pandemic. Besides outlining the different components of the new legislation, the association also provides information on estimated costs. According to health ministry estimates, the association expects to spend approximately an additional €10 per month per person with care needs for protective equipment. Assuming additional costs for seven months for four million people with care needs, this results in an additional cost of €280 million.

Costs for additional carers for ambulatory care and care in residential settings cannot be estimated even approximately. In the example provided, the monthly costs of an additional care assistant in an institutional setting for the employer is estimated to be around €2,200, while the cost of a qualified carer in an ambulatory care setting is estimated to be €3,300. It cannot be predicted how many additional carers and care assistants are likely to be required.

In addition, the association outlines how people with care needs can be supported in cases where the usual ambulatory care or replacement care cannot be provided. The document states that the cost of support through other people can be reimbursed for up to three months. In the first example provided, a care recipient (care level 5) who usually receives care through an ambulatory care provider and without direct family support receives support from an employee of a temporarily closed day care institution. The care recipient can claim up to €1,995 to cover the cost of the replacement support. The second example describes the situation of a person with care level 2 who usually receives care from her daughter as well as from an ambulatory care provider. The care recipient receives direct payments (60%) and in-kind support (40%). In this hypothetical

case, the ambulatory care provider is unable to provide its services due to quarantine or illness of the carer and the daughter is unable to step up her care commitment due to employment. A neighbour steps in to provide the 40% the ambulatory service would have covered. The neighbour in this case can bill the care insurance for support she or he has been providing for up to €275 (40% in-kind support) (26).

4.1.2 Other funding related activities

The Bavarian Minister for Health and Care and the Bavarian Minister of Finance announced that the catering for all staff in health and care setting (hospital, care or nursing homes) will be financially supported (€6.50 per member of staff per day) as a sign of appreciation of their role in responding to the pandemic (as of 1 April 2020) (27).

On 7 April 2020, it was reported the Bavarian cabinet had decided that around 250,000 paid carers working in care and nursing homes as well as in care settings for people with special needs will receive a single payment of €500 (tax-free) in recognition of the work they have been providing during the pandemic. This will cost the federal state of Bavaria €126 million (28).

The trade union *VERDI* reported on 6 April 2020 that following meetings with the federal association of employers in the care industry (*Bundesvereinigung der Arbeitgeber in der Pflegebranche (BVAP)*) they had agreed on key points for a special payment for care workers in institutional long-term care settings and ambulatory care to reflect the additional burden during the pandemic. According to this agreement, the parties have agreed that full-time staff should receive a single payment of an additional €1,500 as part of their July pay. Part-time workers should receive the premium proportional to their hours worked and apprentices should receive €900. The organisations will continue working towards the implementation of this plan (29).

4.2 Care coordination issues

4.2.1 Hospital discharges to the community

General criteria for the discharge from hospital into community settings have been provided by the **RKI**. People can be discharged into isolation at home where, following medical assessment, ambulatory support can be provided. Discharge without further restrictions is possible if the patient has not had relevant symptoms for at 48 hours and had two negative tests (24 hours apart) (30).

4.2.2 Hospital discharges to residential and nursing homes

People with long-term care needs who have been living in care or nursing homes or those that require care in residential settings following hospitalisation pose the greatest care coordination challenge. Due to the vulnerability of residents living in care and nursing homes, as outlined above, many care home providers fear an outbreak. Some larger care homes, such as a care home in Kiel, have freed up short-term spaces specifically for people discharged from hospital. However, the isolation of residents following hospitalisation poses challenges for smaller institutions (31).

The federal state of **North-Rhine Westphalia** (*Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen*) responded to the challenge with updated legislation (4 April 2020). These changes aim to ensure that hospitals can continue to discharge patients into care and that care homes can take on new residents. The legislation requires hospitals to test patients at the point of discharge for COVID-19. If there are possible signs of infection, the receiving care institution needs to be informed in writing. Similarly, where a care institution receives a new resident, the person is required to be tested. In both cases, the tests should be marked so that their analysis can be prioritised. In addition, institutional care settings are required to have prepared isolation and quarantine areas appropriate in size to the number of residents. It is

planned that those infected and people without symptoms, but without a negative test result, will be housed separately.

All residents, whether returning following hospitalisation or entering the institution as new residents, should be separately placed in the quarantine or isolation area for 14 days. Care staff who are only look after people in the isolated or quarantined areas will be tested by the company doctor depending on risk. As above, these tests should receive priority (32).

The Ministry for Social Affairs and Health of Lower Saxony responded differently to the issue of new care home admissions, by imposing a freeze on admissions to care and nursing homes. An exemption is only possible if the institution can ensure a two-week quarantine of the new resident or if the institution was especially prepared to take in new residents. This new rule was issued following the COVID-19 outbreak in a care and nursing home in Wolfsburg (33). People discharged from hospitals in Lower Saxony are now being sent to around 80 rehabilitation-hospitals that were asked to create extra spaces during the COVID-19 outbreak and that will be providing short-term care that is usually delivered in nursing homes (34).

The **Senate Administration for Health, Care and Equality Berlin**, on the other hand, points out that people discharged from hospitals into institutional care settings cannot be routinely tested due to limited capacity. It is further pointed out that a negative test result at the point of discharge does not mean that a person not showing symptoms (without respiratory infection) will not develop symptoms later on. For this reason, it is not suggested that nursing homes should stop receiving people discharged from hospitals that have not been tested (6 April 2020) (35).

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

The high risk of infection to people living in care and nursing homes has been recognised and different bodies across Germany have issued guidance and recommendations.

4.3.1 Prevention of COVID19 infections

The latest update of the recommendations regarding prevention and management of COVID-19 in long-term care settings for older people and people with special needs by the **RKI** (as of 14 April 2020) recommends that the management of residential institutions together with the relevant health authority should develop a COVID-19 plan. This plan should follow the regulations issued by the relevant state government (*Landesregierung*). Aspects that should be considered in the development include (36):

- Putting together a team with designated responsibilities for specific areas (e.g. hygiene, communication, acquisition of materials)
- Informing residents, their relatives and staff of relevant protective measures
- Informing and training staff regarding the use of protective measures and equipment
- Training of all staff, especially cleaners, in hygiene, physical distancing and other relevant procedures
- Organising measures to reduce the numbers of contacts within the institutional setting
- Setting and implementing rules for visitors and external providers
- If possible, providing alternative ways for communication
- Implementing regulations for absence for staff
- Small groups of designated residents should be organised for activities that need to be done collectively. This reduces the number of contacts in case of a COVID-19 infection.
- Staff should work, if possible, in designated, independent teams.

The updated document further provides detailed information on hygiene measures as well as for infection control in residential care settings.

- Basic hygiene rules, including hand hygiene should be strictly adhered to.
- All staff with direct contact to particularly vulnerable people should be wearing mouth-nose protection to protect patients, even when they are not engaging in direct care tasks.
- In addition, when caring for people at risk who display respiratory symptoms, the person cared for should also wear mouth nose protection, if tolerable.

Furthermore, a number of recommendations have been made regarding the provision of single use tissues, location of bins, types of disinfectants to be used, daily disinfection routine and medical equipment.

While the RKI offers information based on epidemiological studies, binding guidelines and directives, as well as recommendations, are provided by the ministries responsible for health and by the *Landesgesundheitsämter* (health authorities) in each of the 16 federal regions (*Bundesländer*).

Since 2 April bans on visitors to care and nursing homes have been put in place in many federal states. These include Baden-Württemberg, Bremen, Brandenburg, Hamburg, Mecklenburg-Western Pomerania, Rhineland-Palatinate, Saxony, Saxony-Anhalt, Schleswig-Holstein and Thuringia (3).

The **Ministry for Social Affairs and Health of Lower Saxony** (*Niedersächsisches Ministerium für Soziales, Gesundheit und Gleichstellung*), for instance, had already (effective 16 March) declared a ban on visitors in care and nursing homes, unless they are the loved ones of a person receiving palliative care. This document remains in force until 18 April. On 17 March, the health authority in Lower Saxony (*Landesgesundheitsamt Niedersachsen*) recommended care and nursing homes to pause community activities and for staff to avoid close contact with each other.

Recommendations from the health authority suggest that residents living in institutional care settings should not leave the premises, such as to visit their relatives or to go shopping. It was further recommended that care homes should postpone taking in new residents (non-urgent cases) to free up spaces for patients released from hospital (see recommendations 20 March 2020).

Other recommendations provide information on symptoms, ways of infection, detailed hygienic standards, physical distancing and use of protective equipment (37).

Berlin, on the other hand, operates under more relaxed rules. On 17 March 2020 the **Senate administration for Health, Care and Equality Berlin** advised that residents in nursing homes can receive one daily visitor for one hour. However, this does not apply to children aged 16 and younger and people with respiratory infections. People receiving palliative care can receive visitors without restrictions (35).

4.3.2 *Controlling spread once infection is suspected or has entered a facility*

In the extended advice document (as of 14 April) the RKI provides information on measures regarding space and personnel.

- Residents that have tested positive or are suspected of having COVID-19, residents with symptoms and their contacts should be moved into single rooms, ideally with their own wet room. These residents must not participate in activities with residents that have tested negative.
- If there is evidence of COVID-19 in an institution, the institution (space and staff) should be separated into three areas: one area for those without symptoms and without contact with affected people; one area for those with suspected cases (residents showing symptoms or who have been in close contact with infected residents) who have not yet had test results; and one area for people who have tested positive for COVID-19. The guidance states that should additional

infectious diseases be prevalent (e.g. influenza), additional areas need to be established. Staff should only be working in one of the designated areas.

- Staff supporting residents with suspected and confirmed cases should be trained and not be asked to care for others.
- Staff caring for residents with suspected and confirmed cases should wear personal protective equipment including mouth-nose protection or preferably FFP2 masks, protective gown, safety goggles and single use gloves. For all activities that involve aerosol production breathing masks (FFP2 or higher) should be worn.
- Personal protective equipment should be put on before entering the room of the resident and taken off before leaving the designated decontamination area or the resident's room.
- Protective equipment and information for its use should be placed immediately at the entrance to living quarters.
- Bins for the disposal of single-use equipment should be placed on the inside by the door.
- Single use gloves should be disposed of before leaving the room into a closed container.
- The health status of the staff should be monitored.

There is also guidance regarding hand hygiene and the type of disinfectant to be used.

The document further describes procedures for the cleaning and disinfection of the surrounding environment (e.g. surfaces), of medical products, crockery, mattresses, bedding and laundry as well as for waste disposal.

Information on strategies to protect residents should be made available to staff, residents and their visitors.

The guidance document also provides specific advice for moving residents infected with COVID-19 within as well as outside the institutional care setting:

- The destination should be informed regarding the arrival ahead of time (if this is an external transfer the receiving institutions is to be informed about the suspected/confirmed COVID-19 infection).
- Only one person should be transported, and the person should wear mouth-nose protection as far as their health status allows for this.
- Contact with other residents or visitors should be avoided.
- The means of transport as well as other contact surfaces should be disinfected immediately after transport.

The RKI document emphasises that currently there is no confirmed evidence regarding virus excretion. Current advice states that people in nursing homes generally can be released from isolation, irrespective of severity of the COVID-19 infection or location of the isolation, if they have been free of COVID-19 symptoms for at least 48 hours and had two negative tests. In specific cases there can be deviations from these guidelines, but only in close agreement with the clinic, laboratory and health authority.

In addition, there are recommendations on the management of visitors in care and nursing homes. The RKI recommends that social contacts should be maintained as far as possible via telecommunication rather than through in-person visits. Visitors with symptoms of a cold or who are a contact person to someone with COVID-19 should stay away. In the case where visitors are allowed, every visitor (name, date of visitor, name of resident visited) should be registered. Visits should be minimal and there should be a time limit. In addition, visitors must adhere to protective measures that involve maintaining a distance of at least 1.5-2 meters from the resident, must wear a protective gown and mouth-nose protection and disinfect their hands when leaving the resident's room.

The guidelines also recommend contact tracing of contact persons in cooperation with the local health authority. Successful contact tracing enables the interruption of infectious chains. The RKI has made a graphic available for contact tracing and management in care homes.

The importance of monitoring the situation in institutional care settings is further emphasised in the updated guidance document. It is recommended that a trained person should be responsible for clinical monitoring. This involves (at least) daily documentation of clinical symptoms among residents and staff. The minimum symptoms to be monitored include fever (>37.8°), coughing, shortness of breath, sore throats and sniffing. Additional symptoms to be monitored include muscular and joint pain, headaches, nausea/vomiting, diarrhoea, loss of appetite, weight loss, conjunctivitis, skin rash, apathy and somnolence. This information should be put together with other relevant information of the individuals. Templates for the monitoring will soon be provided. Residents and staff should be encouraged to self-report if they experience respiratory symptoms or they feel feverish.

Testing for this at-risk population should be done at a low threshold (more details in the guidance document) and the local health authority is to be informed regarding suspected, confirmed and deceased cases of COVID-19. In collaboration with the local health authority regular testing (e.g. twice per week) could be implemented to monitor the ongoing situation in the institution (36).

The RKI also announced that teams are supporting outbreak containment measures in care and nursing homes in several federal states (3).

On 17 March, the **health authority in Lower Saxony** (*Landesgesundheitsamt Niedersachsen*) recommended that care and nursing homes strictly separate those suspected of COVID-19 and non-infected residents (37).

The Bavarian Ministry for Health and Care (*Bayerisches Staatsministerium für Gesundheit und Pflege*) also published updated guidance for care- and nursing homes (as of 3 March 2020). The guidance includes:

- Every institutional care setting should name a commissioner for the pandemic who coordinates measures in the case of an outbreak and also acts as a contact person for the authorities.
- As soon as there is suspicion of an infection, appropriate prevention and protection mechanisms need to be put in place.
- Should there be a COVID-19 infection in an institution, the Infectiology Task Force will be mobilised.
- To stop chains of infections, affected residents should immediately be isolated and/or those who have become ill should be moved into hospitals or other institutions (38).

4.3.3 *Managing staff availability and wellbeing*

The RKI also included guidance on how to support care staff:

- The health status of staff should be monitored daily (see above).
- Staff should monitor their own health and inform management if they experience relevant symptoms.
- Leave of staff due to respiratory symptoms, a confirmed COVID-19 infection or due to quarantine/isolation following contact with an infected person should be recorded.
- There should be a low threshold for testing of care and nursing home staff and testing should be done without delay. In high risk institutions (very large care settings with dense occupancy or in regions with high COVID-19 incidence) the possibility for regular (weekly or more frequently) testing before shift commences should be explored (36).

In addition, the RKI has released recommendations for leave procedures during a COVID-19 outbreak in care and nursing homes with both regular and reduced staff availability.

Under regular staffing levels, staff identified as contact person category 1 (higher risk of infection = at least 15 minutes face-to-face contact with a COVID-19 case and/or direct contact to body fluids or secretion) have to isolate at home for 14 days. This includes physical distancing from other household members, regular handwashing and adhering to coughing and sneezing hygiene rules. Until the 14th day of isolation, contact persons in category 1 must monitor their temperature twice a day, maintain a diary and inform the local health authority on a daily basis.

A person identified as risk category 2 (low risk = less than 15 minutes face-to-face contact with a COVID-19 case and no direct contact to body fluids or secretion) can continue to work with mouth and nose protection as long as they don't develop any symptoms. Staff in risk category 2 will be asked to monitor and document their health for up to 14 days after exposure. They should strictly adhere to all hygiene recommendations and where possible maintain a distance of at least 1.5 metres from others, including during breaks. If they develop symptoms, there should be an immediate test.

Staff without contact with an infected person, but who exhibit symptoms of a cold, should stay at home and can only start working if they have been symptom-free for at least 48 hours. If possible they should be tested for COVID-19.

In the case of any of the staff testing positive for COVID-19 they should stay at home in quarantine for at least the time they experience symptoms or for 14 days. They can start working again once they have been symptom-free for 48 hours and had two negative tests 24 hours apart.

In case of staff shortage, the recommendations only change for staff identified as risk category 1. These staff should then stay at home and quarantine for at least seven days, but can return to work afterwards if they remain symptom free and wear mouth-nose-protection during the entire time they spend at work. Otherwise the routines continue as for staff identified as risk category 2 (39).

4.4 Community-based care

The RKI recommends that non-residential care settings should not be looking after people who have tested positive for COVID-19 (36).

Carers providing ambulatory care in people's homes (having direct contact with the at risk population) should wear mouth-nose protection even when they are not directly caring for a patient (guidance from 23 April 2020) (40).

- Staff with respiratory disease should stay at home.
- When caring for people with fever and respiratory disease, protective equipment in line with recommendations should be worn.
- The health status of long-term care staff should be monitored. (40)

4.4.1 Measures to prevent spread of COVID19 infection

4.4.1.1 Day and night care

Across Germany, many day and respite centres have closed. **The Bavarian Ministry for Health and Care**, for example, states that people with care needs are no longer allowed to attend day care centres and must be looked after at home. An exception for care is only possible if care at home cannot be provided during the day (41).

Similarly, the **Senate Administration for Health, Care and Equality of Berlin** announced that in order to slow the spread of COVID-19 all day and night care centres must close. Where possible

people's care needs will be addressed through unpaid and ambulatory care. However, in cases where alternative arrangements are not feasible, day care centres can provide emergency care. Relevant reasons for needing of emergency care include the next of kin being a key worker. (35)

4.5 *Impact on unpaid carers and measures to support them*

The **Senate Administration for Health, Care and Equality Berlin** (*Senatsverwaltung für Gesundheit, Pflege und Gleichstellung – Abteilung Pflege*) has developed recommendations for people with care needs and unpaid family carers in the context of the COVID-19 pandemic. (42)

The need for appointments outside the home should be carefully considered. There should be consideration whether these could be replaced by phone calls or through online activity.

- Should an appointment outside the home be essential, the use of public transport should be avoided, and private cars or taxis be used instead. The use of an outing with a wheelchair may be an alternative if the environment allows for this and the person with care needs is adequately dressed and protected.
- When medication is required, a conversation should be sought as to whether the prescription can be made over a longer time period and whether the prescription can be sent straight to the pharmacy.
- People at high risk should avoid going to the supermarket and instead make use of delivery services or neighbourhood initiatives.
- The document recommends low contact care, which means that children aged 16 years and younger and people with symptoms of illness have to refrain from visiting.
- Care that does not require contact, such as conversation, preparation of medication or meals, cleaning or documenting care tasks, should be performed following thorough disinfection of the hands and with 2 meters physical distance. It is recommended that the person with care needs stays in a different room while the carer performs these activities.
- Personal care tasks, such as body hygiene, dressing or wound dressing, should only be performed following thorough disinfection of the hands and with mouth-and-nose protection. The carer should not speak to the care recipient while performing these tasks. Duration and extent of these tasks should depend on consideration about need and patient protection.
- Social contacts, where possible, should be maintained via regular telephone calls, online chats or videoconferencing. Handwritten letters are also mentioned as a possibility to stay in touch.
- It should be ensured that emergency calls can be made.
- Should ambulatory care providers not be ensuring the care of the person with care needs, it should be considered who in the family or neighbourhood could take on these tasks. The number of people providing support should be as small as possible.

Updated advice on support from neighbours recognises the many initiatives that aim to support at risk population with shopping and running of errands. While people are encouraged to contact these sources of support, they are urged to focus on infection protection.

People with care needs are reminded that they are entitled to financial support (€125 per month) for the use of recognised sources of support and neighbourly help (§ 45 b SGB XI) (42).

Other than guidance on how to support or engage people with care needs at home, there appears to be limited information available.

Some newspapers have picked up on the problems many families face. One article reports on the stress families experience due to the temporary closure of day and respite care centres and cancellation of ambulatory care services. Many families are reported to have chosen to go without paid care support to reduce the risk of infection. According to a news article, the Federal State of Bavaria does not plan financial reimbursement for relatives facing additional costs. Similarly, long-

term care insurance providers mostly refer only to support, advice from experts and existing budgets for emergency situations (see caregiver leave act (*Pflegezeitgesetz*) below) (43). Similarly, the **Bavarian Ministry for Health and Care** referred unpaid carers to the 110 offices for unpaid carers which have been in place in Bavaria for 20 years. Those offices have been advised to provide advice via telephone and email (38). Similarly, the Senate of Berlin provides a list of sources of support and advice for family carers (42).

Organisations such as the Germany Alzheimer's Society and other charitable organisations and interest groups call for recognition of family carers, financial support, protective equipment and prioritised testing (43).

The *Süddeutsche Zeitung* (newspaper) has picked up on existing financial support available for employees with care responsibilities. The article notes that an employed relative based on the caregiver leave act (*Pflegezeitgesetz*) can take up to ten days leave to ensure care or to organise replacement care if the care recipient has been assessed to have at least care level 1. If the carer does not continue to receive their pay during their care leave, they can apply for care support through long-term care insurance. This amounts to 90 per cent of the lost income (after tax). If others step in to support the relative, they can be reimbursed (for a limited time period and up to a limit) for the support, as outlined in the example presented by The National Association of Statutory Health Insurance Funds above.

Another option for employed family carers possible through the caregiver leave act is to reduce employment to up to 15 hours. Employees are entitled to maintain this reduced workload for up to 24 months. To cover their costs, they can access an interest-free loan from the state (44).

4.6 Impact on people living with dementia and measures to support them

4.6.1 The added complexity of caring for people with dementia in care homes

Where care homes predominantly look after people with dementia, such as in the situation in Wolfsburg, the challenge of responding to an outbreak is even more complex. In response to the situation, the residents who tested negative were separated from those who tested positive.

Many people with dementia benefit from routines and may seek close contact with others. This makes adhering to hygiene protocols difficult. Some people may find it difficult to understand why they should stay in isolation and they may find it difficult to adjust to disruption in their daily routines.

In Wolfsburg, the care home initially considered evacuating those that were not infected, but as this may have caused considerable disruption to residents' lives, it was decided instead to move residents who tested negative to a separate floor, where they will continue to be tested every three days to monitor the spread of the virus (45).

5. Lessons learnt so far

5.1 Short-term calls for action

- In response to the infection of care home residents, the professional association of carers in Lower Saxony (*Pflegekammer Niedersachsen*) has called for care staff to join doctors and emergency services in communal crisis management groups. The association has further been demanding that care recipients should regularly be tested for COVID-19. The association argues that this would be important because even though visitors have been banned from care homes, staff could still carry the virus unknowingly into a care home. For this reason, the association was also critical of the loosening of quarantine guidance for care staff by the RKI. The length of isolation specified in this guidance for medical

personnel has been reduced from 14 to 7 days if the person concerned does not show any symptoms although this is only in the case of staff shortage and in agreement with the health authority (46).

- The chairman of the Foundation for Patient Protection (*Stiftung Patientenschutz*) criticised that residents in care and nursing homes so far had not been tested (interview with Spiegel Panorama, 31 March 2020). He called for residents and staff to be tested and for isolation to be maintained until results have been obtained. He also criticised the lack of protective equipment in care and nursing homes and pointed towards the high costs the institutions face when trying to purchase equipment affected by shortages (47).
- On 31 March the German Society for Gerontology and Geriatrics (*Deutsche Gesellschaft für Gerontologie und Geriatrie*) called on the government to stop measures that are based purely on chronological age. The society urged government and media to use carefully chosen words to avoid ageism and discord between generations. The statement emphasised that age is heterogenous: many older people are in good subjective health and satisfied with their lives, even if they live with chronic illness. While it is recognised that there are vulnerable older people with multiple health and care needs, these also exist across other age groups. The society concludes that it would unethical, discriminatory and irresponsible to enforce quarantine on one million people based on their chronological age, while younger people do not have to endure such measures. The statement further declares the responsibility to reflect carefully on the consequences of measures and to offer possibilities for interventions that can support groups such as people living with dementia and their relatives during this difficult time. Should triage decisions become necessary in Germany, they should not purely be based on age. The statement finishes with a reminder that German history has taught us the awful consequences of selection (48).

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