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Germany and the COVID-19 long-term care situation

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1. Key points

- The German government has issued financial support and loosened monitoring for care providers during this pandemic so that the residential and ambulatory care that people receive can be maintained.
- The German government has announced an increase in care workers' wages. In addition, care workers in Bavaria and Schleswig-Holstein care workers are due to receive a bonus payment.
- 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 recommendations for care homes in case of an outbreak include the establishment of zones to physically separate residents without symptoms and no contact to people with COVID-19, residents who are suspected of an infection and residents with confirmed results. It is further recommended to pursue contact tracing in care homes.
- 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.
- 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 5 May 2020), there had been 163,860 confirmed cases of COVID-19 in Germany (an increase of 685 in comparison to the day before). Of the confirmed cases, 19% were in people aged 70 years or older. Out of all confirmed cases an estimated 135,100 have recovered and 6,831 people (4.2%) have died. Of those who have died, 87% of people were aged 70 or older (1).

The RKI estimates that the reproduction number for Germany on 5 May 2020 was $R=0.71$ (95%CI: 0.59-0.82). The means that on average every person with a COVID-19 infection infects one other person and that the number of newly infected people is showing a small reduction (1).

2.2 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 (2). This outbreak resulted in 22 deaths (3).

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 (4). By 13 April, the number of deaths had 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(5).

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 (6). 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(7). 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 (8).

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 deaths. 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 (9).

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 (10).

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 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 (11). 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 arrangements. 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 these procedures as extremely dangerous (12).

On 5 May 2020 the RKI reported that 12,675 residents and 7,458 staff with confirmed COVID-19 infections have been recorded in care settings. These numbers include the number of cases in care setting for older people, people with special needs, people with care needs, homeless people, people living in residences for asylum seekers, other forms of mass accommodation and prisons. Among this group, 2,474 of residents and 31 (0.4%) members of staff have been reported to have died (1). According to the RKI, 20 per cent of all infected residents in institutional care settings have died. The number of staff that died in care settings is higher than that of staff in health care settings (13).

The RKI also records COVID-19 cases among health care staff. Of the confirmed cases, 10,101 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 (14). There were 16 COVID-19 related deaths recorded among health care workers. However, information is missing from around 36% of recorded cases. This means that the true numbers of people infected with COVID-19 and those that have died as a result of the infection in health and long-term care setting may be higher(1).

There is no information available about how many people in receipt of community-based care, or their unpaid or paid carers may be infected.

2.3 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 (15,16). The Federal State of Bavaria has enforced a curfew from 20 March 2020 (starting at midnight) for two weeks initially (17). 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 (18). 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 (19). 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 (20,21).

The districts (*Landkreise*) Jena and Nordhausen City (*Stadt*) have made the wearing of a cover of mouth and nose mandatory in shops, public transport and official buildings (e.g. town halls). The city of Jena outlines that scarfs, fabric or home-made masks that cover mouth and nose are sufficient (9). All federal states have now moved from recommending the wearing of mouth-nose protection in public to announcing their mandatory use in public transport and/or shops and in some states also on markets (22 April 2020). This includes Baden-Württemberg, Bavaria, Berlin, Brandenburg, Bremen, Hamburg, Hessen, Mecklenburg-Western Pomerania, Lower-Saxony, North Rhine-Westphalia, Rhineland-Palatinate, Saarland, Saxony, Saxony-Anhalt, Schleswig-Holstein and Thuringia (22).

On 20 April 2020, Chancellor Merkel announced that the Federal Ministry of Health will finance the training of mobile teams that will be established to support the local health authorities with contact tracing (23). The aim is to establish a 5 person contact tracing team for every 20,000 residents (24). These teams will be hosted within the health authorities and will be supported by police officers. The people employed on the contract tracing teams have started receiving online training since 6 April 2020. After that they will receive training specific to the context of the health authority to which they are deployed (25). In addition, a service unit at the RKI will be established to enable a continuous point of contact for local health authorities(23).

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) (26). 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) (26).

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 (27).

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 (28).

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 (29).

Where care providers (ambulatory and residential) are no longer able to meet the services they are due to provide they have to contact the care insurances immediately and search for alternatives in collaboration with health and regulatory authorities to ensure that people's care needs can be met in (30).

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 National Association of Statutory Health Insurance Funds 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) (31).

4.1.2 Improving care workers' wages

On 23 April the German government announced minimum wage for nursing assistants will be increased from 1 May 2020 to 1 April 2022 in four steps until they reach €12,55 across Germany. Qualified assistants that have undergone a one-year apprenticeship will receive a minimum wage of €12,50 (West) or €12,20 (East) as of 1 April 2021. From 1 April 2022 minimum wage across Germany for this group will be €13,20. For care workers with three-year apprenticeship minimum wage will be €15 as of 1 April 2021. This will increase to €15,40 by 1 April 2022. In addition to the vacation days workers are legally entitled to, all care workers will receive additional paid days off (32).

4.1.3 Other funding related measures

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) (33).

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 (34). As part of the updated measures, the Bavarian Ministry for Health and Care announced that care workers in care and nursing homes, hospitals, rehabilitation hospitals, care settings for people with special needs, ambulatory care services and ambulance staff who regularly work more than 25 hours per week can apply to receive €500. Those regularly working 25 hours or fewer per week can apply to receive €300. This money comes out of a special fund put together to respond to COVID-19 (25).

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 (35).

It has been reported that in **Schleswig-Holstein** all 20,000 care workers will receive a COVID-19 care bonus of €1,500. The government will pay this out of its own household if no nationwide agreement can be arranged (36).

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. This guidance was updated 17 April 2020. People can be discharged into isolation at home where, following medical assessment, ambulatory support can be provided and if they meet relevant criteria (i.e. do not fall into groups at risk of complications, such as immunosuppression, relevant chronic illnesses, old age, can care for themselves, can adhere to recommended behaviours, possibility to stay in single room that can be aired, ambulatory medical support, contact to local health authority, availability of support from a health person (without risk factors))(37). Discharge without further restrictions is possible if the patient has not had relevant symptoms for at 48 hours and had two negative tests (one oropharyngeal, one nasopharyngeal) taken at the same time (38).

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 (39).

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 (40).

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 (41). 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 (42).

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) (43). The responses from other federal states can be found in Table 1.

The **RKI** outlines the following criteria for hospital discharge in nursing homes (updated version from 17 April 2020). First, there has to have been clinical improvement that, based on medical assessment, allows for continued ambulatory support in isolation in the care home as well as a requirement that the environment in which the patient will be looked after is appropriate. Patients discharged from hospitals into a care home can only be released from isolation in the care home after at least 14 days following hospital discharge, and if the patient has been free of COVID-19 related symptoms for at least 48 hours. A medical consultation for this decision is required. If patients are being discharged from hospital they only do not have to be quarantined in nursing homes if they have been free of COVID-19 related symptoms for at least 48 hours and had 2 negative polymerase chain reaction (PCR) tests (one oropharyngeal, one nasopharyngeal) taken at the same time (38).

Table 1: Overview of regulations and recommendations around new or returning residents to care homes across federal states in Germany

Baden-Württemberg	<p>New residents and residents returning from hospital should be treated as persons suspected of COVID-19 (44).</p> <p>The 14 days “quarantine care” can also take place in other care settings should the care or nursing home be unable to meet the quarantine requirements (44).</p>
Bavaria	<p>Since 4 April 2020 care and nursing homes in Bavaria do not take on any new residents. Exceptions can only be made if the institution can ensure that the new resident can be quarantined for 14 days and if the relevant health authority agrees to the arrangement (25,45).</p> <p>Return from residents following hospitalisation is also only allowed if the person can be isolated for 14 days and if there is sufficient protective equipment available. Otherwise the person has to go into short-term care settings, such as in rehabilitation hospitals where this care can be provided in the form of short-term care (25,45).</p>
Hamburg	<p>Unless care homes have received order to stop taking on new residents or they have no capacity they are expected to take in new residents (46).</p> <p>Before receiving a new resident, the relevant doctor has to confirm that a negative COVID-19 test has been obtained relevant to the timing of entering the care setting.</p>
Lower Saxony	<p>Care and nursing homes are not allowed to accept new residents (47).</p> <p>Exceptions can be made if care homes can ensure that the new residents will be accommodated separately from other residents and kept in quarantine.</p> <p>People discharged from hospitals can be discharged into care settings or rehabilitation clinics that have been prepared for this type of care and have been approved for the provision of short-term care. Other exceptions are possible following communication with the health authority (47).</p> <p>There are around 80 rehabilitation hospitals that can support the care of people with care needs (42).</p>
North-Rhine Westphalia	<p>The hospitals are responsible to test the persons discharged to residential care setting for COVID-19. Hospitals also have inform receiving care or nursing about possible COVID-19 symptoms in writing. Tests should be marked for priority testing.</p> <p>New residents have to be tested for COVID-19. Tests should be marked for priority testing.</p> <p>In general people who have newly entered or returned to a residential care setting should be placed in quarantine or isolation from other residents for 14 days (40).</p>
Rhineland-Palatinate	<p>People discharged from hospital can return to their care or nursing homes unless there is an explicit stop or if there is no capacity in the receiving care setting.</p> <p>Isolation and quarantine areas need to be prepared for new residents and those returning following hospitalisation (48).</p>

Saarland	<p>The plannable admission of new residents should be reduced or paused to enable capacity for COVID-19 patients (49).</p> <p>All new admission to care and nursing homes immediately require testing for COVID19. These tests should be prioritised (50).</p>
Saxony	<p>When residents did not have a COVID-19 infection/suspected infection a written statement responding to three questions is required by the hospital/relative:</p> <p>Q1: Has the person been in an at-risk area within the last 14 days?</p> <p>Q2: Has the person had contact to a person suspected of or with a confirmed COVID-19 infection in the last 14 days?</p> <p>Q3: Has the person had symptoms during the last 48 hours that could indicate a COVID-19 infection?</p> <p>It is recommended that residents should stay in a single room for ideally 14 days, but at least for 7 days (51).</p>

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*) in each federal state. Aspects that should be considered in the development include (52):

- 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-üürttemberg, Bremen, Brandenburg, Hamburg, Mecklenburg-Western Pomerania, Rhineland-Palatinate, Saxony, Saxony-Anhalt, Schleswig-Holstein and Thuringia (16).

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 (53).

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 (43).

An overview of responses by other Federal States can be found in Table 2.

Table 2: Overview of regulation and recommendations around care homes visitors across federal states in Germany

Baden-Württemberg	<p>Ban of visitors maintained; visitors can be allowed if appropriate protective measures against infection have been put in place, and can be use for example for relatives of a person at the end of their life; Group activities have been stopped (17.04.2020 – 15.06.2020)</p> <p>Residents can only leave their residential care setting to take up medical services, to go shopping for items of daily needs if these needs are not met by the institution, for a walk (alone or with one other person), however, only if there is not enough space for outdoor physical activity on the premises of the care setting (07.04.2020-03.05.2020) (54).</p> <p>Visitors should wear mouth-nose protection, gloves and an overcoat and a 2meter physical distance must be adhered to. If physical aid is required for the resident, staff should be sought out for help (44).</p>
Bavaria	<p>Ban of visitors maintained (25). People at the end of their lives can be visited by their closest relatives (55).</p>
Berlin	<p>No events with external people (56).</p> <p>Visits should be limited to necessities. Residents can have one visit per day for one hour. Visitors must be 16 years or older and not have respiratory illness. There should be visiting times so that visitors can be listed and introduced to hygienic measures (56).</p> <p>Residents can enter and leave the house as they please but should be advised not to attend events or gatherings of people; going for a walk outdoors does not cause concerns. Residents should avoid travelling (56). Residents that have returned from a risk area should stay 14 days in isolation (no symptoms) (56).</p>
Brandenburg	<p>No visitors, unless they attend to someone at the end of their life (17.04.2020) (57).</p>
Bremen	<p>Visitors are not allowed unless they attend to someone at the end of their life (58).</p>
Hamburg	<p>Visitors cannot be accepted unless they come to visit a person nearing the end of their life (59).</p>
Hessen	<p>Visitors are not allowed in care and nursing home. This is expected to last until 3 May 2020. Visitors may be permitted to be with a resident at their end of life. Visitors must adhere to hygiene rules and the length of the visit may be limited. A person that has entered Germany in the last 14 days is not allowed to be a visitor (60).</p>
Mecklenburg-Western Pomerania	<p>Ban of visitors maintained (20.04.2020) (61).</p>
Lower Saxony	<p>Visiting of residents in care homes is forbidden unless the resident is nearing the end of their life (47).</p> <p>Residents should be advised not to leave the premises of their care home (47).</p>
North-Rhine Westphalia	<p>Visitors are not allowed to enter care or nursing homes. Exceptions can be made if there medical or socio-ethical reasons, such as when a resident is receiving palliative care (62).</p>

	Residents are allowed to leave the premises of the care setting, however, should only have contact with other people living or working in the care setting. If this cannot be ensured, the resident is required to spend 14 days without direct contact with other residents of the care setting (62).
Rhineland-Palatinate	<p>The visiting of residents in care and nursing homes is not permitted. Spouses, Fiancées or Life partners are permitted to visit. Exceptions can be made for people who are gravely ill or nearing the end of their life. The care settings have to ensure that hygienic standards are being maintained throughout the visits. Children under 16 are not allowed. These people need to be healthy and not have been in contact with a COVID-19 infected person (48).</p> <p>Residents can leave the care setting if they are healthy and there is not sufficient outdoor space as part of the care/nursing home. Residents are only allowed to go outside with one other person or member of staff to be walking on the premises or its near surrounding. Residents and staff should be wearing mouth-nose protection and gloves. Residents are not allowed to have contact with people outside the care setting. If this cannot be ensured, the resident concerned is required to be quarantined for 14 days (63).</p>
Saarland	Visits in residential care settings are not allowed. A maximum of one person (registered) per visitor per day for a maximum of one hour can be made. Visitors must adhere to hygiene rules. Exceptions can be made for residents nearing the end of their lives or for other medical or ethnic-social reasons (49).
Saxony	<p>Ban of visitors maintained (17 April 2020); exceptions can be made following agreement with management of the institution and adhering to relevant terms;</p> <p>Residents can have contact with closest relatives outside when adhering to physical distancing & hygiene rules, up to 5 visitors are allowed to be with a resident at the end of life (64).</p>
Saxony-Anhalt	Visitors in care and nursing homes are not allowed. There can be exceptions for patients receiving palliative care, however, visitors cannot enter if they are infected with COVID-19, have been a contact person (I and II according to RKI criteria) or have been abroad (65).
Schleswig-Holstein	Visitors are not allowed in care and nursing homes. Exceptions may be given on a case by case basis. If visitors enter, they need to be registered and can stay for up to one hour, adhere to hygiene and personal protection rules. The time limit does not apply to visitors of people receiving palliative care. Visitors with respiratory illness are not allowed to enter the care settings (31.03.2020) (66).
Thuringia	Visitors are not allowed to enter care or nursing homes. Management of care and nursing homes can allow visitors under special circumstances. In these cases, they are required to ensure protective and hygienic measures. Visitors are not allowed to enter if they had contact with a COVID-19 case (67).

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 Robert Koch Institute has provided an overview for contact tracing in the case of COVID-19 infection. The local health authority has to be informed about each suspected and confirmed case of COVID-19. It is then the health authority's responsibility to contact the person and identify potential contacts, to provide information and establish preventive measures (68).

The RKI recommends that all contacts a COVID-19 case has had until up to two days before symptoms began should be listed. These contacts then are being categorised into category 1, category 2 and category 3.

Category 1 contacts are people that have cumulatively been exposed to at least 15 minutes face-to-face contact or where there has been direct contact of secretion or body fluids of the infected person (for medical and care personnel exposure without protective equipment). These contacts are deemed as at high risk of having been infected. Their details will be registered with the health authority and there will be a follow-up investigation. Category 1 contacts will be asked to isolate at home away from other household members, to maintain frequent handwashing and coughing etiquette, to monitor their body temperature twice a day, to keep a diary and to inform the relevant health authority on a daily basis.

Category 2 contacts are people that had less than 15 minutes face-to-face contact (i.e. people in the same room) and that had no direct contact to secretion or body fluids. The health authority is not required to register the contact's name, but may provide information on the disease and routes of infection, contact reduction and steps to take if they should develop symptoms. Category 2 contacts should reduce contacts to third parties where possible, they should maintain hand hygiene and adhere to coughing etiquette, they should once a day check for symptoms and maintain a diary (69). Should the contact develop symptoms within 14 days since last contact with the confirmed case diagnostic follow-up is recommended (70).

Category 3 contacts are medical staff that had contact with a confirmed case ($\leq 2\text{m}$, for example while providing care or as part of a medical examination) while wearing adequate protective equipment throughout the entire contact time as well as medical staff with contact ($>2\text{m}$) without direct contact with secretion, excretions or aerosol exposure.

The institution's hygiene expert in collaboration with the company doctor and the health authority should inform and train medical staff on the correct use of protective equipment and self-monitoring of symptoms. They should ideally exempt staff providing care for COVID-19 cases from caring for other patients/ care recipients and centrally document results of the self-monitoring of symptoms and record test results (if applicable) obtained within 14 days of contact to the confirmed case. The health authority should be informed about exposed staff. Should a member of staff develop symptoms they should immediately stop duty, possible situations of exposure should be explored. The health authority needs to be provided with the name of the affected member of staff and the relevant person should be self-isolating until there is diagnostic clarity of their situation.

Medical staff working with confirmed COVID-19 cases are encouraged to maintain a diary in which they record self-checking of symptoms (examples of diary are available on the RKI website). Medical staff should also immediately inform the company doctor and the health authority if they have been exposed without adequate protective equipment or realised that protective measures were impaired. Depending on judgment of risk it may be appropriate to self-isolate at home (70).

Contact tracing of COVID-19 cases in care or nursing homes is to be prioritised. Some care homes have provided information that they will ask visitors (in line with RKI guidance) to register when visiting their relatives in care settings to enable contact tracing should this become necessary (71).

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 ($>37.8^{\circ}$), 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 (52).

The RKI also announced that teams are supporting outbreak containment measures in care and nursing homes in several federal states (16).

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 (53). Guidance from **Hamburg** adds that contact between staff and residents should be reduced as much as possible and the number of people one carer support should also be lowered (59). In **Saxony** 53 institutions have been prepared to provide short-term care in case care or nursing homes are being placed under quarantine (3 April 2020)(72).

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 (73).

Authorities in **Saarland** have also developed a “protection plan” for residential care settings. This document, as the documents found in other federal states are largely in line with RKI recommendations (50).

Some differences between federal states can be observed regarding testing of residents and staff in residential care settings. An overview of the different approaches can be found in Table 3.

Table 3: Overview of regulation and activities around testing in residential care setting across federal states in Germany

Baden-Württemberg	One medical doctor in charge of testing for a whole institution that can respond quickly if necessary (44). Tests can only be conducted if there is a reasonable suspicion of an infection (following RKI recommendations). All residents and staff that develop symptoms should be tested as soon as possible. Residents should also be tested if they develop unspecific symptoms or if their general state is deteriorating. As soon as there is awareness of an infection, contact persons (category 1) will be tested. If there are several cases, other asymptomatic residents and staff can be tested (44).
Bavaria	If there a suspicion that there may be several persons infected within one care or nursing home, testing among residents and staff should happen immediately (25,45). Bavaria pursues the strategy to test persons where there is a reasonable suspicion that they may have a COVID-19 infection and their contact persons. Staff working in health and long-term care should be prioritised (25).
Berlin	If there is a suspected COVID-19 case, residents to be isolated in their room in the care setting until testing result available (currently it takes 1 day) (56). If close contacts are being tested depends on the situation and will be decided on a case by case basis. Staff who have been classed as close contact and who are needed in care will be tested (56).
Hamburg	If a COVID-19 infection has been confirmed in a resident or member of staff, the care provider is required to test all care recipient and all staff immediately for COVID019 and to repeat this at a useful time interval (46). If staff shortage, quick testing of staff if there have been cases; staff from other institutions (i.e. closed day care centres) can be used (59).

Mecklenburg-Western Pomerania	Preventing testing of care-home staff to be increased (20.04.2010). Priority testing of symptomatic patients & testing of care- and nursing homes and ambulatory carers if they are possible contact of a COVID-19 case (61).
North-Rhine Westphalia	Staff that is only working in quarantine or isolation area, will depending on risk be tested by the company doctor. These samples are to be prioritised (40).
Rhineland-Palatinate	<p>The company doctor (or other relevant doctors) need to ensure that staff working in the isolation and quarantine areas depending on risk are being tested for COVID-19 (63).</p> <p>If a resident is diagnosed with COVID-19, all other residents that had contact with that person 48 prior to the development of initial symptoms need also be communicate to the local health authority. The local health authority is in charge of allocating the risk categorisation for each contact.</p> <p>If there are more than two cases in one care home all residents should ideally be accommodated in single rooms, particularly if they are in the high risk group (74).</p> <p>Screening of all staff can be considered. All organisational measures need to be coordinated with the local health authority (74).</p> <p>If a member of staff is urgently needed but has had contact with a COVID-19 case or experiences symptoms, they need to have swabs taken on day 3,5 and 7 as well as day 14. In addition, they need to wear mouth-nose protection, which has to be changed at least every 2 hours or as soon as it becomes moist (74).</p>
Saarland	<p>According to a news report the health ministry Saarland and the University hospital Homburg have developed a concept to test all resident and staff in care and nursing homes. They are starting with 116 out of 157 care and nursing homes. The residents will be checked twice (one-week time difference between tests) and staff continuously twice per week. The initiative starts with care settings that so far have not experienced COVID-19 cases.</p> <p>The testing of residents will be conducted by staff in the care and nursing home. The staff have received specific online training. The swabs are supposed to be done using a procedure developed by institutes that reduce the amount of material required. As soon as an anti-body test becomes available, carers and residents shall we tested as a second step (75).</p>
Saxony	<p>If there is a COVID-19 infection among staff or residents in a residential care setting, all staff with possible and all residents will be tested. If there is spatial separation between groups, only those in the affected group will be tested, otherwise the whole institution requires testing. Testing is coordinated through the relevant health authority.</p> <p>If a carer experiences symptoms, they have to be tested before starting their shift. Until results have arrived the person is only allowed to work wearing protective equipment. If residents show symptoms they need to be tested immediately. (17 April 2020) (76).</p> <p>The federal state of Saxony carries the costs for testing. Costs of tests for residents and care staff with symptoms are covered by the GKV. If tests are requested without there having been a positive case, the institution carries the cost.</p>

4.3.2.1 Protective equipment

The Federal Ministry of Health has become involved in the procurement of protective materials. The Federal Ministry of Health distributes supplies to the federal states and to the Association of Statutory Health Insurance Physicians (*kassenärztliche Vereinigung*). While the Association of Statutory Health Insurance Physicians distributes supplies to physicians providing ambulatory health care, the federal states supply all other areas requiring protective equipment (30).

The different states have taken different routes to support care providers with protective equipment. Some states have provided information on their distribution system and given insights into the amount of equipment provided to health and social care providers. An overview can be found in Table 4.

Table 4: Overview of regulation and activities around protective equipment in residential care setting across federal states in Germany

Baden-Württemberg	<p>The provision of protective equipment is usually organised by the provider or institutional management. Due to shortages, the federal government and the state are supporting the provision. Distribution is organised through local authorities. Care providers that are running low on protective equipment can communicate their need for support through dedicated regional e-mail contacts (44).</p> <p>Since 26 March, 300,000 protective gloves and more than 300,000 protective masks of different categories were provided. Daimler provided 110,000 FFP2 masks that in part have already been distributed to local authorities (77).</p>
Bavaria	<p>Residential care homes will be supplied with mouth-nose protective equipment as hospitals and doctor surgeries (45). The health authority will put in place a task force to support authorities and care and nursing homes in combating COVID-19. As far as available, all people in residential care settings should be wearing mouth-nose protection (45).</p> <p>Following RKI guidance, mouth-nose protective equipment can be reused if resources are scarce (45). If no single use disposable smock available, reusable smock can be used. They need to be washed in a disinfection laundry process (45).</p>
Brandenburg	<p>Brandenburg has received 2 million mouth-nose protective equipment and 80,000 litres of disinfection liquid. In Brandenburg police distributes the supply. The provision of material was organised through the “task force supply” of ministry coordination group “Corona” of the government of Brandenburg (78). Suppliers of protective equipment can register their offers with the police on a dedicated website, so that they can be purchased and organised centrally (78).</p>
Mecklenburg-Western Pomerania	<p>Weekly improvement of equipment available; production of equipment in Mecklenburg Vorpommern starting (61).</p>
North-Rhine Westphalia	<p>The company Dr Feist Automotive Bielefeld GmbH (DFA Bielefeld) has been commissioned by the state government of North-Rhine Westphalia to produce 29 Million mouth-nose protective masks. From 8 April until 29 July the company will deliver 320,000 masks to the state government on a daily basis for a cost of around €17 Million (79).</p>

	<p>The protective masks are being distributed to care settings via local authorities and communal crisis teams (79).</p> <p>So far (8 April) the Health Ministry of North-Rhine Westfalia has distributed 3.7 million protective masks, 1.7 million gloves, 78,000 protective gowns, 3,000 safety goggles, 250,000 test tubes and 22,000 litres of disinfectant (79).</p>
Rhineland-Palatinate	<p>Protective equipment so far has been distributed through the Authority for Social Aspects, Youth and Care (<i>Landesamt für Soziales, Jugend und Versorgung</i>) to health and care settings that experienced shortages. Now a regular supply will be provided. Prior to the delivery each institution was presented with an overview of materials allocated and had the opportunity to alter the figures according to need. Many institutions have lowered the number of equipment needed (80).</p>
Saarland	<p>The Ministry of Health as provided 11,200 FFP2 masks (30 March) and 30,00 simple surgery masks (3 April) to the Saarland Society of Care (75).</p> <p>Special controls by the Saarland authority for residential care (<i>saarländische Heimaufsicht</i>) are planned. This is supposed to check the occupancy of the institution and staffing. If relevant, this may have to be controlled in the premises.(50)</p>
Saxony	<p>The Red Cross has distributed 182,000 mouth-nose protective mask provided by the federal government in equal shares to the different districts from where they can be further distributed (1 April) (76).</p>
Thuringia	<p>Protective equipment in Thuringia is ordered centrally to the office for consumer protection (<i>Landesamt für Verbraucherschutz</i>). Information on the supply needed is regularly obtained. In the care sector, supply is distributed through organisations such as the Red Cross (81).</p>

4.3.3 Advanced directives and COVID-19 infections in care homes

Only guidelines from Baden-Württemberg have been found to specifically reflect on the issue of the use of advanced directives. They state that if a resident develops a severe form of COVID-19, the advance directive to exclude artificial respiration should be considered critically as an infection, such as COVID-19 and its related survival and recovery chances, may not have been considered by the person when signing the document. (44)

4.3.4 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 (52).

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 continues as for staff identified as risk category 2 (82).

Table 5: Overview of regulation and activities around staff availability and wellbeing across federal states in Germany

Bavaria	'Carepool' (<i>Pflegepool</i>): Since 23 March Bavaria has a website where people who have a qualification or experience in health and social care, that do not fall into an increased risk group and are not currently actively employed in care related jobs can register. The volunteers are being allocated centrally according to need. Volunteers employed in other jobs will be freed from their duty and continue to receive their income; the self-employed will receive compensation for their loss of business (73).
Berlin	People with a qualification in a care-related profession from abroad will be receiving priority over other health related qualification when applying for permission to work in Germany (83). Over 400 newly qualified care professionals could be employed in Berlin as examinations could be completed following RKI recommendations (83).

Bremen	<p>In Bremen people with health and care qualifications are encouraged to register with the city government. This doesn't mean that they have to work in care related jobs. It offers the opportunity to contact potential additional support in case of staff shortages (84).</p> <p>People are also encouraged to register with volunteering portals (84).</p>
Rhineland-Palatinate	<p>The nursing council Rhineland-Palatinate encourages care professionals (people with relevant qualifications) to register with the care pool in Rhineland-Palatinate. Service providers urgently requiring staff can contact the care insurances. They, together with the advice and auditing authority assess the situation. Following this people registered from the 'volunteer pool' can be allocated. Currently there are 344 persons registered in the pool (85).</p>

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 (52).

Updated guidance from 22 April 202 further outlines that 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 (86).

The guidance further recommends that:

- If a person develops a respiratory illness or fever this should be followed up with medical consultation
- If relevant, care staff should advise the care recipient or people in their personal environment that the care recipient should not be receiving visitors, especially not if they have an acute respiratory illness or other infectious disease
- When caring for people with fever and respiratory disease, protective equipment in line with recommendations should be worn. The required protective equipment should be available to care staff
- The health status of long-term care staff should be monitored
- Staff with respiratory disease should stay at home
- If a person is being moved from or to a different care environment, information regarding respiratory illness or a suspected COVID-19 infection should be shared ahead of time. (86)

Federal states have picked up on the guidelines and also provide additional rules and recommendations (see Table 6).

Table 6: Overview of regulation and recommendations around ambulatory care across federal states in Germany

<p>Baden-Württemberg</p>	<p>Staff that has been travelling from a high-risk area within the last 14 days should not be working. Staff with respiratory symptoms are not allowed to work. In these cases, there should be testing for COVID-19.</p> <p>If no single use disposable gown available, reusable gown can be used. They need to be washed in a disinfection laundry process.</p> <p>It can be useful to have the same staff on the same routes and to avoid rotation. Visiting COVID-19 patients at the end of the tour could reduce the risk of spreading (not obligatory).</p>
<p>Berlin</p>	<p>Care and support that doesn't require physical contact should be performed following hand disinfection and by maintaining 2m distance. While these activities take place the person with care needs should be in a different room (87).</p> <p>Personal care should be performed following hand disinfection with gloves and mouth-nose protection. During the care the carer should not speak with the care recipient. Length and extent of the tasks should be based on need and patient protection (87).</p>
<p>Brandenburg</p>	<p>Ambulatory care workers in Brandenburg have received special permission until 30 June 2020 to park in certain restricted areas for up to two hours while they provide care services (88).</p>
<p>Hamburg</p>	<p>Contact between carer and care recipient needs to be minimised as professionally required; the number of carers per care recipient should be minimised (46).</p> <p>Care staff has to reduce contact among each other as much as possible(46)</p> <p>Care recipients and their household should be reminded not to have receive visitors. If other members of the household become ill they should consequently adhere to prevention measures or if that no possible wear mouth nose protection. Care recipients and their household members or other unpaid carers should inform the ambulatory care services if there is a suspicion of a potential COVID-19 infection (89).</p> <p>In case of staff shorting, ambulatory services should make use of the extended regulation around working hours, use staff from other parts of the organisation, use agency staff, indicate need for staff to health authority (89).</p> <p>If ambulatory services are unable to provide all care services needed, they should explore whether some care recipients may be able to receive care from family members. Care service points may be able to support families in navigating support structures; the relevant authority should be informed in these cases (89).</p>
<p>Rhineland-Palatinate</p>	<p>Care staff can be allocated to work in ambulatory as well as residential care setting to enable great flexibility in planning (90).</p> <p>If relative or others are to take on medical care tasks this needs to be coordinated with the relevant medical doctor and the care recipient (90).</p> <p>If medical care services cannot be provided the provider needs to inform the care recipient or their legal carer, the prescribing GP and the health insurance</p>

	immediately. The ambulance services are to be contacted in medical emergencies (90).
Thuringia	A newspaper report stated that ambulatory care providers in Thuringia struggle as the number of clients drop. In many cases, relatives are staying home due to the COVID-19 pandemic and take on relevant care tasks. This may in part be to reduce financial costs in the family but also to reduce the risk of infection. Several providers already had to apply for reduced work hours (<i>Kurzarbeit</i>) to get their companies through this situation ¹ (91).

In addition, interventions, such as by the medical service of the health and long-term care insurances (*medizinischer Dienst der Krankenversicherung*) in Berlin-Brandenburg provides an advisory telephone services for ambulatory and residential care providers. This gives care professionals an opportunity to ask questions around COVID-19 (92).

4.4.1 Measures to prevent spread of COVID19 infection

4.4.1.1 Day and night care

Across Germany, day and respite centres have closed (see Table 6). Most state governments, such as **the Bavarian Ministry for Health and Care**, state 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 (93).

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 (43). Similar arrangements have also been found in other Federal States (see Table 7).

Table 7: Overview of regulation around day and night care across federal states in Germany

Baden-Württemberg	Day and night care settings had to close. They can only provide care for individual persons in emergency situations ² (18.03.2020-15.06.2020) (94).
Bremen	Day care options are closed .Services are available for in emergency situations ² (58). This emergency care must be kept to a minimum. It can also be provided to people who only recently developed care needs (58).
Hamburg	Day care settings have to close and can only provide emergency care ² (46).
Hessen	Day and night care centres remain closed until at least 3 May. Emergency care can be provided if necessary ² . This does not apply if the care recipient

¹ The federal government has enabled a law to make the use of short-term work easier for long-term care providers. Only 10 per cent of employees of a company need to be affected by loss of work for the company/service provider to apply for short-term work (30).

² This applies in when their unpaid carers work in critical infrastructure, when no alternatives can be arranged or if this loss of care would pose a (health) risk to the cared-for, there is a medical prescription for specific type of care.

	develops symptoms, or have had contact with an infected person in the past 14 days (95).
Lower Saxony	Day care services are cancelled. Services can only be provided to people in emergency situations ² (47).
Saarland	Part-time day or night time services are not allowed to be entered (49).
Saxony-Anhalt	Day or night care services are closed, unless people have an emergency need ² . Management of the institution decides on case by case basis (65).
Schleswig-Holstein	Day or night care services are closed, unless people have an emergency need ² (96).

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. (87)

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) (87). Information about the availability of financial support and reduced barriers to enter the scheme have also been provided by the state of **Saxony** and **North-Rhine Westphalia** (see Table 8) (97).

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) (98). 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 (73). Similarly, the Senate of Berlin provides a list of sources of support and advice for family carers (87,99).

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 (98).

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 (100).

Table 8: Overview of regulation and recommendations around unpaid care across federal states in Germany

<p>Bavaria</p>	<p>For 20 years there have been specialist agencies in Bavaria to provide advice for unpaid carers. These agencies have been advised to be available via telephone and e-mail (25).</p>
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<p>Berlin</p>	<p>Testing only if there is a reasonable suspicion (symptoms & contact to COVID-19 case or recent stay in an at risk area in the past 14 days (87).</p> <p>There are a number of neighbourhood initiatives that offer support (87).</p> <p>Sources of support for people with care needs and unpaid carers are care support centres. These centres offer neutral advice free of charge. These services currently only happen over the telephone. The availability of these services has been extended in terms of hours and is also available on Sunday and on bank holidays (99).</p> <p>AOK (<i>sickness fund</i>) care academic: the provision of advice on care at home during the COVID-19 pandemic (99).</p> <p>Voluntary visits to people with care needs had to stop, however, contact is maintained via telephone and advice also remains available (99).</p> <p>Care in distress, this source of advice can help people experiencing violence of conflict in their care. The hours for advice have been extended to support unpaid carers during this period (99).</p> <p>Silvernet – A telephone support service for lonely and isolated people (99).</p>
<p>Brandenburg</p>	<p>During the COVID-19 pandemic (until 31.05.2020) people with care needs in their everyday life can now also receive financial support for services they receive telephonically. This services has been put in place to enable people with care needs to live independently for as long as possible and to provide support for unpaid carers.</p> <p>The minister of social affairs explains that support to enable everyday life for people with care needs usually is offered through group interventions or hourly support in their own home. Due to the risk of infection this is currently not possible. Some of this contact time, however, could alternatively be provided via telephone or virtually to reduce the risk of social isolation (101).</p>
<p>North-Rhine Westphalia</p>	<p>People with care needs (levels 1 to 5) and are living at home can claim up to €125 per month from their care insurance for support or for relief of their unpaid carer. Those with care level 2 to 5 can use up to 40 per cent of the value of in-kind support to finance support with daily living. This money can be saved up over several months and moved forward into the other half of the calendar year. This funding can be used for group or individual support, household help, company to go shopping, company for administrative, medical or religious appointments, support to enable social contacts, company to attend cultural events or other leisure activities. Due to COVID-19 eligible services have been expanded to ‘services to the front door’ (shopping, running errands, pick-up or delivery services, organisation of administrative matters, personal conversations via telephone, skype or e-mail) until 30.9.2020 (102).</p> <p>In addition, requirements for reimbursable neighbourhood help have been eased. The person providing neighbourhood support does not require to provide a certificate until 30.9.2020 (102).</p>
<p>Rhineland-Palatinate</p>	<p>Advice for vulnerable groups: reducing visitors to a minimum. Reducing social activities (especially with relatives) (103).</p>

Saxony	<p>People with care needs can claim up to €125 per month from their care insurance to reimburse neighbourhood supporters for their help (shopping, laundry, food delivery, running errands (post, pharmacy). Usually neighbourhood supporters need to have recognised skills (participation in course, proof of experience) to be eligible for the scheme.</p> <p>The requirement to complete a course to be eligible for reimbursement has been lifted until 30 September 2020 (97).</p>
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4.6 Impact on people living with dementia and measured 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 (104).

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 (105).
- The chairman of the Foundation for Patient Protection (*Stiftung Patientenschutz*) criticised that residents in care and nursing homes so far had not been not 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 (106).

- 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 (107).
- On 24 April the German Society for Gerontology and Geriatrics (*Deutsche Gesellschaft für Gerontologie und Geriatrie*) published a statement paper on enabling the participation and social involvement of older people despite the COVID-19 pandemic. This statement has ten key demands:
 - *Chronologic age cannot not be an argument to withhold social participation.*
There are no scientific reasons for excluding older people disproportionately and blanket measures are ageist. It is a form of age discrimination.
 - *Countering stigma through the message that older people are an indispensable part of society.*
Older people as grandparents, partners, workers, volunteers, friends and consumers are an important part of society.
 - *Social participation in employment and volunteering*
Workers and volunteers should not be excluded based on chronologic age. It is important that based on a professional risk assessment hygiene measures are consequently implemented in work environments. Flanked by altering the work environment for workers with health risks these measures protect all workers and prevent ageist working culture. Organisations and institutions that work with volunteers should communicate the risks involved in volunteering and where appropriate help finding satisfying alternatives for people to pursue volunteering activities.
 - *Social participation of older people during the COVID-19 pandemic through radio and television*
Currently media report mostly about older people. It would be welcomed if older people would be given a voice in the media and if they were to be addressed as active people, able to take decisions and actions.
 - *Maintaining support structures even under the protective measures of the COVID-19 pandemic*

Service providers and authorities are requested to build up and expand innovative access especially to delivery-structures. This could include pharmacy, physiotherapy, ergotherapy, psychotherapy, delivery services or social services. Technical possibilities as well as social innovations are to be taken into consideration. The development and awareness raising around emergency numbers and emergency help to support older people in emergency situations should be part of the measures that should urgently be implemented so that older people and professional support providers can ensure people's participation and care.

- *Enabling opportunities for participation of people receiving care in the community and their relatives*

For the virus not to have dramatic consequences it is crucial that protective equipment becomes available without delay for people with care needs as well as for both unpaid carers and paid carers providing ambulatory care.

- *Enabling social participation of older people living alone*

Especially for this group it can be assumed that lacking social participation will not just lead to loneliness and depressive symptoms but may also cause considerable physical and cognitive damage through inactivity, malnutrition, lack of fluids, mismedication and medical under provision. This is also a risk for people in residential care settings focusing on autonomy and optional support structures. Locally organised support programmes in all areas of support for older people needs to be better coordinated. In addition to ambulatory care and the expansion of care service points, the provision of neighbourhood support and civic support play important roles in responding to the many new and diverse challenges that have occurred in the context of the COVID-19 pandemic.

- *Enabling social participation of older people in residential care settings*

The organisation demands to expand quickly the digitalisation of residential care settings and to also enable the use and usability of these resources through, for example, especially trained companions.

Social participation can also be enabled if the occupancy rate gets temporarily reduce to create conditions in which the recommended physical distancing can be maintained. It should be checked whether there are possibilities for mobile residents to temporarily move into rehabilitation settings or empty hotels. This would enable receiving visits from relatives and close friends. Protected areas could be established for these visits as they are known from infection wards in hospitals.

Concepts to support people with dementia and adequate forms of communication for people with dementia should be considered especially in the daily care routine during this crisis (e.g. through specific training of staff)

- *Enabling social participation in hospitals*

The concern around COVID-19 should not keep older patients from attending hospitals if they are in need of treatment, such as for cancer, severe heart disease or other illness that require hospital treatment. Hospitals are encouraged to make the development and implementation of intelligent and flexible concepts a priority to reduce social isolation to a minimum.

- *Avoiding paternalism and encouraging self-determination*

Older people need to be supported through balanced (not anxiety inducing) information to make a differentiated assessment of their situation including their individual resources and risk profile. Self-determination based on weighing-up their options should be supported (108).

5.2 Long-term implications

- The state government of Mecklenburg-Western Pomerania has decided to develop a pilot project over two years. Researchers of the Medical Universities Rostock and Greifswald will be investigating how diagnosis and therapy care pathways can be improved in the COVID-19 pandemic. In the first phase they will test residents and staff of nursing homes and ambulatory care homes. This is aimed to improve the prognosis of patients whose lives are at risk (61).

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