



INTERNATIONAL  
LONG TERM CARE  
POLICY NETWORK

# The Impact of COVID-19 on Long-Term Care in South Africa

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Corrections and comments are welcome at [info@itccovid.org](mailto:info@itccovid.org). This document was last updated on 31 May 2020 and may be subject to revision.

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# 1. Introduction

## 1.1. Socioeconomic challenges

South Africa is one of the most unequal societies in the world, with a Gini coefficient in 2015 of 0.63 (The World Bank, 2018a). The country faces the 'triple challenge' of high poverty (76% of the population), inequality, and unemployment.

Even before the massive and as yet unquantified loss of employment triggered by the Covid19 lockdown, the national unemployment rate at the first quarter of 2019 stood at 27.6% and the expanded unemployment rate (which includes people who have stopped looking for work) at 38% (StatsSA, 2019a).

Between 2011 and 2015, the poverty rate in South Africa increased from 36 to 40% (The World Bank, 2018a), with the economically dependent population outnumbering and relying upon a minority of employed individuals. Female-headed households, black South Africans, the less educated, the unemployed, and larger families experience higher levels of poverty in South Africa, especially those who live in rural areas (The World Bank, 2018a).

Prior to the outbreak of Covid19, South Africa's economy had already been crippled by years of corruption, maladministration, and growing government debt, which stood at US\$67,998 million in the third quarter of 2018 (Trading Economics, 2019). It is now being dealt a further blow by the combined costs of the Covid19 pandemic and the losses created by an extended hard lockdown. With long-term elder care not being a priority of the South African government, this represents a crisis for the current functioning and longer-term sustainability of the sector.

Owing to widespread poverty and unemployment, dependency on social grants from the South African government has grown to such an extent that in 2018 grants represented the second most common source of income (45.2%) for households nationally (StatsSA, 2019b). This exposes an economic threat to the country, as it illustrates how few economically active taxpayers are contributing to the country's revenue.

With many more South Africans now out of work due to the lockdown, the government has temporarily increased social grants and is providing financial relief for certain sectors of society, including through increasing unemployment insurance fund (UIF) payments. This, however, is contributing to government debt and further compromising the ability of the state to support vulnerable groups like the elderly in the future.

## 1.2. Health and safety challenges

Rates of non-communicable diseases (NCDs) in South Africa are very high. In 2016, 51% of all deaths were attributed to NCDs, including cardiovascular diseases (19%), cancers (10%), diabetes (7%), and chronic respiratory diseases (4%) (WHO, 2018). This is of great concern, considering the high mortality rates of people with chronic diseases who are dying with Covid19 as a comorbidity.

Compounding the chronic disease burden are the very high numbers of people living with communicable diseases such as HIV (an estimated 7.52 million people in 2018) (StatsSA, 2018)

and tuberculosis (TB), with an estimated 80% of the population infected, 301,000 active cases, and 63,000 people dying of TB in 2018 (WHO, 2019).

While the lockdown has temporarily reduced South Africa's high mortality rate due to homicide, road injuries and accidental gunshots, it is likely that deaths due to interpersonal violence (ranked as the eighth highest causes of premature death in South Africa in 2015) (Groenewald et al., 2017) will continue to plague vulnerable families, especially as stress increases due to confinement, joblessness, poverty and hunger.

### **1.3. The healthcare sector**

About 82% of South Africans (45 million) depend on public healthcare (StatsSA, 2017), this sector being governed by the National Department of Health (DoH). Provincial health departments are responsible for providing primary, secondary and tertiary care services through public clinics and hospitals (Mahlathi & Dlamini, 2015). Having to serve the vast majority of South Africans, these overburdened public healthcare services are further constrained by factors that include poor management, a shortage of professionals, weak service delivery, and the inadequate supply of products and technologies (for example, the limited availability of personal protective equipment (PPE) at this time).

Access to private medical care is largely contingent on whether South Africans have access to medical insurance, with only 17% (12.7 million) persons able to make use of these services (StatsSA, 2016, 2017a). The private sector consists of services provided by general practitioners, medical specialists and private hospitals and tend to be located in more urban areas (Mahlathi & Dlamini, 2015). Private healthcare is extremely expensive and unaffordable to the majority of the population

### **1.4. Government responsibility for dementia care**

The Ministries of Health, and Social Development are primarily responsible for the wellbeing of people living with dementia in South Africa. There is no representative within National Government who is responsible for dementia, nor is there a dementia-specific national policy or plan.

The relevant government programmes include:

- Department of Social Development (DSD): Older persons programme (South African Older Person's Forum).
- Department of Health (DoH): Non-communicable diseases.

According to the Older Persons Act (no.13 of 2006), the DSD is responsible for developing community-based programmes aimed at dementia prevention and promotion, as well as home-based care with regards to information, education, counselling services and care for Alzheimer's disease and dementia (amongst others) (see section 11 (2)(c) of the Older Person's Act, p.13) (Government Gazette, 2006). This Act also requires that services be provided for people living with dementia at residential facilities (see section 17 (b) and (d), p.17).

The White Paper on the Rights of Persons with Disabilities (Government Gazette, 09 March 2016, no.39792) also briefly mentions older persons with dementia (see p.71) (DSD, 2015).

Currently, no information is collected or analysed to assess the healthcare system's performance for persons living with dementia specifically.

With dementia remaining a low priority of the South African government, most support services for persons living with dementia and their families are provided by the NGO sector, for example Alzheimer's South Africa (ASA) and Dementia-SA.

## **2. Impact of COVID19 on long-term care users and staff so far**

### **2.1. Number of positive cases in population and deaths**

Covid19-related statistics are updated daily on the official government website, <https://sacoronavirus.co.za/> (see also <https://datastudio.google.com/reporting/1b60bdc7-bec7-44c9-ba29-be0e043d8534/page/hrUIB>). As at 13h30 on 31 May 2020, 725,125 tests had been conducted and 32,683 positive cases identified. A total of 16,809 recoveries and 683 deaths had been reported.

The rise in infections has been surprisingly slow in South Africa, possibly helped by the early implementation of a 'hard lockdown' which started at midnight on Thursday 26 March, when only 1,170 infections had been reported. The first death was only reported the following day (27 March 2020) ([https://en.wikipedia.org/wiki/COVID-19\\_pandemic\\_in\\_South\\_Africa](https://en.wikipedia.org/wiki/COVID-19_pandemic_in_South_Africa)).

### **2.2. Rates of infection and mortality among long-term care users and staff**

By the time of writing of this report, it was not possible to determine how many infections, recoveries or deaths from Covid-19 had occurred in long-term care facilities in South Africa. It was also not clear if these data were being collected and collated by government departments.

A member of the advisory group for the STRiDE Covid-19 project, who runs a care home at which there had been a suspected Covid-19 case, reported that the officials to whom she had reported the case did not record the fact that the person lived in a care home. However, in a [radio interview](#) on 28 May 2020, Mr Robert Mc Donald, Head of Social Development in the Western Cape, reported that the department was keeping a record of infections and that 140 people in 20 old age homes were known to have been infected, 65 of them being staff members.

These data were not freely available, however. In response to the death of a resident at [Sen-Cit Resthaven](#) Old Age Home in the Western Cape, Mr Joshua Chigome, spokesperson for the Western Cape Member of the Executive Council (MEC) for Social Development, [stated](#) that the DSD could not "disclose any confidential information on any old age home that has positive cases".

Consequently, the only available sources of information drawn on to produce this report have been the mainstream- and social media, as well as personal communications with colleagues in the sector.

It is of concern that, knowing that Covid-19 disproportionately affects older people, and having seen the devastation the disease has wrought in the elder care sector in other countries, the DSD, the national government department responsible for the sector, does not appear to be compiling and communicating statistics on infections and deaths in elder care facilities in South Africa.

A [follow-up article](#) about infections at Sen-Cit Resthaven reported that the home had waited 11 days to receive 32 positive test results from 60 Covid-19 tests conducted after a nurse had tested positive, during which time two residents had died of the virus. The report stated that they felt that “their pleas for help have fallen on deaf ears as they grapple with a crisis.” With so many staff self-isolating, the home was dealing with a serious shortage of carers.

Considering that the elderly are the most vulnerable to Covid-19, the home had expected the DSD and health authorities to act fast after they reported that a nurse, and a resident who had died in hospital, had both tested positive. The health authorities had arrived a day later than arranged, after a second resident admitted to hospital had also died.

The manager of the home stated that, “Our sadness and concern is that the government departments who are tasked to help are struggling to make a rapid and adequate response. Even the Disaster Management Team who I was told was contacted on our behalf has yet to make the promised site visit to assess how to assist us. We are a small organisation with limited resources and a huge task.”

### **2.3. Population level measures to contain spread of COVID-19**

Government advice to the public, available on their [official website](#), includes basic advice on avoiding infection, namely to:

- Avoid touching your eyes, nose, and mouth with unwashed hands
- Avoid close contact with people who are sick
- Cover your cough or sneeze with a flexed elbow or a tissue, then throw the tissue in the bin, and
- Clean and disinfect frequently touched objects and surfaces.

In March 2020, President Cyril Ramaphosa [announced](#) the start of the hard lockdown from 11:59 pm on Thursday, 26 March 2020. All South Africans would have to stay at home, unless strictly for the purpose of performing an essential service, obtaining an essential good or service, collecting a social grant, or seeking emergency, life-saving, or chronic medical attention. On 9 April, he announced the extension of the lockdown for a further two weeks until the end of April 2020.

On 23 April, the President announced a five-level risk-adjusted strategy, details of which can be found on the same [website](#). On 1 May 2020, Lockdown moved from Level 5 to Level 4, allowing a few people to return to work and people to exercise between 6 am and 9 am within five

kilometres of their homes. Wearing of cloth masks was mandatory unless at home. Since then, on 24 May 2020, he announced that on 1 June 2020 the country would move to Level 3, allowing many more people to return to work, people to exercise between 6 am and 6 pm, and limited grades to return to school.

### **3. Brief background to the long-term care system**

South Africa provides old-age pensions to persons who are financially needy (WHO, 2017). All older persons are entitled to free primary healthcare, while access to hospital care is free only for those who do not have the means to pay for these services. This includes long-term care services such as residential care services.

Long-term care in South Africa reflects the legacy of Apartheid, with availability of and access to residential care catering primarily for the older white population, while the care of older black South Africans is primarily a family responsibility (Lloyd-Sherlock, 2019).

The quality of long-term care services in South Africa is highly variable. This is especially obvious when public and private sector facilities are compared. Private care is limited to those who can afford it. Typical of the private sector in South Africa, it is expensive and inaccessible to most South Africans.

The South African government funds public long-term care for older persons, mainly through residential facilities (WHO, 2017). Public services cater for a small portion of the older population only and this is largely confined to urban areas (WHO, 2017). Persons seeking residential care must undergo a rigorous assessment process, and only the frail and destitute are eligible and will be admitted. The public sector cannot cope with the demand and long waiting lists present significant barriers, even for eligible persons (WHO, 2017).

Furthermore, the lack of training of primary healthcare nurses undermines efforts to create an integrated health- and social care system for older persons, especially in rural areas (Lloyd-Sherlock, 2019).

All registered facilities can apply for subsidies for individual residents, with eligibility restricted to the frail and destitute (South African Government, 2019). Reductions in subsidy amounts paid out by the Department of Social Development (DSD) has become a barrier to care, as it has resulted in facilities failing to provide services to poor, frail persons who are eligible, while admitting wealthier persons who can afford to pay (Lloyd-Sherlock, 2019).

Currently DSD subsidies cover 51.9% of the costs of frail care, with non-profit organisations left to cover the remaining costs, which amount to R3,800 per person per month (TAFTA, 2019).

Historical racial discrimination and cultural preferences in admissions restrict racial transformation and the care of all population groups at facilities. An audit of residential care homes in 2010 revealed that:

- Only 4% of residents across 405 homes were black

- Ten homes had physically separated white and black residents, and these groups had clearly not received the same quality of care
- In some instances, family members had threatened to remove older persons should homes become integrated, and
- There was very little knowledge of and sensitivity toward different religions and cultural practices (e.g. language and food preferences) (Department of Social Development, 2010; Lloyd-Sherlock, 2019; WHO, 2017).

There are an estimated 1,150 residential care homes for older persons in South Africa, of which 415 are officially registered with the DSD, as mandated by the Older Person's Act (Mahomed, 2017). Residential care is largely run by Non-profit Organisations (NPOs) and Faith-based Organisations (FBOs), and only eight of these registered facilities are managed directly and fully subsidised by the State (Lloyd-Sherlock, 2019; Mahomed, 2017).

All registered facilities can apply for subsidies for individual residents, but will only qualify if the older person is frail and destitute, in need of full-time care, 60 years and older, and a South African resident (South African Government, 2019). According to Dr Leon Geffen in a [webinar](#) hosted by the University of East Anglia on 1 May 2020, a concern relating to the Covid-19 lockdown is that it is the resident rather than the care home who is subsidised by the DSD. In the event that a resident should die during lockdown, that subsidy will be lost, and the home will not be able to admit a new resident, thus losing that income.

There are over 1,000 private sector long-term care facilities for older persons in South Africa (Mahomed, 2017). These include residential homes, retirement villages, frail care facilities, nursing homes and step-down facilities. Private facilities offer a range of long-term care services, such as assisted living, frail care, convalescence, as well as old age care (nursing/retirement homes). Residents can buy or rent accommodation and are responsible for the full cost of their stay.

Medical aid schemes in South Africa cover medical events, but long-term care such as frail care is rarely supported (Du Preez, 2015).

Most people living with dementia in long-term care facilities are looked after by caregivers who are supervised by nursing staff. While nurses are regulated by the South African Nursing Council (SANC), to date the caregiver sector is relatively informal and unregulated. Recommendations to the Older Persons' Act amendment bill have called for all caregivers of older persons to be registered with the DSD (SAHRC, 2017).

The DSD has published Generic Norms and Standards for Social Welfare Services that state that:

- together with the DOH, practitioners should be trained and understand the dynamics of ageing and disability when rendering services to older people, and
- the application of this understanding should be monitored through performance management (DSD, 2011).

However, according to Dr Leon Geffen, a doctor attached to various care homes in Cape Town, who addressed a [webinar](#) organised by the University of East Anglia, after ten years of trying, no training curriculum or register of caregivers exists.



The carer sector experiences high levels of attrition due to poor remuneration, challenging workplace conditions and workloads, lack of professional development, workplace insecurity, low morale, poor relationships with management, and risk to personal safety and health. The DOH reported a staff turnover rate of up to 80% in some provinces (DOH, 2011; Rawat, 2012; WHO, 2017).

## 4. Long-term care policy and practice measures

### 4.1. Whole sector measures

According to the [Western Cape Government](#), as a condition of registration, all old age homes run by NPO partners must have an infectious disease control policy and a disaster management plan in place. These are submitted to and monitored by the DSD. Having these in place would have helped to prepare care homes in their response to Covid-19.

The response of the South African Government to the threat to long-term care facilities of Covid-19 has been slow, vague and for most of lockdown period, inadequate. The first reference to 'Old Age Homes and Frail Care Facilities' was a list of four directives in the Government Gazette [No. 43182](#) published on 30 March 2020, Page 7, section (d) (i)-(iv): *Directions issued in terms of Regulation 10(5) of the regulations made under Section 27(2) of the Disaster Management Act, 2002 (Act No. 57 of 2002): Measures to prevent and combat the spread of Covid-19*. These included that: no clients be released from the facilities; no visitation be allowed during the lockdown period; the family reunification and interaction programme be suspended; and no new admissions be allowed, except in the case of persons with disabilities in distress.

When consulted on 28 May 2020, the National Department of Social Development's official website was found to provide no obvious information relating to the impact of Covid-19 on the elder care sector.

One of the first responses to Covid-19 in the Western Cape was the publication, on 6 May 2020, by the provincial DoH of *Circular H 70 of 2020: Preventing and managing coronavirus infection in the workplace*. This general document provided in-depth guidelines, including:

- Background on how the virus is spread and how to prevent its spread
- Advice on what to do if someone in the workplace is infected, and
- Additional guidance to specific sectors re preventing infection.
- Section C13 provided brief guidance to care facilities and old age homes on prevention of infection (recommending education and training, screening, social distancing, and the use of PPE) and management of a resident diagnosed with Covid-19.

On 7 May 2020, communication from the Western Cape DSD to long-term care facilities in response to the Level 4 Lockdown announcement, consisted of a one-page notice only. Entitled *Containment measures for Covid-19 at residential facilities (old age homes) for older persons under Lockdown – Level 4*, it simply stated that old age homes and similar facilities should:



- Practise good hygiene,
- Identify infected people and trace contacts,
- Not allow visitors, and separate new intakes until they were tested,
- Manage those found positive according to the World Health Organisation (WHO) guidelines,
- Implement an infection prevention and control programme, and
- Implement a safety programme referring to a disaster plan and dealing with clinical emergencies.

This was followed on 19 May 2020 (about two months after most care homes had gone into voluntary lockdown) by a two-and-a-half page *Circular H70: Protocol for funded residential facilities where there are suspected positive or confirmed positive Covid-19 cases*. Interventions required included:

- Training and advice: to implement the WHO guidance, and stating that homes would receive training materials and could get support with policies from the DoH
- Identification and testing: to practice protocols (screening, masks, sanitising hands, social distance) and, if there were concerns, phone the Covid-19 helpline
- Random testing arranged through a local health facility: this could be escalated to the DSD
- Infection and treatment: to isolate people with symptoms, contact a health facility for testing, and identify persons who had been in contact; to inform the DSD of confirmed cases of residents or staff members infected and what steps had been taken
- Vaccination: recommending the flu vaccine, and
- PPE: explaining that due to high demand, it was a challenge to get hold of these and that the DSD National and donors had been asked to help.

The document also stated that the DSD would continue to monitor containment of Covid-19 and give advice.

The Western Cape Department of Health (DoH) then published *Circular H77 of 2020: Guidelines for the prevention and management of coronavirus infection in healthcare facilities*, which was officially distributed on 13 May 2020. Although not specifically aimed at long-term care facilities, this proved helpful to the sector.

Thereafter, collaboration between the DSD and DoH finally resulted in the publication of [a guideline document](#) specifically for long-term care facilities, which was released on 21 May 2020, entitled *Practical guidelines for the prevention and management of coronavirus infection in long term care facilities (LTCF)*.

## **4.2. Care coordination issues**

### **4.2.1. Hospital discharges to the community**

This report focuses on long-term care facilities and not community-based care. However, the Disaster Management regulations state that care home residents may not be released to their communities during lockdown, so it would not be possible for a care home resident to be

discharged from hospital into the care of their families.

#### **4.2.2. Hospital discharges to residential and nursing homes**

According to guidelines, upon return to a long-term care facility, a patient should be placed in isolation and monitored for 14 days.

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

#### **4.3.1. Prevention of COVID19 infections**

For about the first two months after concerns about the impact of Covid-19 on long-term care facilities started mounting, the DSD referred care home managers to the WHO guidelines on preventing infections. As described above, at least in the Western Cape, detailed guidelines have since been developed for long-term care facilities by the DoH and DSD in the province.

Basic infection prevention and control include:

- Identifying a responsible officer, washing and sanitising of hands, respiratory etiquette, environmental cleaning and disinfection, ventilation, laundry, catering, receiving of goods and supplies, waste management and travelling to work.
- Physical distancing in the facility, including visitors, offices, residential areas, communal areas.
- Risk identification: daily screening, staff member risk assessments and work procedure plans, and workplace health risk assessments.

In addition to these measures, care homes have reported that they have also:

- Placed non-essential staff members on 'temporary lay-off' to reduce the number of people entering the premises; required essential staff to isolate themselves in the facility in which they were employed; accommodated essential staff members within the facility, ([Nazareth House](#))
- Introduced lockdown nine days before the official lockdown; trained staff to use PPE; issued face masks in mid-April for travelling and for use in the facility; no longer served food in communal rooms; quarantined all residents who needed hospitalisation, had medical appointments or had to leave the facility for urgent matters, for two weeks ([Highlands House](#)).

Despite over two months having elapsed since the official start of lockdown, it appears that relatively few infections or deaths from Covid-19 have been recorded in long-term care facilities in South Africa. For example, during a [radio interview](#) on 28 May 2020, a spokesperson for the NPO BADISA, which runs 47 old age homes accommodating 3,800 residents, reported that only three residents had tested positive, two of whom had later tested negative, and one of whom was in hospital.

This is, however, likely to change as the lockdown progresses into its third month, and as the country moves to Level 3 lockdown on 1 June.

On the same radio programme, a retirement home called Panorama Palms, despite having put extensive protocols in place, reported that 41 residents and 35 staff had tested positive since the first case had been detected on 15 May. The home partnered with a private lab and tested all staff, frail residents, and contacts of the first resident, discovering that even asymptomatic people tested positive. Now, as the manager reported, the greatest challenge is “having to do so much with so few” – dealing with the increased demands of accommodating, monitoring, and communicating with families about, those infected, while a large proportion of the staff are in quarantine.

Available media reports all confirm that, where infections and deaths have occurred, this has been in spite of close adherence to the guidelines.

Sources include:

[31 March 2020](#): Three more test positive for Covid-19 at Durban old age home

[31 March 2020](#): Covid-19 spreads tentacles into townships, old age homes

[6 April 2020](#): How Cape Town old age home [Kensington Home for the Aged] is ensuring safety for its elderly

[12 May 2020](#): Resident at Sen-Cit Old Age dies while tested positive for Covid 19, nurse also tested positive

[13 May 2020](#): Covid-19: As infections surge, how well are older persons in SA protected?

[13 May 2020](#): Covid-19: Nazareth House care home in Cape Town confirms death of third resident

[14 May 2020](#): How we are dealing with Covid-19 in care homes

[14 May 2020](#): Fears for elderly as more Covid-19 deaths reported at old age homes

[20 May 2020](#): 16 by Othello-aftreeoord met virus besmet

[26 May 2020](#): Old-age home's desperate pleas 'ignored' after two deaths, 32 positive cases

Despite being the government department responsible for lower socio-economic elder care facilities, according to the article *How we are dealing with Covid-19 in care homes*, the response from the DSD to the early outbreaks of Covid-19 in Western Cape care homes has been poor. When criticised about its response to the outbreak at Sen-Cit Resthaven, which receives funding from the DSD, the department’s response was that it did not “operate or own any residential facilities for older persons,” but that these were “independent from government and managed by a Board.”

The detailed guidelines that the DSD spokesperson stated had been circulated to care homes had not been released until nearly ten days after the outbreak at Resthaven. By then most care homes had developed their own policies and protocols. While there was a referral protocol in place, the home clearly experienced delays in both testing and in the results being provided (see *Old-age home's desperate pleas 'ignored' after two deaths, 32 positive cases*).

In a [radio interview](#), Robert Mc Donald, Head of the DSD in the Western Cape, acknowledged that the smaller independent homes in particular were battling to implement the measures outlined. Homes that were part of a larger organisation were coping better because their head offices had helped them to put these measures in place. He mentioned that BADISA had also assisted an independent home with staff when all their nurses had fallen ill.

A concern expressed by Dr Leon Geffen in a webinar hosted by the University of East Anglia, is that in subeconomic homes, residents may be accommodated in wards rather than in private or twin rooms, making social distancing unlikely.

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

According to the DSD, persons with symptoms or confirmed Covid-19 cases must be isolated, and the local health facility must be contacted to assist with testing. Ideally, persons who have been in contact with the confirmed case should be identified for testing. Strict hygiene protocols apply. Staff who test positive should immediately be relieved of their duties and placed on sick leave.

Managers need to inform the DSD as soon as there is a confirmed case at the facility and indicate what steps have been taken to manage situation. A decision-support guide is available to support decision making. Counselling should be offered.

One of the first care homes to be affected by Covid-19 was [Bill Buchanon](#) Home in Durban, KwaZulu-Natal. The manager described how they handled the situation: Four patients were isolated in a separate building, and one was in hospital. The nurses who treated only the four sick patients wore disposable hazmat suits. After each visit, the suit was disposed of in a box at the door.

Problems experienced included the financial impact of purchasing PPE, including the hazmat suits (this home had spent R350,000 buying supplies). Masks and hand sanitizer were in short supply and extremely difficult to find, and some companies ruthlessly exploited the situation by vastly inflating prices. At the time, the manager warned other care homes to stockpile masks and protective gear so that if the disease hit, they could protect their staff.

As an indication of the spread of Covid-19 panic, the manager of Bill Buchanon Home was approached by local banks, asking that healthy residents not come to the branches to collect their pensions.

At [Highlands House](#) in Cape Town, the day a resident became ill, a Covid-19 test was done. The resident died within 48 hours. Within 24 hours of getting the positive result, plans were put in place to test all residents who had been in contact, and all staff, totalling 30 tests. Fourteen staff were advised to quarantine at home. The next day management decided to test all staff and residents.

What followed may have been unprecedented in any care facility worldwide: more than 460 tests were conducted by private labs over 48 hours. Results were received within 48 hours and 12 residents and 26 staff tested positive. About 185 residents were quarantined in their rooms (which was very difficult for them) and 40 of 280 staff were quarantined or in isolation at home.

All positive residents were seen daily by a doctor who monitored their symptoms. Those who tested negative but presented with symptoms were retested. This was only possible because the facility is well-resourced.

At [Nazareth House](#) in Cape Town, after the first resident died, the movement of residents and staff was further restricted and a deep clean took place. An investigation was carried out to trace contacts, who were tested and placed in quarantine. The remaining residents were tested and three more were found to be infected. They were placed in isolation.

#### **4.3.3. Managing staff availability and wellbeing**

In a [radio interview](#), Robert Mc Donald, Head of the DSD in the Western Cape, noted that care homes were recognised as an essential service, and therefore staff were required to continue working. However, it was the movement of care home staff between their communities and the facility that presented the greatest risk of infection.

In the same interview, it was mentioned that the Cape Peninsula Organisation for the Aged (CPOA), with homes accommodating 2,300 residents, had offered to have their staff members sleep in, or to transport them to and from home in private vehicles in order to reduce the risk of infection through traveling on public transport. They had also provided all staff with PPE.

Sadly, at [Kensington](#) Home for the Aged, the home decided to ask some of the carers who live in township areas to stay at home because their lives were being threatened by some in the community who feared that they were bringing the virus to their communities from the care homes.

[Dr Leon Geffen](#) expressed concern that the DSD had not prepared many of the long-term care facilities to deal this situation. Staff members who had received minimal training and support from the DSD were fearful. Family members were also anxious and tended to lash out and blame the staff when family members became sick or died. This was profoundly unhelpful and disrespectful to people who were doing their best under extreme stress. Staff members often put their own health in jeopardy in their efforts to provide care. They needed to be supported rather than criticised.

#### **4.3.4. Provision of health care and palliative care in care homes during COVID-19**

To date, no official guidelines have been found dealing with this. Initially, care homes were dissuaded from sending all but emergency cases for medical attention.

### **4.4. Impact on people living with dementia and measures to support them**

All residents in long-term care facilities, whether living with dementia or not, have been struggling to come to terms with being confined to the homes, and in some cases for extended periods to their rooms, without any physical contact with their loved ones. In a [radio interview](#), Waldi Terblanche, BADISA's Coordinator for Disability and Elder Care programmes, stated that residents have been experiencing acute loneliness and an ongoing need for human contact. They are very concerned about the effect of social isolation on residents and have developed daily programmes to keep them busy and encouraged electronic contact with loved ones. They

hoped that it would soon be possible to allow contact with loved ones, but according to the regulations this might only be possible once Level 2 of lockdown was reached.

[Dr Leon Geffen](#) agreed that restricted access was psychologically difficult for both residents and their regular visitors. He observed that Covid-19 had immeasurably changed the lives of residents in care facilities because they were no longer able to socialise with friends. Residents living with dementia needed close contact with staff and were difficult to isolate in their rooms. They were frightened by staff wearing masks, which caused behavioural disturbances.

Lockdown is distressing for residents of long-term care facilities, as two elders living in a [Neighbourhood Old Age Home](#) (NOAH) in Cape Town explained:

*I'm a person who doesn't sit indoors much ... you miss the interacting with other people ... it is good to be amongst people. - Maureen Phillips*

*That personal contact though is what you need. That's really getting to everybody. Especially people my age, who have children and are always with them. [Doreen had to celebrate her birthday under lockdown without family.] I was all alone, which was very, very sad. I'm starting to feel very, very frustrated because I can't go anywhere. I am feeling very dispirited. It's a very scary situation to be in. - Doreen Stoltenkant*

The Manager of the [Kensington](#) Old Age Home agreed that it was very difficult for the residents, even though they tried to keep them occupied with music and activities. He drew attention to the impact of one of the uniquely South African lockdown regulations – the ban on the sale of tobacco products – which was having a negative impact on residents who had been smoking for decades.

## 5. Lessons learnt so far

The lessons in this section are drawn from the following sources:

1. Comments by Dr Leon Geffen, a medical doctor and the Executive Director of SIFAR (Samson Institute for Ageing Research), in two articles:
  - <https://www.spotlightnsp.co.za/2020/05/13/covid-19-as-infections-surge-how-well-are-older-persons-in-sa-protected/>
  - <https://www.groundup.org.za/article/how-we-are-dealing-covid-19-care-homes/>
2. An email from Wayne Devy, CEO of Nazareth Care, on 16 May 2020 to colleagues in the aged care sector, sharing insights from having experienced Covid-19 infections and deaths at Nazareth House and The Villa.
3. An email from Rob Jones, MD of Shire Retirement Properties, on 11 May 2020 to Vrye Weekblad and colleagues in the aged care sector, sharing insights from their experiences

4. An email from Syd Eckley, TruCare Consult Age, a Member of the Section 11 Committee on older persons of the SA Human Rights Commission, on 1 May 2020 to Vrye Weekblad and colleagues in the aged care sector, sharing background about the retirement and elder care sector in relation to Covid-19

A key dilemma of the Covid-19 lockdown – balancing safety and individual rights – was expressed by [Dr Leon Geffen](#), who referred to the severe limitations on the movement of older people in long-term care facilities: *We'd like to protect people. However, that means that we are limiting their rights and ability to go out and participate in their normal daily activities.*

## 5.1 Regulation and management of the elder care sector

- Very few elder care facilities in South Africa are owned and managed by the DSD. The care industry in South Africa is 98% voluntarily owned and managed, and therefore responsible for regulating themselves. The DSD is responsible to inspect and evaluate that the standards and norms set in *The Older Persons Act, No. 13 of 2006* are correctly applied. Unfortunately, this function does not always happen, meaning that some facilities may have been relatively unprepared for Covid-19.
- The DSD is responsible for registering and monitoring long-term care facilities in South Africa; however 25-28% of care facilities are not registered, including an increasing number of small care homes, normally situated in ordinary houses. This represents a risk to residents and staff, and the impact of Covid-19 in these homes is unknown and may not be accounted for.

## 5.2 A lack of government support

- In South Africa, the priority of government lies mainly with children and HIV-infected persons, not with older persons. This is reflected in the inadequate response of the government to the threat of Covid-19 to elder care sector, despite older people being recognised globally as the most vulnerable age group.
- Other than four points in the Government Gazette No. 43182 (30 March 2020), no directives or guidelines pertaining to older persons were issued by the authorities nationally. Organisations therefore had to produce their own guidelines and many facilities struggled to do so on their own, especially the smaller independent homes that lacked the support of a head office infrastructure.
- The DSD has provided little to no assistance to care homes, with facilities where residents receive government subsidies receiving some masks and hand sanitizer only. One care home where residents had died reported that there had been no response to a request for psychosocial support or counselling for staff and residents. The DSD needs to provide



support to facilities that lack resources and staff and cannot afford the costs of infection prevention and control.

- The DoH has been unable to provide much assistance, as they have minimal swabs, and many staff have been in quarantine due to infection. Homes therefore have had to fend for themselves and arrange their own swabs and testing. Care homes are therefore advised to train staff to do the swabs and manage the paperwork, and to identify local doctors to assist.
- Because the DoH will only swab those who screened positive and are symptomatic, infected but asymptomatic staff may continue to work, resulting in the infection of residents and staff previously confirmed negative.
- The turnaround time for tests can be 4-5 days in the private sector and 8-11 days in the public sector, due to a huge backlog of tests at the state-run National Health Laboratory Service. This makes testing everyone both expensive and pointless, as by the time the results are available, someone who tested negative may well have been infected.

### 5.3 Long-term care facilities' responses to Covid-19

- Having witnessed devastating scenes unfolding in other countries, care homes and care centres within retirement villages did not wait for government permission or guidance but responded rapidly to the threat of Covid-19.
- The response was firm and unapologetic, erring on the side of caution. Actions taken included:
  - Going into voluntary lockdown before the official announcement
  - Introducing a Covid-19 infection control officer to co-ordinate the implementation of protocols
  - Increasing monitoring to ensure compliance
  - Encouraging staff to stay on site, and ensuring that these staff were accommodated according to the zones in the facility where they worked
  - Allocating one person to do the shopping, and sanitising items entering the home
  - Reducing the use of public transport by transporting staff privately
  - Having a color-coded system to identify isolation zones within the home and the staff allocated to these zones (colour-coded badges)
  - Cleaning more thoroughly.
- Even with the most stringent controls, infections can occur. As [Dr Geffen](#) stated, *“It’s important to temper expectations and accept the grim truth. No matter what we do, there will be Covid-19 outbreaks in care homes and people will die. Once infections get into a care home, it’s likely that within a few weeks, most of the residents will be infected.*

- At the same time, though, it needs to be remembered that Covid-19 is not the only cause of death in long-term care facilities at this time. Many residents are also terminally ill, with existing medical conditions and comorbidities.
- Older persons who need ordinary health and medical care and possible operations have been forced to go without these services. Hospitals have been found to be a source of infection for some care homes, with returning residents being infected with Covid 19.
- Some residents who have died have shown no symptoms. Only once positive test results have been received have people realised that the virus had been present in the facility for at least two weeks.
- The possibility of managers and administrators getting infected should not be underestimated. Facilities should ensure access to information by more than one person. Consider the contingency of the general manager, nursing services manager or registered nurse being infected. The shortage of staff becomes a real threat to the care of residents.
- Contract service providers (e.g. catering, cleaning and laundry staff) who have been infected have been quickly isolated, tested and replaced. Finding replacement staff is proving difficult as increasing numbers become infected.
- Tests have been carried out in some homes based on contact with known positive cases rather than on detection of symptoms.
- Many residents in care homes are highly dependent on close contact with staff who wash, dress, and feed them, brush their teeth and hair, and assist them with the toilet and walking. It is not possible to practise 'social distancing' in these situations.
- The willingness to share policy and opinion between facilities has been a great help.
- Family members and communities have in many cases been helpful and supportive.

#### **5.4 Financial and resource issues**

- The response to the virus reflects South Africa's highly unequal society, with wealthy homes being able to afford to test all their staff and residents privately, but others having limited testing and having to wait more than ten days for results from overburdened public laboratories.
- The cost of testing and PPE is far too high. A private lab test costs about R850, the price of hand sanitisers has increased nearly four-fold, and one disposable mask costs R15.
- In addition to the vastly increased expenses caused by Covid-19, many retirement villages and care homes are unable to earn an income from the resale of units during the lockdown.

The long-term financial implications of Covid-19 and the lockdown on this sector are likely to be dire.

## 5.5 Emotional concerns

- Staff at long-term care facilities are concerned for themselves and their families, and rightfully so.
- The media have contributed to panic amongst the staff, who tend to equate a positive test result with a death sentence.
- There have been numerous training programmes on managing the virus at work and at home, but these have tended to focus on clinical aspects and prevention. It is imperative for staff to be educated about the actual percentages of people at risk, infected, and deceased, in order to reduce the fear of the virus.
- As panic spreads through facilities, staff have been absconding and/or self-isolating, even if they work in a different unit at the facility.
- Many staff expect to be tested and do not understand that they have to be symptomatic before they will be tested by the DoH.
- Support, in the form of counselling, therapy and debriefings, needs to be made available. As residents test positive and die, staff members feel the pain and responsibility. Those living in and not seeing their families also need assistance.
- Some homes that have experienced deaths from Covid-19 have experienced harassment from reporters and the sensationalising of the situation in the media. This is extremely stressful for organisations and individuals trying their best to protect residents and staff. A home that experienced this recommends that residents, staff and families be asked to forward all requests for information to a designated spokesperson. He warned that reporters had made up stories in order to get a response from staff members.
- The emotional pressure on older persons living in isolation is disturbing for residents, family members and staff. There have been reports that some very frail persons have just given up and died because they were not able to bear the stress and loneliness.
- Lockdown has had the most adverse effects on residents in the early stages of dementia, who struggle to understand the changes to routine and the lack of visits.
- Due to concerns for the mental wellbeing of residents, some homes have been allowing visits from family members, especially during end-of-life periods. This isolation cannot continue without taking measures to ease their distress and loneliness.

- We do not know what lasting effect the Covid-19 lockdown will have on older persons in long-term care facilities, especially those living with dementia. It is highly likely that trauma- and grief counselling services will be needed to assist staff, residents and family members to come to terms with the long-term effects of the Covid-19 lockdown.

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